<u>Information on Medicare</u>

What is the Skilled Therapy Criteria?

. Resident has the potential for functional improvement
. Complexity of therapy requires Skilled Therapist
. Treatment is reasonable and necessary for illness or injury
. Significant functional improvement is made in a reasonable period of time
. Resident can follow commands and actively participate in treatment program
. Resident's functional status prior to admission was higher than current

What is the Skilled Therapy Discharge Criteria?

. Resident is functioning independently
. Resident is functioning back to level prior to admission (baseline)
. Therapy goals have been met
. Resident has made no functional improvement in 5 days or more
. Resident is unable/unwilling to participate in therapy on a regular basis
. Resident's medical condition has deteriorated so skilled therapy is longer safe or appropriate
. Resident's current functional status can be maintained via non-skilled assistance

What Services are Non-Covered?

. Expected restorative potential is insignificant
. Expectations for improvement will not materialize
. General range of motion to maintain function
. Unskilled assistance to ambulate
. Activities for diversion or motivation
. Cognitive therapy if only service performed
. Electrotherapy for Bell's Palsy
. Vocational/Prevocational assessment

What is the Medicare Skilled Nursing Facility Benefit?

Medicare covers care in a Skilled Nursing Facility for **<u>up to</u>** 100 days per benefit period. A benefit period must be preceded by a 3-day qualifying hospital stay and there must have been a lapse of at least 60 days since the patient last received skilled care. Per Medicare, your Medicare coverage ends if you have used all 100 days of coverage in the benefit period, **<u>or</u>** you no longer need care covered under Medicare criteria (see above).

The necessity of Medicare coverage (skilled care) is determined by structured guidelines given to Skilled Nursing Facilities by Medicare. Our medical staff operates within these requirements as determined by Medicare. The necessity could end anywhere within the 100 day period.

If the beneficiary is covered by Medicare, the first 20 days will be paid in full by Medicare Part A. For the remainder of the benefit period there is a daily co-insurance, which will be billed to you or your secondary insurance carrier. **The 2010 co-insurance amount is $137.50 per day.**

At such time that you or the person you represent no longer meets these medical guidelines, Daughters of Sarah will make every attempt to give you as much advance notice as possible given your medical progress.