



Ensuring Medicare Eligibility in a SNF

Deep dive into SNF Medicare regulatory guidance.



Judy Wilhide Brandt



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Agenda

- Explain the ways a resident can access the SNF Part A Benefit
- Understand the SNF benefit period
- Understand the technical requirements for skilled care
 - Physician Certification
 - Qualifying hospital stay
 - Benefit days available
- Explain the level of care requirements for skilled care
 - Direct skilled nursing
 - Indirect skilled nursing
 - Skilled therapy
- Documentation to support the skilled need
- Understand the presumption of coverage



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Resource Regulations

Medicare Benefit Policy Manual, Chapter 8, Source for Requirements for Skilled Care:

<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c08pdf.pdf>

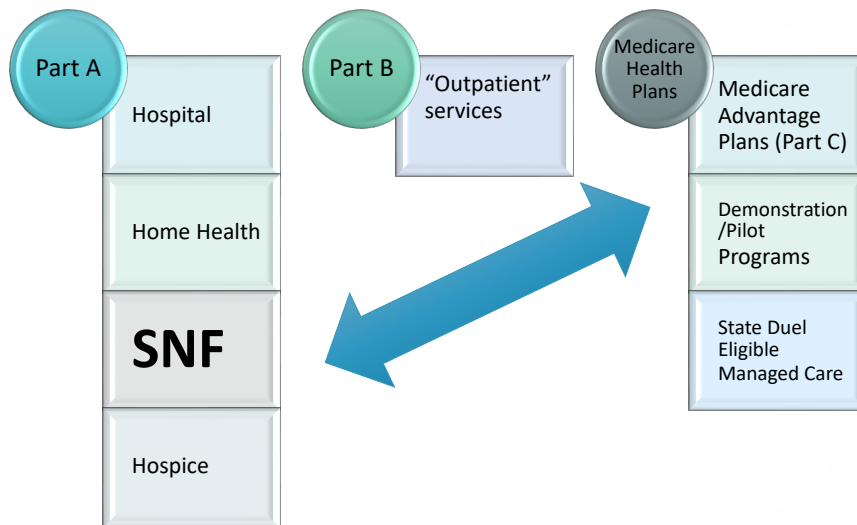
Physician Certification of Need for Skilled Care Regulation: <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/ge101c04.pdf>

CMS PDPM Website: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM>



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SNF Medicare Options



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Medicare Advantage Plans

- Private insurance companies receive a risk-adjusted set amount of federal Medicare funding for each beneficiary's care each month regardless of actual services provided.
 - They can offer things Medicare does not cover, like vision, hearing, dental and fitness programs, transportation to doctor visits, OTC drugs.
- Also financed by monthly premiums paid by subscribers. The premium amounts vary by company and plan.
 - Subscribers may also be asked to pay a certain amount of their expenses in the form of a deductible or copayment.

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Medicare Advantage: 2025 landscape

- Over the last decade, Medicare Advantage has taken on a prominent role in the Medicare program. In 2024, nearly 33 million Medicare beneficiaries are enrolled in a Medicare Advantage plan, more than half, or 54%, of the eligible Medicare population.
- Despite concerns that modifications to the payment formula and higher utilization would impact the number of Medicare Advantage plans offered in 2025, the Medicare Advantage market appears to be relatively stable. While Medicare Advantage insurers have made some adjustments in their offerings, the average Medicare beneficiary has a choice of more than 30 Medicare Advantage prescription drug (MA-PD) plans, and virtually all plans provide multiple extra benefits like vision, hearing and dental benefits, similar to last year.
- Major insurers are both expanding into new counties and exiting others. For example, Humana is entering 12 new counties and exiting 70 counties, while UnitedHealthcare is entering 42 new counties and exiting 38 counties. Both insurers are offering plans in nearly 90% of all U.S. counties.

<https://www.kff.org/medicare/issue-brief/medicare-advantage-2025-spotlight-a-first-look-at-plan-offerings/>



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Medicare Advantage:

- **Benefit:** Must cover the same SNF benefit as Original Medicare but may have different rules and restrictions.
- **Management:** Medicare Advantage plans have more flexibility in managing SNF care. This can include:
 - **Prior authorization:** May require pre-approval for SNF stays.
 - **Network limitations:** May require you to use SNFs within their network.
 - **Utilization review:** May monitor the length of stay and services provided to ensure they are medically necessary.
 - **Case management:** May assign a case manager to coordinate care and ensure a smooth transition from hospital to SNF to home.



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Definitive Source for Original Medicare Part A SNF Benefits

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance



Technical Criteria



Level of Care Requirements

<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c08pdf.pdf>



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Technical Requirements for SNF Medicare A Coverage

Qualifying Hospital Stay (QHS)

Physician Certification

Benefit Period Eligibility

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Technical Requirements for SNF Medicare A Coverage

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Medically Necessary 3 Day Qualifying Hospital Stay (QHS)

- 1 Required for Original Medicare, may not be required for MA plan or alternate payment model (e.g. bundled payment programs)
- 2 Must be consecutive *midnights* as an **inpatient**, **may be different hospitals**
- 3 Must be transferred to a SNF within 30 days of QHS discharge
- 4 May be Medicare hospice **general inpatient** care if hospice revoked
- 5 May be in a foreign hospital as long as it qualifies as an emergency hospital. Will have to submit proof of hospitalization to MAC.
- 6 May be in a psychiatric hospital, but a patient with only a psych condition transferred from a psych hospital to a SNF is likely to receive only non-covered care.



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Hospice Revocation in Hospital

Chapter 9, Medicare Benefit Policy Manual: Coverage of Hospice Services Under Hospital Insurance, Section 40.1.5

- If a hospice patient receives **general inpatient care** for 3 days or more in a hospital, and chooses to revoke hospice, then the 3-day stay (although not equivalent to a hospital level of care) **would still qualify the beneficiary for covered SNF services.**
- There are 2 possible levels of care for a Medicare hospice resident in a hospital:
 - Respite: Relief of family members or those who normally are caregivers at home (does NOT count towards qualifying hospital stay for SNF benefit)
 - General inpatient care: DOES count towards qualifying hospital stay for SNF benefit. Includes: pain control, symptom management, medication adjustment, observation other stabilizing treatment such as psycho-social monitoring.



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Hospice & SNF Benefit:

Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance, Sec 20.3

- Resident can access both Medicare Hospice and SNF benefit as long as the [reason for the SNF stay is in no way related](#) to the terminal condition.
- Example from CMS Web-based training:
- Res. w/terminal GI cancer falls & breaks leg at home. After qualifying hospital stay, goes to SNF for rehab.
 - “Instances of such cases may be rare.” Broken leg can’t be r/t bone mets, sedation for terminal condition, etc.
 - “Furthermore, the beneficiary must be able to tolerate rehab and rehab must be R&N.”

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20.2 Thirty-Day Transfer: Details

- The 30-day period begins on the day following discharge from the hospital and continues until the individual is admitted to a participating SNF and requires and receives a covered level of care.
- The timely transfer requirement is met even if actual **Medicare payment** does not commence until later (for example, in a situation where another payment source that is **primary to Medicare** has assumed financial responsibility for the initial portion of the SNF stay).
 - Remember! PPS 5 day must be day 1 – 8 of Medicare stay once it starts.



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20.2.2 - Medical Appropriateness Exception

- SNF stay starting more than 30 days from QHS is permitted when patient's condition makes it medically inappropriate to begin active course of treatment in a SNF immediately after hospital discharge, and it is medically predictable at the time of the hospital discharge that he or she will require covered care within a predeterminable time period.
 - Condition code 56 on SNF claim: Medical appropriateness condition code indicates the patient's SNF admission was delayed more than the 30 days after hospital discharge as patient's condition made it inappropriate to begin active care within that period.



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20.2.2 - Medical Appropriateness Exception

Example: Under the established pattern of treatment of hip fractures it is known that skilled therapy services will be required subsequent to hospital care, and that they can normally begin within four to six weeks after hospital discharge, when weight bearing can be tolerated. Under the exception to the 30-day rule, the admission of a patient with a hip fracture to a SNF within 4 to 6 weeks after hospital discharge for skilled care, which as a practical matter can only be provided on an inpatient basis by a SNF, would be considered a timely admission.



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Sources for SNF Benefit Period Rules

- **Medicare Benefit Policy Manual**
 - **Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance, Section:**
 - 20.2: 30 day transfer requirements
 - 20.2.1 General: skilled need between day 31 -60
 - 20.2.3 - Readmission to a SNF: 30 day tracking
 - 60 - Covered Extended Care Days: Medicare Benefit Policy Manual, Chapter 3, "Duration of Covered Inpatient Services," for the following topics:
 - Post-hospital extended care benefit days available in a benefit period;
 - Definition of an inpatient benefit day;
 - Late discharge;
 - Leave of absence;
 - Discharge or death on first day of entitlement or participation; and
 - Inpatient service days counting toward benefit maximums.

**Benefit Period
Eligibility**



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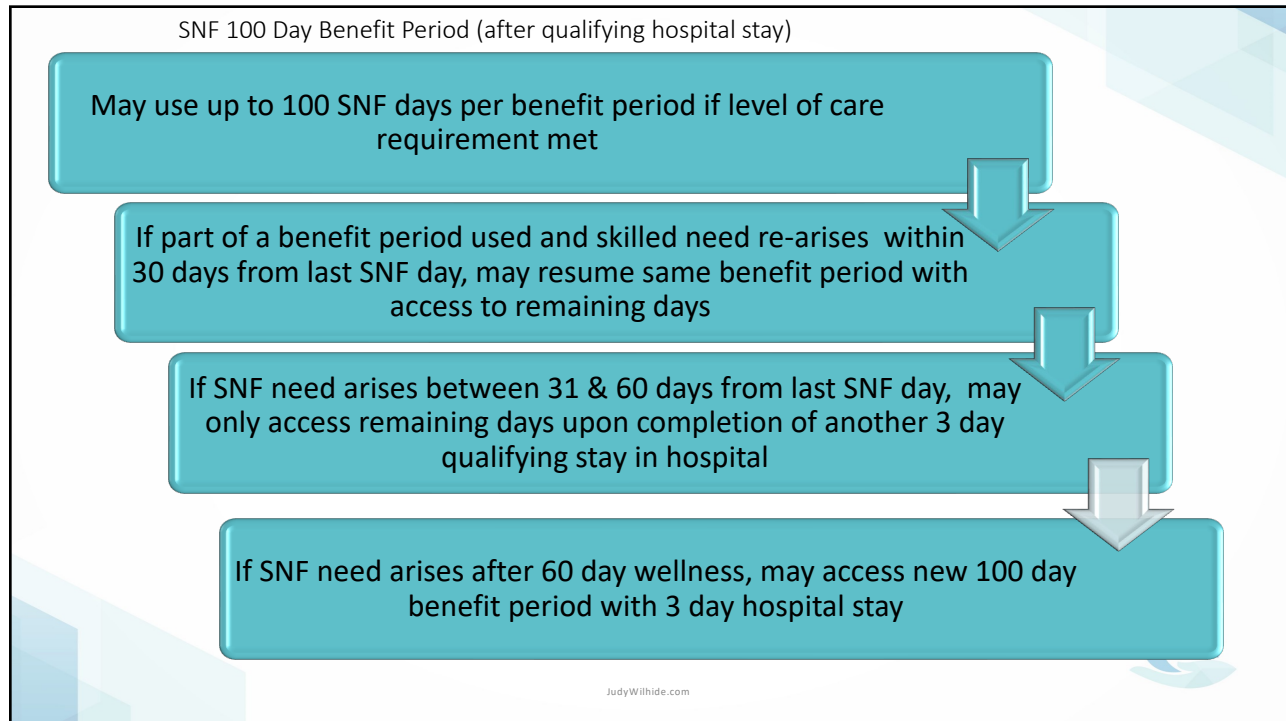
Sources for SNF Benefit Period Rules

- **Medicare Benefit Policy Manual**
 - **Chapter 3, Duration of Covered Inpatient Services, Section:**
 - 10 - Benefit Period (Spell of Illness): General description
 - 20.b: Posthospital Extended Care Days
- **Medicare General Information, Eligibility, and Entitlement**
 - **Chapter 3 - Deductibles, Coinsurance Amounts, and Payment Limitations, Section:**
 - 10.4 - Benefit Period (Spell of Illness)
 - 10.4.3.2 - SNF Stay and End of Benefit Period
 - 10.4.4 - Definition of Inpatient for Ending a Benefit Period

**Benefit Period
Eligibility**



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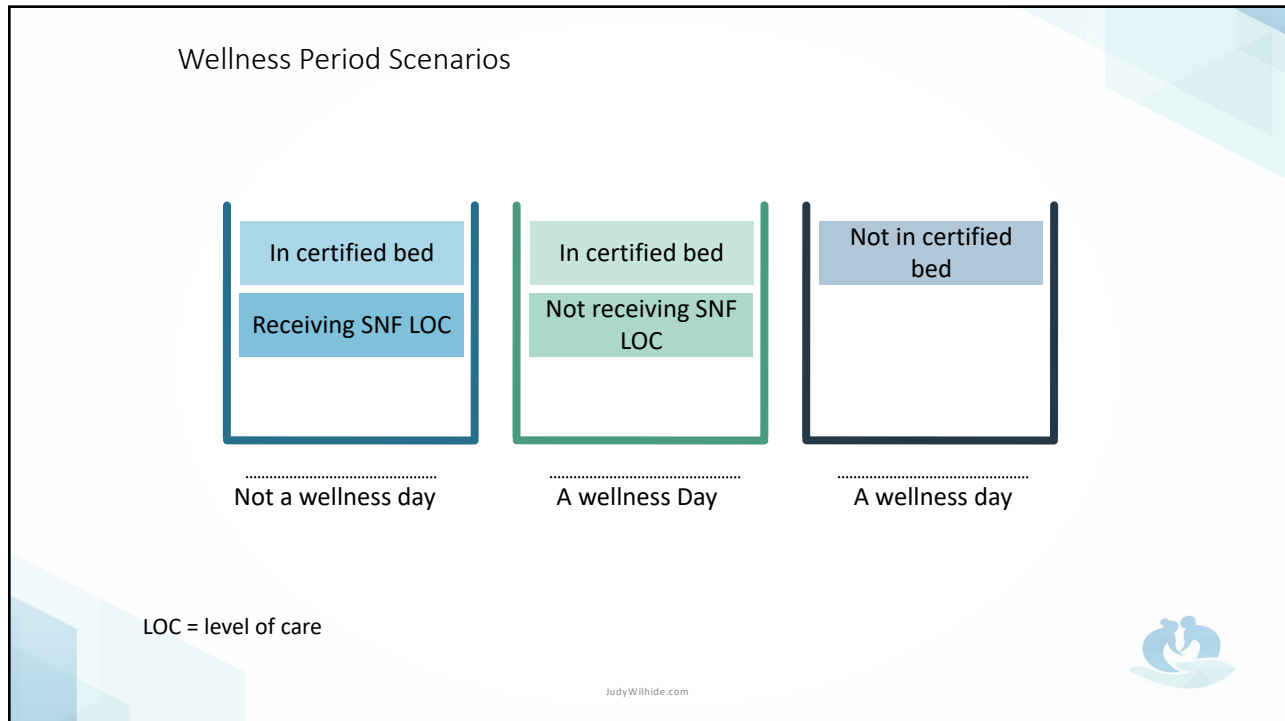
60 Day Wellness Period

60 consecutive days in which resident is:

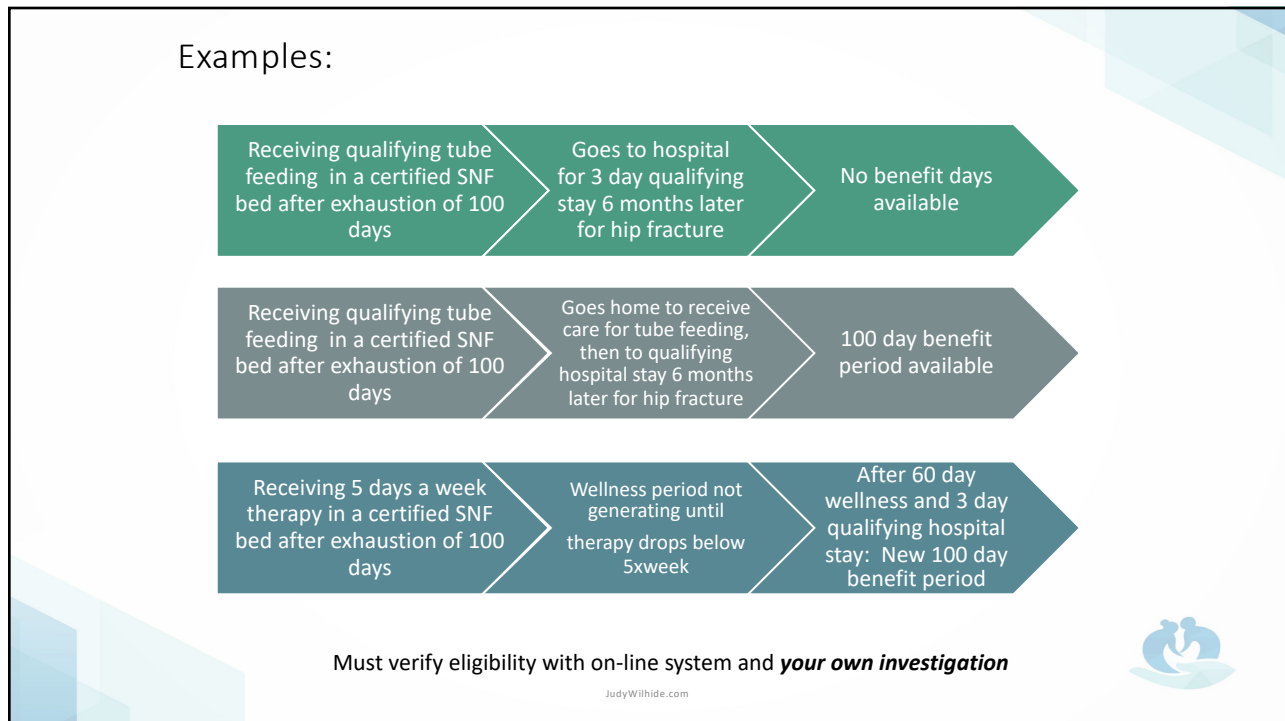
1. Not in a certified bed, regardless of care provided
 - Medicare and/or Medicaid certified bed in NF or higher (hospital)
2. **OR in a certified bed but not receiving a skilled level of care**

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Resident used part of a benefit period AND:

Scenario	Rule
Skilled need rearises within 30 days of last covered day	Resume Part A benefit period. No QHS required. Skilled need must be related to something treated in the hospital or that arose in the SNF while being treated for something treated in the hospital.
Skilled need rearises between day 31 – 60	Must have QHS to resume benefit period. This can now be related to this QHS. If no QHS, no benefit days available.
Skilled need arises after 60 day wellness period. Could have exhausted 100 days or used some days in 100 day benefit period without exhausting.	Must have QHS for new 100 day benefit period



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Technical Requirements for SNF Medicare A Coverage

Qualifying Hospital Stay (QHS)

Physician Certification
Three sources

Benefit Period Eligibility

- Medicare General Information, Eligibility, and Entitlement, Chapter 4 - Physician Certification and Recertification of Services, Section 40 - Certification and Recertification by Physicians for Extended Care Services
- Medicare Benefit Policy Manual, Section 40 - Physician Certification and Recertification of Extended Care Services
- Chapter 6, RAI manual, Section 6.5



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Content

Initial Cert

SNF services are required on an inpatient basis because of the resident's need for skilled nursing or rehabilitation care on a continuing basis for the condition(s) for which s/he was receiving inpatient hospital services prior to his/her transfer to the SNF.

Subsequent

- Continued need for extended care services,
- Estimated period of time required for skilled care
- Any plans for home care,
- Need for SNF care is for a condition related to hospital stay or which arose during the SNF stay

No requirement for a certain form

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Certification Points:

<p>MD, PA, NP may sign all Medicare certifications</p> <p>Non-physician providers must be working in collaboration w/physician may not have direct or indirect employment relationship with SNF</p>	<p>Faxed signatures accepted</p>	<p>Delayed certs may be honored when isolated oversight/lapse with written explanation.</p>	<p>Do not restart certification schedule with interrupted stay</p>	<p>Do restart certification schedule with NEW (not interrupted) stay</p>	<p>May bill only if written certification present</p>
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Required Timetable:

Initial Certification:

On admission or "as soon thereafter as practical."

First Recertification:

On or before day 14 of the stay. Initial and 1st recert may be signed at the same time.

Subsequent Recertifications:

Not more than 30 days from date of last certification.



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Admission Date: _____

**CERTIFICATION AND RECERTIFICATION
(Skilled Nursing Facility)**

Resident Name - Last: _____ First: _____ MI: _____ ID #: _____ Health Insurance Claim Number: _____

CERTIFICATION of resident admission.
Required at time of admission.

I certify that SNF services are required to be given on an inpatient basis because of the above named resident's need for skilled nursing care and/or rehabilitation services on a continuing basis for the condition(s) for which he/she was receiving inpatient hospital services prior to his/her transfer to the SNF.

Physician: _____ Date: _____

RECERTIFICATION of continued SNF inpatient care.
On or before the 14th day after admission.

I certify that continued SNF inpatient care is necessary for the following reason(s): _____

I estimate that the additional period of SNF inpatient care will be _____ days (or _____ weeks).

Plans for post-SNF care are: Home Health Agency Office Care Other (specify) _____

Continued SNF care is for same condition(s) for which resident received inpatient hospital services OR for a condition which arose while he/she was in the SNF for treatment of the condition(s) for which he/she received inpatient hospital services: Yes No

Physician: _____ Date: _____

Date Due: _____

RECERTIFICATION of continued SNF inpatient care.
Within 30 days of the prior recertification.

I certify that continued SNF inpatient care is necessary for the following reason(s): _____

I estimate that the additional period of SNF inpatient care will be _____ days (or _____ weeks).

Plans for post-SNF care are: Home Health Agency Office Care Other (specify) _____

Continued SNF care is for same condition(s) for which resident received inpatient hospital services OR for a condition which arose while he/she was in the SNF for treatment of the condition(s) for which he/she received inpatient hospital services: Yes No

Physician: _____ Date: _____

Date Due: _____

RECERTIFICATION of continued SNF inpatient care.
Within 30 days of the prior recertification.

I certify that continued SNF inpatient care is necessary for the following reason(s): _____

I estimate that the additional period of SNF inpatient care will be _____ days (or _____ weeks).

Plans for post-SNF care are: Home Health Agency Office Care Other (specify) _____

Continued SNF care is for same condition(s) for which resident received inpatient hospital services OR for a condition which arose while he/she was in the SNF for treatment of the condition(s) for which he/she received inpatient hospital services: Yes No

Physician: _____ Date: _____

Date Due: _____

AMBULANCE SERVICE

I hereby certify that ambulance service was medically necessary for the above named resident.

Physician: _____ Date: _____

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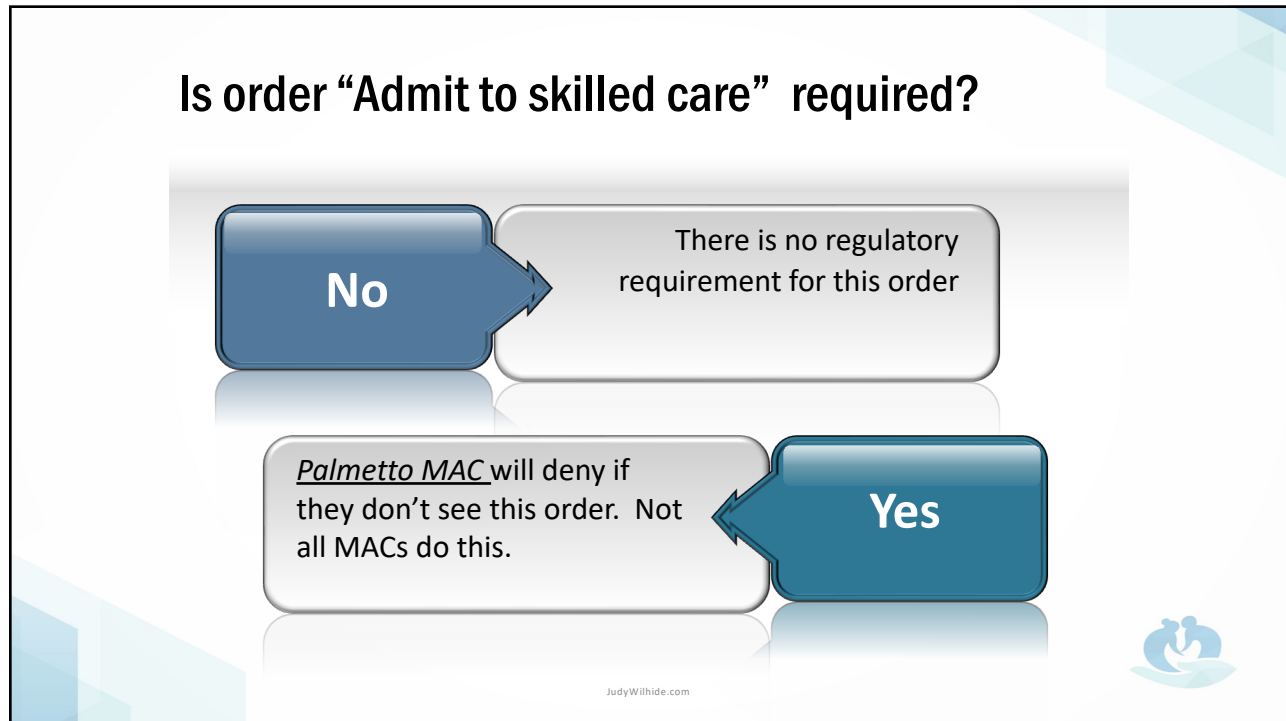
If all blocks are not filled out or checked, it is not a valid certification

If signature, date, credentials illegible, the entire claim will be denied.

May send a signature log
Consider electronic certification statements: No legibility issues



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The great Palmetto Insanity

- Palmetto for a long time has been denying SNF claims because there is no order to admit to skilled care. They cite Fed Reg title 42 483.40 when denying.
- The Qualified Independent Contractor (QIC) at the second level of appeal will overturn Palmettos' 1st two denials.

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§ 483.40 Physician services.

A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.



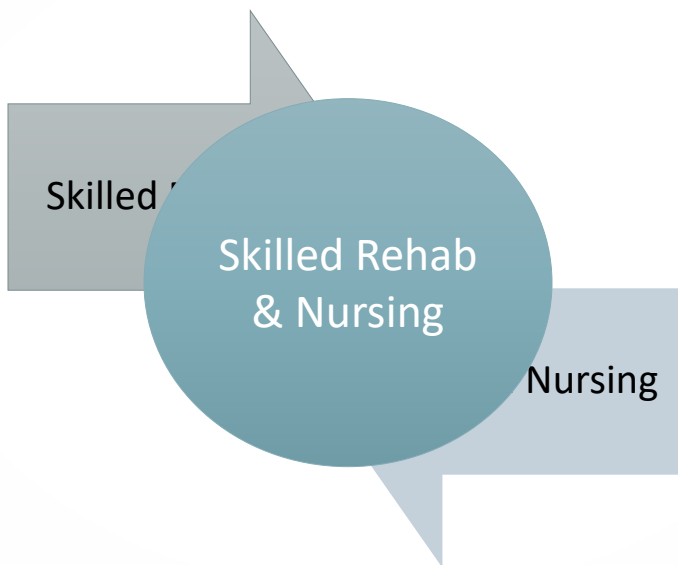
Palmetto is clearly insane. But, it is prudent to write "Admit to Skilled Care" for all Part A residents. It's not worth the fight.

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Skilled Level of Care Requirements



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Care in a SNF is covered if all of the following four factors are met:

1. Requires skilled nursing services or rehab **for any condition**
 - For which the patient ***received inpatient hospital services*** or
 - That ***arose while receiving care in a SNF*** for a condition for which he received inpatient hospital services

Nursing/Rehab services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of an RN/LPN or Therapist/Assistant (Professional or technical personnel)



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Care in a SNF is covered if all of the following four factors are met:

2. The patient requires these skilled services on a daily basis
 - 5 days a week rehab
 - 7 days a week nursing
3. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF
 - May have short LOA during Part A stay for brief period of time



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- Skilled rehabilitative therapy must be required 5 calendar days a week to meet SNF criteria.
- Therapy that is purposefully spread out over five days just to make it look like the “five day a week” criteria is met will be prohibited.

Su	Mo	Tu	We	Th	Fr	Sa
	OT	ST	OT	ST	OT	

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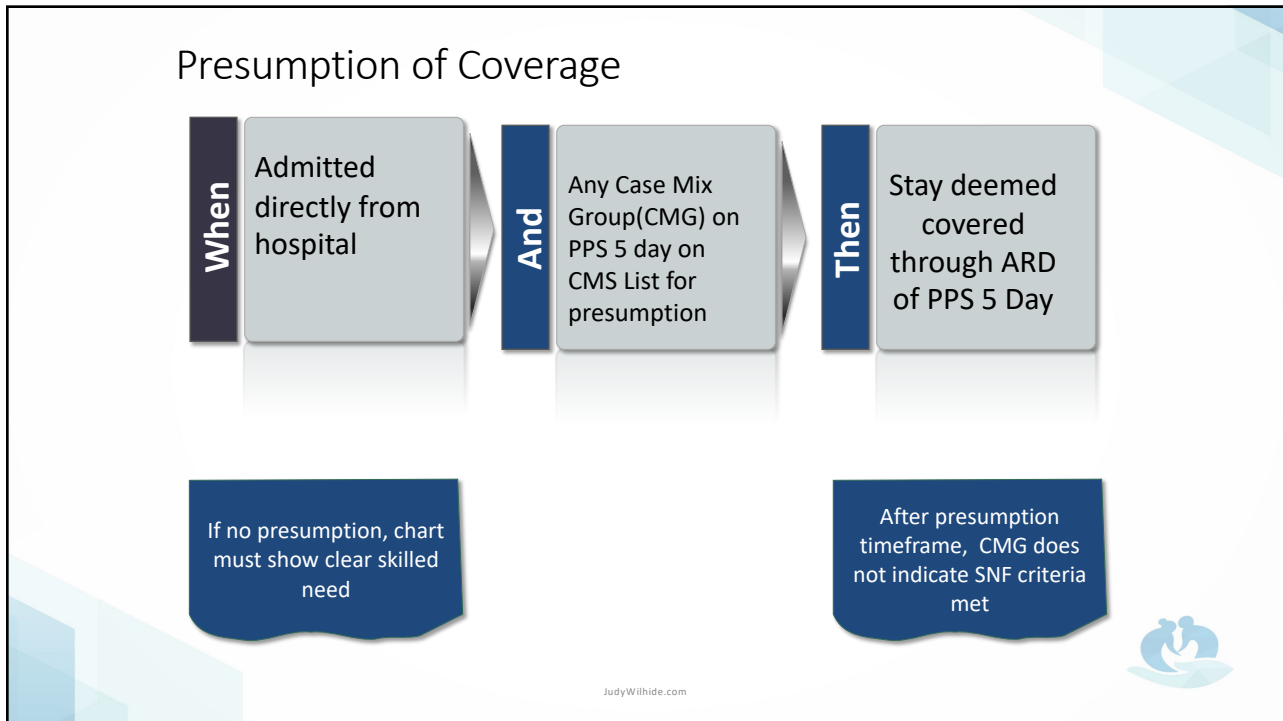
Care in a SNF is covered if all of the following four factors are met:

4. The services *delivered are* reasonable and necessary for the treatment of a patient’s illness or injury,
 - *are* consistent with the nature and severity of illness or injury, particular medical needs, and accepted standards of medical practice.

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Nursing

- Extensive Services
- Special Care High
- Special Care Low
- Clinically Complex
- Behavioral Symptoms & Cognitive Performance
- Reduced Physical Functioning

NTA

NTA Score	NTA CMG
12+	NA
9 - 11	NB
6 - 8	NC
3 - 5	ND
1 - 2	NE
0	NF


PT/OT

Major Joint/Spinal	TA
	TB
	TC
	TD
Other Ortho	TE
	TF
	TG
	TH
Acute Neuro & Non-ortho Surgery	TI
	TJ
	TK
	TL
	TM
	TN
Medical Management	TO
	TP

Presumption of Coverage

SLP

Acute neuro SLP Comorbid Cog Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case-Mix Group
None	Neither	SA
	Either	SB
	Both	SC
One	Neither	SD
	Either	SE
	Both	SF
Two	Neither	SG
	Either	SH
	Both	SI
Three	Neither	SJ
	Either	SK
	Both	SL



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30.2.1 - Skilled Services Defined

- Skilled nursing/rehab:
 - **Require** skills of qualified health personnel such as RN, LPN(LVN), PT, OT, SLP, COTA, PTA due to the **nature of the service** and
 - **Must be provided** directly by or under the general supervision of these skilled nursing/rehab personnel to assure the safety of the patient and to achieve the medically desired result.
 - *Skilled care may be necessary to improve current condition, to maintain current condition, or prevent or slow further deterioration of the patient's condition.*

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30.2.2 - Principles for Determining Whether a Service is Skilled

While a particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is skilled.

Are skilled nurses/therapists **providing the service** because it is **beyond the scope** of unskilled (CNA/Rehab Tech) staff?

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30.2.2.1 – Documentation to Support Skilled Care Determinations

Claims for skilled care coverage need to include sufficient documentation to enable a reviewer to determine whether—

- Skilled involvement is required in order for the services in question to be furnished safely and effectively; and
- The services themselves are, in fact, reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The documentation must also show that the services are appropriate in terms of duration and quantity, and that the services promote the documented therapeutic goals.



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30.2.2.1 – Documentation to Support Skilled Care Determinations

- Thorough and timely documentation with respect to treatment goals can help clearly demonstrate a beneficiary's need for skilled care in situations where such need might not otherwise be readily apparent, as when the treatment's purpose changes (for example, from restoration to maintenance), as well as in establishing the efficacy of care that serves to prevent or slow decline—where, by definition, there would be no "improvement" to evaluate.



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Therefore the patient's medical record must document as appropriate:

- *H&P exam, (including the response or changes in behavior to previously administered skilled services);*
- *Skilled services provided;*
- *Patient's response to the skilled services provided during the current visit;*
- *Plan for future care based on the rationale of prior results.*
- *Detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences;*
- *Complexity of the service to be performed;*
- *Any other pertinent characteristics of the beneficiary.*

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- Medical record documentation must be accurate, and avoid vague or subjective descriptions of the patient's care that would not be sufficient to indicate the need for skilled care.
- For example, the following terminology does not sufficiently describe the reaction of the patient to his/her skilled care:
 - Patient tolerated treatment well
 - Continue with POC
 - Patient remains stable

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Record should contain:

- Objective documented measurements of:
 - physical outcomes of treatment should be provided and/or
 - a clear description of the changed behaviors due to education programs
- So that all concerned can follow the results of the provided services.

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30.2.3 - Specific Examples of Some Skilled Nursing or Skilled Rehabilitation Services

30.2.3.1 - Management and Evaluation of a Patient Care Plan

- Constitutes skilled services when they require the involvement of skilled personnel to
 - Meet medical needs,
 - Promote recovery, and
 - Ensure medical safety.
- However, planning and management of a treatment plan that **does not** involve the furnishing of skilled services may **not** require skilled nursing personnel;
 - e.g., a care plan for a patient with organic brain syndrome who requires only oral medication and a protective environment.
- The sum total of nonskilled services would only add up to the need for skilled management and evaluation **when the condition of the beneficiary is such that there is an expectation that a change in condition is likely without that intervention.**
- Clinical record must clearly establish that there was a **likely potential for serious complications** without skilled management

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30.2.2 - Principles for Determining Whether a Service is Skilled

EXAMPLE:

- An 81-year-old woman who is aphasic and confused, has hemiplegia, CHF, A-fib, post CVA, is incontinent, has a Stage 1 PrU, and is unable to communicate and make her needs known.
- Even though no specific service provided is skilled, the patient's condition requires daily skilled nursing involvement to manage a plan for the total care needed, to observe the patient's progress, and to evaluate the need for changes in the treatment plan.
- *The medical condition of the patient must be described and documented to support the goals for the patient and the need for skilled nursing services.*

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Mgt/Eval of Care Plan

- Example from BPM:
- Pt is recovering from pneumonia, lethargic, disoriented, has residual chest congestion, is confined to bed as a result of his debilitated condition, and requires restraints at times.
- MD orders frequent changes in position, coughing, and deep breathing.
- While the residual chest congestion alone would not represent a high risk factor, the patient's immobility and confusion represent complicating factors which, when coupled with the chest congestion, could create high probability of a relapse.

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Observation and Assessment of Patient's Condition

- Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's condition is essentially stabilized.



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Observation & Assessment

- Pt with CHF may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from medication(s) that serve as indicators for adjusting therapeutic measures.
- Documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition, to maintain current condition, or to prevent or slow further deterioration.



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Observation & Assessment

- If patient did not develop a further acute episode or complication, the skilled observation services still are covered so long as there was a reasonable probability for such a complication or further acute episode.
 - “Reasonable probability” = “likely possibility”
- *Information from the patient's medical record must document that there is a reasonable potential for a future complication or acute episode sufficient to justify the need for continued skilled observation and assessment.*

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Observation and Assessment

- Such signs and symptoms as abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal/fluctuating lab values, and respiratory changes on auscultation may justify skilled observation and assessment. Where these signs and symptoms are such that there is a reasonable potential that skilled observation and assessment by a licensed nurse will result in changes to the treatment of the patient, then the services are reasonable and necessary.
- However, observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness or injury where these characteristics are part of a longstanding pattern of the patient's waxing and waning condition which by themselves do not require skilled services and there is no attempt to change the treatment to resolve them.



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Teaching and Training Activities

- Teaching and training activities, which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage their treatment regimen, would constitute skilled services.
- *Documentation must thoroughly describe all efforts that have been made to educate the patient/caregiver, and their responses to the training.*

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30.3 - Direct Skilled Nursing Services to Patients

- A condition that would not ordinarily require skilled nursing services may nevertheless require them under certain circumstances.
- In such instances, skilled nursing care is necessary only when
 - (a) the particular patient's special medical complications require the skills of a registered nurse or, when provided by regulation, a licensed practical nurse to perform a type of service that would otherwise be considered non-skilled; or
 - (b) the needed services are of such complexity that the skills of a registered nurse or, when provided by regulation, a licensed practical nurse are required to furnish the services.



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Examples of Direct skilled nursing services

- IM or IV injections or feedings
- Tube feeding at least 26 % calories/501 cc per day
- Naso-pharyngeal and tracheotomy aspiration
- Insertion, sterile irrigation, and replacement of suprapubic catheters
- MD Rx Heat treatments as part of active treatment
- Treatment of decubitus ulcers, Stage 3 or worse, or a widespread skin disorder
- Application of dressings with prescription medications and aseptic techniques
- Rehabilitation nursing procedures
- Initial phases of oxygen therapy
- Early post op colostomy care in present of complications

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Services that are NOT skilled:

Routine care of:

- Oral meds, eye drops, ointments, oxygen
- Colostomy/ileostomy
- Indwelling catheter/incontinence
- Plaster casts/braces
- ADL assist/exercises
- Minor skin issues/turning/repositioning
- Dressings for uninfected post op/chronic/palliative skin problems

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Skilled therapy services must meet all of the following conditions:

- **Directly and specifically** related to an active written treatment plan based on initial evaluation by qualified therapist after admission to the SNF and prior to the start of therapy services in the SNF that is approved by the physician after any needed consultation with the qualified therapist.
- Services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified therapist
- Services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition
- Services must be reasonable and necessary for the treatment of the patient's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable

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It's not the condition, it's **what we are doing about it** that determines need for skilled care.



Would the person be safe in a lower level of care, without RN/Therapist Oversight?

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Review:

- There must be documentation of medical instability or the probability of change in the resident's condition.
- Evidence of risks/potential complications requiring careful supervision.
- Evidence skilled licensed personnel are assessing/supervising care.



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Questions/Discussion



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