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# Rehab Continuum Report™

The essential monthly management advisor for rehabilitation professionals

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## IN THIS ISSUE



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# Outpatient therapy cap: The wolf may actually be at the door come July 1

*Legislation to repeal cap yet to get a vote*

It may be tempting to brush off the latest warning that the Centers for Medicare & Medicaid Services (CMS) will begin enforcing the $1,590 annual cap on outpatient rehabilitation therapy starting July 1. After all, the cap has been placed on moratorium three times since it was first mandated in the Balanced Budget Act of 1997. But sources close to the negotiations for another moratorium or outright repeal of the cap say it's unlikely Congress will deal with the issue before July. That means outpatient therapy providers need to prepare to deal with the cap at least temporarily.

Legislators in both the Senate and the House of Representatives introduced bills March 6 that would repeal the cap. Sen. **John Ensign** (R-NV), along with 10 cosponsors, introduced the bill in the Senate. In the House, Rep. **Phil English** (R-PA) introduced an identical bill with 44 cosponsors.

It's the same legislation that was introduced but never voted on last year. Given the estimated $400 million Medicare cost savings of implementing the cap, the legislation may take a back seat to other national priorities such as the situation in Iraq and the $400 billion Medicare prescription drug benefit President Bush is advocating, says **Peter Clendenin**, executive vice president of the National Association for the Support of Long Term Care in Alexandria, VA.

"We're trying to get this on the table," Clendenin says. "We feel confident it will eventually pass, but it is unlikely Congress will take it up before July. We are meeting with CMS to convince them to further postpone the effective date based on a number of confusing legal and statutory requirements in the bill."

At press time, CMS had not changed the July 1 implementation date.

Clendenin's organization is part of a national coalition of rehab providers and patient advocates who are working to overturn the cap,

which would limit Medicare beneficiaries to $1,590 worth of physical and speech therapy combined per year. (The original amount for the caps was $1,500, but because it is indexed by the Medicare Economic Index each year, the 2003 amount will be $1,590.) Beneficiaries also would be subject to a $1,590 cap on occupational therapy services. The limitation does not apply to services provided at hospital outpatient departments. **(For more information, see related story, p. 64.)**

"The law would repeal the caps entirely, and we feel very strongly that's an important step to take that would benefit hundreds of thousands of Medicare beneficiaries who will have to go without therapy otherwise," Clendenin says. "No one thinks it's a good idea. Neither Congress nor CMS is really committed to enforcing it, but they've never gotten around to repealing it either."

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Clendenin estimates that one in seven Medicare Part B beneficiaries would exceed the cap. "And they'll exceed it big, especially patients who have strokes or hip replacements," he says. "These are the frailest individuals with the highest level of acuity. Their therapy needs are well over $1,500. We estimate someone who's had a stroke is going to need $3,000 to $4,000 worth of physical, occupational, and speech therapy to fully recover."

Patients still could pay out of pocket to receive services, but many can't afford that expense, Clendenin says. "This will have a dampening effect on the amount of therapy," he says. "Patients could end up rehospitalized in a setting that's 8 or 10 times more expensive than outpatient therapy. It's 'pay me now or pay me later.' It's cost-shifting."

**Dave Mason**, vice president for government affairs at the American Physical Therapy Association in Alexandria, VA, says the cost issue will be the biggest hurdle with Congress. "Because Congress enacted this in 1997, savings were assumed because of the reduction of benefit payments. Those savings were built into the budget baseline," he says. "So repeal has a big cost impact. It's not so much a policy argument that would defend the idea of a dollar limit. It's more that to get rid of the policy will cost a lot of money. But this needs to be taken care of. The cap is just a bad idea."

Mason says no study was done to justify the amount of the cap. "The most onerous thing about the Medicare cap is the arbitrary dollar amount," he says. "There was no consideration of the patient's needs. The patient is not even part of the equation."

APTA is making a strong suggestion that providers go ahead and make certain beneficiaries aware of the cap, Mason says. "There is a real dilemma here: Do I tell them now? On the one hand, I don't want them to be surprised, but on the other hand, this may not come through, and I don't want to worry them needlessly," Mason says. "If you have a chronic patient who is clearly going to need continuing therapy for an extended period of time, I think those folks need to know."

The beneficiary notification issue is one of the problems many rehab providers have with the cap. The cap applies per beneficiary, not per provider, so providers may not always know when a patient reaches the cap. Thus, providers run the risk of providing services that will not be covered. According to the therapy cap Program Memorandum published by CMS in

February, "it is the provider's responsibility to present each beneficiary with accurate information about the therapy limits." Providers are advised to use the Notice of Exclusion from Medicare Benefits form to inform beneficiaries of the limits at their first therapy visit.

"The problem is that no one will know they've hit the cap until they get a denial of services from Medicare," Mason says. "If beneficiaries get services at different locations, there is no way for the practitioner to know ahead of time when that will happen."

### *Therapy cap info will lag behind treatment*

CMS officials told *Rehab Continuum Report* that this will indeed be an issue between July and October, when beneficiaries will begin to get a notice of how much money Medicare has paid toward the cap on the Medicare Summary Notice they receive monthly. Until October, the MSN will only notify beneficiaries when they have exceeded the cap. But providers and patients will need to remember that even the monthly notices will still lag behind the actual treatment. Providers eventually will be able to access a beneficiary's progress toward the cap through CMS' Common Working File system, which will track the therapy limit. "All providers who bill electronically will have access to these screens," a CMS official says.

The 2004 Medicare handbook will contain information about the cap, but CMS will not notify all beneficiaries about the cap until then. For now, CMS is relying on providers and a consortium of beneficiary advocates to disseminate information about the cap to beneficiaries.

**Carolyn Zollar**, vice president for government relations for the American Medical Rehabilitation Providers Association in Washington, DC, says the original intent of the cap may already have been accomplished by implementation of the physician fee schedule for rehab. "The fee schedule has had the effect of decreasing the amount and possibly the volume of services. That was the original objective of the cap," Zollar says. "There might be the question if you need the therapy cap at all if your objective was to reduce outpatient payments."

That theory was borne out in a CMS-commissioned study of the effects of the cap during 1999, the one year when it was applied. The DynCorp Report on Outpatient Therapy Utilization (see the full report at www.cms.hhs.gov/medlearn/therapy/dyncorprpt.asp) found that the application of the fee schedule, which began in 1999, "created a relatively level playing field of payments to providers furnishing similar services, and created the significant cost reductions desired by Congress." The study found that of those patients most likely to surpass the caps, a disproportionate number were women; people over age 80; racial minorities; and patients with stroke, hip fractures, Parkinson's disease, swallowing disorders, and musculoskeletal conditions affecting the knee, hip, and shoulder.

Another report presented to CMS in 2001 by The Urban Institute of Washington, DC (available at www.cms.hhs.gov/medlearn/therapy/impactcover) found that as many as 13% of beneficiaries were in danger of exceeding the cap.

**Christina Metzler**, director of federal affairs for the American Occupational Therapy Association

## Get ready for therapy cap

Experts **Peter Clendenin**, **Tracy Gregg**, **Dave Mason**, and **Christina Metzler** give the following advice on getting your facility ready for the outpatient therapy cap, which is slated to go into effect July 1:

- Plan as if the cap is indeed going into effect in July. If there's another moratorium, you'll be that much more prepared when it comes around again.
- Work with your patients to develop a way to keep track of charges.
- Call your congresspeople or senators and tell them what effects this will have on your community.
- Plan educational programs for therapists.
- Put a policy in place at each location that specifies when you'll notify patients of the cap, who will be notified, and who will be designated to speak with patients' families.
- Figure out what you'll do for patients who reach the cap. Will you teach them a home program? Will you teach family members or nurses maintenance activities to help?
- Look at your patient profiles to determine which patients are likely to exceed the cap. Look at diagnoses, care paths, and community options for ideas on how to help those folks. ■

in Bethesda, MD, says the cap brings up a host of clinical and ethical problems aside from the administrative headaches. "What do you do when you reach the cap and you know the patient can't pay? You are supposed to refer them to an outpatient hospital department, but what if the patient has no transportation? Therapists will have to discharge the patient when they know the therapy isn't over," Metzler says.

Therapists will need to tell patients up front about the cap and the likelihood of exceeding it, Metzler says. Given that many of those patients are frail elderly people who are likely to have memory impairment, it's a huge burden to lay at their feet. "When patients are in crisis, this is one more thing they shouldn't have to deal with," she says. "We've been working on this thing for five years. It was a bad policy to begin with, and it's still a bad policy. We need to put the decision-making back into the arena between the professional and the patient. The government shouldn't be dictating clinical practice." ■

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# Think you're exempt from the therapy cap?

*Think again; satellite clinics may not count*

Here's an issue you may not have considered amid all the headaches of Medicare's pending $1,590 outpatient therapy cap. The Balanced Budget Act of 1997 built in a safety valve for patients who exceed the therapy cap; they still can receive services at an outpatient hospital department. But facilities must apply for the exemption, and the requirements are extensive.

"Congress was told there were a number of hospitals building satellite clinics that were not attached to the hospital and may not even be on the same campus. The question had to be asked, 'Is that a hospital outpatient department?'" says consultant **Ken Mailly**, PT, of Mailly & Inglett Consulting in Wayne, NJ. "So they created the notion of a provider-based entity, which could still be considered part of the hospital so long as it met certain requirements."

The requirements take up a 30-page application and include such items as having a physician on site, having an arrangement to take care of emergency needs without calling 911, and having the same governance and payroll as the hospital. "This isn't the only requirement, but for instance, if you have to call 911 when someone has a heart attack at your facility, you're freestanding," Mailly says. "In a hospital, you would just send them over to the emergency room. If you're 10 miles away, you're going to need an ambulance. If you're a freestanding entity, you're subject to the cap just like everybody else is."

The provider-based rules make no difference without the cap, Mailly says. But with the pending implementation of the cap, they do make a difference. "This becomes a very important issue. Nobody's talking about this yet, and it's simply because, quite frankly, they forgot," he says. "The focus was very much on the cap and whether it would be re-implemented. The whole issue of provider-based entities just slipped off the radar screen. Now — guess what — it matters again."

The way a facility is originally certified by the Centers for Medicare & Medicaid Services (CMS) is how it will remain certified unless a new application is submitted, Mailly says. "If you've changed something, you have to come back and say that to CMS. If you don't do that, the way they certified you 10 years ago is how they recognize you now."

Fraud is an issue here, Mailly says. "If you build a satellite one mile away and pretend it's attached to the hospital, that's fraud."

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CMS' instructions on this issue (read them at www.riverbendgba.com/prov/audit&reimb/pbinst.doc) say a facility is not entitled to be treated as provider-based just because the main provider is. "The facility or organization must be determined by CMS to be provider-based before the main provider bills for services of the facility or organization as if it were provider-based, or before it includes costs of those services on its cost report," the instructions read. "A facility that is not located on the campus of a hospital and is used as a site of physician services of the kind ordinarily furnished in physician offices will be presumed to be a freestanding facility, unless it is determined by CMS to have provider-based status."

Even if a facility does meet the requirements and is able to see patients who would otherwise have their services capped, that doesn't solve the problem, says **Tracy Gregg**, PT, president of SunDance Rehab in Alexandria, VA. "If a skilled nursing facility patient had a family member who could take them to the hospital, they could get therapy. But they would have to be transported, and that's difficult for elderly patients," she says. "It's brainless when you have a therapist right next door to their room."

Gregg says this issue is what bothers her the most about the cap. "The ones it impacts are the ones who are least able to advocate for themselves. It's only a problem for people who don't have the ability to move around and get to a hospital," she says. "We have a decision to make as citizens about how we'll take care of our elderly." ■

# CMS not convinced 75% rule should be changed

*October enforcement date set*

It makes sense to the rehab field that the 75% rule for qualification as an inpatient rehabilitation facility should be changed. A rehab coalition has waged an all-out campaign to convince the Centers for Medicare & Medicaid Services (CMS) to change the 75% rule before October, when CMS plans to begin "aggressive enforcement."

But the rehab field's position doesn't seem to make sense to CMS. **Tom Barker**, special assistant to the administrator, says he has yet to be convinced that the rule needs to be changed.

"No one has convinced me there is anything wrong with the existing 75% rule other than possibly the definition of polyarthritis," Barker says. "I really, truly don't understand why we would scrap a regulation that, as far as I have been able to determine in the many, many meetings I've had on this, has worked perfectly well, with one exception, for 20 years — and replace it with a brand-new definition that quite likely is going to have unpredictable outcomes. I feel pretty strongly about that."

The rehab field was eagerly awaiting a proposed rule on the subject from CMS at *Rehab Continuum Report*'s press time. Rehab advocates were to have another chance to present their opinions on the subject at a May 19 town hall meeting scheduled by CMS in Baltimore. But there was no indication that CMS was planning to do anything other than begin aggressive enforcement of the 75% rule in October. Barker says the proposed rule would not discuss polyarthritis or any specific diagnoses but instead would address the subject of compliance.

### *CMS to resume suspended enforcement of rule*

"We have found what appears to be pretty significant non-compliance with the rule as we understand the current interpretation of the rule," Barker says. "We announced close to a year ago that we were going to suspend enforcement of it. All we're proposing to do is to begin re-enforcing the rule. We're doing it because it's the law."

Barker emphasizes that there "appears" to be non-compliance. "I don't think we can flatly say there is widespread non-compliance," he says. "There appears to be non-compliance, but I can't accuse the field of non-compliance with the rule because I think there is some limitation on the data that we have."

Organizations such as the American Hospital Association (AHA), the American Medical

Rehabilitation Providers Association, and the American Academy of Physical Medicine and Rehabilitation, as well as a number of state associations and individual providers, have joined forces to effect change in the 75% rule. In 1978, the Health Care Financing Administration (HCFA, now renamed CMS) developed screening criteria for admission to rehab hospitals. A list was established of the 10 most common conditions resulting in admission (known as the HCFA-10): stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur, brain injury, polyarthritis, neurological disorders, and burns. CMS requires that at least 75% of patients fall into one of those 10 diagnoses in order for the hospital to be paid as an inpatient rehabilitation facility.

### AHA attacks 'fundamental inconsistency'

The rehab field asserts that rehabilitation has drastically changed since the 1970s and now includes cardiac, pulmonary, transplant, and cancer patients whose diagnoses are not part of the HCFA-10. Advocates say the problem could be fixed if CMS would use the 21 rehabilitation impairment categories (RICs) that were established for the prospective payment system instead of the HCFA-10. "CMS designed the prospective payment system, and the field agrees it's a workable system. Yet they have a different set of rules for determining eligibility to be billed under that system. We feel that's a fundamental inconsistency," says **Rochelle Archuleta**, senior associate director for policy development—post-acute care for the AHA in Washington, DC.

But CMS doesn't see it that way. Barker says CMS is "disinclined" to substitute the RICs for the HCFA-10. "I do not find the arguments that the field has made particularly persuasive," Barker says. "To the best of my understanding, that's not what the problem is. Changing the definition of rehab hospitals to use the 21 RICs would drastically expand the number of hospitals that could qualify as rehab hospitals, and I'm not certain that's appropriate public policy."

Barker says the main problem he can see is the definition of polyarthritis, one of the HCFA-10 categories. An apparent lack of consistency in defining polyarthritis among fiscal intermediaries around the country is what originally led CMS to suspend enforcement of the 75% rule. That's the topic on which CMS most wants to hear input from the field. "As far as I've been able to determine, the problem that hospitals have with the 75% rule is what constitutes polyarthritis," Barker says. "No one has convinced me that there's any problem other than that, so I don't know why you would throw open the definition of rehab hospitals, and completely throw out a definition that's worked pretty well for 20 years and replace it with something completely untested."

### Compliance will be difficult

**Theresa Edelstein**, vice president of continuing care services for the New Jersey Hospital Association in Princeton, NJ, says that without a better definition of polyarthritis before October, it will be hard to comply with the rule. "My advice is to closely monitor your patients to make sure compliance won't be a question mark. Be mindful of that single-knee replacement, and make sure the physician provides documentation for polyarthritis if it exists," she says.

**Ken Aitchison**, president and CEO of Kessler Rehabilitation Corporation in West Orange, NJ, says the majority of rehab facilities will find themselves non-compliant when CMS begins enforcing the rule. "This will decimate the industry," says Aitchison. "If the rule is enforced as it is now defined, it will significantly restrict access for patients. Hospitals will risk losing Medicare participation, and some will have to deny care to certain patients in order to stay within that 75%. If I'm at 24.999% and the next person through the door will put me over, I'll have to deny care. There shouldn't be an artificial barrier like that." ■

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*The Road to PPS Success*

# Reporting innovations make PPS manageable

*Innovative quality monitoring system helps*

Many rehab units have found that the inpatient prospective payment system (PPS) has either improved their bottom line or left it alone. But such programs tend to have a case mix that runs toward the average. For The Institute of Rehabilitation and Research (TIRR) in Houston, which has an unusual case mix, PPS has resulted in less reimbursement — and even the discontinuation of one of the services the hospital was known for.

**Jean Herzog**, PhD, executive vice president and chief operating officer, says TIRR received better reimbursement under the old TEFRA system. TIRR, a 116-bed not-for-profit hospital in the Texas Medical Center, focuses on catastrophic rehab and tends to have younger patients. The hospital also has a large stroke population and does not have as many orthopedic patients as other rehab facilities. "We have an unusual Medicare population, so PPS is not as straightforward for us," Herzog says. "The system was designed for the average, and we have a much higher case-mix index. We are looking at how to continue our mission as a provider for catastrophic rehab. It's difficult under PPS."

TIRR was forced to make a heart-breaking decision to eliminate a specialty service that had made a name for the hospital, Herzog says. TIRR is unusual in that it has two operating rooms where surgeons have implanted Baclofen pumps for patients with spasticity of cerebral and spinal origin. "We had a very good protocol here where we did the surgery, and then the patients came back for rehab once they had healed and could tolerate therapy," Herzog says. "But under PPS, if a patient stays three days or less, we are paid approximately $2,200. The surgery, pump, and nursing care cost about $18,000, with the pump itself making up a major portion of that cost. We had to stop doing it. We also cannot treat patients differently based on payer, so that eliminated the protocol for our non-Medicare patients as well."

Because TIRR's patients tend to have such complex problems, there often isn't a lot of change in the functional independence measure (FIM) scores required for PPS, Herzog says. "The key is showing progress, but if the patient is paralyzed from the chin down, you're just not going to see that in the scores," she says. For patients who are minimally responsive, a large part of the care includes educating family members. That won't show up on the FIM score either.

Because of the PPS challenges, TIRR has had to make a special effort to examine its costs. The hospital put together a team with managers from physical therapy, occupational therapy, neuropsychology, nursing, medical records, social work, administration, nursing education, and case management. "It was quite the crowd," Herzog says. "We had representation from anyone who touches the IRF-PAI [inpatient rehabilitation facilities patient assessment instrument]."

The team decided not to hire a separate IRF-PAI coordinator. They did hire one administrative assistant who collects and submits IRF-PAI data. The assistant also sends out a weekly e-mail report that tells staff members when IRF-PAI scores are overdue. **(See excerpt of the IRF-PAI report, p. 68.)** But on the whole, the case managers serve as IRF-PAI coordinators for each of their patients. "We thought it would help to keep the coordination as close as possible to the people who are dealing with the patients on a daily basis," Herzog says. "Our case managers know each individual situation as it is occurring, they know the nurses, they know the patients. They all know how to do the FIM scores so they can monitor them for accuracy. One case manager caught the fact that a clinician had accidentally flipped the scoring system. She caught it because she knew the patient and knew the score couldn't be right."

The decision not to hire a separate coordinator also made financial sense, says **Mary Ann Beachler**, RN, MS, executive director for patient, clinical, and support services. "PPS means we are paid less, so how can we afford another body to pay? We already had a good system in place, and we knew we could pull it off as a team," she says.

With the help of the hospital's information technology department, the team came up with a system that prevents clinicians from entering a charge into the computer system without also entering the initial FIM score. The system also allows for a detailed report to be completed on each patient about every two weeks. "We can look at how we are managing all of our patients from several angles, such as cost, length of stay,

*(Continued on page 69)*

IRF-PAI

# COMPLETION REPORT

As of April 9, 2003 - 12:00 PM**

## Admissions

| Patient | PCU | Admit Date | IRF-PAI Due | ALL IRF Data RECEIVED No | ALL IRF Data RECEIVED Yes | MISSING DATA RN | MISSING DATA Therapies/Other |
|---|---|---|---|---|---|---|---|
| Patient 1 | 3C | 1-Apr | 4-Apr | No | | | NP |
| Patient 2 | 4 | 4-Apr | 7-Apr | | Yes | | |
| Patient 3 | 3C | 31-Mar | 3-Apr | | Yes | | |
| Patient 4 | 5 | 2-Apr | 5-Apr | No | | RN | |
| Patient 5 | 5 | 2-Apr | 5-Apr | | | RN | SW |
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## LOA

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## Discharges

| Patient | PCU | Discharge Date | IRF-PAI Due | ALL IRF Data RECEIVED No | ALL IRF Data RECEIVED Yes | MISSING DATA RN | MISSING DATA Therapies/Other |
|---|---|---|---|---|---|---|---|
| Patient 6 | 4 | 27-Mar | 27-Mar | | Yes | | |
| Patient 7 | 3 | 2-Apr | 2-Apr | No | | RN | NP/PT |
| Patient 8 | 4 | 29-Mar | 29-Mar | | Yes | | |
| Patient 9 | 4 | 21-Mar | 21-Mar | | Yes | | |
| Patient 10 | 4 | 8-Apr | 8-Apr | | Yes | | |
| Patient 11 | 6 | 22-Mar | 22-Mar | | Yes | | |
| Patient 12 | 4 | 25-Mar | 25-Mar | | Yes | | |
| Patient 13 | 4 | 5-Apr | 5-Apr | No | | | MR |
| Patient 14 | 3 | 27-Mar | 27-Mar | No | | | SLP |
| Patient 15 | 3C | 4-Apr | 4-Apr | No | | RN | |
| Patient 16 | 3 | 1-Apr | 1-Apr | No | | | CM |
| Patient 17 | 4 | 3-Apr | 3-Apr | | Yes | | |
| Patient 18 | 3C | 27-Mar | 27-Mar | | Yes | | |
| Patient 19 | 5 | 1-Apr | 1-Apr | No | | RN | |
| Patient 20 | 4 | 2-Apr | 2-Apr | | Yes | | |
| Patient 21 | 4 | 25-Mar | 25-Mar | | Yes | | |
| Patient 22 | 4 | 21-Mar | 21-Mar | | Yes | | |
| Patient 23 | 4 | 4-Apr | 4-Apr | No | | | MR |
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*Source:* The Institute of Rehabilitation and Research, Houston.

and use of outside tests," Beachler says. "We use that to retrospectively look at what we could do better."

The hospital is developing another tool that will allow this reporting to be done concurrently. "When it's ready, all of our case managers and physicians will be able to see the cost per day per patient in each category and compare that to the larger population of patients with that diagnosis," Beachler says. "They'll be able to see things that are outside the norm immediately."

Other ways TIRR has worked to improve under PPS include:

- Looking at how admissions are staged. Would the patient do better coming from acute care to long-term acute care and then to acute rehab?
- Appointing a quality monitor in each department who looks at the FIM scores and the underlying documentation to ensure accuracy. Beachler also does a final review to make sure the scores are consistent.
- Starting a reporting system that makes case managers responsible for notifying their team members once the initial IRF-PAI is done on a patient. The case managers let the team know what case-mix group has been assigned, what the average length of stay would look like, and what kinds of resources are available.
- Looking for better prices on outside diagnostic tests.

"PPS is really pushing the envelope with us," Beachler says. "I don't know that we would have had the data collection we have now that allows us to make these comparisons. It appears that even though our patients are at the extreme in terms of their injuries, our outcomes are actually better than the average. We knew we were doing a good job, but now we can prove it." ■

## Need More Information?


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# CMS issues HIPAA checklist for providers

*Checklist addresses business associates*

The Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) has issued a checklist to help health care providers who do business electronically and their business partners to comply with the administrative simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

HIPAA does not require a health care provider to conduct all transactions — such as claims or equivalent encounter information, payment and remittance advice, claim status inquiry and response, eligibility inquiry and response, and referral authorization inquiry and response — electronically. But any of these things that are done electronically must be done in the standard format outlined under HIPAA.

"Whether you contract a third-party biller or clearinghouse to conduct any of these transactions for you, it is up to you as the health care provider to see to it that your transactions are being conducted in compliance with HIPAA," the checklist says.

Checklist items include:

- determining, as a health care provider, if you are covered by HIPAA because you conduct any of the typical transactions electronically;
- assigning a HIPAA point person to handle the remaining checklist items and having that person educate others on the office staff;
- familiarizing yourself with key HIPAA deadlines such as Oct. 16, 2003, the date providers must be ready to conduct transactions electronically in the standard HIPAA format with health plans and payers;
- determining that software is ready, finding out what needs to be done differently to comply for all electronic transactions, and asking vendors how and when they will be making HIPAA changes and document the response.

Talk to health plans and payers you bill to find out what they are doing to prepare for HIPAA, and ask for trading partner agreements that specify transmission methods, volumes, and time lines as well as coding and transaction requirements that are not specifically determined by HIPAA. ■

# Encryption for HIPAA not necessarily a given

*Change in final rule eliminates blanket requirement*

Medical Banking Project founder **John Casillas** says one of the changes in the final Health Insurance Portability and Accountability Act of 1996 (HIPAA) security rule eliminated any requirement to encrypt electronically transmitted protected health information, even over the Internet or other open networks. Encryption is now an "addressable" implementation specification, which means a provider or payer organization must determine whether it is appropriate to use the technology. Encryption was one of many required procedures or technologies in the proposed rule that now are addressable as the Department of Health and Human Services seeks to make the final rule more scalable for health organizations of all types and sizes.

Casillas says many providers implementing the security rule likely will decide encryption is a reasonable and appropriate way to protect data, but their trading partners may not agree. One area providers will have to consider is the electronic transmission of payment information, including protected health information, between providers, payers, and financial institutions.

### Encryption still a good idea

For instance, an insurer may electronically transmit to its bank a payment file containing payment instructions for a batch of claims from multiple providers. The bank will transmit the file to the banking industry's automated clearinghouse network, which transmits the payments to the appropriate banks serving the providers listed in the payment file. The individual banks then will transmit electronic remittance advices that contain protected health information to their provider customers.

Technically, under the final security rule, none of these transfers of information need be encrypted. But to protect themselves from liability, providers will have to demand that their payers and financial institutions adequately encrypt the data. "That's inevitable," Casillas has said. "Providers are the ones on the line and will want to make sure their data is protected throughout the entire banking system." ■

# OSHA warning letters double for hospitals

*Injury rates are too high, agency says*

More hospitals than ever have received warning letters from the U.S. Occupational Safety and Health Administration (OSHA) because they have lost-time injury and illness rates that are twice the national average for all industry.

When OSHA lowered its threshold this year to six lost-time injuries per 100 full-time-equivalent (FTE) employees, 156 hospitals received letters alerting them to their high rates, or about 9% of the 1,600 hospitals surveyed. Last year, 73 hospitals received the letters.

While the letters point out specific issues for individual hospitals, they also highlight the relatively high rate of injuries in the hospital sector. Hospitals overall have a lost-time rate of 4 injuries per 100 FTEs, compared to a rate of 3.1 injuries per 100 FTEs among private-sector employers as a whole.

The high injury rates reflect, in part, the stressful environment of health care, says **Bradley Evanoff**, MD, associate professor of medicine at the Washington University School of Medicine and medical director of the BJC ergonomics program at BJC Health Care in St. Louis. Barnes-Jewish West County Hospital in St. Louis was one of the hospitals on the list.

"Patient acuity has gone up, and length of stay has gone down. This means that patients are turning over much more quickly," he says. "The nursing workload goes up significantly when you have patients staying for a shorter period of time.

"I think hospitals everywhere are short-staffed. Nurses and nursing aides are working longer hours," he says. "You crank up the production rate, you decrease the number of people working — that will lead to an increase in injury rates unless you make some fundamental changes in the way people do their jobs."

BJC Health Care has a number of programs designed to reduce injury rates, including one targeting slips and falls.

Overall last year, OSHA cited hospitals most frequently for violations of the bloodborne pathogen standard — product selection, product use, and staff training related to safer needle devices.

The most common lost-time injury in hospitals is back injury.

New Britain (CT) General Hospital, which also received a letter, had already begun reviewing its ergonomic interventions, says **Angelina Jacobs**, MD, medical director of employee health. "I'm looking at how [the lifts] are actually being utilized," she says. "You can have them in place, but if the staff doesn't spend the time to use them, they're not going to do any good."

Still, New Britain is taking the OSHA notice to heart. "We're planning to have a consultant come in also and see what we can do and where we can improve further," she says. ■

# Simple PUSH spells improved senior health

*Exercise program can reduce fractures*

One out of three seniors who breaks a hip this year will die as a result of complications from the fracture, but simple fitness measures can greatly reduce a senior's risk of falling, say University of Arkansas at Fayetteville (UA) researchers. A pilot outreach project, sponsored by the UA Office for Studies on Aging, has proved that seniors can achieve significant gains in strength and balance in a matter of weeks by following a simple exercise program that places minimal strain on the body or the budget.

UA researchers developed the PUSH (Project Urging Senior Health) program to demonstrate the ease of establishing and maintaining senior exercise programs in the community. As a trial run, the researchers initiated simple fitness regimens at two senior centers in Arkansas. But the results they observed among seniors who participated were so significant, they now suggest that similar programs across the nation could significantly reduce the number of senior citizens who suffer from falls and fractures each year.

"Our scheme was to go into senior centers and teach the staff that exercise programs could be easily integrated into their services — that fitness could be inexpensive, easily administered, and fun," says **Ro DiBrezzo**, PhD, UA professor of exercise science. "We didn't expect to see any statistically measurable changes in senior health in only ten weeks, but when we looked at the data, our participants had made surprising gains."

## Data collected

Though the researchers regarded PUSH primarily as an outreach program, they collected data anyway, hoping the results would bolster the case for providing exercise services to the elderly. They tracked 19 participants from the two Arkansas senior centers, conducting physical and mental assessments at the beginning of the program and again at the end of ten weeks. The participants ranged in age from 60 to 90, with a significant representation in the age range of 80 and above.

The physical assessment led seniors through eight tests of strength, balance, flexibility, and dynamic balance (ability to balance while in motion). According to the researchers, initial results showed Arkansas seniors to be significantly below national fitness norms for the elderly.

For 40 minutes a day, three times a week, the seniors in the program performed stretching and strengthening exercises, using Therabands and exercise balls and learning proper exercise techniques. At the end of ten weeks, the physical assessment tests showed statistically significant improvement in measures of balance, strength, and dynamic balance. In addition, the participants improved their levels of HDL, the "good" form of cholesterol.

"According to fitness norms for the elderly, the participants in this program ranked in the tenth percentile in strength and dynamic balance when we started. But just performing simple exercises

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over a couple of months, they moved from the tenth percentile to the sixty-fifth," DiBrezzo says. "We had people on oxygen doing these exercises, people using walkers. That's a huge leap for people who are so frail."

And the benefits were not exclusively physical. The researchers also conducted a mental assessment that tested more than cognitive functioning. It included a questionnaire that asked how active the participants were on a daily basis and recorded their general states of mind — whether they usually felt anxious or calm, energetic or worn out.

"We found connections between mental state and both initial and final physical performance scores," says **Barbara Shadden**, PhD, a professor of communication disorders at UA. "Mind and body interact more than you'd think, and both are important to our quality of life as we age."

If senior centers across the nation were to offer simple exercises programs such as the one used in PUSH, elderly Americans could improve their overall health, reduce their risk of falling, and reap mental health benefits that could keep them active and involved in the community, the PUSH researchers say. They intend to expand the reach of PUSH this spring by conducting a training seminar for individuals involved in senior services. The workshop will teach people how to properly implement senior exercise programs in a manner that is both safe and cost-effective.

"Pretty much anyone who works with older adults is in a position to implement this program," notes Shadden. "Starting an exercise program in a couple of senior centers isn't going to fully serve the elderly population. The point is to train as many people as possible how to do it." ■

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# HHS encourages voluntary compliance with HIPAA

U.S. Department of Health and Human Services Office of Civil Rights (OCR) director **Richard Campanelli** says voluntary compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) medical privacy rule is the best way to protect health information. He also told a HIPAA workshop that the federal government's enforcement of the regulation will be largely complaint-driven. Campanelli said most complaints about violations of the HIPAA privacy rule can be resolved easily. "OCR's goal is not to maximize enforcement," he said. "Our goal is to protect personal health information." Campanelli says he recommends that patients register complaints with their health care providers before coming to the government with privacy violations. ■