Helping Older Persons With Legal & Long-Term Care Problems

Medicare & Skilled Nursing Facility Care

1. When Does Medicare Cover Skilled Nursing Facility Care?

Skilled nursing facility (SNF) care is generally covered by Medicare Part A if you were admitted to a SNF within 30 calendar days after the date of discharge from an inpatient hospitalization of at least 3 consecutive days, not counting your day of discharge. Also, your doctor must order and you must receive either skilled nursing services on a daily basis or skilled rehabilitation services 5 or more days a week. You must need care for a condition treated during the qualifying hospital stay or that occured in the SNF while you were being treated for a condition that arose during the hospital stay. Medicare does not cover custodial care. [1]

2. How Much Of My Skilled Nursing Facility Stay Will Be Paid By Part A?

Once you meet the above Part A criteria and as long as you continue to receive skilled nursing or rehabilitation services, Medicare will cover up to 100 days in a SNF. Medicare will pay the entire cost of your first 20 days but you must pay a $204 (2024) co-payment for each of days 21 through 100 during any one benefit period.

If you are on a Medicare Advantage Plan (MAP), you should review its co-payment policies as many MAPs have higher co-payments than original Medicare. You may have to pay more or all of your SNF care if you don't tell your MAP before you are admitted. It may be less expensive to go to a SNF that is in your network. [2]

3. How Does Hospital Outpatient Status Affect Medicare SNF Coverage?

Hospitals can admit patients as inpatients or outpatients. Outpatients are admitted under observation status and are covered by Part B. Inpatients are covered by Part A. If the hospital classifies you as an outpatient for too long you will not meet the 3-day inpatient stay requirement for Medicare coverage of a SNF stay. As a result, you will have to pay for a posthospital stay at a SNF out-of-pocket.

If a hospital puts you on observation status and you receive this outpatient service for 24 hours, the hospital is required to notify you within 36 hours. The hospital

is required to explain its reasoning and the implications of outpatient status, including its effect on SNF coverage. While there has been no way to appeal, the government is now drafting regulations that will allow you to appeal a hospital's decision to reclassify you as an outpatient. [3]

4. What Services Are Covered If I Qualify For Part A SNF Coverage?

Medicare-covered services can include:

a) Semi-private room (a room you share with other patients)
b) Meals
c) Skilled nursing care
d) Physical therapy
e) Occupational therapy
f) Speech-language pathology services
g) Medical social services
h) Drugs and biologicals
i) Medical supplies and equipment used in the facility
j) Ambulance transportation (when other transportation endangers health) to the nearest supplier of needed services that aren't available at the SNF
k) Dietary counseling
l) Swing bed services. [4]

5. What Are Skilled Nursing And Skilled Rehabilitation Services?

Skilled care nursing and rehabilitation services are services ordered by a physician that can only be safely and effectively performed by professional health personnel or under their supervision. Skilled care must be necessary to improve or maintain your current condition or to prevent or slow the deterioration of your condition.

Skilled services are provided or generally supervised by a registered nurse, licensed practical nurse, physical or occupational therapist, speech pathologist or audiologist. General supervision means that the supervisor provides the initial direction and periodically inspects the actual activity. However, the supervisor does not always need to be present when services are performed.[5]

6. What Determines Whether A Service Is Skilled?

Skilled services are so complex that they cannot be performed safely and effectively without the general supervision of a professional and technical personnel. Although your doctor will consider your medical condition when deciding if you need skilled services, your diagnosis or prognosis should not be the only factor. Medicare also covers services that require skilled personnel to prevent further deterioration or preserve current capabilities.

A non-skilled service can also be considered skilled if medical complications require skilled personnel. For example, a plaster cast on a leg usually does not require

skilled care, but skilled personnel may be needed to watch for complications if you have a preexisting acute skin condition or need traction. [6]

7. What Are Examples Of Covered Skilled Nursing Services?

Services that can qualify as skilled nursing services include:

a) Intravenous or intramuscular injections and intravenous feeding.
b) Certain enteral feeding;
c) Nasopharyngeal and tracheostomy aspiration;
d) Insertion and sterile irrigation and replacement of suprapubic catheters;
e) Application of dressings involving prescription medications and aseptic techniques;
f) Treatment of extensive decubitus ulcers or other widespread skin disorder;
g) Heat treatments specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate the patient's progress;
h) Initial phases of a regimen involving administration of medical gases;
i) Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment, e.g., the institution and supervision of bowel and bladder training programs. [7]

8. What Are Examples of Covered Skilled Rehabilitation Services?

Services that can qualify as skilled rehabilitation services include:

a) Services needed to develop a patient care plan and for ongoing assessment of rehabilitation needs and potential;
b) Therapeutic exercises or activities;
c) Gait evaluation and training if they can significantly improve your walking ability;
d) Range of motion exercises;
e) Maintenance therapy;
f) Ultrasound, short-wave, and microwave therapy;
g) Hot packs, hydrocollator, infra-red treatments, paraffin baths, and whirlpool baths if you have medical complications; and
h) Speech pathologist or audiologist services necessary to restore speech or hearing. [8]

9. What Are Examples of Services That Are Not Skilled?

Personal care services are usually not considered skilled services because they normally do not require the skills of qualified technical or professional personnel. They are only considered skilled nursing services when they require skilled personnel because of a special medical complication. Personal care services can include:

a) Administration of routine oral medications, eye drops, and ointments;
b) General maintenance care of colostomy and ileostomy;
c) Routine services to maintain satisfactory functioning of indwelling bladder catheters;

d) Changes of dressings for noninfected postoperative or chronic conditions;
e) Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;
f) Routine care of the incontinent patient, including use of diapers and protective sheets;
g) General maintenance care in connection with a plaster cast;
h) Routine care in connection with braces and similar devices;
i) Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator;
j) Routine administration of medical gases after a regimen of therapy has been established;
k) Assistance in dressing, eating, and toileting;
l) Periodic turning and positioning in bed; and
m) General supervision of exercises which have been taught to the patient including maintenance programs and performance of repetitive exercises. [9]

10. Medicare Will Not Pay For My SNF Services. Do I Have To Pay?

If the care you receive while you are in a SNF will not be covered by Medicare, you must be personally given advanced written notice two days before the termination of services. You or your representative must sign and date the notice for it to be valid.

Only if in-person delivery is not possible can the notifier deliver notice to you by other means such as direct telephone contact, mail, secure fax, or internet email. The notifier must receive a response from you or your representative to validate delivery. Telephone contact must be followed up with a hand-delivered, mailed, emailed or faxed notice. Notification that is not made in person must be documented. To considered effective, you cannot have disputed that contact was made.

This protection is strictly regulated and the SNF must carefully follow proscribed procedures for the advance written notice to be considered effective. In most cases, you cannot be charged for services if you do not receive proper notice. [10]

11. I Received A Notice of Medicare Non-Coverage. What Should I Do?

Medicare beneficiaries are often turned down for coverage when Medicare law is interpreted too strictly by an insurance company or other agency that oversees Medicare. If a SNF denies your Medicare claim, you should appeal. Remember that wrongful claim denial is common. Denials are frequently reversed on appeal. [11]

12. What Can I Do If I Am Told That Medicare Will Not Cover My Care?

First, request a copy of the written Medicare denial from the SNF. If the SNF has not submitted a claim to Medicare, ask that it do so as a Medicare claim that the patient insists be submitted.

For Original Medicare, once the Medicare contractor makes a determination, you can appeal within 120 days by asking in writing for a redetermination of the decision. If

the redetermination is adverse, you may request a reconsideration by a Qualified Independent Contractor (QIC) within 180 days. If coverage is again denied, and the amount in controversy is at least $180 (2024) you can request a hearing before an Administrative Law Judge (ALJ) within 60 days. If the ALJ rules against you, you can request a review of the ALJ decision by the Medicare Appeals Council within 60 days of receiving the denial notice. You can appeal the Appeals Council's decision to a federal district court within 60 days of receiving the denial if the amount in controversy is at least $1,840.[12]

There is also an appeals process for those on Medicare Advantage plans. The appeal times are much shorter, you have as little as 60 days from the date of a decision to the next administrative level. [13]

13. Where Can I Get Help?

If you live in Ohio, Pro Seniors can give you free information. We may be able to help or refer you to an attorney who may take your case for a reduced fee. For more information, call Pro Seniors' Senior Legal Helpline at (513) 345-4160 or (800) 488-6070.

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Pro Seniors' Legal Helpline for Older Ohioans provides free legal information and advice by toll-free telephone to all residents of Ohio age 60 or older. If you have a concern that cannot be resolved over the phone, then the hotline will try to match you with an attorney who will handle your problem at a fee you can afford.

In southwest Ohio, Pro Seniors' staff attorneys and long-term care ombudsmen handle matters that private attorneys do not, such as nursing facility, adult care facility, home care, Medicare, Medicaid, Social Security, protective services, insurance and landlord/tenant problems.

This pamphlet provides general information and not legal advice. The law is complex and changes frequently. Before you apply this information to a particular situation, call Pro Seniors' free Legal Helpline or consult an attorney in elder law.

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Endnotes: [*Click the endnote number "[1]" to return to the text*]

[1] 42 C.F.R. § 409.30; 42 C.F.R. § 409.31; 42 C.F.R. § 409.34; 42 U.S.C. § 1395y(a)(9).

[2] 42 C.F.R. § 409.61(b); 42 C.F.R. § 409.85; Centers for Medicare & Medicaid Services, Medicare Coverage of Skilled Nursing Facility Care, p. 7, available at https://www.medicare.gov/Pubs/pdf/10153-Medicare-Skilled-Nursing-Facility-Care.pdf.

[3] 42 U.S.C. § 1395cc(a)(1)(Y); 42 C.F.R. § 405.926(u); 88 Federal Register 89506 (Dec. 27, 2023); *see also*, Current Developments in Medicare & Nursing Home Practices, A summary of a presentation by Toby Edelman, Senior Policy Attorney, Center for Medicare Advocacy, Bifocal, A Journal of the ABA Commission on Law and Aging, Volume 39, No. 5, May-June 2018.

[4] 42 C.F.R. § 409.20(a); see generally, 42 C.F.R. §§ 409.20–409.27. Centers for Medicare & Medicaid Services, Skilled nursing facility (SNF) care, available at https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care.

[5] 42 C.F.R. § 409.31; Medicare Benefit Policy Manual, Coverage of Extended Care (SNF) Services Under Hospital Insurance, Ch. 8, §§ 30.2.1, 30.2.2 (Oct. 5, 2023); Centers for Medicare & Medicaid Services, Skilled nursing facility (SNF) care, available at https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care.

[6] 42 C.F.R. § 409.32; *see also* Medicare Benefit Policy Manual, Coverage of Extended Care (SNF) Services Under Hospital Insurance, Ch. 8, § 30.2.2 (Oct. 5, 2023).

[7] 42 C.F.R. § 409.33(b).

[8] 42 C.F.R. § 409.33(c).

[9] 42 C.F.R. § 409.33(d).

[10] 42 C.F.R. 405.1200 (Original Medicare); 42 C.F.R. § 422.624 (Medicare Advantage); Medicaid Claims Processing Manual, Financial Liability Protections, Ch. 30, §§ 50.5 to 50.9 (Dec. 20, 2023).

[11] *See* 42 C.F.R. § 405.904 , 42 C.F.R. § (Original Medicare); 42 C.F.R. §§ 422.560–422.634 (Medicare Advantage); *see* U.S. Department of Health and Human Services Office of Inspector General, Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials (Sept. 2018).

[12] *See* HHS Primer: The Medicare Appeal Process, available at https://www.hhs.gov/sites/default/files/omha/files/medicare-appeals-backlog.pdf; Centers for Medicare & Medicaid Services, Original Medicare (Fee-for-service) Appeals, Third Level Appeal & Fifth Level of Appeal, available at https://www.cms.gov/medicare/appeals-grievances/fee-for-service.

[13] *See e.g.* Centers for Medicare & Medicaid Services, Appeals if you have a Medicare health plan, available at https://www.medicare.gov/claims-appeals/file-an-appeal/medicare-health-plan-appeals-level-1-reconsideration; Centers for Medicare & Medicaid Services, Medicare health plan appeals - Level 1:

Reconsideration, available at https://www.medicare.gov/claims-appeals/file-an-appeal/medicare-health-plan-appeals-level-1-reconsideration.