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IN THIS ISSUE

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New 75% rule could be disastrous for inpatient rehab, providers say

Plan could cut patient access, hospitals' business

Rehab advocates have seen the future of inpatient rehab in a new proposed rule from the Centers for Medicare & Medicaid Services (CMS), and they say it doesn't look bright.

Comments on CMS' proposed changes in the criteria for classifying hospitals as inpatient rehabilitation facilities range from disappointing to disastrous.

After two years of fighting the 75% rule, a coalition of rehab providers held out some hope that CMS might use the 21 rehabilitation impairment categories (RICs) from the prospective payment system to determine compliance. However, coalition members, including such groups as the American Hospital Association (AHA), the American Medical Rehabilitation Providers Association (AMRPA), and the American Academy of Physical Medicine and Rehabilitation, didn't get nearly the relief they had anticipated.

The proposed rule, published in the Sept. 9 *Federal Register*, temporarily would reduce from 75 to 65 the percentage of patients who must fall into a list of diagnoses for the hospital to be paid as an inpatient rehabilitation facility.

The list of the 10 most common conditions requiring rehabilitation was set in 1978 and includes stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur, brain injury, polyarthritis, neurological disorders, and burns. Rehab providers have argued that the list is outdated.

But the only change in the list proposed by CMS is to replace the term polyarthritis with three groups of conditions that will identify more precisely the types of arthritis-related ailments appropriate for care in a rehab facility. As a result, the proposed 65% rule would apply to a total of 12 medical conditions.

CMS is taking comments on the proposed rule until Nov. 3 and plans

to publish a final rule as soon as possible after that date. The final rule would be effective for cost reporting periods beginning on or after Jan. 1, 2004, and before Jan. 1, 2007. CMS expects to save $223 million through these changes.

CMS also proposes to:

• Presume that if the facility's Medicare population complies with the rule, then the facility's total population complies.

• Count patients who have secondary medical conditions that fall into the 12 categories as part of the proposed 65%, but only if the secondary condition causes such a significant decline that the patient would need inpatient rehab even without the admitting condition.

• Use the most recent, appropriate, and consecutive 12-month period to review data to determine compliance.

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• Change the compliance percentage back to 75% in three years.

"In this proposed rule, we are taking a fresh look at the current 75% rule to see if it should be changed," said CMS administrator **Tom Scully** in a news release. "We are proposing significant revisions to the rule."

To many rehab providers, the revisions aren't nearly significant enough. **Carolyn Zollar**, JD, vice president for government relations at the AMRPA, says her organization doesn't believe the proposal is of any assistance at all.

"Our view is it's very confusing," she adds. "The 65% is a good step forward, but when coupled with the other things, it really won't provide adequate relief. The polyarthritis conditions are highly qualified. You have to have exhausted at least one other prior course of rehabilitation, so it's very hard to say these provide any relief to the facilities."

Rochelle Archuleta, senior associate director for policy development post-acute care for the AHA in Washington, DC, says her organization is highly disappointed with the rule. "We look at it as being the same old 75% rule, except that it's more restrictive," she says. "Dropping the threshold on a temporary basis to 65% does help some providers, but it certainly falls far short of the modernization of the rule that we were seeking."

Under the rule, some rehab facilities would have to drastically change how they view which patients are eligible for admission. "The initial reaction we're hearing from our members is that this will be devastating," she says. "It would be a significant change in how they provide rehab care in their communities today."

Cardiac, pulmonary, cancer, and transplant patients who need rehab care will face significant barriers to access, Archuleta points out. "This doesn't provide much in the way of allowing patients who we feel should be included in the 75% rule greater access to care. What you have are categories of patients that currently don't count for the 75% rule that will continue to be shut out."

While CMS did address the polyarthritis issue, the AHA wasn't happy with the result. "The narrowing of polyarthritis is incredibly severe, and we're highly concerned about that," she adds. "Whenever we've had experienced physiatrists review the rule, they cannot imagine what the origin of this provision is. It's so incredibly inconsistent with clinical practice."

One inpatient rehab unit that stands to lose a

significant number of potential patients under the proposed rule is at St. Francis Hospital in Greenville, SC. St. Francis' case mix leans heavily toward orthopedic patients. **Joe Golob**, PT, director of the 19-bed Inpatient Rehabilitation Center, says the proposal will make it hard to admit many of the joint replacement cases that are due to arthritis. "It requires that the patients have been receiving active and intensive treatment for that condition in other less intensive rehabilitation settings immediately preceding the inpatient admission."

Those patients may have to be sent to subacute or skilled nursing facility (SNF) beds, potentially increasing the overall length of stay because they won't be getting the intensive rehab they need, he says.

Golob says the rehab unit has never been at risk for failing to meet the 75% rule in the past, under its interpretation of polyarthritis. But with CMS's new definitions, that will change. "This will be a tremendous challenge to the inpatient rehabilitation industry."

St. Francis has the majority of the market for joint replacements in the area, with a steady stream of referrals filling the beds. "We will have to change our gears and go in a different direction," Golob says. "We will have to reroute patients, and we will have to be more discriminatory about the patients we allow to be part of the 35%. We will have to start marketing for stroke, neurological, and amputation patients."

Theresa Edelstein, vice president of continuing care services for the New Jersey Hospital Association (NJHA) in Princeton, says she, too, is disappointed with the proposed rule. New Jersey is the state where the whole polyarthritis debate erupted, and the NJHA doesn't think this proposal helps at all. "The categories for polyarthritis are so limited, they essentially don't make any difference," she says. "There is still a significant portion of the orthopedic population that our members serve that will, in essence, have significantly reduced access to inpatient rehab because of the way the proposal is constructed."

At best, those orthopedic patients will find alternating levels of access to care, depending on how close facilities are to the 65% threshold, Edelstein says. Such patients theoretically could be treated in an SNF, but she says the SNF Medicare resources may not pay for everything the patient needs. That means the SNF wouldn't be able to take that patient either.

"One of the really unsavory options is that the patient ends up staying in the hospital a heck of a lot longer than they really need to while the hospital struggles to find an appropriate placement," she says. "In New Jersey, we are struggling with Medicare length-of-stay issues. We have a growing elderly population, and if you squeeze tighter on the post-acute side, our length-of-stay problem on the acute side is only going to get exacerbated."

Bruce Gans, MD, a physiatrist and chief medical officer at the Kessler Institute for Rehab in West Orange, NJ, agrees that restricting rehab access only will create problems for acute care hospitals. "The health care system is so highly focused on through-put that the ideal admission to an acute care hospital is somebody who gets discharged the day before they get admitted," he jokes. "It's absurd how much pressure there is.

"We no longer have acute care hospitals that provide a healing and caring environment. They only provide acute technical intervention just long enough until we can get you out the door to someplace else," he continues. "Rehab hospitals are largely that someplace else. If we have to say no, then acute beds will stay occupied. It backs up the emergency room, and the whole chain is all backed up. This is only going to increase the pressure on that piece of interconnectedness of the health care system."

Rehab hospitals can take much more complicated patients now than they could 25 years ago,

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Gans says. "We never used to be able to take a patient who needed intravenous medication, who needed tracheotomy, or ventilator management. At Kessler, now we don't blink an eye if somebody's a ventilator-dependent quadriplegic and on IV antibiotics and needs to be treated for deep vein thrombosis. We simultaneously provide rehab services. So there's really more bang for the buck."

Many providers will have to turn their attention to finding new categories of patients who would benefit from rehab. There probably are enough patients out there to fill those beds, Gans says.

"That's said with embarrassment because it means we've still done a pretty poor job in this country of recognizing when somebody actually needs medical rehabilitation. So the good news is that this will put some extra oomph to finding those underserved people who would benefit from it," he says. "The risk of course is that we're not taking care of people now who need to be taken care of. People don't go to rehab hospitals as resorts. I'm very worried about how they're going to get access to care."

Rehab providers are busily working on comments to the proposed rule. The coalition is still pursuing a legislative remedy as well, says Archuleta of the AHA. "We are seeking external analysis to identify the clinical characteristics of patients who should appropriately be treated in an IRF; we are suggesting a moratorium during the study period; and we want the threshold to be dropped to 50%," she says.

On Sept. 10, Sens. Ben Nelson (D-NE) and Jim Jeffords (I-VT) filed an amendment to the Labor/Health and Human Services appropriations bill being debated in the Senate. The bill (S.1222) would amend title XVIII of the Social Security Act, requiring the Secretary of Health and Human Services to use the 21 RICs as criteria for inpatient rehab payment. The bill also:

- places a moratorium on the proposed rule;
- reduces the 75% requirement to 50%;
- requires the Institute of Medicine to conduct a study to update the criteria and use that information to update the proposed rule. ■

Providers say draft policy could hurt

'The noose has tightened'

The rehab community by and large considers the Centers for Medicare & Medicaid Services' (CMS) proposal to change the 75% rule a big disappointment. But providers and advocates are even more worried about the draft Local Medicare Review Policy (LMRP) for inpatient rehabilitation admission that three fiscal intermediaries recently proposed.

"We're very concerned with the LMRP. That would be a disaster for inpatient rehab as we know it," says **Bill Munley**, MHSA, CRA, administrator of the rehab/neuro/ortho service line at St. Francis Hospital in Greenville, SC.

The document was drafted by fiscal intermediaries Riverbend Government Benefits Administrator (Tennessee and New Jersey), Blue Cross and Blue Shield of Georgia and Veritus Medicare Services (Pennsylvania). It defines the medical necessity for the provision of therapy services in an inpatient rehabilitation environment.

The summary of the LMRP (go to: www.riverbendgba.com/vlmrp/d103-03a.html) says inpatient rehab is covered for patients who have a reasonable expectation of practical improvement and are receiving medically necessary rehabilitative services that include all the following:

1. require around-the-clock availability of an RN and/or frequent (every two to three days) assessment and intervention by a physician;

2. require coordinated multidisciplinary care;

3. require intensive (typically three hours per day) skilled intervention;

4. cannot be provided in a less intensive setting.

Inpatient rehabilitation typically is covered for:

1. Pathology that results in significant loss of function to two or more extremities.

2. CNS (central nervous system) pathology that results in significant loss of function of a single extremity along with the loss of higher functions such as speech/language, balance, and coordination.

3. Single extremity loss of function combined with medical complications that necessitate continuous RN or physician supervision and which is not part of the normal acute inpatient recovery process.

Inpatient rehabilitation typically is not covered for:

- single extremity deficits (except amputations);
- simple fractures;
- joint replacement;
- compression fractures and laminectomies/fusions;

• diffuse weakness or general debility;
• post-op recovery;
• niche rehabilitation (coma, cognitive, cardiac, pulmonary, pain, etc.).

Different from 75% rule

Dan Duvall, MD, medical director for the Chattanooga, TN-based Riverbend, says the fiscal intermediaries felt the need to clearly delineate the criteria for medical necessity after a 2002 program memorandum from CMS gave them the responsibility for auditing inpatient rehab claims. For 10 years prior, it had been unclear who had that responsibility, which meant there wasn't a lot of review activity going on, Duvall says.

"We have had the authority to make these decisions for the last year but we thought it would be better to try to get a good working document put together first so that it would be as clear as possible how we are interpreting these regulations that we're now responsible for," he explains.

Duvall says the LMRP has nothing to do with the 75% rule. The LMRP deals with individual cases and whether they meet CMS requirements.

"There is a reasonable correlation in that a lot of patients who fall in the 25% of the 75% rule also are patients who have diagnoses and treatment plans that are borderline under Medicare requirements for inpatient coverage," he adds. "There's a rough correlation but not an absolute correlation by any means. The other thing is that the 75% rule was actually written in such a way that if a hospital is truly pursuing its rehab status in the way CMS originally envisioned it, then the hospital should have no problems meeting the 75% rule."

Theresa Edelstein, vice president of continuing care services for the New Jersey Hospital Association in Princeton, might agree with Duvall that the two issues are unrelated, but for a different reason.

"The LMRP renders the 75% rule almost moot," she says. "The draft LMRP together with the 75% rule proposal has the makings of disastrous results for some rehab providers. The fiscal intermediaries are saying that orthopedic patients rarely if ever need inpatient rehab. Some will face significant downsizing or closure depending on their orthopedic referrals. Nurses will probably be absorbed in other parts of the health care system, but therapists, custodians, dietary workers, housekeeping staff will be out of work."

Edelstein says that if the LMRPs are approved as written, the face of rehab will change. "The noose has tightened with this draft," she says.

Duvall, however, says there are no absolutes in the document. "The policy says that everything should be evaluated on a case-by-case basis. It does say that, in general, uncomplicated joint replacements typically don't require the level of intensity that would require inpatient care. That's a long way from saying no inpatient joints can be in the hospital."

For example, a single knee replacement probably would not require inpatient care. But a patient who had multiple joints replaced at the same time or who had a single joint replacement along with significant upper extremity impairment likely would qualify, Duvall says.

"The decision criteria would say that the care for certain patients in an inpatient environment is not medically necessary because those same services can be delivered as efficiently in a skilled nursing facility or on an outpatient basis," Duvall says. "It shouldn't be throwing out patients who need the care, but rather it's saying that if you have a patient who only needs physical therapy, then they could just as well get the therapy in a skilled nursing facility [SNF] environment."

Bruce Gans, MD, chief medical officer at the Kessler Institute for Rehabilitation in West Orange, NJ, says that as a physiatrist, he finds the LMRP to be a disturbing document. "As I see it, it shows a great deal of medical naiveté being expressed with regards to understanding the rehabilitation purposes and processes," he says. "The documents talk almost exclusively about impairment level issues, counting the number of limbs that are involved. It's almost completely devoid of recognition that somebody gets admitted to a rehab program not just because they have an impairment but because there is a major functional limitation, a disabling condition."

Gans says he rejects "the entire premise of the LMRP." He says it's hard to believe that any rehab physicians were involved in writing the document.

Duvall points out that a number of physicians, including rehab specialists, were consulted throughout the one-year draft process.

Gans agrees that not every joint replacement patient needs to be in the hospital. Some can be served on an outpatient basis, while those who need nursing care but not three hours a day of therapy can be served in a SNF. But there's a third category of patients who have a lot of active

medical problems along with the joint replacement and who need inpatient rehab. "They need much more intensive therapy because of the combination of the effect of the arthritis and the joint replacement on their ability to dress, feed themselves, transfer, and manage wound care. It's a combination of factors that collectively say this patient really needs to be in the hospital.

On a positive note, Gans says these policies could force rehab doctors to get involved upstream by working to get patients so capable before elective surgery that they will do better after. "We don't do a good enough job of pre-surgically rehabilitating people and getting them prepped to the ideal position to recover quickly," he says.

"Unfortunately, the rehab doctors are usually not involved in the care until after the surgery."

Carolyn Zollar, JD, vice president for government relations at American Medical Rehabilitation Providers Association in Washington, DC, also is puzzled at the origin of the LMRP. "The fiscal intermediaries are issuing medical review policies saying who can and cannot be admitted to rehab. This issue is larger and more critical than the 75% rule.

They're very tight — tighter than the 75% rule — and we don't know where they came from," she says. "They have to be fought tooth and nail in every state, and we're working on that as well. If they go into effect, you won't be able to admit patients to even come in the door."

Duvall says the LMRP is not likely to have the major impact the rehab providers fear. "It is my expectation that we're talking about a relatively small number of patients at each hospital but that it's fairly uniform across hospitals. The majority of cases at rehab hospitals still clearly require inpatient care, and it's the minority that fall in the borderline category.

"The hospitals should have been reasonably consistent all along. Clearly, it's going to make some difference because if it wouldn't, there would be no reason for having the policy in the first place. Over the 10 years without any significant review, facilities tend to have had a fairly diverse interpretation of the regulations," he adds. ■

Therapy cap freeze could offer relief

2004 moratorium possible

Senate and House conferees on the Medicare prescription drug bill agreed Sept. 9 to include a one-year moratorium on the $1,590 outpatient therapy cap for 2004.

But don't give a sigh of relief yet. The moratorium was among the less controversial items discussed in conference to clear the way for issues still in dispute. That means that if the entire bill doesn't go forward, neither does the moratorium.

"Essentially, as it's currently placed, if there is a deal on the prescription drug legislation, the cap should be part of it," says **Dave Mason**, vice president for government affairs for the American Physical Therapy Association (APTA) in Alexandria, VA. "Nothing is final until everything is final."

The therapy cap went into effect Sept. 1, and will apply at least until Dec. 31. "The basic message is that the cap is in place, and providers need to be talking to beneficiaries about it. They will have to abide by CMS's [the Centers for Medicare & Medicaid] program memorandum," Mason says. "At least for this year, the $1,590 cap is only for four months. It won't squeeze as tight as it will over 12 months."

Christina Metzler, director of federal affairs for the American Occupational Therapy Association (AOTA) in Bethesda, MD, says the shorter time period this year will help some patients, but not all. "The people who will get hurt are the people with serious injuries. They will hit the cap pretty quickly," she says. "Someone with macular degeneration who can't function at home might need occupational therapy twice a week for two months. That's $2,200 already. There will be people who will hit this cap in the four-month period."

The AOTA estimates that 12% to 15% of patients who need therapy would exceed the cap on an annual basis and 5% to 10% will exceed it in the four-month period for 2003. "These situations will crop up, and people will have to make some unfortunate choices," she says. "For somebody who has a serious injury, four months is going to be their lifetime."

The AOTA advises providers to make sure patients are informed. Patients will have to do their own coordinating if they require both speech therapy and physical therapy, since those two services are grouped under the $1,590 cap. Patients get a separate $1,590 for occupational therapy.

Many patients and providers are confused, Metzler says. "This just reinforces that there is no good way to implement a bad law."

Another avenue for relief could come from a

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lawsuit filed in June against CMS in the District of Columbia District Court (*American Parkinson Disease Association, et al. v. Tommy G. Thompson, No. 03-1378*). U.S. District Judge **Emmet Sullivan** guided a settlement in which CMS agreed to delay implementation of the cap from July 1 to Sept. 1, giving more time to notify beneficiaries of the cap.

At the June 30 hearing, Sullivan appeared to side with the plaintiffs. According to the transcript, he said: "I mean, it almost amounts to me as a cruel hoax on those Americans who are truly the neediest, you know, those Americans who are disadvantaged, who are challenged in many ways, without notice. Now they have to bear a significant portion of Medicare expenses that they would not have to bear if the moratorium remained in place for a reasonable period of time."

Sept. 15, the plaintiffs went back to court to argue that the government had not kept its pledge to notify 90% of beneficiaries by Sept. 1. They suggested that beneficiaries be sent a special notice in October and November and asked that the cap be further delayed until Dec. 1. The government argued that their previous statement about notifying 90% of beneficiaries was only an estimate of what they thought they could accomplish in July and August, says Metzler, who attended the hearing.

"The judge was very concerned that the government was not able to figure out a way to notify all Medicare beneficiaries that their benefits were going to be changed," Metzler says. "He indicated a great deal of frustration with the government. As the judge put it, when the government wants to find you for tax purposes, they seem to be able to get in touch with you."

Sullivan was expected to issue a final ruling Sept. 18, but the hearing was delayed due to the effects of Hurricane Isabel. At press time, the hearing had not yet been rescheduled.

At best, however, the lawsuit will result in a one-year moratorium. "So in a year, we could be doing this again," says Mason of the APTA.

Legislation to repeal the cap is still pending. Identical bills introduced in March by Sen. John Ensign (R-NV) and Rep. Phil English (R-PA) are gaining steam in Congress, Mason says. The House bill now has a majority of representatives as co-sponsors, and 50 senators have signed on.

"It does kind of indicate that there is a lot of understanding on the Hill that this is a very bad policy that needs to be replaced," he says. "The problem we continue to run into, though, is that the Congressional Budget Office says it costs in the neighborhood of $7.5 billion over 10 years to get rid of it, and in a deficit situation like we're facing now, it's going to be very hard to find that kind of money."

Mason says the budget situation will force the need for a creative solution to get rid of the cap. "Unless we come up with a way to pay for it, a lot of Congress members who agree that the policy should be repealed will probably vote against it not wanting to add another $7 billion to the deficit," he says. "We've probably won the policy debate, but we haven't necessarily won the budget debate. It's a difficult box to get out of." ■

Investigate slips and falls, identify ways to prevent

Respond quickly and thoroughly

You're busy with a dozen other issues when you get a phone call notifying you that a visitor has fallen in the lobby and broken her arm. Do you chalk it up to "just another fall" and get back to work, or do you spring into action?

The answer may depend on how well you've prepared for the moment and how seriously you take slips and falls in your institution. The experts say that if you're taking the right steps to reduce falls and all the attending liability, you'll probably get up from your desk and make investigating the incident a top priority.

A speedy response and full-scale investigation may not be necessary for every incident. But the more serious the fall, the more you should pull out all the stops in your response. A serious injury such as a broken arm is enough to justify a

full response, says **Ronald Miller**, CSP, director of training and consulting services for the occupational safety and health group of the National Safety Council in Itasca, IL.

"Most employers handle this rather poorly," he says. "Most of the companies I've worked with needed extensive training on how to do a good investigation. If a health care provider wants to reduce falls, you need to take a hard look at what happens when someone falls."

There could be a tough decision to make in some circumstances, though, with the primary question being: If you document the incident well enough to learn from it, will you create ammunition for a plaintiff's attorney?

Many willfully avoid documenting the incidents for fear of creating evidence that can be used against them in court, says **Russell J. Kendzior**, CSP, president of the nonprofit National Floor Safety Institute (NFSI) and Traction Plus, a manufacturer of slip-and-fall prevention products, both in Southlake, TX. He often testifies as an expert witness for slip-and-fall cases, and says health care staff often are conspicuously unable to show documentation of the incidents.

The problem is bad, especially in nursing homes, where the risk and potential liability from falls are the greatest, he says. "One unfortunate reality in health care is that they often have been trained by risk managers, loss-control experts, and third-party claims managers to be very vague in gathering information," he says. "They will say you don't want to collect or track certain information because it can only come back to haunt you in court. I know that sounds crazy, but I see it a lot."

Some health care providers even choose not to have a policy on the prevention of slips and falls, for fear that a plaintiff's attorney will use it to prove that the facility was not following its own policy. Kendzior says that is a very poor strategy if you're trying to reduce falls, which he calls "by far the biggest risk your patients face while they're in your care."

Responding properly to a fall is important, but Kendzior says a proactive program is even more effective. The risk manager should work closely with the engineering and housekeeping departments to ensure that floors are maintained in such as way as to minimize the risk of falls, he says.

Every fall, and most near misses, should be investigated thoroughly, Miller says. Sometimes, the local supervisor can be trusted to conduct the investigation and document the incident, but sometimes, the seriousness of the fall requires a multidisciplinary team approach. That team may include the risk manager, director of safety, the facility's head engineer, the director of housekeeping, and the manager of the unit where the incident happened.

Employees, especially managers, should be educated about the need to preserve evidence and investigate after falls.

"Incident investigations should be done immediately because conditions change," he says. "If there is a hazard on the floor like a spilled liquid or bodily fluid, someone is going to clean it up quickly, especially after there is an incident. Unless the investigation is done quickly, you may never find that root cause. The cause could be a motorized equipment cart with an oil leak, and if the spill has been cleaned up and no one remembers leakage from that cart, you may never find it."

When you investigate a fall, Miller says you should gather as much information as possible about the area and the activity leading to the fall. Document the information and consider photographing pertinent scenes, especially those that may mitigate the institution's liability for the fall. Investigators often photograph the area in which the person fell and maybe even the fluid spill that caused it, but they sometimes overlook documenting the precautions that mitigate the damages. For instance, you may wish to photograph the "wet floor" sign that housekeeping had in place to warn people, or the handrails that helped the person avoid a more serious fall.

The incident investigation after a serious fall should follow the same methodology and strive for the same goals as a root-cause analysis after an adverse medical event, Miller says. The goal should be to uncover the real cause of the fall, not just the defect that appears most obvious.

Just as with less-than-optimal investigations of medical incidents, a common failing of fall analyses is blaming the employee who fell or who made the fall possible by leaving a hazard on the floor, he says. That rarely is the root cause.

"Most reports by a supervisor will conclude that the way to fix the problem is to retrain the employee, but you'll never see one that says, 'Retrain the supervisor,'" Miller says. "If you don't focus on the root-cause analysis, you'll stop before you find the real problem."

Punishing employees or laying all the blame on them also will discourage the free reporting that is so important for good fall investigations, he says. If your employees only report the ones they have to report — the falls that leave someone lying on

the floor needing medical help — you'll miss the opportunity to learn.

When investigating and analyzing the data, Miller says you should focus on these four areas that lead to most slips and falls:

- **Equipment:** Check to see if any items were defective, such as handrails that did not support the person or anything that could have led to tripping.
- **Environment:** This area includes all types of hazardous conditions, such as the condition of stairs and floors. Was there blood or other fluid on the floor? Why? How long had it been there?
- **Management:** Ascertain whether there was a breakdown in management, such as allowing employees to run through the department. Was management condoning it or even encouraging it?
- **People:** Who fell? Was the person impaired in any way? What was he or she doing at the time of the fall? Also consider the type and condition of the person's shoes.

Miller says most falls can be traced to failures in at least three of those categories.

"And remember that you have to do something with the data," he says. "If you don't use it to improve, you're just wasting your time and opening yourself up for more incidents." ■

One-size-fits-all ergo rule put to the vote

Ballot initiative could repeal Washington rule

Once again, a controversial ergonomics rule has come under fire; but this time, voters in Washington state will be the ones to decide whether to keep the rule or repeal it. The outcome of Initiative 841 on the Nov. 4 ballot could have implications for ergonomics efforts across the nation.

"It would set us back," says **Bill Borwegen**, MHP, health and safety director of the Service Employees International Union (SEIU), which is hoping to strengthen the California ergonomics regulation, the only other one in the country.

Washington state's rule requires businesses to identify "caution zone jobs" that put workers at risk and to reduce the hazards of musculoskeletal disorder (MSD) injuries. The rule becomes effective on a staggered timeline, with the more hazardous industries, such as nursing homes, the first that must comply. Hospitals were required to begin assessing job hazards by July 1, 2003, and to begin reducing those hazards by July 1, 2004.

Concerns about the costs and burden of the rule arose as soon as it was adopted by the Washington Department of Labor and Industries in 2000. Based on the advice of the Blue Ribbon Panel on Ergonomics, which was appointed to consider the feasibility and impact of the rule, Gov. Gary Locke delayed enforcement for two years. For that period, employers will not be fined if they are not in compliance.

Yet Washington business leaders want the rule quashed altogether. (The Washington State Hospital Association has remained neutral and has not endorsed the initiative.) "Every business in the state must follow this one-size-fits-all ergonomics rule," says **Erin Shannon**, public relations director for the Building Industry Association of Washington in Olympia. "Washington's rule is actually more restrictive than the rule that was overturned by Congress [in 2001]."

The business coalition tried but failed to get support from the state legislation to repeal the rule, or to make compliance voluntary. A superior court judge upheld the process of adopting the rule. As of press time, the state Supreme Court had not ruled on arguments that the rule was adopted improperly.

Meanwhile, the business coalition gathered 260,000 signatures to place an initiative on the ballot and began to campaign for repeal of the rule. "You have to let the voters have the final say," Shannon says.

Their slogan: Ergonomics is a job killer. The business coalition asserts that the rule will discourage businesses from coming to Washington. They also say it unnecessarily will restrict workers from being able to fulfill their job tasks by limiting the amount of time they can do activities deemed hazardous.

"What they don't want to talk about is job safety," says **David Groves**, spokesman for the Washington State Labor Council in Seattle. "Their pollsters have told them that's a losing position, that people won't vote to repeal job safety. They're cynically taking advantage of a weak economy and everybody's fears about losing their job and suggesting that passing this initiative will somehow maintain jobs."

The Department of Labor and Industries is vigorously defending its rule, asserting that it saves employers money in reduced workers' compensation and medical costs and other indirect expenses.

In fact, the agency estimates that the rule will cost employers $80.4 million annually, while it will prevent 40% of MSD injuries, saving about $340.7 million annually.

Before creating the rule, the department surveyed Washington employers and found that 40% knew of MSD hazards in their workplaces but had not used ergonomics interventions to reduce them.

"The rule allows the employer choices for meeting the requirement to reduce employee exposure below hazardous levels or to the degree economically and technologically feasible," the department said in a written response to criticisms. "It does not dictate the methods employers must use to meet the requirement for hazard reduction."

Yet even that flexibility has been criticized. "How are businesses supposed to know whether or not they're meeting that vague standard?" Shannon asks.

Many employers began implementing ergonomics programs voluntarily, or in response to the rule, Groves says. "But there continue to be some employers and some special interest lobbying groups that are just ideologically opposed to the government forcing them to do anything. Those are the people financing this initiative," he says.

If Initiative 841 passes, the state will be prohibited from creating an ergonomics rule until there is a federal standard.

(Editor's note: For a full description of the Washington ergonomics rule, go to the Washington Labor and Industries web site: www.lni.wa.gov/wisha/ergo/default.htm.) ■

Get a handle on claims denials with database

Denial rates impact reimbursement

If you think your hospital doesn't have a problem with denials, then you aren't doing anything to track them, says **Christine Collins**, CHAM, director of patient access for Brigham & Women's Hospital in Boston.

The heart of successful denial management, she emphasizes, is a denial database that categorizes the bills that are denied and the reasons why.

With the challenges of clinical vs. administrative denials, observation vs. inpatient status denials, and complicated time-sensitive authorization processes, she adds, the cash flow can be difficult to follow.

To get a handle on what wasn't getting paid and why, the hospital formed an inpatient denial team — co-chaired by Collins and a physician — to oversee the process, with representation from patient access, billing, medical records, and care coordination. Boston-based Partners Healthcare system, of which Brigham & Women's Hospital is a member, awarded the team a 2001 Partners in Excellence Award for outstanding efforts in improving management of denials. Collins says the team continues to be recognized for its achievements.

Building a denial database was the first order of business, she says. An analyst in the patient access department provides upkeep of the database, while other functions are handled by the following areas:

- **Care coordination** provides analysis of clinical/utilization review denials.
- **Patient access** assesses authorization processes.
- **Patient accounts** pursues final outcome.
- **Medical records** handles documentation needs.
- **Medical director** handles clinical appeals.

The process begins, she explains, when accounts receivable gets a denial and puts it into the database, assigning it to a person based on the kind of denial it is.

"What we do that's wonderful is assign denials so we can track them. If [a denial] comes to my office, but is clinical, I reassign it to a person who can handle it," Collins notes. "If it's a pre-cert or pre-authorization [issue], it's assigned to my staff."

"Most hospitals," she adds, "don't have the IT [information technology] to have this information at their fingertips — [information about] who's working what."

Pat O'Keefe, denial manager in patient access services, is in charge of handling all technical and administrative denials, Collins says, and at times works very closely with care coordination personnel. "In every area, care coordination has one or two people who own this [denial management] process."

O'Keefe says she consults with utilization review nurses to determine whether a patient has inpatient or observation status, which often is a point of contention with insurance companies responding to claims.

On a day-to-day basis, O'Keefe notes, she is

responsible for researching any [technical and administrative] denials that are related to inpatient admission. "[That includes] writing the appeal and getting any kind of documentation I need to support our case, [including] screen prints of notes saying who we spoke to [at the insurance company], what authorization number we got, and also getting any necessary medical documentation, and sending it off to the insurance company," she says.

Even in the case of technical or administrative denials, O'Keefe says, many insurance companies require that a patient's medical record accompany the appeal. "I have a spreadsheet that I've developed," she adds, "and every time I send out an appeal, I enter it on the spreadsheet so I can keep a running total, including what the status is, if an appeal is still out."

Collins is reluctant to make before-and-after comparisons regarding dollars recouped by the denial management initiative. A reimbursement denial that's now quickly reversed via the new denial management process eventually might have been handled successfully through appeals, she points out.

"[In the past], if we had these denials and weren't tracking them but did a lot of legwork and eventually got paid anyway, it might have taken six months instead of six weeks," Collins says. "In the old days, and still at many hospitals, people in accounts receivable are constantly resubmitting bills."

The beauty of the tracking process, she adds, has been in the ability to notice trends, improve processes, and work with payers on better system-to-system communication.

"Data are so powerful," Collins notes. "Until you have that, you're looking at [denials] one by one. Once we track them, we have the documentation to support why we shouldn't have been denied. Settlements with payers can be made based on data. We maintain all the documentation on-line, and we follow up denied claims until resolution."

Within the database, there is the capacity for electronic communication to prompt steps in the appeal process, she says.

Need More Information?

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"If we notice that something is a trend and should not be a denial, we can include that in the next contract negotiation," Collins says.

Examining individual problems can lead to long-term solutions in other areas. Some redundancies in the preauthorization process can be beneficial to the payer as well as the hospital, she points out. "They want to make their administrative burden smaller, too."

While in the past, a payer might contend that the hospital never had made a preauthorization call on a particular case, the capacity for electronic communication puts the accountability on both sides, Collins points out. "When we start to do an autopsy on denials, we say, 'Gee, their system has its own problems.' Sometimes, what we have here is different from what they think. If you don't dot an I on one system, the other system kicks [the bill] out," she says.

"When we first started doing appeals, [the payers] had not had a lot of hospitals doing them," O'Keefe adds. "It would take five months or longer for them to acknowledge that we'd sent an appeal. Then they would send a letter saying we would be notified in 45 days."

Tracking denials prevents certain groups of patients from slipping through the cracks in the admitting/screening process, she notes.

What Brigham & Women's system provides, Collins points out, "is more understanding so we can improve our process. Until you have a common, integrated database that is completely open, honest, and hospitalwide, you're not going to have that. It's the little things. It's truly understanding the business, and what the issues are, and [asking] how can we fix them." ■

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