

Medicare Information

Eligibility

All persons aged 65 or over who qualify for social security benefits, certain disabled persons and those needing kidney transplants or dialysis who meet specific criteria are eligible for Medicare part A & B.

Medicare Part A & B

Medicare part A is referred to as “hospital insurance” and covers inpatient hospital care, inpatient care in a skilled nursing facility, home health care and hospice services. Recipients pay no premiums for Part A but are subject to deductibles and coinsurance charges. Medicare part B is referred to as “medical insurance” and covers doctors visits and other qualified ancillary services. Recipients with Part B coverage pay a monthly premium for the coverage and are also subject to coinsurance charges.

Skilled Nursing Facility Criteria

Any person admitted to the facility for skilled care must meet the following criteria to be covered by Medicare:

- ❑ The person has been in the hospital for three consecutive days, not counting the day of discharge.
- ❑ The person is transferred to a skilled nursing facility within 30 days of discharge from the hospital.
- ❑ The attending physician certifies the patient requires skilled or rehabilitative care.

Medicare will pay for the following:

- Semi-private room
- Meals (including special diets)
- Nursing services
- Therapy services (physical, occupational, speech)
- Medications and Medical supplies
- Use of medical equipment (wheelchair, walker, cane, etc.)

Medicare will not pay for the following:

- Private telephone services and cable television.
- Private duty nursing care.
- Private rooms unless it is determined to be medically necessary.

Benefit Periods

A benefit period consists of 100 days. In general, Medicare pays the first 20 days in full (that's if the Resident needs skilled care for the entire 20 days). Days 21 – 100 are referred to as the Medicare coinsurance days. The coinsurance amount is either paid by the resident or by their secondary insurance if applicable. If the resident has used skilled nursing days within sixty (60) days prior to admission, those days will count toward the 100 day maximum in the benefit period (i.e. the resident transferred from another skilled nursing facility or used days in a hospital skilled care unit). To qualify for a new benefit period, the Resident must have a 60-day break from skilled care as well as meet the aforementioned criteria.

Medicare does not guarantee payment for a specific number of days. Medicare considers the resident's diagnosis and prognosis. Once the resident hits a plateau in progress, Medicare coverage ends. Families and residents will be notified in advance of the last covered Medicare day. Residents staying beyond the last covered day must inform the facility of their primary payer source after Medicare.

On the day of admission to the facility, please bring the resident's Medicare, social security and secondary insurance cards. We will photocopy them enabling us to submit the resident's bill to Medicare and the insurance company.

If you have questions concerning Medicare, please contact the facility Admissions Director or Business Office Manager. You may also contact the Social Security Administration at (800) 772-1213.