Skilled Care – 100 days of Covered Service
by
Debbie Gitner, LCSW & Linda Sullivan, RN – ElderCare Resource Services

Medicare will cover up to 100 days in a skilled facility for rehabilitation. There are a number of important factors that must be considered in order to qualify for the 100 days of Medicare benefits.

There must be a three midnight stay in the hospital. Midnight is defined as being admitted to the hospital and spending three nights in the hospital. Spending time in the emergency room does not count as one midnight nor does an observation period in the hospital. There are times that a person is not admitted to the hospital but is under observation. That time being observed, even if it falls at midnight, does not count as a midnight stay. You MUST be in a bed (admitted) and in a room over three midnight periods to qualify.

If in a rehabilitation facility, that facility must have a contract with Medicare. Certain Nursing Homes do not have the ability to bill Medicare. When looking for rehabilitation facilities, ask if that facility has a Medicare contract.

Under the Medicare guidelines there is a statement that Medicare will cover 100 days in a skilled (rehab) facility. The definition of "skilled" services is when a senior needs Physical Therapy, Occupational Therapy, Speech Therapy, and/or has a medical need that requires a nurse. For example, if someone has a wound, that wound needs monitoring, treatments changed, and vital signs taken by a nurse to check for infection. That is considered "skilled care". Changes in medications are considered "skilled care" because a nurse needs to monitor for side effects. Lab tests that require a change in medications are considered "skilled". Once a senior's health is stable Medicare will no longer cover. If a senior needs help with personal care, that is not considered a skill because an aide can provide that care.

If a senior has a doctor's order for Physical Therapy, Occupational Therapy, and/or Speech Therapy and is seen five or more days in a given week, that is considered "skilled care". Once a senior is back to their baseline or needs therapy less than five times per week, Medicare will no longer cover.

If a senior is out of the hospital for sixty consecutive days after their last covered day under Medicare, then the senior is entitled to another 100 day benefit. If a senior leaves a skilled facility before they have exhausted their 100 days and returns to the hospital and back to the skilled facility within 30 days after being discharged, Medicare will continue to cover from where they left off up to 100 days.

Medicare will cover 100% of the cost of a skilled facility from day 1 through day 21. After that time there is a deductible of $128 per day, however, if the senior has supplemental insurance, the insurance will cover the deductible. If there is no supplemental insurance then the senior will be responsible for the $128 per day.

There are situations when a senior has stayed in a facility for 100 days under “skilled care”. There are situations when a senior no longer meets the definition of skilled care in less than 100 days. When that happens, the facility must inform the senior and/or family member that Medicare will no longer cover the benefits and benefits are being “denied”. When that happens, the senior and/or family have the right to appeal the decision and Medicare will review the medical records to see if there is a reason to continue benefits.

In summary, Medicare will cover up to 100 days in a skilled facility if a senior has a three midnight stay in a hospital and continues to meet the definition of skilled care. If your relative is in a skilled facility receiving skilled care always feel free to contact your lawyer to discuss your situation. If you think your relative continues to need skilled care then appeal the denial of benefits. Consider hiring an advocate such as a Geriatric Care Manager who can review the medical records to help with the appeal process.