Center for Medicare Advocacy
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MEDICARE SKILLED NURSING FACILITYCOVERAGE

Se habla español

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Medicare Part A covers care in a skilled nursing facility (SNF) for up to 100 days during each spell of illness. If coverage criteria are met, the patient is entitled to full payment for the first 20 days of care. From the 21st through the 100th day, the patient is responsible for a daily co-insurance amount which generally increases each year.

Unfair denials of Medicare coverage for skilled nursing facility care occur with surprising frequency. Because Medicare uses rules and procedures which may improperly restrict coverage, patients are sometimes required to pay for care which should be covered by Medicare.

Medicare should pay for skilled nursing facility care if:

- The patient received **inpatient** hospital care for at least three days and was admitted to the SNF within 30 days of hospital discharge. (In unusual cases, it can be more than 30 days.)

  Important: Be certain that the patient was admitted to the hospital by the treating physician as an inpatient and not under "observation status." Observation days in the hospital do **not** count as inpatient days and will not satisfy Medicare requirements for SNF coverage.

- A physician certifies that the patient needs SNF care.
- The beneficiary requires skilled nursing or skilled rehabilitation services, or both, on a daily basis. Skilled nursing and skilled rehabilitation services are those which require the skills of technical or professional personnel such as nurses, physical therapists, and occupational therapists. In order to be deemed skilled, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.
- The skilled nursing facility is a Medicare certified facility.

IMPORTANT ADVOCACY TIPS

- The restoration potential of the patient is not the deciding factor in determining whether skilled services are needed. As set forth in the *Jimmo v. Sebelius* settlement, Medicare coverage for skilled services does not require that the beneficiary's condition improve. The need for skilled services to prevent or slow a decline in condition is considered reasonable and necessary.

- The management of a plan involving only a variety of "custodial" personal care services is skilled when, in light of the patient's condition, the aggregate of those services requires the involvement of skilled personnel.

- The requirement that a patient receive medically reasonable and necessary "daily" services will be met if skilled rehabilitation services are provided five days per week or skilled nursing services are provided seven days per week.

- Some examples of skilled services:
  - Overall management and evaluation of care plan;
  - Observation and assessment of the patient's changing condition;
  - Ongoing assessment of rehabilitation needs and potential;
  - Therapeutic exercises or activities;
  - Gait evaluation and training;
  - Intravenous or intramuscular injections;
  - Enteral feedings.

- The doctor is the patient's most important ally. If it appears that Medicare coverage will be denied, ask the doctor to help demonstrate that the standards described above are met.

- If the nursing home issues a notice saying Medicare coverage will end, appeal.

Don't be satisfied with a Medicare determination unfairly limiting coverage; appeal for the benefits the patient deserves.

- If the denial is oral (no written notice), call the Center for Medicare Advocacy for advice.
- If the denial is in writing, appeal.

FIRST STEP TO APPEAL A MEDICARE DENIAL

- Two days prior to Medicare coverage ending, the skilled nursing facility (SNF) should provide a written notice stating when and why Medicare covered-care will end.

- The notice will include the telephone number for the Beneficiary Family Centered Care Quality Improvement Organization (QIO).
  - In Connecticut this number is (866) 815-5440
- To appeal the Medicare denial, you must call the QIO no later than noon of the day following *receipt of the notice.*
  - *Speak to the patient's doctor* and ask the doctor to also call the QIO explaining why the patient still needs skilled care in the SNF
- The QIO should issue a decision within 72 hours. In the event the QIO denies coverage, consider appealing to the next step. To do so, follow the instructions on the QIO notice.

RESTORATION POTENTIAL IS NOT REQUIRED TO OBTAIN MEDICARE COVERAGE.

- Medicare is available if a skilled professional is needed to maintain current capabilities or prevent further deterioration.

- Medicare coverage should not be denied simply because the individual's condition is chronic or expected to last a long time.

For more assistance and to obtain a copy of our Skilled Nursing Facility Self-help Packet visit the Center's website at www.MedicareAdvocacy.org

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QUALITY OF CARE COMPLAINTS

- To report poor quality of care in a skilled nursing facility, contact the BFCC-QIO or your State's nursing home Survey Agency

- In Connecticut, the QIO telephone is (866) 815-5440, the State Survey Agency telephone is (860) 509-7400

RESTORATION POTENTIAL IS NOT REQUIRED TO OBTAIN MEDICARE COVERAGE.

MEDICARE IS AVAILABLE IF A SKILLED PROFESSIONAL IS NEEDED TO MAINTAIN CURRENT CAPABILITIES OR PREVENT FURTHER DETERIORATION.

MEDICARE COVERAGE SHOULD NOT BE DENIED SIMPLY BECAUSE THE INDIVIDUAL'S CONDITION IS CHRONIC OR EXPECTED TO LAST A LONG TIME.

Need help?

Contact your State's Health Insurance Assistance Program (SHIP)

In Connecticut, this is CHOICES, (800) 994-9422.

There is also a great deal of information and Self-help packets on the Center for Medicare Advocacy's website:
www.MedicareAdvocacy.org

HELP US KEEP THIS INFORMATION AVAILABLE!

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CENTER FOR MEDICARE ADVOCACY, INC.

The Center for Medicare Advocacy, founded in 1986, is a national non-profit law organization that works to ensure fair access to Medicare and quality health care. The Center is based in Connecticut and Washington, DC, with offices around the country.

Based on our work with real people, the Center advocates for policies and systemic change that will benefit all those in need of health care coverage and services.

Staffed by attorneys, legal assistants, nurses, and information management experts, the organization represents thousands of individuals in appeals of Medicare denials. The work of the Center also includes responding to over 7,000 calls and emails annually from older adults, people with disabilities, and their families, and partnering with CHOICES, the Connecticut State health insurance program (SHIP).

Only through advocacy and education can older people and people with disabilities be assured that Medicare and health care are provided fairly:

- We offer education and consulting services to help others advance the rights of older and disabled people and to provide quality health care.

- We draw upon our direct experience with thousands of Medicare beneficiaries to educate policy-makers about how their decisions play out in the lives of real people.

The Center for Medicare Advocacy is the most experienced organization for Medicare beneficiaries and their families.

Visit our website:
www.MedicareAdvocacy.org