Case Management Monthly

Sample FAQ: Skilled nursing facilities and the three-day rule

Below is a question and answer form created by **Ronald Hirsch, MD, FACP, CHCQM,** vice president of the Regulations and Education Group at R1 Physician Advisory Services in Chicago, to help outline some basics regarding the complex rules surrounding the three-day qualifying stay required, which Medicare requires in order for patients to qualify for the skilled nursing facility (SNF) benefit.

You can use this as a starting point to create your own physician and provider training materials on this topic. Ensuring that providers are well-trained on this topic can help ensure patients get accurate information, which can make these discussions less difficult.

Q. Who qualifies for Part A SNF care?

A. Part A SNF care is a healthcare service provided when the patient needs skilled nursing or therapy staff to manage, observe, and evaluate his or her care. Examples of skilled care include intravenous injections and physical therapy. Medicare certifies facilities as SNFs if they have the staff and equipment to give skilled nursing care, therapy services, and/or other related health services.

Medicare doesn't cover custodial care if it's the only kind of care the patient needs. Custodial care is nonmedical care that helps the patient with usual daily activities like getting in and out of bed, eating, bathing, dressing, and using the bathroom. It may also include care that most people do themselves, like using eye drops or oxygen and taking care of colostomy or bladder catheters. Custodial care is often provided in a nursing or long-term care facility.

The patient must get the required skilled care on a daily basis and the services must be ones that can only be provided in a SNF on an inpatient basis. Medicare covers up to 100 days for Part A SNF care, but coverage may end prior to that point if the need for skilled services ends.

There must be a preceding inpatient admission of three or more days. That admission must have been medically necessary, meaning that inpatient admission was required for the patient to receive services or to reduce the risk to the patient risk. It also means that care could not have been safely provided at any other level of care.

Q. What do we do when families want their loved one admitted as a hospital inpatient so he or she can qualify for a transfer to a SNF?

A. If the patient has a condition that warrants hospital care that is expected to require two or more midnights, the patient should be admitted as inpatient. If that inpatient stay lasts more than three days, the patient can be evaluated for transfer to a SNF under Part A.

If the patient does not require an inpatient level of hospital care, he or she should not be admitted to the hospital as an inpatient solely to accumulate the three inpatient days needed for a qualifying covered SNF stay. The patient is unlikely to have a condition that requires skilled care on a daily basis if he or she does not require an inpatient stay. It is more likely that the patient requires custodial care that the family is no longer able to provide, and custodial care is not a covered Medicare benefit.

When a patient or family insists on inpatient admission, the physician has the option of admitting the patient and then notifying the care management staff who will issue a Preadmission Hospital-Issued Notice of Non-Coverage (HINN). This form will notify the patient and family that the hospital feels the admission is for non-medical reasons (a social admission) and therefore the hospital will be billing the patient—not Medicare—for the hospital stay. Furthermore, an admission accompanied by a Preadmission HINN will not be considered a qualifying stay for SNF coverage.

The family will have the option of taking the patient home, agreeing to transfer to a long-term care facility and pay out of pocket, or allowing the patient to be admitted and accepting financial responsibility (without accruing the needed days for SNF qualification.) The hospital will assist the family in arranging transfer to a long-term care facility for the needed custodial care or arranging needed home assistance.

Q. What are the implications of diagnosing a patient with failure to thrive?

A. Failure to thrive is not a diagnosis that requires acute hospital care. Patients with failure to thrive need assistance with eating, bathing, and using the bathroom; those are not skilled services.

In the past, we would admit these patients and then send them to a SNF. What changed?

As the Medicare trust fund drops, Medicare has started looking more closely for areas where it has been paying for services that were not a Medicare benefit. Custodial care is one area where billions of dollars have been paid improperly to SNFs for patients who did not require skilled care, so Medicare is now targeting this area for strict compliance with the rules.

Q. Why does a patient need a three-day inpatient stay to have covered care at a SNF?

A. The three-day requirement dates back to 1967. It is obsolete today, but remains in place despite lobbying by many organizations. This harms beneficiaries who would benefit from SNF skilled care after an acute illness or injury, such as a pelvic fracture with difficulty ambulating and need for therapy, but until the rule is changed, we must work with it as is. Medicare has allowed some accountable care organizations (ACO) to waive the three-day requirement for cases such as this, but those ACOs are financially accountable for the SNF costs so they use it wisely. Some hope that Medicare will adopt a three-day waiver in the future.

Q. Where can I read more about qualified SNF stays?

A. Medicare publishes a guide called "Medicare Coverage of Skilled Nursing Facility Care" that helps explain SNF care.

Q. Who can my patients speak with if they have complaints about the ways in which Medicare handles SNF stays and the three-day stay requirement?

A. The three-day rule and lack of coverage for custodial care comes from Congress. If patients do not agree with it and wish to take action, they can talk to their Congressional representative about the effect the requirement has on their care. Personal stories from constituents go a long way to getting changes in regulations.

*Source: Adapted with permission from **Ronald Hirsch, MD, FACP, CHCQM,** vice president of the Regulations and Education Group at R1 Physician Advisory Services in Chicago. Please note that this document was not approved or endorsed by CMS.*