Discharge Planning Education
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 two days. For Total Knee Replacement surgery the anticipated length of stay is three days.

Most patients receive a phone call from a Case Manager 10-14 days prior to your surgery, to discuss your post hospital needs. A Case Manager is also available to meet with you after the Preoperative Education Class.

After surgery, most patients return home with home care services. Your Case Manager will make the necessary referral for home care services and contact your insurance company regarding benefits and authorizations.

**HOME CARE SERVICES**

Your Case Manager will assist in arranging a referral to a home care agency of your choice, as well as one that participates with your insurance carrier. These services might include RN visits, Physical Therapy, Lab work, and 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. As per your insurance policy, you may be required to pay a co-pay for all visits in the home. Make sure you check with your insurance carrier to find out if you have a co-pay and the amount of the co-pay. In order to qualify for home care services, you must be considered home bound. This means that you cannot leave the home except for doctor visits. If you are not homebound, you will be expected to go to an outpatient facility for services.

Many home care agencies offer additional physical therapy visits for the first 2 weeks after total joint replacement surgery. Normally, patients receive 3 physical therapy visits per week however many home care agencies will provide 5 visits per week if approved by your insurance carrier. Since Medicare does not require prior approval for home care visits, if you are a Medicare beneficiary you will be able to receive additional visits. If you are interested in this program or if your physician recommends it to you, your Case Manager will discuss the program in more detail and make the referral to a home care agency.

**Many insurance plans do not cover Home Health Aide Services.** Others will consider Home Health Aide services based on the results of the nurse evaluation in the home. These services cannot be provided without other services as well. They will only be provided if you also require RN or Physical Therapy services. An RN will visit your home within 24 hours of discharge. Physical Therapy will begin the same day as the RN or the day after. Home Health Aide services, if determined necessary, may not begin for several days. If you feel that you will require assistance with activities of daily living, such as bathing, dressing, etc 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 additional home care services. 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.
INPATIENT REHABILITATION POST HOSPITALIZATION

In some instances, due to complex medical conditions, a patient may require inpatient rehabilitation upon discharge from the hospital. It is important to understand that there are certain criteria for admission that must be met in order for you to be accepted to the facility and for the insurance to cover the rehabilitation facility admission.

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 availability of beds and that you will need to receive rehabilitation at your second or third choice facility. 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 you are requesting and if the facilities that you are interested in are included in your insurance network. It is important to understand that insurances will cover inpatient rehabilitation services only after an assessment of your post-surgical medical and functional needs and progress towards achieving your therapy goals. Please be aware that even if you have an inpatient rehabilitation benefit, authorization by your insurance company is based on medical necessity as determined by the insurance company’s medical director. Your Case Manager will provide the clinical information to the insurance company for the medical director to review and make a decision.

In choosing a rehabilitation facility it is important to know the difference between acute and sub-acute rehabilitation facilities.

Some General Rules of Thumb:

**Acute Rehabilitation Facilities** (such as Burke, North Shore Glen Cove, NewYork- Presbyterian):

- Provide approximately 2 to 3 hours of intense therapy a day with an expected length of stay of 3 to 5 days.
- **Typically, single joint replacements and spinal surgeries are not approved or appropriate for acute rehabilitation.**
- An assessment of your progress in physical therapy is necessary to justify admission to acute rehab.

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

**Sub-acute Rehabilitation Facilities**

- Provide approximately 1 to 2 hours of rehabilitation therapy a day.
- Sub-acute rehabilitation is usually provided in a nursing home setting but is designed for short-term rehabilitation with an expected length of stay of 5 to 7 days.
- Some facilities have separate units for patients requiring sub-acute therapy.
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 and taken home upon discharge.

TRANSPORTATION

Your Case Manager will discuss with your physician the safest, most appropriate way for your transfer to home or a rehab facility. Most of our patients can travel by car. However, an ambulette (wheelchair transport) or ambulance (stretcher transport) can be arranged by the Case Manager if necessary. **Insurance usually does not cover transportation by either ambulance or ambulette.** Your Case Manager will explore if your benefits cover non-emergent transportation. Even if you have the benefit and authorization is obtained, the insurance company may deny payment due to lack of medical necessity. The insurance companies determine medical necessity when the bill is submitted; after the transportation has been provided. In the event that transportation is not covered, you will be advised of the cost and will need to provide a credit card number to the transportation company prior to discharge.

Medicare does not provide ambulette transport but will provide ambulance transport under certain conditions. Medicare regulations dictate that patients must pay for mileage for ambulance transport if the facility is more than 20 miles away from HSS.

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 surgery. Stairs might also present a challenge, so if you have two floors in your home, you may want to consider the option of staying on one floor.

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

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Case Management Department
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Monday through Friday
9am-5pm