

Medicare Minute Teaching Materials — December 2025

Medicare and Skilled Nursing Facility Care

1. What is skilled nursing facility care?

Skilled nursing facility (SNF) care is post-hospital care provided at a SNF. Skilled nursing care includes services such as administration of medications, tube feedings, and wound care. Keep in mind that SNFs can be part of nursing homes or hospitals.

Medicare Part A may cover your SNF stay if:

- You were formally admitted as an inpatient to a hospital for at least three consecutive days
- You enter a Medicare-certified SNF within 30 days of leaving the hospital, and receive care for the same condition that you were treated for during your hospital stay
- And, you need skilled nursing care seven days per week or skilled therapy services at least five days per week

Note: The day you become an inpatient counts toward your three-day inpatient stay to qualify for Medicare-covered SNF stays. However, the day you are discharged from the hospital does not count. Also remember that time spent receiving emergency room care or under observation status does not count toward the three-day hospital inpatient requirement for SNF coverage.

If you meet all of the above requirements, Medicare should cover the SNF care you need to improve your condition, maintain your ability to function, or prevent your health from getting worse.

Speak to your doctor or hospital discharge planner if you need help finding a SNF that meets your needs. Ask them to find Medicare-certified SNFs in your area that will meet your medical needs. You can also compare SNF facility quality ratings using [Medicare's SNF comparison tool](#). If you are in a Medicare Advantage plan, contact your plan to find out which SNFs are in the plan network.

2. What are the costs and coverage related to a SNF stay?

During a Medicare-covered SNF stay, Part A covers:

- A semi-private room and meals (room and board)
- Skilled nursing care provided by nursing staff
- Therapy, including physical therapy, speech therapy, and occupational therapy
- Medical social services and dietary counseling
- Medications
- Medical equipment and supplies
- Ambulance transportation to the nearest provider of needed services, when other modes of transportation would endanger your health

Each benefit period (see question 3), Part A covers the full cost of your first 20 days in a SNF. For days 21-100, Part A covers part of the cost and you pay a daily coinsurance. To be eligible for Medicare SNF coverage, your care must be medically necessary.

Note: If you are not eligible for a Part A covered SNF stay, Part B can cover needed services in a SNF if you are paying your own room and board.

3. What is a benefit period?

Benefit periods measure your use of inpatient hospital and SNF services. A benefit period for Original Medicare Part A begins the day you are admitted to a hospital as an inpatient, or to a SNF, and ends the day you have been out of the hospital or SNF for 60 days in a row.

After you meet your deductible, Medicare pays in full for days 1 to 60 that you are in a hospital. For days 61-90, you pay a daily coinsurance. If you have used your 90 days of hospital coverage but need to stay longer, Medicare covers up to 60 additional lifetime reserve days, for which you will pay a daily coinsurance. These days are nonrenewable, meaning you will not get them back when you become eligible for another benefit period.

Medicare Part A covers the full cost of your first 20 days in a SNF. For days 21-100, Part A covers part of the cost and you pay a daily coinsurance.

Medicare will stop paying for your inpatient-related hospital costs (such as room and board) if you run out of days during your benefit period. To be eligible for a new benefit period, and additional days of inpatient coverage, you must remain out of the hospital or SNF for 60 days in a row. When you start a new benefit period, you will also have a new Part A deductible.

Note: Medigap policies A through N pay for your hospital coinsurance and provide up to an additional 365 lifetime reserve days. Additionally, Plans B through N pay some or all of your hospital deductible.

If you are enrolled in a Medicare Advantage plan, contact your plan to learn about the costs and coverage rules for inpatient care.

4. What if I need to stay in a SNF past 100 days?

Medicare covers up to 100 days of care in a SNF each benefit period (see question 3). If you need more than 100 days of SNF care in a benefit period, you will need to pay out of pocket. If your care is ending because you are running out of days, the facility is not required to provide written notice. It is important that you or a caregiver keep track of how many days you have spent in the SNF to avoid unexpected costs after Medicare coverage ends.

Remember that you can again become eligible for Medicare coverage of your SNF care, once you have been out of a hospital or SNF for 60 days in a row. You will then be eligible for a new benefit period, including 100 new days of SNF care, after a three-day qualifying inpatient stay.

If you are receiving medically necessary physical, occupational, or speech therapy, Medicare may continue to cover those skilled therapy services even when you have used up your SNF days in a benefit period—but Medicare will not pay for your room and board, meaning you may face high costs. Check with your provider to

see if you qualify for therapy at home through Medicare's home health benefit, or if you could safely receive therapy as an outpatient while living at home.

If you have long-term care insurance, it may cover your SNF stay after your Medicare coverage ends. Check with your plan for more information. If your income is low, you may be eligible for Medicaid to cover your care. To find out if you meet eligibility requirements in your state, contact your local Medicaid office.

5. What happens if I return to a SNF after leaving?

If you leave a SNF and return to that SNF or another one within 30 days, you do not need another three-day qualifying hospital stay. If you return after 30 days have passed, Medicare will not pay unless you have been in the hospital for another three-day qualifying stay in the 30 days before you enter the SNF.

Medicare will only cover your care in a SNF while you are there. If you need to leave the SNF for any reason, including going to the hospital, Medicare will not pay to hold your bed at the SNF. Also, though you may qualify for Medicare-covered SNF care after you leave the hospital, you may not be able to return to the same SNF, for instance if the SNF no longer has space for you.

In some cases, you may be able to save a bed at a SNF if you need to leave the SNF for a short period. The SNF can charge for this service, and you will be responsible for paying the full cost of the charge out of pocket. In some states, Medicaid may pay for the bed-hold. If you have Medicaid, contact your local Medicaid office for more information.

6. What should I do if I am discharged from my SNF before I am ready to leave?

If you are receiving care from a SNF and are told that Original Medicare or your Medicare Advantage plan will no longer pay for your care (meaning that you will be discharged), you have the right to a fast (expedited) appeal if you do not believe your care should end. There are separate processes depending on whether you are enrolled in Original Medicare or a Medicare Advantage plan.

Note that this process is different if your care is being reduced but not ending, and you do not agree with that reduction (see question 7).

If you have Original Medicare:

1. If your care is ending at a SNF because your provider believes Medicare will not pay for it, you should receive a Notice of Medicare Non-Coverage. You should get this notice no later than two days before your care is set to end.
 - o If you have reached the limit in your care or do not qualify for care, you do not receive this notice and you cannot appeal.
2. If you feel that your care should continue, follow the instructions on the Notice of Medicare Non-Coverage to file an expedited appeal with the Quality Improvement Organization (QIO) by noon of the day before your care is set to end. The QIO should make a decision no later than two days after your care was set to end. Your provider cannot bill you before the QIO makes its decision.

- Once you file the appeal, your provider should give you a Detailed Explanation of Non-Coverage. This notice explains in writing why your care is ending and lists any Medicare coverage rules related to your case.
 - The QIO will usually call you to get your opinion. You can also send a written statement.
 - If you miss the deadline for an expedited QIO review, you have up to 60 days to file a standard appeal with the QIO. If you are still receiving care, the QIO should make its decision as soon as possible after receiving your request. If you are no longer receiving care, the QIO must make a decision within 30 days.
3. If the QIO appeal is successful, you should continue to receive Medicare-covered care, as long as your doctor continues to certify it. If the QIO denies your appeal, you can choose to move to the next level by appealing to the Qualified Independent Contractor (QIC) by noon of the day following the QIO's decision. The QIC should make a decision within 72 hours. Your provider cannot bill you for continuing care until the QIC makes a decision. However, if you lose your appeal, you will be responsible for all costs, including costs incurred during the 72 hours the QIC deliberated.
 - If you miss the QIC deadline, you have up to 180 days to file a standard appeal with the QIC. The QIC should make a decision within 60 days.
 4. If the appeal to the QIC is successful, you should continue to receive Medicare-covered care, as long as your doctor continues to certify it. If your appeal is denied and your care is worth at least \$190 in 2025, you can choose to appeal to the Office of Medicare Hearings and Appeals (OMHA) level within 60 days of the date on your QIC denial letter. If you decide to appeal to the OMHA level, you may want to contact a lawyer or legal services organization to help you with this or later steps in your appeal—but this is not required. OMHA should make a decision within 90 days.
 5. If your appeal to the OMHA level is successful, you should continue to receive Medicare-covered care, as long as your doctor continues to certify it. If your appeal is denied, you can move to the next level by appealing to the Council within 60 days of the date on your OMHA level denial letter.
 6. If your appeal to the Council is successful, you should continue to receive Medicare-covered care, as long as your doctor continues to certify it. If your appeal is denied and you are appealing care that is worth at least \$1,840 in 2025, you can choose to appeal to the Federal District Court within 60 days of the date on your Council denial letter. There is no timeframe for the Federal District Court to make a decision.

If you have a Medicare Advantage plan:

1. If your care is ending at a SNF because your provider believes Medicare will not pay for it, you should receive a Notice of Medicare Non-Coverage (you may also receive an Integrated Denial Notice, or IDN, from your plan). You should get this notice no later than two days before your care is set to end.
2. If you feel that your care should continue, follow the instructions on the Notice of Medicare Non-Coverage to file an expedited appeal with the Quality Improvement Organization (QIO) by noon of the day before your care is set to end. The QIO should make a decision no later than the day your care is set to end. Your provider cannot bill you before the QIO makes its decision.
 - Once you file the appeal, your provider should give you a Detailed Explanation of Non-Coverage. This notice explains in writing why your care is ending and lists any Medicare coverage rules related to your case.

- The QIO will usually call you to get your opinion. You can also send a written statement.
- 3. If the appeal to the QIO is successful, your care will continue to be covered. If your appeal is denied, you can file an appeal with the QIO a second time. A different set of staff will review your appeal and reconsider whether care should be continued. You have 60 days following the QIO's initial denial. The QIO should issue a second decision within 14 days of getting the appeal. Your provider cannot bill you for continuing care until the QIO makes its decision. However, if you lose your appeal, you will be responsible for all costs, including costs incurred during the time the QIO deliberated.
- 4. If the second appeal to the QIO is successful, your hospital care will continue to be covered. If the appeal is denied and your care is worth at least \$190 in 2025, you can choose to appeal to the Office of Medicare Hearings and Appeals (OMHA) level within 60 days of the date on your QIO denial letter. If you decide to appeal to the OMHA level, you may want to contact a lawyer or legal services organization to help you with this or later steps in your appeal—but this is not required.
- 5. If your appeal to the OMHA level is successful, your care will be covered. If your appeal is denied, you can choose to appeal to the Council within 60 days of the date on your OMHA level denial letter. There is no timeframe for the Council to make a decision.
- 6. If your appeal to the Council is successful, your care will be covered. If your appeal is denied and you are appealing care that is worth at least \$1,840 in 2025, you can choose to appeal to the Federal District Court within 60 days of the date on your Council denial letter. There is no timeframe for the Federal District Court to make a decision.

7. What should I do if my SNF is reducing my services?

You have the right to appeal if your SNF decides to reduce your care because it believes Medicare will no longer cover the services you are receiving. Be aware that the process is slightly different depending on whether you have Original Medicare or a Medicare Advantage plan. Also note that there is a separate process if you are appealing because your care is ending / the SNF wants to discharge you (see question 6).

Original Medicare

If you have Original Medicare, and your SNF decides to reduce services prescribed by your doctor because it believes that Medicare will no longer cover these services, it should give you a notice explaining why services are being reduced. You should receive a notice indicating that Medicare may deny part of your care. This notice is often called a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN). The notice will ask you to choose one of the following three options:

- Request care and ask the SNF to bill Medicare (demand bill). If Medicare denies coverage, you have the right to file an appeal. If your appeal is unsuccessful, you may be responsible for the cost of care. A SNF may refuse to demand bill.
- Request care but agree to pay for the care out of pocket.
- Turn down care. You can look for another SNF that might cover the needed care.

Remember, you have the right to a demand bill if your care is being reduced because your SNF doesn't believe Medicare will cover it. Be aware that demand billing rules can vary depending on the kind of care you are receiving. If you ask a SNF to demand bill Medicare, you cannot be billed for those services until Medicare makes a coverage decision.

Medicare Advantage

If you are in a Medicare Advantage plan and your SNF is reducing your services because it believes that Medicare will no longer cover some of the services you are receiving, you typically have to appeal to ask your plan for a fast (expedited) review of the decision to change your plan of care. To do this, the SNF must first contact the plan for a coverage decision, prior authorization, or demand bill (depending on the plan). The plan then responds to this request with a Notice of Medicare Non-Coverage (or an Integrated Denial Notice, or IDN) if the plan agrees with the reduction. The patient can then use this denial notice to begin their appeal of the reduction in services.

8. Can I appeal my hospital status changing from inpatient to outpatient?

During a hospital visit, it's possible that the hospital may change your status from "inpatient" to "outpatient getting observation services." This change in status affects your costs and could affect your future coverage. For example, it may prevent you from reaching the three-day qualifying inpatient stay required for a subsequent Medicare-covered SNF stay (see question 1). If your hospital makes this change to your status, you have the right to appeal.

You should receive a notice titled "Medicare Change of Status Notice (CMS-10868)" if the hospital changes your status from "inpatient" to "outpatient getting observation services." The notice explains that it will bill Medicare Part B (not Part A) for your outpatient stay. It also says that Medicare won't pay for your SNF stay after you leave the hospital. The notice includes information on how you can appeal this change to your status.

It's best to begin your appeal while you're still in the hospital, but you can also appeal after you've left the hospital. You will send your appeal to your state Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO). Depending on where you live, your BFCC-QIO may be called Livanta or Acentra Health. The BFCC-QIO will notify the hospital of your appeal and review the hospital's medical records, before informing you of its decision within two days of you filing your appeal.

If the BFCC-QIO agrees with the hospital that your status should have been changed, you'll be responsible for the Part B costs associated with your hospital stay. You also won't have the three-day inpatient stay required for a Medicare-covered SNF stay.

9. Does Medicare cover care coordination after leaving a SNF?

Medicare Part B covers care coordination (also called transitional care management) if you need assistance organizing your care after leaving a facility, whether you were an inpatient or an outpatient. Your primary care provider (PCP) may automatically provide care coordination, or you can request services by asking that your SNF notify your PCP about your discharge home.

Under this benefit, you should receive an in-person visit from your provider within 7 or 14 days of your return home, depending on the complexity of your condition. Your provider should offer the following services, as necessary:

- Contact you within two days of leaving the SNF
- Work with your other health care providers to provide education and other services to help you transition back to living at home

- Review your need for follow-up visits and help you schedule them
- Identify medical needs you have and arrange referrals to follow-up care and other community resources

Part B covers care coordination after a SNF stay at 80% of the Medicare-approved amount if you receive the service from a participating provider. You pay a 20% coinsurance after you meet your Part B deductible (\$257 in 2025; \$283 in 2026). If you have a Medicare Advantage plan, contact your plan for more information about costs and coverage related to care coordination upon leaving a SNF.

If you have questions about receiving this benefit, speak to your primary care provider.

10. How can I prevent, detect, and report SNF fraud?

SNFs are an important part of many patients' recovery after a hospital stay. Unfortunately, some facilities (even some associated with national chains) have taken to fraudulent billing. SNFs can use fraudulent billing practices to make more money than they've earned from Medicare or from the patients themselves. Look out for the following red flags:

- You see on your Medicare Summary Notice (MSN) or Explanation of Benefits (EOB) charges for:
 - Services that were not deemed medically necessary by your doctor
 - Therapy services or visits that were billed to Medicare but were not provided
 - More expensive services than what you were provided or more therapy than what was provided to you
 - Skilled nursing services for dates after you were released from the SNF
- You are forced to remain in a SNF until your Part A benefits have expired even though your condition has improved and you wish to change to home health care services

If you believe you have experienced potential Medicare fraud, errors, or abuse, contact your Senior Medicare Patrol (SMP). Contact information for your local SMP is on the last page of this document.

11. Who can I contact for more help?

Your doctor or hospital discharge planner: Speak to your doctor or hospital discharge planner if you need help finding a SNF that meets your needs. Your doctor can also help answer your questions about receiving SNF and care coordination benefits.

Your Medicare Advantage plan: Contact your plan to learn which SNFs are in network. You can also learn about any specific costs and coverage rules that apply to your plan's SNF coverage.

State Health Insurance Assistance Program (SHIP): Contact your local SHIP for help understanding your SNF coverage or for help appealing a discharge or reduction in care. Contact information for your local SHIP is on the last page of this document.

Senior Medicare Patrol (SMP): Contact your local SMP if you have experienced potential Medicare fraud, errors, or abuse. Contact information for your local SMP is on the last page of this document.

SHIP case study

Patricia was admitted to the hospital as an inpatient on March 3 after falling in her home and injuring her hip. She received a written notice on March 7 from her hospital saying that she would be discharged on March 8 and could return home. She felt ready to go home at the time. However, after over a month at home she began to have some pain in her hip. She talked to her doctor who said she should go to a SNF for daily rehab care. Patricia plans to be admitted to a Medicare-certified SNF the next day.

Will Medicare cover Patricia's SNF stay?

- No. Since Patricia was formally admitted as a hospital inpatient for five days, she would meet the qualifying hospital stay requirement for Medicare to cover SNF care. However, since she goes home after being discharged and enters the SNF over 30 days later, Medicare will not cover the SNF stay since Patricia exceeded the 30-day timeframe from hospital discharge to SNF entry.
- Medicare may not cover room and board, but if Patricia were to pay the room and board herself and get rehabilitative therapy, it would be considered outpatient therapy and could be covered by Part B.
- Patricia could also ask her doctor if home health could alternatively be appropriate for her. She could receive daily rehab care in her home if her doctor agrees that she qualifies for home health and that this plan of care is medically appropriate for her.
- If Patricia needs more help learning about SNF coverage, she can contact her local State Health Insurance Assistance Program (SHIP).
 - If she doesn't know how to contact her local SHIP, she can visit www.shiphelp.org or call 877-839-2675.

SMP case study

Mimi recently had a 14-day stay in a SNF following surgery. She received a Medicare Summary Notice (MSN) from Medicare indicating that Medicare had paid for 20 days of SNF coverage. Mimi is concerned that Medicare does not have the right information about her SNF stay and wants to know what she should do.

What should Mimi do?

- Mimi should call her Senior Medicare Patrol (SMP) for assistance
 - If Mimi doesn't know how to reach her SMP, she can call 877-808-2468 or visit www.smpresource.org.
- The SMP will let Mimi know that she is right to be concerned about the incorrect information on her MSN—if the SNF intentionally billed Medicare for a longer stay than she actually had, this could be considered Medicare fraud. Even if it was an error, it results in excess costs to the Medicare program and could create a barrier for Mimi getting additional SNF care in the future.
- The SMP can instruct Mimi to call the SNF to let them know about the error, and to ask them to correct the error and resubmit the claims to Medicare correctly.
- If the SNF is unresponsive or refuses to correct the error, the SMP can help Mimi report the potential fraud to Medicare and the correct authorities.
- The SMP will remind Mimi of the importance of continuing to check her MSNs and the bills that she receives from her providers, so that she can catch errors like this one.

Local SHIP Contact Information	Local SMP Contact Information
<p>SHIP toll-free: 800-247-4422 SHIP email: IdahoSHIBA@doi.idaho.gov SHIP website: https://doi.idaho.gov/SHIBA/</p> <p>To find a SHIP in another state: Call 877-839-2675 and say “Medicare” when prompted or visit www.shiphelp.org.</p>	<p>SMP toll-free: SMP email: SMP website:</p> <p>To find an SMP in another state: Call 877-808-2468 or visit www.smpresource.org.</p>
<p><i>This document is supported by the Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$3,000,000 with 100 percent funding by ACL/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by ACL/HHS, or the U.S. government.</i></p> <p>SHIP Technical Assistance Center: 877-839-2675 www.shiphelp.org info@shiptacenter.org SMP Resource Center: 877-808-2468 www.smpresource.org info@smpresource.org © 2025 Medicare Rights Center www.medicareinteractive.org</p> <p><i>The Medicare Rights Center is the author of portions of the content in these materials but is not responsible for any content not authored by the Medicare Rights Center.</i></p>	