Medicare Coverage in a Skilled Nursing Facility (SNF)

Medicare’s limited coverage for skilled nursing facility (SNF) care is one of the most confusing areas of coverage under Part A. This information may help you understand Medicare’s coverage benefits and limitations.

What is SNF Care?
Skilled care is health care given when you need skilled nursing or therapy staff to treat, manage, observe, and evaluate your care. Skilled nursing and therapy staff includes registered nurses, speech-language pathologists, audiologists, and more. If the care can be given by non-professional staff, it is not considered skilled care.

Coverage Criteria
Numerous strict requirements must be met before Medicare will make any payment for nursing home care. This strict criteria means that the majority of nursing home stays in the U.S. are not covered by Medicare. This is due, in part, to the fact that Medicare was never designed to provide a “long-term care” nursing home benefit. Rather, it was designed to provide a short-term, rehabilitative benefit. The following is a list of the seven criteria that must be met for Medicare coverage for nursing home care.

1) Medicare-Certified Facility—The care must be provided in a MEDICARE-CERTIFIED SNF. An SNF may choose whether or not to participate in Medicare and not all SNFs are Medicare-certified. Beneficiaries should always ask whether a facility is Medicare-certified.

2) Three-Day Prior Hospitalization—Prior to entering a SNF, the beneficiary must have been hospitalized as an inpatient (not observation) for at least 3 consecutive days, not counting the day of discharge. Staying overnight one or more nights in the hospital does not mean s/he was admitted as an inpatient. When entering the hospital, beneficiaries should always check with the hospital about their status, and advocate for inpatient status if a subsequent nursing home stay seems likely.

3) Admit to SNF within 30 Days—The beneficiary must be admitted to a Medicare-certified SNF within thirty (30) days of discharge from the hospital. After the beneficiary leaves the SNF, if s/he re-enters the same or another SNF within 30 days, s/he may not need another three-day qualifying hospital stay to get additional SNF benefits.

4) “Conditions” Test—The services received in the SNF must be for a condition which was treated during the hospitalization (condition does not have to have been the primary diagnosis in the hospital).
Coverage Criteria—Continued

5) “Practical Matter” Test—The services required and provided must be such that “as a practical matter,” they can only be provided in a skilled nursing facility (SNF). This means, for example, that the SNF stay cannot be provided simply because it is more convenient than receiving the same services at home. Cost is generally not considered.

6) “Skilled Care” Required—Generally considered the most difficult requirement, Medicare law requires that the care given must be “skilled.” This means that 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 Medicare law provides many examples of what is considered “skilled care.” Generally services are those which require the skills of professional personnel, such as: registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech-language pathologists, etc. and are furnished by, or under the supervision of, these skilled personnel. Care deemed “custodial” is not covered by Medicare.

7) “Daily Basis” for Skilled Care—Medicare requires that the skilled care be provided on a daily basis, which generally means that the skilled nursing or skilled rehabilitation services must be needed & provided seven days a week. A patient whose inpatient stay is based solely on the need for skilled rehabilitation services meets this requirement when they need and receive those services at least five days a week. The “daily test” can also be met even if care is provided less than seven days a week if, such as when skilled rehabilitation services are not available seven days a week, or if the physician orders a break of one/two days in rehabilitation services because the beneficiary is suffering from extreme fatigue.

Amount of Coverage
Medicare’s coverage for SNF care is limited to 100 days per benefit period. Within the 100 days, Medicare pays in full only for days 1-20. For days 21-100, the beneficiary (or his/her supplemental insurance policy) pays the daily co-insurance rate and Medicare pays any charges above that rate. Once the beneficiary uses those 100 days, the current benefit period must end before s/he can renew SNF benefits.

The benefit period ends a) when beneficiary has not been in a SNF or a hospital for at least 60 days in a row, OR b) if beneficiary remains in a SNF, when s/he has not received skilled care there for at least 60 days in a row. There is no limit to the number of benefit periods a beneficiary can have. However, once a benefit period ends, the beneficiary must have another three-day qualifying hospital stay and meet the Medicare requirements before s/he can get up to another 100 days of SNF benefits.

Medicare Supplement Coverage
In addition to Medicare coverage for nursing home stays, there is an additional benefit that all Medicare supplement insurance policies filed after November 1978 must provide 30 days of skilled nursing care. These Medicare supplement insurance policies must provide coverage in some situations even when Medicare does not pay. Coverage may be limited to care that is “medically necessary” and “skilled”, but the criteria for “skilled care” need not be as high as Medicare’s. Rather, the “skilled care” criteria under these policies must be the same standard that the insurance company uses with regular (non-Medicare supplement) health insurance. The attending physician must certify the care as “medically necessary” and recertify the necessity every seven days. To access this benefit, a three-day prior hospitalization IS NOT NECESSARY. In addition, while the facility must be licensed by the state, it does not have to be a Medicare facility.

For local assistance with Medicare or other benefits questions, contact the ADRC of Brown County.

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