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SLIDE SHOW C

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HEAD:

Winter Blues, Social Admissions, and Lack of Medical Necessity: Are you RAC-ready?

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As the winter of 2010-2011 continues to deliver a cruel blow to many states, hospitals are dealing with the stark reminder that the streets are home to hundreds of people who suffer through the harsh weather with no hope.

What makes this picture drearier is that while the problem of homelessness has grown worse recently, a lack of resources surrounding the issue has followed suit.

A RAC-ready hospital has a process in place for taking care of patients who do not require acute-care hospitalization – every day of the week, 24 hours per day.

An Old Hospital Dilemma with a New Consequence

Consider this scenario: one night local police transport a homeless man to your hospital's emergency department because they have nowhere else to bring him. He was found wandering the streets during a snowstorm; thoughtful neighbors called 911 and now he is in

your ED. It is nighttime, there are no shelter beds available, no insurance, no money and ultimately no place to go.

Calls to case management and social services are made while the patient remains a disposition problem.

What to do? Short stay versus inpatient admission? Discharge?

This hospital has a dilemma that is not uncommon. Ultimately, there may be discussions among various facilities, but there is no immediate safe discharge plan and probably no real medical necessity for admission.

As we know, RACs are not bound to apply commercially available screening criteria when determining whether an inpatient admission is appropriate. RACs follow their own guidelines and definitions of medical necessity when issuing denials for inpatient admissions due to lack of medical necessity.

Are Shelters A Resource?

Beginning in 1983, emergency public shelters for the homeless began opening in cities nationwide. During the next couple of decades, shelters grew from being a temporary emergency response to a permanent industry. There were 62,000 homeless shelters in the U.S. in 2002.

As most hospitals already are aware, most homeless shelters for individuals allow people to stay only at night to sleep. This is done because the homeless are expected to spend their days looking for work and permanent housing. Some shelters also allow homeless people to assemble and eat meals during the day.

Many shelters do not provide storage space for belongings, and if they do, it often is very limited. Storage spaces certainly are not large enough to hold any significant amount of medical supplies or medications. If there is no place to store belongings in shelters, they often are stolen.

Many homeless people refuse to go to shelters because they are crowded and considered unsafe. Many physicians refuse to agree to a discharge plan if it means placing a patient in a homeless shelter.

Most shelters for individuals operate on a first-come, first-serve basis, although most refuse people who are drunk or abusing drugs. Another criterion is that an individual must be able to climb into a top bunk.

Some homeless people are discharged to hotels or motels, but just for a night or two so they can find an alternative place to stay. Again, many times physicians do not agree with this discharge plan either and will not order a patient to be discharged.

It is blatantly apparent that trying to use shelters is an inadequate solution to addressing the magnitude of this problem.

The Importance of Case Management Staff

A hospital's social workers and case management staff are vital to the process of handling admissions, particularly social services admissions. They are the front line. These staff members often are thrown into the most difficult kinds of medical work without the external resources needed to accomplish what needs to be done for these patients. All the while, they are working under a huge microscope as the hospital's lengths of stay continually are being scrutinized.

In order for admissions to be considered medically necessary under the Medicare program, a patient must have a condition requiring treatment that can be provided only in an inpatient setting. If the patient can receive treatment safely in a less intensive setting, such as outpatient observation, the patient should not be admitted.

A RAC-ready hospital has a process and system in place for taking care of patients who do not require acute-care hospitalization – every day of the week, 24 hours per day.

Legal as Part of the Team

The in-house counsel has become a very valuable department in assisting with these social admissions and lessening the impact they can have on resources, lengths of stay, and ultimately RAC audits. Even more importantly, the in-house counsel can be sure that patient rights are being upheld by the hospital during the process of trying to discharge a patient safely and appropriately.

At the disposal of the in-house counsel are various databases that can be used to search to see if any relatives for a patient exist. It is not unusual to locate a relative who either may assist in getting financial documentation to the social worker, or even to assist in placing the patient elsewhere. Although this does not always happen, since families may be estranged or unable to be located, the search process is always a great first step. Once all the available searches have been performed and phone calls have been made, it can be discussed further with social workers and case management as to the next-best options for placement.

In-house counsel needs to work directly with case management and social workers to assist in weighing the various legal options for a safe discharge available under Medicare, joint commission and state law. It also is very important that the patient's physicians are involved in the conversations.

For too long, in-house counsel or legal only has been called when a guardianship has been determined to be necessary. Now, with legal involved on a continuous basis, many guardianship assignments may be avoided and patients will have a better chance of being placed in the right setting more quickly.

Conclusion

Using the above strategy involving legal, pressure-test your hospital system and assess whether its structure will withstand an upcoming RAC review – or whether it will become immobilized and "freeze up" under focus of medical necessity.

Think warm.

About the Author

Patricia Furci is currently part-time, In-house Counsel at several hospitals, providing legal services specially addressing inpatient issues, Case Management functions and Guardianship services.

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