

HOSPITAL  
FOR  
**SPECIAL  
SURGERY**



# Hospital for Special Surgery

## Discharge Planning Education

Case Management Department

In preparation for your upcoming surgery, there is information that is important for you to know in order to prepare for your post hospital needs. There are questions that you may have forgotten to ask or answers that you might want repeated. We hope that the following will provide the answers you need.

The type of surgery you have will determine your anticipated length of stay in the hospital. For example, if you will be having Total Hip Replacement surgery, the anticipated length of stay is three days. For Total Knee Replacement surgery the anticipated length of stay is three to four days.

A member of the case management staff will see you after you are admitted to the hospital and assist with your post hospital needs.

Depending on your medical condition and progress in the hospital, you might need services at home or in another facility. Your case manager will make the necessary referrals and contact your insurance company regarding benefits and authorizations. Please be aware that even if your insurance covers certain services, these services may not be authorized since authorization of services is specific to medical/surgical diagnosis and progress. It is recommended that you contact your insurance carrier to become familiar with your benefit coverage and limitations as insurance benefits vary greatly.

## **INPATIENT REHABILITATION POST HOSPITALIZATION**

If you think you might need inpatient rehabilitation after discharge, you must understand that there are certain criteria for admission that must be met in order for insurance to cover. In addition, it is recommended that you and/or your significant other(s) visit facilities prior to admission to the hospital as you will need to provide your case manager with three choices. It is possible that your first choice of facility may not be available due to insurance or bed availability and that you will need to receive rehabilitation at your second or third choice. It is required that you be transferred to the first available appropriate facility to ensure that you receive rehabilitation as soon as possible, once you are ready for discharge.

Please check with your insurance company prior to your admission to the hospital to determine if your insurance (including Medicare, Managed Medicare, Medicaid and Managed Medicaid) covers the rehabilitation services that you are requesting and if the facilities that you are interested in are in your insurance network. ***It is important to understand that insurances will cover inpatient rehabilitation services only after an assessment of your post hospital needs and progress.*** This information will be sent to your insurer by your social work case manager.

There are different levels of rehabilitation: acute rehabilitation and subacute rehabilitation. It is very important that you understand the differences and understand why one level might be more appropriate for you than another.

## Some General Rules of Thumb:

Acute Rehabilitation Facilities such as Burke, North Shore Glen Cove, New York Presbyterian:

- ▶ Provide approximately 2 to 3 hours of intense therapy a day.
- ▶ **Typically, single joint replacements and spinal surgeries are not approved/appropriate for acute rehabilitation.**
- ▶ An assessment of your progress in physical therapy is necessary to justify admission to acute rehab.

**Reasons for denial:** Your progress has been slow and therefore you do not have the endurance for acute level of rehab, or you have reached too high a level of functioning to require such intense post hospital therapy.

### Subacute Rehabilitation Facilities

- ▶ Provide approximately 1-1.5 hours of rehabilitation therapy a day.
- ▶ Subacute facilities are usually in a nursing home setting but designed for short term rehabilitation with a length of stay of one to three weeks.
- ▶ Some facilities have separate units to provide a subacute level of care for post hospitalized patients, while others do not.

## HOME CARE SERVICES

For patients who require home care, your case manager will assist in arranging a referral to preferred community agencies. These services might include RN visits, Physical Therapy, Lab work, and/or Home Health Aide, all of which must be approved by your insurance carrier. Many insurance carriers will only approve one RN and one Physical Therapy evaluation in advance. **Authorization for additional services will be the responsibility of the home care agency after the initial home evaluation.** In order to qualify for home care services, you must be considered home bound. Otherwise, you will be expected to go to an outpatient facility for services.

**Many insurance plans do not cover Home Health Aide services.** Others will consider Home Health Aide services based on the results of an in-home evaluation. These services are not considered primary and will be provided only as long as RN or Physical Therapy services are also required. An RN will visit your home within 24 hours of your discharge to evaluate you for the additional services. Physical Therapy and/or Home Health Aide services, if determined necessary by the RN, may not begin for several days. Should you feel that you will require assistance managing at home after discharge, you should speak with your family/significant others to determine if they can be of assistance to you and can support you during your transition to home for a minimum of two weeks.

If you would prefer, you can pay privately for home care. A list of agencies is available to you through the case manager. You should also check with friends and your place of worship for alternative means of private pay home care. Private pay home care should be arranged prior to hospitalization so that the services are in place at the time of your discharge.

## **DURABLE MEDICAL EQUIPMENT**

Any equipment (DME - Durable Medical Equipment) that you might need such as a wheelchair, walker or hospital bed, can be arranged through the hospital. Insurance criteria and authorizations will determine whether the equipment will be covered. Depending on your needs, equipment can be delivered to your home or to the hospital. There is certain equipment that can be provided to you in the hospital to be taken home upon discharge.

## **TRANSPORTATION**

Your case manager will discuss with your physician the safe, most appropriate way for your transfer to home or a rehab facility. Many of our patients can go in a car. However, an ambulette (wheelchair transport) or ambulance (stretcher transport) can be arranged by the case manager if necessary. ***Insurance does not necessarily cover transportation by either ambulance or ambulette.*** Your case manager will explore if you are covered for this service and obtain authorization.

Medicare does not provide for ambulette transport but will provide for ambulance transport under certain conditions. New Medicare rulings dictate that patients must pay for mileage for ambulance transportation if the facility is more than five miles away from HSS. In the event that transportation is not covered, you will be advised of the cost in advance.

## **CONSIDERATION WHEN RETURNING HOME**

Whether you are returning home directly from the hospital or from a facility, please survey your home to assure that the furniture is of an appropriate height and accessibility. For example, low chairs and beds are not appropriate for those having hip replacement. Stairs might also present a challenge, so if you have two floors in your home, consider the option of staying on one floor.

If you have any questions regarding your discharge planning options, please contact us at:

**Hospital for Special Surgery  
Case Management Department  
212.606.1271  
Monday through Friday  
8am-5pm**