Helping Older Persons With Legal & Long-Term Care Problems

Medicare Coverage of Skilled Nursing Facility Care

1. When does Medicare cover nursing facility care?

Skilled nursing facility (SNF) care is covered if you were admitted to a nursing home within 30 calendar days after the date of discharge from a hospitalization of at least 3 consecutive days. 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***. Medicare does not cover custodial or intermediate care in a nursing facility..

2. How much of my skilled nursing facility stay will be paid by Medicare?

Medicare will cover a total of 100 days in a SNF. Medicare will pay for your first 20 days in a SNF. You must pay a $105.00 co-payment (2003) for each day of days 21 through 100 during any one spell of illness.

If you are in a Medicare HMO, you should review their co-payment policies very carefully, as many HMOs have even higher SNF co-payments than traditional Medicare in 2003.

3. What services are covered if I qualify for Medicare skilled nursing facility coverage?

Medicare coverage of skilled nursing facility services includes

(a) nursing care provided by or under the supervision of a registered nurse;
(b) bed and board;
(c) physical, occupational or speech therapy;
(d) medical social services;
(e) drugs, biologicals, supplies and equipment; and
(f) other services necessary to your health.

4. What are skilled nursing and skilled rehabilitation services?

Skilled nursing and skilled rehabilitation services are services that 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. What determines whether a service is skilled?

A service is skilled if it is so complex that it cannot be performed safely and effectively without the general supervision of a skilled person. 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 covers services that require skilled personnel whether or not you are expected to fully recover.

A non-skilled service can also be considered skilled if certain medical complications require skilled personnel.

6. When is overall management and evaluation of a care plan a skilled service?

This is considered skilled nursing if your physical or mental condition requires a skilled person to plan, perform and meet your medical needs, and to do what is necessary to help you recover and to ensure medical safety.

For example, an older patient with diabetes and high blood pressure who is recovering from an open reduction of a fracture could qualify for skilled service. This patient's need for specialized skin care, diabetic diet, oral medication, an exercise program to maintain muscle tone and body condition and observation to detect signs of deterioration requires a skilled person to understand the relationship between the services and to evaluate the effectiveness of the care plan.

7. When are observation and assessment skilled services?

Observation and assessment are considered skilled services when the skills of a technical professional are required to identify and to evaluate your need to modify treatment for additional medical procedures.

For example, a patient with congestive heart failure may need to be closely watched to detect signs of abnormal fluid or a bad reaction to medication.

8. What are examples of direct skilled nursing services?

Examples of these services are

(a) intravenous, intramuscular or subcutaneous injections or feeding;
(b) nasogastric tube feedings; insertion and sterile irrigation and replacement of catheters;
(c) application of dressings involving prescription medications and aseptic techniques;
(d) treatment of extensive decubitus ulcers or widespread skin disorders;
(e) physician-ordered heat treatments that require a skilled professional to observe the progress; and
(f) rehabilitative bowel and bladder training.

9. What physical therapy procedures are covered?

Generally, these procedures are covered:

(a) range of motion, strength, balance, coordination, endurance and ability tests;
(b) therapeutic exercises that are supervised by a physical therapist;
(c) gait evaluation and training if they can significantly improve your walking ability;
(d) ultrasound short-wave microwave and diathermy treatment; and
(e) hot packs, infra-red treatments and whirlpool baths if you have medical complications.

10. When is maintenance therapy a skilled service?

It is skilled if you need a physical therapist to carry out your doctor's treatment plan and to regularly re-evaluate your condition and exercise program.

11. What services are not skilled?

Unless you have a medical complication requiring these services, they are not skilled and will not be covered by Medicare:

(a) administering routine oral medications and ointment;
(b) maintaining and routinely servicing indwelling bladder catheters;
(c) changing dressings for noninfected postoperative or chronic conditions;
(d) preventing skin disorders;
(e) using heat for comfort;
(f) administering medical gases after establishing a therapy regimen; and
(g) changing the position of a patient in bed.

12. Do I have to pay for skilled nursing care I did not know Medicare would deny?

If the care you receive while you are in a nursing home will not be covered by Medicare, you must be given advanced written notice. In most cases, you cannot be charged for services if you do not receive this notice.

13. If my Medicare claim is turned down, is this a final decision?

No. 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 skilled nursing facility denies your claim, you should appeal. It's easy and costs you nothing. Remember that wrongful denial is common. In fact, almost 50% of these denials are reversed on appeal.

14. 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 skilled nursing facility (SNF). If the SNF has not submitted a claim to Medicare, ask that they do so as a Medicare claim that the patient insisted be submitted.

Once the Medicare intermediary (such as an insurance company) makes a determination, you can appeal within 4 months by writing to ask for a reconsideration of the decision. If coverage is denied, you can request a hearing before an Administrative Law Judge (ALJ) within 60 days if the bill is more than $100. If the ALJ rules against you, you can request a review of the ALJ decision by the Social Security Appeals Council within 60 days of receiving the denial notice. If the bill is at least $1,000, you can appeal the Appeals Council's decision to a federal district court.

15. Where can I get help?

If you live in Ohio in Butler, Clermont, Clinton, Hamilton or Warren County, contact Pro Seniors' for free help with appealing Medicare home health or skilled nursing facility denials. Pro Seniors' Health Care Consumer Rights Project can also help you appeal other types of Medicare denials.

If you live elsewhere in Ohio, outside the five-county southwest Ohio area, Pro Seniors can give you free information and refer you to an attorney who may take your case for a reduced fee. For more information, call **Pro Seniors' Free Legal Hotline at (513) 345-4160 or (800) 488-6070.**

Pro Seniors' Legal Hotline 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 Hotline or consult an attorney in elder law.

Pro Seniors, Inc.
7162 Reading Rd.
Suite 1150
Cincinnati, Ohio 45237

Switchboard: 513.345.4160
Clients Toll-free: 800.488.6070
Fax: 513.621.5613
TDD: 513.345.4160

E-mail: proseniors@proseniors.org
Web Site: www.proseniors.org