

Chapter 22

Hospital Discharge Planning: Advocating for Seniors' Medicare Rehabilitation Benefits

Michele M. Lawonn, J.D., P.T.
Medical-Legal Advocates, LLC

SYNOPSIS

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22-1. Discharge Planning

Seniors can best advocate for their rights to Medicare Parts A and B rehabilitation benefits by understanding the Medicare guidelines and medical systems, knowing the appropriate rehabilitation admission criteria, and then making an informed choice regarding all the available options for your rehabilitation. Seniors, their families, and their health-care 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 www.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.” Seniors and their families or other health-care advocates need to communicate as soon as appropriate with the discharge planner, so seniors’ needs and concerns are considered in discharge plans.

Discharge planning usually is conducted with a multi-disciplinary team approach and includes input and discharge recommendations from the patient’s physicians; nurses; and physical, occupational, and speech therapists (speech-language pathologists). Information and recommendations are given to the senior’s hospital discharge planner (who usually has a nursing or social work background), to arrive at reasonable options for the safe discharge of each patient. These options are then discussed with the senior and his or her family or other health care advocate. It is *highly* recommended that the senior have an advocate assist him or her with discharge planning and that he or she is present during the discussions with the discharge planner.

The discharge plan provides recommendations regarding a senior’s medical and rehabilitation needs for discharge from the hospital. Its purpose is to ensure seniors receive continuity of medical care and all the services they need 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 a senior 65 years old or older may have. *See* Chapter 3, “Health Insurance Beyond Medicare.” Many Colorado seniors choose to assign their Medicare Part A and Part B benefits to a managed care organization or health maintenance organization (HMO) and obtain benefits under Medicare Part C, or “Medicare Advantage.” Frequently, these HMO plans, in spite of the obligation to provide as a minimum the same coverage for skilled nursing facility (SNF) and Part B rehabilitation services as are provided under original Medicare Parts A and B, may not always afford seniors their legally entitled rehabilitation benefits. This chapter is limited to discussing original Medicare Parts A and B fee-for-service coverage and encourages Medicare Advantage beneficiaries to investigate the rehabilitation benefits of their plans.

22-2. Patient Discharge Planning Factors

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

- ▶ Insurance coverage and Medicare eligibility. To trigger Medicare Part A benefits, the senior must be admitted as an in-patient and be *hospitalized for three consecutive calendar days*, not kept on “observation” status. If a senior is on observation and meets the “in-patient criteria,” his or her status must be changed to “in-patient admission,” with the admission date being the same day as when he or she was admitted to the hospital, in order to trigger eligibility for Medicare Part A rehabilitation benefits;
- ▶ Cognitive status, especially his or her judgment and safety awareness abilities;
- ▶ Age;
- ▶ Fall history and risk for future falls;

- ▶ Level of independence in ambulation and ADLs (activities of daily living) prior to hospital admission;
- ▶ Living situation (*i.e.*, lives alone or lives with a family member, spouse, or friend);
- ▶ Where he or she lives (*i.e.*, in a house, condominium, townhouse, mobile home, assisted living facility, senior independent apartment (with or without meal availability), or skilled nursing facility);
- ▶ Egress/ingress into living quarters (*i.e.*, stairs, elevator, ramp, hand railings);
- ▶ Support and resources available to senior 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);
- ▶ Nutrition, feeding tubes to provide nutrition, and availability of meal service;
- ▶ History of being compliant or non-compliant with medical treatment/medications; and
- ▶ Medical diagnosis and complexity, including, but not limited to, having cancer and receiving chemotherapy and/or radiation; end-stage renal disease and receiving dialysis; chronic obstructive pulmonary disease (COPD) and needing pulmonary treatments and oxygen; cerebral vascular accident (stroke), closed-head injury, or subdural hematoma with extensive rehabilitation needs; morbid obesity; multiple sclerosis; cardiac complexity, including coronary artery bypass graft, pacemaker implantation, myocardial infarction, and atrial fibrillation (a-fib); total joint replacements; and fractures, including location in legs or arms and weight-bearing status (amount of weight allowed) on legs and arms.

22-3. 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; use of 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 2009 daily co-insurance charge of \$133.50. Most supplemental or Medigap insurance plans cover this co-insurance charge; seniors are urged to purchase these insurance policies.

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.

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

- ▶ 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 a senior 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 senior 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. Most SNFs in the Denver metro area provide skilled therapy services a minimum of 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 senior 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 senior after skilled nursing and rehabilitation services are no longer deemed reasonable and medically necessary.

The senior and his or her health-care advocates need to maintain frequent and open communication with the SNF rehabilitation personnel so that they are informed as to the senior's progress and expected discharge date and plan. SNFs are required to develop a post-discharge plan of care to ensure a safe and orderly discharge. Frequently, a physical or occupational therapist performs a home safety assessment in advance of the senior's discharge to determine the senior's discharge and adaptive equipment needs, home egress and ingress accessibility, and overall mobility and safety concerns in the senior's home.

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

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 for an outside pass or a short leave of absence for the purpose of attending a special religious service, holiday meal, family occasion, car ride, or for a trial visit home. It is not, by itself, evidence that the individual no longer needs to be in an SNF for the receipt of required skilled care. However, the beneficiary needs to get his or her physician to order and permit this outside pass.

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. IRFs provide intensive three hours per day rehabilitation services in an in-patient setting.

To pass the criteria for admission to an IRF, the senior must:

- ▶ Be able to tolerate three hours per day, five days per week, 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 senior is allowed three days under PPS (the Prospective Payment System) to ramp up to a tolerance of therapy three hours per day;
- ▶ 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(s) who agrees with transfer to acute rehab when medically stable and there is documentation in the senior's medical record;
- ▶ 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 75% 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 75% Rule requires IRFs to fill 75 percent of their beds with patients having one of the 12 diagnoses listed below).

CMS 75% Rule Impairment Categories for IRF Admission Eligibility

An in-patient rehabilitation facility must fill 75 percent of its beds with only these 12 patient diagnosis and impairment categories in order to be in compliance and maintain its IRF status:

- ▶ Cerebrovascular accident (recent or old cerebrovascular accident (CVA), thrombosis, hemorrhage, or embolism of the brain, *i.e.*, stroke);
- ▶ Spinal cord injury (paraplegia or quadriplegia);
- ▶ Congenital deformity (spina bifida);
- ▶ Amputation;
- ▶ Major multiple trauma (multiple fractures, fracture with internal injury);
- ▶ Hip fracture (femoral head or neck);
- ▶ Brain injury (obstructive hydrocephalus, closed-head injury, open-head injury, brain tumor, encephalopathy, West Nile complications);
- ▶ Neurological disorder (*i.e.*, multiple sclerosis, muscular dystrophy, amyotrophic lateral sclerosis (ALS), Huntington's disease, Guillian-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 ambulation and other ADLs.

Seniors with cardiac and respiratory compromises, status post-total joint replacement surgery, and medically complex patients may be precluded from the availability of medically necessary intensive in-patient rehabilitation under this 75% Rule.

Seniors with these types of impairments, such as total joint replacements, now can be included only in the “other 25 percent” of admissions to IRFs, rather than counting in the 75 percent mix. As health-care insurances generally follow Medicare guidelines, this rule change adversely may affect people of all ages in obtaining intensive rehabilitation in an in-patient rehabilitation hospital. The trend easily may be toward the use of skilled nursing facilities for the rehabilitation of all adults.

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* Chapter 2, “Medicare.”

Long-Term Acute Care Hospital (LTAC)

LTACs generally accept patients who tend to be very medically complex and who 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 \$267 per day co-insurance, and the possibility to tap into the lifetime reserve of 60 days at \$534 per day.

Home Health Care Services

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

Reimbursement is under Medicare Part B if the senior has this insurance coverage and has not been hospitalized for three days or at all. Home care services must commence within 14 days of discharge from the in-patient facility or SNF. The patient must be “homebound” or “confined to home” to be eligible for home health 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. While an individual does not have to be bedridden to be considered “confined to his home,” the 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, or accredited, to furnish adult day-care services in the 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. For purposes of the preceding sentence, any 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, pursuant to the patient's care plan and ordered by the patient's physician. After the initial assessment, home therapy visits are usually scheduled one to four times per week.

Home health care agencies must provide a Medicare beneficiary a pre-deprivation written notice of its intent to cut back or terminate services, whether the reason for that change is a Medicare coverage determination, lack of physician certification, a home health agency's unwillingness to provide services for business reasons unrelated to coverage, or sheer caprice. These mandatory two-day Home Health Advance Beneficiary Notices (HHABNs) must explain the procedure for seeking review of the termination or cutback in services.

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 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" order is not required in order to receive hospice care, nor must the patient be "homebound" to receive hospice.

The following services are provided by hospice care:

- ▶ Physical, occupational, and speech therapy skilled services for purposes of symptom control or to enable the senior to maintain functional skills;
- ▶ Physician services and nursing care;
- ▶ Durable medical equipment 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*);
- ▶ Home health aides and homemaker services;
- ▶ Medical social worker and case manager services;
- ▶ Spiritual, grief, and loss counseling;
- ▶ General in-patient hospital care, not for treatment of 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.

Discharge Planning

There are new hospice Medicare regulations that prior to “any termination of service, 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 determination by independent review.

A senior (hospice beneficiary) can be discharged under only three circumstances:

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

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

- ▶ Advise the senior that it is considering a discharge for cause;
- ▶ Make efforts to resolve the issues caused by the senior’s behavior or home situation; and
- ▶ Show that this proposed discharge is not based upon the senior’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 patient 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 senior fell at home and sustained injuries, was seen and treated in the emergency room, and then was sent home with a prescription 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 an SNF patient exhausts his or her Medicare Part A rehabilitation benefits of 100 days, and skilled rehabilitation services continue to be deemed reasonable and necessary (for example, the senior sustained a cerebrovascular accident with profound deficits).

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. There has been a moratorium on these payment caps since 1998.

Recently, the moratorium was extended until December 31, 2009, with exceptions to these cap amounts based upon the senior's showing of "medical necessity" for Part B rehabilitation services. The maximum yearly capped reimbursement for occupational therapy outpatient skilled services is now \$1,840; for both physical and speech therapy skilled services combined, it is also \$1,840.

Allowing a reimbursement cap on outpatient Part B rehabilitation benefits has a detrimental effect on the majority of seniors, especially those seeking both physical and speech therapy skilled services in the same fiscal year. Seniors should consider contacting their elected representatives regarding the expiration of the moratorium on applicability of these capped rehabilitation reimbursements and request that this problem be corrected permanently. The Medicare Access to Rehabilitation Services Act of 2009 (H.R. 43, S. 46) was introduced January 6, 2009, by a bipartisan group of legislators to eliminate permanently Medicare Part B spending caps. The American Health Care Association, the Alliance for Quality Nursing Home Care, and many other organizations support it.

22-4. Rehabilitation

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

Assuming the patient'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, the following functions:

Physical Therapy

- ▶ Evaluates and facilitates the senior's ability to achieve safe and independent mobility in his or her environment;
- ▶ Assesses the senior's safety, judgment, and problem-solving skills. Facilitates the person's development and use of appropriate skills during the performance of all functional tasks;
- ▶ Assesses the senior's need for durable medical equipment such as a wheelchair, cane, walker, crutches, or other assistive device; tub/shower bench; raised toilet seat; and adaptive equipment such as grab bars and home ramp access;
- ▶ Facilitates the senior's development of independently and safely performed functional skills, which include, but are not limited to:
 - The ability to get in and out of bed;
 - Transferring between bed and a wheelchair;
 - Walking without risk of falls, with or without an assistive device;
 - Transferring to the toilet; and
 - Independent mobility outdoors in his or her community;
- ▶ Facilitates the achievement of functional leg, arm, and trunk strength and mobility;
- ▶ Facilitates the achievement of functional sitting and standing balance;
- ▶ Evaluates the senior for use of pain management modalities; and
- ▶ Conducts pre-discharge home safety evaluations and assesses a home's need for modifications and adaptive equipment.

Occupational Therapy

- ▶ Evaluates and facilitates the senior'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;
 - Safe toilet, bed, tub/shower bench, and wheelchair transfers;
 - Bathing;
 - Independent dressing of upper and lower body, with or without adaptive equipment; and
 - Safely done household skills such as cooking and cleaning.

- ▶ Occupational therapy, like physical therapy, facilitates the senior's development and use of appropriate safety and judgment during the performance of ADLs and all functional skills;
- ▶ Administers the Allen Cognitive Assessment tool to assess and predict the appropriate level of care needed by the patient post-discharge;
- ▶ Assesses the senior's need for durable medical equipment and adaptive equipment such as grab bars, tub/shower bench, hand-held shower, raised toilet seat, reacher, dressing aides, eating and food preparation aides, wheelchairs, and seating systems;
- ▶ Facilitates the achievement of functional sitting and standing balance;
- ▶ Facilitates the achievement of functional arm and trunk strength and mobility; and
- ▶ Conducts pre-discharge home safety evaluations and assesses a home's need for modifications and adaptive equipment.

Speech and Language Therapy

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

22-5. 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 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.

The Medicare appeal procedure and forms can be found at www.medicare.gov and the Colorado Health Insurance Assistance Program (SHIP) offers seniors appeal filing assistance at (800) 544-9181, (888) 696-7213, or (303) 899-5151.

22-6. 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 especially the critical triggering eligibility criteria for seniors' rights to Medicare Parts A and B rehabilitation benefits, seniors will obtain these benefits. Vigilant advocacy by the senior and his or her healthcare advocate will increase the senior's probability of success at returning to his or her previous level of independent functioning and living situation.

22-4. Resources

Medicare

www.medicare.gov

Colorado Health Insurance Assistance Program (SHIP)

Offers seniors appeal filing assistance

(800) 544-9181

(888) 696-7213

(303) 899-5151

The Center for Medicare Advocacy, Inc.

National nonprofit organization

P.O. Box 350

Willimantic, CT 06226

(202) 293-5760

(866) 456-7790

www.medicareadvocacy.org

