PROVIDENCE Transitional Care Center

PLACE RESIDENT LABEL HERE

PROVIDENCE Extended Care

MEDICARE COVERAGE FOR SKILLED NURSING FACILITIES (SNF)
2019

Many people believe that Medicare will cover more nursing home care costs than it actually does. The Medicare Manual states that 100 days of skilled nursing facility care are allowed per "spell of illness." However, 100 days of Medicare payment is not guaranteed and there are many exceptions and restrictions so that very few persons are actually eligible for the full 100 days. The following information is provided to assist you with financial and/or discharge planning.

Beneficiaries must meet all of the following established clinical eligibility requirements in order for Medicare to pay for SNF-level services. The beneficiary must require:

- And receive medically necessary skilled care on a daily basis. These services are provided by or under the direction of skilled nursing or rehabilitation professionals. **NOTE: daily participation in therapy is required.**
- Services that can only be provided, as a practical matter, in a SNF.
- Skilled services for a condition for which the resident:
    - Was treated during the qualifying hospital stay, or
    - Arose while the resident was in the SNF for treatment of a condition for which he/she was previously treated for in a hospital.

Even though a person suffering from a serious chronic illness needs much care, unless the condition requires "skilled" care, Medicare will not cover the stay. Services such as administration of routine oral medication, eye drops and ointments, catheter or colostomy care, and assistance in dressing, bathing, or toileting, intermittent or routine therapy services are not considered "skilled" care. Such care is considered custodial and does not meet the clinical eligibility requirements for Medicare coverage.

When all requirements for eligibility are met, Medicare covers costs for the first 20 days. For 2019, a copayment of $170.50 per day is required from the 21st to the 100th day. Medicare revises this copayment rate January 1st of each year.

Medicare payment will end when a resident is no longer meeting the clinical eligibility requirements, that is, no longer receiving the skilled nursing or therapy services on a daily basis. You will receive a decertification notice from our Medicare Reviewer indicating that payment by Medicare will end the day following decertification.

We realize the disappointment and possible financial hardship experienced by residents and families when they expect more Medicare coverage than Medicare is prepared to give. However, as an institution certified to provide skilled care for Medicare, we must follow their guidelines. You are encouraged to begin planning for alternate payment sources by applying for Medicaid or by making arrangements for an home or assisted living facility discharge. Your social worker and business office staff can assist you with these plans.

We hope this letter assists you to form realistic expectations regarding what you can expect. If you have further questions, please contact the Admissions Office.

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Initials Resident/Representative