

Chapter 19

Hospital Discharge Planning: Advocating for Aging Adults’ Medicare Rehabilitation Benefits

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SYNOPSIS

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19-1. Discharge Planning

Aging adults can best advocate for their rights to Medicare Parts A and B rehabilitation benefits by understanding the Medicare guidelines and healthcare systems, knowing the appropriate rehabilitation admission criteria, and then making an informed choice regarding all the available rehabilitation options. Aging adults, their families, and healthcare advocates also need to be willing to appeal any adverse decision that inappropriately terminates rehabilitation benefits or seeks to deny reimbursement for Medicare Parts A and B benefits. An excellent Medicare resource organization is the Center for Medicare Advocacy, Inc., at <https://medicareadvocacy.org>.

Acute-care hospital discharge planning begins almost *immediately* upon your admission to the hospital. Medicare defines “discharge planning” and states the requirements for conducting discharge planning. Its purpose is “to ensure a timely and smooth transition to the most appropriate type of setting for post-hospital or rehabilitation care.” Aging adults and their healthcare advocates need to communicate as soon as appropriate with the discharge planner and stay engaged in the process, so the aging adults’ needs and concerns are considered in discharge plans.

Discharge planning usually is conducted with a multi-disciplinary team approach and includes discharge recommendations from the patient's physicians; nurses; and physical, occupational, and speech therapists, which are given to the aging adult's hospital discharge planner (who usually is a nurse or social worker) to arrive at reasonable options for safe discharge. These options are then discussed with the aging adult and family or healthcare advocate. It is *highly* recommended that the aging adult have an advocate assist with discharge planning and that person is present during *all* discharge planning discussions.

The discharge plan provides recommendations regarding an aging adult's medical and rehabilitation needs post-hospital discharge. Its purpose is to ensure aging adults receive continuity of medical care and all needed services pursuant to "Health Insurance for the Aged and Disabled," Title 42, Chapter 7, Subchapter XVIII of the Social Security Act.

There are many variables in insurance coverage that an aging adult 65 years old or older may have. *See* Chapter 3, "Health Insurance Beyond Medicare." Many Colorado aging adults choose to assign their Medicare Part A and Part B benefits to a private organization or insurance company and obtain benefits under Medicare Part C, or "Medicare Advantage." These Medicare Advantage plans may or may not afford aging adults their legally entitled rehabilitation benefits, in spite of the obligation for Medicare Advantage plans to provide, at a minimum, the same coverage for rehabilitation services as are provided under original Medicare Parts A and B.

This chapter is limited to discussing original Medicare Parts A and B fee-for-service coverage and encourages Medicare Advantage beneficiaries to investigate their plan rehabilitation benefits before these benefits are needed, including the appeal process if benefits are denied.

19-2. Patient Discharge Planning Factors

The discharge planner and the discharge planning team consider numerous patient risks and factors in making their recommendations. These include, but are not limited to:

- ✦ Insurance coverage and Medicare eligibility. To trigger Medicare Part A rehabilitation benefits, the aging adult *must be admitted* as an in-patient and be *hospitalized for three consecutive calendar days*, not kept on "observation" status. If an aging adult is on observation and meets the "in-patient criteria," his or her status must be changed to "in-patient admission" in order to trigger eligibility. Clarify admission status **immediately** and the date of admission with the hospital in order to determine that this threshold criteria is met.

During the COVID-19 Public Health Emergency (PHE), CMS issued a waiver of this three-day inpatient hospital stay requirement and provided that beneficiaries could access SNF (Skilled Nursing Facility) services without it if the beneficiary's medical record documentation justified "medical necessity" for SNF admission. This waiver and the national and PHE declarations expired on May 11, 2023. *See* "COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers," www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf, at page 16.

Thus, a Medicare beneficiary only can be admitted directly to an SNF from a hospital with a qualifying three-day inpatient stay to get full Part A SNF benefits. Other patient risks and factors that may be considered for discharge planning include:

- ✦ Cognitive status, especially his or her judgment and safety awareness abilities;
- ✦ Fall history and risk for future falls;
- ✦ Age;
- ✦ Level of independence and safety in walking and ADLs (activities of daily living) prior to this hospital admission;
- ✦ Living situation (*i.e.*, lives alone or with others);
- ✦ Where he or she lives (*i.e.*, in a house, condominium, mobile home, assisted living facility, aging adult independent apartment (with or without meal availability), or skilled nursing facility);
- ✦ Ease of egress/ingress into home (*i.e.*, stairs, elevator, ramp, hand railings);
- ✦ Support and resources available to the aging adult from family, friends, and community;
- ✦ Wound and skin care needs (*i.e.*, decubitus ulcers or potential for development);
- ✦ Infectious disease processes (*i.e.*, need for intravenous antibiotics);
- ✦ Nutritional needs, and availability of meal service;
- ✦ History of being medically and medication compliant or non-compliant; and
- ✦ Medical diagnosis and complexity, including, but not limited to: mental health concerns; having cancer and receiving chemotherapy and/or radiation; end-stage renal disease and receiving dialysis; pulmonary disease and needing supplemental oxygen; stroke (cerebral vascular accident), closed-head injury, or subdural hematoma with extensive rehabilitation needs; morbid obesity; multiple sclerosis; cardiac complexity, including coronary artery bypass grafts, pacemaker, myocardial infarction (heart attack), congestive heart failure, and atrial fibrillation (a-fib); total joint replacements; and fractures, including location and weight-bearing status (amount of weight allowed) on legs and arms.

19-3. Discharge Options

Options for discharge from the acute care hospital include:

- ✦ Skilled nursing facility (SNF);
- ✦ In-patient rehabilitation facility (IRF);
- ✦ Long-term acute care hospital (LTAC), also known as critical access hospital;
- ✦ Home with home health services;
- ✦ Hospice care in the home or in a facility;
- ✦ Home with outpatient rehabilitation facility services;
- ✦ Home or SNF with Medicare Part B skilled rehabilitation services; or
- ✦ Home without rehabilitation services.

SNF Rehabilitation Facility

Skilled Nursing Facility (SNF) or Post-hospital Extended Care Services

Medicare Part A hospital insurance benefits provide up to 100 days of in-patient extended care benefit coverage. Days 1 to 20 are covered at 100 percent for all costs. This includes all skilled nursing expenses; all physical, occupational, and speech therapies; durable medical equipment such as wheelchairs, walkers, and special beds; and all other ancillary services such as supplemental oxygen. Days 21 to 100 require a 2026 daily co-insurance charge of \$217. Most supplemental or Medigap insurance plans cover this co-insurance charge and aging adults are urged to purchase this insurance.

A beneficiary does not have an absolute right to payment for 100 days of skilled nursing or skilled rehabilitation services. Rather, skilled rehabilitation services are reimbursed if they are deemed “reasonable” and “medically necessary” and require the skills, knowledge, and judgment of a professional therapist. Additionally, an aging adult needs to cooperate with and actively participate in rehabilitation in order to achieve his or her prior level of function and maintain Medicare coverage for the rehab services.

The criteria necessary to be eligible for Medicare Part A benefits for an SNF are:

- ✦ **A three-day minimum, medically necessary, in-patient hospitalization is required as an admitted patient and not on observation status.** This is the most important triggering event for Medicare Part A rehabilitation benefits eligibility. Days are counted from midnight forward, must be consecutive, and the day of discharge does not count. For example, if an aging adult is admitted to the hospital at 11:50 p.m. (2350), these 10 minutes count as one required day;
- ✦ Admission to the SNF is within 30 days of hospital discharge (though there are a few exceptions to this rule);
- ✦ The aging adult must require skilled nursing care or skilled rehabilitation services, or both, on a daily basis. The “daily” skilled rehabilitation services or therapy requirement is met if skilled services are provided for five days per week;
- ✦ The skilled services are for treatment of a condition that was treated in the hospital or that arose while in the SNF for treatment of a condition for which the aging adult was hospitalized in the qualifying stay;
- ✦ The SNF must be a Medicare-certified facility, and the “bed” must be deemed a Medicare-certified bed; and
- ✦ A physician must certify the need for skilled rehabilitation services.

Discharge Planning

Discharge planning also is done at the SNF, to determine appropriate and safe placement for the aging adult after skilled nursing and rehabilitation services are no longer deemed reasonable and medically necessary.

The aging adult and his or her healthcare advocates need to maintain communication with the SNF rehabilitation personnel so that they know the aging adult’s progress and expected discharge date and plan. SNFs are required to develop a post-discharge plan of care to ensure an orderly and safe

discharge. A physical or occupational therapist may perform a home safety assessment in advance of the aging adult's discharge to determine the person's discharge and DME (Durable Medical Equipment) needs, home accessibility, and home mobility and safety concerns.

If the SNF determines that the aging adult no longer qualifies for skilled services and the facility wants to transfer the aging adult to a non-Medicare certified bed (*i.e.*, end Medicare Part A benefits and/or change rooms), the aging adult must be given a two-day notice of transfer that outlines his or her appeal rights.

The Medicare Benefit Policy Manual states that beneficiaries receiving Medicare Part A in an SNF will not lose their coverage and may leave the facility with a doctor ordered outside pass (usually limited to four hours) for the purpose of attending a special religious service, holiday meal, family event, car ride, or a trial visit home. It is not, by itself, evidence that the individual no longer needs SNF skilled services.

Note: Reimbursement for SNF rehabilitation significantly changed effective October 1, 2019, with the Patient-Driven Payment Model (PDPM). What this means is a Medicare beneficiary's rehabilitation benefit delivery of services and overall benefit has been decreased significantly.

In-Patient Rehabilitation Facility

Patients who have Medicare Part A benefits and meet the in-patient rehabilitation facility (IRF) admission criteria may be transferred to or admitted directly to an IRF, which provides three hours per day rehabilitation services in an in-patient setting.

The criteria for admission to an IRF is the aging adult must:

- ◆ Be able to tolerate three hours per day, five days per week (15 hours), of skilled rehabilitation services, including physical, occupational, and speech and language therapy; be able to benefit from rehab; and agree to participate in the rehab program. The aging adult is allowed three days to increase up to a tolerance of three hours per day of therapy. (The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) waived this requirement during the Public Health Emergency, which ended May 11, 2023.);
- ◆ Need at least two skilled therapy services;
- ◆ Have good rehabilitation potential to achieve a higher functional level;
- ◆ Have the physical and cognitive capacity to benefit from the rehab program;
- ◆ Presently have or be in need of skilled rehabilitation services;
- ◆ Have a physician who agrees with transfer to acute rehab when medically stable;
- ◆ Have no scheduled surgery or procedure that would require a readmission to an acute care hospital prior to his or her rehabilitation program completion;
- ◆ Have documentation of his or her pre-admission status and living situation;
- ◆ Require 24 hours per day of skilled nursing and physician care; and
- ◆ Have received a rehabilitation diagnosis that is one of the 60 Percent Rule categories, or the IRF has beds to take the patient if outside of the Centers for Medicare and Medicaid Services (CMS) rehabilitation impairment categories (the 60 Percent Rule requires IRFs

to fill 60 percent of their beds with patients having one of the 13 diagnoses listed below as either a primary or secondary diagnosis).

CMS 60 Percent Rule Impairment Categories for IRF Admission Eligibility

An in-patient rehabilitation facility must fill 60 percent of its beds with only these 13-patient diagnosis and impairment categories in order to be in compliance and maintain its IRF status. This 60 percent rule was waived during the COVID-19 Public Health Emergency, which expired May 11, 2023:

- ✦ Cerebrovascular accident (stroke);
- ✦ Spinal cord injury;
- ✦ Congenital deformity;
- ✦ Amputation;
- ✦ Major multiple trauma (multiple fractures, fracture with internal injury);
- ✦ Hip fracture;
- ✦ Brain injury;
- ✦ Neurological disorder (*i.e.*, multiple sclerosis, muscular dystrophy, amyotrophic lateral sclerosis (ALS), Huntington's disease, Guillain-Barré, Parkinson's disease, post-polio syndrome, motor neuron diseases, polyneuropathy);
- ✦ Burns;
- ✦ Active polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies;
- ✦ Systemic vasculidities with joint inflammation;
- ✦ Severe or advanced osteoarthritis (osteoarthritis or degenerative joint disease):
 - ✦ Must involve two or more major weight-bearing joints with joint deformity and substantial loss of range of motion (elbow, shoulders, hips, or knees and cannot count a joint with a prosthesis);
 - ✦ Atrophy of muscles surrounding the joint;
 - ✦ Significant functional impairment of walking and ADLs;
- ✦ Knee and hip joint replacement if:
 - ✦ Bilateral (both sides);
 - ✦ The person is morbidly obese and has a Body Mass Index (BMI) over 50; and/or
 - ✦ The person is age 85 or older.

Beneficiaries with cardiac and respiratory diagnoses and medically complex patients had the availability of medically necessary intensive in-patient rehabilitation when CMS waived this 60 percent rule requirement during the COVID-19 Public Health Emergency. *See* "COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers," at page 14.

Since May 11, 2023, the end of the COVID-19 Public Health Emergency Declaration, aging adults with these types of impairments can be included only in the "other 40 percent" of admissions to IRFs. As health care insurances generally follow Medicare guidelines, this rule may adversely affect people of all ages in obtaining intensive rehabilitation in an in-patient rehabilitation hospital. The trend is towards the use of skilled nursing facilities for all adult rehabilitation.

Discharge Planning

This is very similar to that of discharge from a skilled nursing facility. Also, like discharge from an SNF, an expedited appeal process may apply. *See* section 2-3, “Appeal Rights,” in Chapter 2, “Medicare.”

Long-Term Acute Care Hospital (LTAC)

LTACs generally accept patients who are very medically complex and are expected to need acute care in-patient hospitalization for at least 25 days. LTACs are in the same Medicare Part A payment category as acute care in-patient hospitals and in-patient rehabilitation facilities. The benefit period is 60 days without a co-insurance charge, an additional 30 days with the \$434 per day co-insurance, and the possibility to tap into the lifetime reserve of 60 days at \$868 per day.

Home Health Care Services

Either Medicare Part A or Part B can reimburse post-hospital home health care skilled services. If the threshold three-day in-patient hospitalization has occurred to trigger Medicare Part A benefits and the aging adult has Part A, it will reimburse for services.

Reimbursement is under Medicare Part B if the aging adult has this insurance coverage and has not met the three-day hospitalization requirement. Home care services must start within 14 days of discharge from the in-patient hospital or SNF and the patient must be “homebound” or “confined to home” to be eligible for home health skilled services, which are limited to reasonable and necessary intermittent skilled nursing care; physical, occupational, and speech therapy; and home health aide services. “Homebound” is defined as follows:

An individual shall be considered to be “confined to his home” if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. . . . [T]he condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual.

Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State . . . shall not disqualify an individual from being considered to be “confined to his home.” Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of a relatively short duration. . . . [A]ny absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration.

Skilled rehabilitation services must be provided by a Medicare-certified home care agency, following the patient’s care plan and ordered by the patient’s physician. After the initial assessment, home therapy visits are usually scheduled one to three times per week.

Home health care agencies must provide a Medicare beneficiary a pre-deprivation written notice of its intent to terminate services. This mandatory two-day Notice of Medicare Non-Coverage (NOMNC) must explain the procedure for seeking review of the termination of services. If you do not agree with this termination of services, call the Quality Improvement Organization (QIO), Acentra Health (formerly known as) Kepro, at (888) 317-0891 to file an expedited appeal.

Note: Reimbursement for home health services significantly changed effective January 1, 2020, with the Patient-Driven Groupings Model (PDGM). It changed the unit of home health care payment from a 60-day to a 30-day episode, eliminated payment based upon the number of therapy visits, and relies heavily on clinical characteristics and medical diagnoses to determine Medicare payment categories.

Overall, it might decrease the number and availability of home health visits a beneficiary receives. Refer to the Center for Medicare Advocacy article, “Potential Impacts of New Medicare Payment Models on Skilled Nursing Facility and Home Health Care,” at www.medicareadvocacy.org/potential-impacts-of-new-medicare-payment-models-on-skilled-nursing-facility-and-home-health-care.

Hospice Care

Hospice care benefits are covered under the Medicare Part A hospital insurance benefit if the patient has Medicare Part A and has chosen to elect this benefit. Patients are entitled to two 90-day election periods, followed by an unlimited number of 60-day periods. Hospice care is concerned about maintaining the patient’s quality of life as he or she approaches death.

Medicare will pay for a consultation visit with the hospice medical director or other hospice physician if the patient is terminally ill and has not yet elected the hospice benefit. Eligibility for hospice care includes situations where:

- ✦ The patient’s attending physician and the hospice medical director or other hospice physician certify that the patient is terminally ill and has six months to live if the terminal illness runs its normal course. For any subsequent 90- or 60-day periods, only one physician needs to do the certification;
- ✦ The patient signs a hospice benefit election form with the hospice of choice, choosing hospice care over regular Medicare Part A–covered benefits for the terminal illness; and
- ✦ A Medicare-approved hospice program provides hospice care.

It is important to note that a “Do Not Resuscitate” (DNR) order is not required, nor must the patient be “homebound” to receive hospice care.

The following services are provided by hospice care:

- ✦ Physical, occupational, and speech therapy skilled services for purposes of symptom control or to enable the aging adult to maintain functional skills;
- ✦ Physician services and nursing care;
- ✦ Durable medical equipment (DME) such as hospital bed and wheelchair rental, commode chair, raised toilet seat, or walkers;

- ◆ Pain-relieving and all other medications (*Note:* Medicare Part D changes some of these reimbursements). See “Hospice and Part D Prescription Medications” chart by National Council on Aging in Chapter 2, “Medicare”;
- ◆ Home health aides for personal care services and homemaker services such as light cleaning or laundry;
- ◆ Medical social worker and case manager services;
- ◆ Spiritual, grief, and loss counseling;
- ◆ General in-patient hospital care, not for treatment of the terminal illness;
- ◆ Respite care covered for five consecutive days; and
- ◆ Bereavement care.

Room and board costs in a hospice facility (or an SNF) generally are not a covered benefit unless the beneficiary requires general in-patient or respite care. However, Medicaid covers these costs for Medicaid beneficiaries.

Discharge Planning

Hospice Medicare regulations require that, prior to “any termination of services, the provider of the service must deliver valid written notice to the beneficiary of the provider’s decision to terminate services.” This notice triggers the right to request an expedited appeal.

An aging adult (hospice beneficiary) can be discharged by his or her hospice provider under only three circumstances:

- 1) The aging adult moves out of the hospice provider’s service area or transfers to another hospice provider;
- 2) The hospice provider determines that the aging adult is no longer terminally ill; or
- 3) The hospice provider determines, pursuant to its policy of discharge for cause, that the aging adult’s behavior (or the behavior of other people in the aging adult’s home) is disruptive, abusive, or uncooperative to the extent that delivery of care to the aging adult or ability of the hospice to operate effectively is seriously impaired.

The regulations regarding discharge for cause require the hospice provider to:

- ◆ Advise the aging adult that it is considering a discharge for cause;
- ◆ Make efforts to resolve the issues caused by the aging adult’s behavior or home situation; and
- ◆ Show that this proposed discharge is not based upon the aging adult’s use of hospice services nor his or her medical record.

Medicare Part B Rehabilitation Benefits

Medicare Part B rehabilitation benefits are available to the beneficiary for skilled therapy rehabilitation services as follows:

- ◆ When the patient does not have a medically necessary, three-day in-patient hospitalization to trigger Medicare Part A benefits and he or she needs home health or outpatient rehabilitation therapy services (*e.g.*, the aging adult fell at home and sustained injuries,

was seen in the emergency room, and then sent home with an order for home health or outpatient physical therapy);

- ◆ While the patient is a resident of an SNF or an assisted living facility or lives in the community, and skilled rehabilitation services are deemed medically necessary, as there has been a change in functional status; and
- ◆ After a SNF patient exhausts his or her Medicare Part A rehabilitation benefits of 100 days, and skilled rehabilitation services continue to be considered reasonable and necessary (example: for stroke rehab).

The Balanced Budget Act of 1997 changed reimbursement for Medicare Part B outpatient rehabilitation benefits to an original total benefit of \$1,500 for occupational therapy skilled services per year and a \$1,500 total benefit for both physical and speech therapies per year. The 2026 maximum yearly capped reimbursement is now \$2,480 for occupational therapy skilled services, and \$2,480 for combined physical and speech therapy skilled services. There are some medical diagnoses that are exceptions to these caps.

When \$2,480 is reached, a special code (KX Modifier) must be added to a beneficiary's therapy claim. Claims exceeding \$3,000 for physical therapy and speech therapy services combined, and \$3,000 for occupational therapy services, may be subject to a medical review process to determine if therapy services are "medically necessary."

I 9-4. Rehabilitation

Rehabilitation skilled services include physical, occupational, and speech therapy. Therapy's primary goal is to facilitate the aging adult's return to his or her previous level of independent living and functioning.

Assuming the aging adult's medical status remains stable, there usually is a direct correlation between the amount, frequency, duration, and type of therapy services received post-hospitalization and the patient's potential to (1) stay as independent as possible, and (2) live in the least restrictive environment in his or her community. All therapy disciplines overlap in some manner, and they operate in a multi-faceted approach.

The emphases of the individual therapy disciplines include, but are not limited to:

Physical Therapy

- ◆ Evaluates and facilitates the aging adult's ability for safe, independent in-home mobility;
- ◆ Assesses the aging adult's safety, judgment, and problem-solving skills. Facilitates the person's learning and use of appropriate skills during all functional task performance;
- ◆ Assesses the aging adult's need for DME such as a wheelchair, cane, or walker; tub/shower bench; raised toilet seat; transfer devices; and other adaptive equipment such as grab bars and home ramps and facilitates their getting needed DME;
- ◆ Facilitates the aging adult's development of independently and safely performed functional skills, which include, but are not limited to:
 - ✦ Safely being able to get in and out of bed;
 - ✦ Safe transfers to all surfaces, including to toilet, bed, and wheelchair;

- ✧ Walking without risk of falls, with or without an assistive device; and
- ✧ Independent mobility outdoors in his or her community;
- ✧ Evaluates the aging adult for use of pain management modalities; and
- ✧ Conducts pre- and post-discharge home safety evaluations and home assessments for need of modifications and adaptive equipment.

Occupational Therapy

- ✧ Evaluates and facilitates the aging adult's ability to perform independent activities of daily living (ADLs), which include, but are not limited to:
 - ✧ Feeding with or without adaptive equipment;
 - ✧ Hygiene and care of teeth, mouth, and hair;
 - ✧ Toileting and bathing;
 - ✧ Safe toilet, bed, tub/shower bench, and wheelchair transfers;
 - ✧ Dressing, with or without adaptive equipment; and
 - ✧ Safely done household skills such as cooking and cleaning.
- ✧ Occupational therapy, like physical therapy, facilitates the aging adult's development and use of appropriate safety and judgment during ADLs and all functional skills performance;
- ✧ Administers the Allen Cognitive Assessment tool to assess and predict the appropriate level of post-discharge care needed;
- ✧ Assesses the aging adult's need for DME and adaptive equipment;
- ✧ Facilitates the achievement of functional sitting and standing balance; and
- ✧ Conducts pre- and post-discharge home safety evaluations and home assessments for need of modifications and adaptive equipment.

Speech and Language Therapy

- ✧ Evaluates and facilitates the aging adult's cognitive development, including judgment, safety, processing skills, and executive functioning skills;
- ✧ Evaluates and facilitates the aging adult's ability to regain language and communication skills;
- ✧ Facilitates the aging adult's use of communication devices such as the telephone, signboards, white boards, and computer-assisted communication;
- ✧ Evaluates the aging adult's ability to safely swallow liquids and food, without risk of aspiration, and makes dietary recommendations;
- ✧ Facilitates the aging adult's ability to regain independent swallowing and eating abilities; and
- ✧ Conducts specialized swallow tests, such as modified barium swallow.

19-5.Appeals

Beneficiaries are required to receive written notice of termination of services, non-coverage, and cutbacks in coverage pursuant to Medicare Parts A and B. This notice should set forth the appeal procedure. Appeals are time sensitive. See Section 2-3 in Chapter 2, "Medicare," for the discussion on appeals of adverse decisions. Beneficiaries are *strongly* encouraged to file an appeal on any denied and terminated services pursuant to Medicare Parts A and B, and to submit physicians' supporting documentation of "medical necessity" for these services.

19-6. Conclusion

Negotiating the Medicare maze of rules and regulations, with its constantly changing legislative landscape of operating policies, is indeed a challenge. However, by knowing the rules and the critical triggering eligibility criteria for beneficiaries' rights to Medicare Parts A and B rehabilitation benefits, aging adults will obtain them. Vigilant advocacy by the aging adult and his or her healthcare advocate, and the aging adult's active participation in his or her rehabilitation, will increase the aging adult's probability of success at returning to his or her previous level of independent functioning and living situation.

19-7. Resources

The Center for Medicare Advocacy, Inc.: *See* section 2-5, "Resources"

Centers for Medicare and Medicaid Services: *See* section 2-5, "Resources"

Colorado Senior Health Insurance Assistance Program: *See* section 2-5, "Resources"

Colorado Gerontological Society and Senior Answers and Services: *See* section 2-5, "Resources"

Acentra (fka) Kepro: *See* section 2-5, "Resources"

Medicare Claims and Helpline: *See* section 2-5, "Resources"

"COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers"

www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf
(updated 10/13/22)