

## **Very Important Information About Medicare Part A Benefits at The Manor**

**The Medicare does not cover long-term stays at The Manor, under certain circumstances Medicare can be billed for a short period of time. To be eligible, these conditions must be met:**

1. You must have been admitted for three consecutive mid nights in the thirty days prior to admission to The Manor. Hospital days during which you were only “observed” and not formally admitted cannot be counted.
2. **You must need daily skilled nursing services or daily rehabilitation services.** Skilled nursing services means those that must be provided by or closely supervised by a professional nurse, not by a nursing assistant. Skilled nursing services do not include bathing, dressing, feeding, toileting, walking, etc. They are usually more specialized and must be provided seven days a week. Examples are a feeding tube, treatment of a decubitus ulcer, and management of severe pain. Medicare is very specific about what satisfies the requirements for skilled care. For example, skilled care might include close monitoring of an unstable condition, but only if it necessitates two or more medicine changes and two or more physician visits in one week. Skilled rehabilitation services can any combination of physical, occupational and speech therapies at least five days a week.
3. Your admission to The Manor must be for the purpose of receiving further treatment of a condition for which you received treatment in the hospital. In this way, The Manor stay is seen as an extension of the hospital stay.

When the above conditions are satisfied, Medicare coverage is for a maximum of 100 days. This includes coverage of the charges for room and board, medication therapy, necessary lab tests and other services related to your stay. *However, coverage continues only as long as you require the skilled service.*

If you are eligible for Medicare coverage for your stay at The Manor, Medicare will pay 100% of the charges for the first twenty days. If you remain Medicare eligible beyond twenty days, Medicare pays a small portion of the charges and requires a significant co-payment to cover the remainder from day 21-100. In 2009, the required co-payment is \$133.50 per day. This co-payment may be covered by your private insurance, your private funds, or by Medicaid for those who are Medicaid eligible. **Not all Medicare supplemental policies cover this co-payment so it is important check with your insurance company as soon as possible.**

**A multidisciplinary team reviews each resident’s Medicare status weekly. When it is clear that the daily skilled nursing or rehabilitation services are no longer required, you will be notified that we have determined that you no longer qualify for Medicare coverage of your stay at The Manor. At that point, you will be responsible for the daily charges and should discuss method of payment with the Social Worker. You can appeal our decision by demanding that we bill Medicare despite our decision, so that Medicare itself must review the case and make the**

**decision. If you appeal the decision you cannot be required to pay the charges for the first 100 days of your stay until you receive notice from Medicare. It may be several months before that decision is made, and if the appeal is denied you will be responsible for the charges incurred from the day of the initial decision made by The Manor.**

Remember:

*To qualify for Medicare Coverage of your stay, you must have been admitted to the hospital for three consecutive nights in the past thirty days and you must be receiving daily skilled nursing and rehabilitation services as described above. Medicare coverage is usually for a short time only.*

**The rules for Medicare coverage in a nursing home are complicated. There are many rules that are not mentioned in this overview. If you have any questions, please contact the Social Worker or call Medicare directly at 603-695-7204.**