Medicare Coverage in a Skilled Nursing Facility

Medicare’s limited coverage for skilled nursing facility 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.

**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 nursing home. A nursing home may choose whether or not to participate in Medicare and not all Wisconsin nursing homes are Medicare-certified. Beneficiaries should always ask whether a facility is Medicare-certified.

(2) **Three-Day Prior Hospitalization** - Prior to entering a skilled nursing facility, the beneficiary must have been hospitalized for at least three days (not counting the day of discharge). This can be more of a problem than it would seem since the trend is towards decreasing time in a hospital. But unless the beneficiary has been in the hospital at least three days, no coverage for nursing home care will be available.

(3) **Transfer Within 30 Days** - The beneficiary must be transferred to a Medicare-certified facility within thirty (30) days of discharge from the hospital.

(4) **“Conditions” Test** - The services received in the nursing home must be for a condition which was treated during the hospitalization although the condition does not have to have been the primary diagnosis in the hospital.

(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. This means, for example, that the nursing home stay can not 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.” The determination must be done on an individual basis. For example, an average individual recovering from certain surgery may not necessarily need “skilled care.” But if that individual is a diabetic with brittle bone disease who needs to be turned every few hours to avoid bedsores, and whose nutrition needs to be watched and vital signs monitored, the care may indeed be “skilled.” There is also a popular MYTH that an individual has to be “improving” in order to meet the “skilled care” requirement. Medicare law, however, does not consider the individual’s rehabilitative potential. Rather, the “skilled care” requirement may be met even when no improvement is being made if the services are needed to maintain current functioning, or avoid further deterioration.

(7) **“Daily Basis” for Skilled Care** - Medicare requires that the skilled care be provided on a daily basis. “Daily” generally means that the skilled nursing or skilled rehabilitation services must be needed and provided seven days a week. However, the “daily test” can be met even if care is provided less than seven days each week if, for example, skilled rehabilitation services such as physical therapy are not available seven days a week, or if the physician orders a break of one or two days in rehabilitation services because the beneficiary is suffering from extreme fatigue.

**AMOUNT OF COVERAGE**

Even if the beneficiary’s care in the nursing home meets Medicare’s criteria, the number of days for which Medicare provides coverage is very limited. Medicare’s coverage for nursing home care is limited to 100 days. And within that 100 days, Medicare pays in full only for days 1-20. For days 21-100, assuming Medicare coverage criteria continues to be met, the beneficiary (or his or her supplemental insurance policy) pays the daily co-insurance rate and Medicare pays any charges above that rate.

**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” may not be the same as Medicare’s definition of skilled care. In other words, the level of care must 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 re-certify the necessity every seven (7) 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-certified facility.