

Collaborating Researchers

and industry leaders share their views regarding Local Coverage Determinations (LCDs) in our feature article. Turn to *Page 2* for more information.

Post-acute Care Symposium

CROR is a co-sponsor of a State-of-the-Science Symposium on Post-acute Care Rehabilitation being held February 11 - 12, 2007. Many high profile speakers are confirmed to participate. More information is on *Page 6*.

Model Systems Research

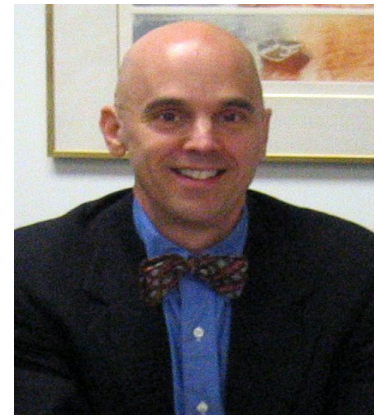
RIC has been designated a "Model Regional Spinal Cord Injury Care System." CROR staff is part of the research team. Details on *Page 4*.

Welcome to the Winter 2007 Issue of CROR Outcomes

We received a good deal of positive feedback about our inaugural issue and are pleased that many found it interesting and useful. This second issue of CROR Outcomes contains feature articles regarding two of the health policy and disability issues currently being studied by CROR staff. In addition, we profile Anne Deutsch and Joy Hammel, two individuals who are critical to realizing our mission.

Our first feature article describes work undertaken as part of our Rehabilitation Research and Training Center on Measuring Rehabilitation Outcomes and Effectiveness to measure community participation. While community participation is a valued outcome for consumers, family members, payers and policy makers, there is no standard way of measuring it. The World Health Organization's

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Dr. Deutsch: Health Services Researcher

The path that led Dr. Anne Deutsch to a career in the field of rehabilitation research, and eventually to her current position as clinical research scientist at the Rehabilitation Institute of Chicago (RIC), had stops all over the map including New York, Ohio, Illinois, and even Canada.

Deutsch was born in England, spent most of her school age years in Montreal, Quebec, and then moved to Cincinnati, Ohio, where she finished high school. For her undergraduate education, Deutsch made the decision to remain in Ohio and enrolled in the College of Nursing and Health at the University of Cincinnati.

"While I was in nursing school, I also worked at the university hospital," she said. "I was working as a nursing assistant on a lot of different floors, and I ended up spending quite a bit of time on the rehabilitation floor. I really enjoyed working with the patients, particularly those with spinal cord injuries."

After Deutsch finished her nursing degree, the University of Cincinnati Medical Center offered

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Measuring Community Participation: A New Approach

The Americans with Disabilities Act of 1990 placed critical importance on an individual's level of participation in society regardless of their level of impairment. However, no viable tool currently exists that can accurately measure participation and draw solid conclusions about post-rehabilitation outcomes.

Participation is more than just functional performance... "[It] cannot be evaluated without fully considering the interaction of the social, physical, sociopolitical, and cultural environment, as well."

Dr. Joy Hammel, Associate Professor

"Community participation is a valued outcome for a variety of stakeholders, such as payers, providers, family members and consumers, but there's no accepted standard way of measuring it," explained Dr. Allen Heinemann, director of the Center for Rehabilitation Outcomes Research at the Rehabilitation Institute of Chicago. "There are ways of trying to classify it, but nothing is established. In part, that is because the concept is ill-defined."

At present, there have been several attempts to classify community participation –most of which depend on the World Health Organization's International Classification of Function and Disability (ICF). The ICF certainly has its merits, as Heinemann said. Its system emphasizes environmental factors that affect human performance, focuses on

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Local Coverage Decisions (LCDs) In Review

Patients who once had access to rehabilitation care in an inpatient rehabilitation setting, such as those who had undergone joint replacement surgery, are now being routinely denied and subsequently routed to skilled nursing and home health

and necessary, based on patients' particular circumstances.

According to the Centers for Medicare and Medicaid Services (CMS), LCDs are a tool to determine what services are necessary, and to ensure claims are submitted correctly

Health Organization International Classification of Function and Disability (ICF) and draw useful parameters for providers.

"One of the things that all contractors are charged with is decreasing error rates, and one of the ways this payment error can be addressed is through the use of LCDs," Feliciano said. "Something we grapple with is whether the right service is being provided to the right person in the right setting at the right time. We're trying to address both the needs of the individual as well as Medicare requirements."

However, many in the field see LCDs as little more than a means of Medicare cost cutting, while often placing patients in a less intensive rehabilitation setting.

FI's recent interpretations of medical necessity for inpatient rehabilitation facilities (IRFs) have been much narrower, requiring

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Local Coverage Determinations (LCDs) vary considerably, causing consternation among providers and advocates.

agencies. This change, which began several years ago, is due, at least in part, to highly restrictive local coverage determinations (LCDs).

Local coverage determinations are regional decisions made by Medicare fiscal intermediaries (FIs) that specify what medical treatments and services are reasonable

for payment. They are based on available evidence including studies and consensus of medical opinion. Harry Feliciano, MD, MPH, director of Part A medical affairs for Palmetto GBA, Camden, South Carolina, said their LCDs – covering home health and outpatient services – are based primarily on the World

Postdoctoral Fellowship Available

In collaboration with Northwestern University's Department of Physical Medicine and Rehabilitation and the Institute for Healthcare Studies, the Center for Rehabilitation Outcomes Research announces the availability of a post-doctoral fellowship available Fall 2007 or Winter 2008.

The two-year fellowship provides an opportunity for an individual who has recently completed a PhD or MD to gain expertise in health services research. A fellow would have an opportunity to join CROR scientists and NU faculty to focus on projects related to a Rehabilitation Research and Training Center on Measuring Rehabilitation Outcomes and Effectiveness. Some of these research projects are described on our website at <http://www.ric.org/research/outcomes/rrtc_projects.php>. The program includes didactic course work offered as part

of a masters in public health program at Northwestern University's Feinberg School of Medicine, a research practicum, an opportunity to complete original research, and development of grant writing skills. Additional fellowship information is available at <<http://www.medschool.northwestern.edu/ihs/education/index.html>>. Inquiries should be directed to:

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Comments?

Your opinions are important to us. If you have a comment or suggestion regarding our research or the CROR Outcomes newsletter, please email your comments to <kstagg@ric.org>.

LCDs In Review (Continued From Page Two)

patients to have a more medically acute condition to qualify, according to Andy Whitener, a physical therapist and post-acute consultant, and Carolyn Zollar, vice president for government relations and policy development at the American Medical Rehabilitation Providers Association, and advisory board member for CROR's Rehabilitation Research and Training Center.

"We're seeing now that the fiscal intermediaries are really cracking down on the inpatient side," Zollar said in an interview.

Diminishing access

This current Medicare trend of steering patients toward lower-cost, outpatient options and skilled nursing facilities (SNFs) in lieu of more expensive inpatient rehabilitation care began in 2003. At that time, Medicare gave FIs the jurisdiction to determine medical necessity and authority to require facilities to document conditions in much greater detail than they had in the past.

In addition, increased enforcement of the 75 percent rule – a mandate requiring that 75 percent of IRF patients must be receiving treatment for one of 13 qualifying conditions – also dramatically limited access to IRFs.

While FIs are currently drafting LCD guidelines in all regions across the country, many of them are not finalized, meaning they have not yet gone into effect. However, seven LCDs are final and their coverage areas encompass Alabama, Florida, Georgia, Indiana, Illinois, Kentucky, Louisiana, Maine, Massachusetts, Missouri, New Hampshire, New Mexico, Ohio, and Vermont. A local coverage determination by Mutual of Omaha finalized on May 14, 2005 restricts inpatient rehabilitation care in 49 states.

What has also caused consternation among providers and advocates is the considerable level of LCD variation from region to region. Two FIs, for instance, may have finalized LCDs, but one may have much more lenient interpretations

than the other, allowing for a higher number of acceptable IRF patients. In some communities such as Phoenix and St. Louis, more than one finalized LCD is in effect, causing providers to wonder which set of regulations they are supposed to follow.

"They're very confusing," said Nancy Richman, OTR/L of Glantz/Richman Rehabilitation Associates, Riverwood, Illinois. "It's difficult to keep a handle on them because many of them are so poorly written."

According to Bruce Gans, MD, Executive Vice President and Chief Medical Officer at the Kessler Institute for Rehabilitation in West Orange, New Jersey, the LCDs have been changing, but FIs have also recently begun to aggressively audit records. "Fiscal intermediaries are now asking for cases to be pulled and they're denying payment to facilities," Gans said.

In addition to FIs, CMS also recently began using recovery audit contractors (RACs) – firms hired to do a separate audit of past settled claims and recover money through coding errors and medical necessity judgments. This pilot project affected providers in Florida, New York and California, and recent budget legislation expanded the program to all 50 states. Although RACs have the task of finding both underpayments and overpayments, they are compensated only for the overpayments they find.

"They're paid for each instance they find where reimbursement was over what was appropriate," Gans said. "There was no review process of the first three states, and now they've expanded the program."

The appeals process

When FIs audit and issue denials because services are deemed medically unnecessary, providers face a significant burden with the appeals process, explained Zollar.

"Denials are extremely harsh on providers," she said. "They are

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Collaborating Researcher Brings a Disability Studies Perspective to CROR Study



Dr. Joy Hammel pointed to several critical moments in her early career that spurred her active involvement in the research areas of community living, accessibility and participation.

Hammel, who now works as an Associate Professor in Disability Studies and Occupational Therapy at the College of Applied Health Sciences, University of Illinois at Chicago (UIC), and as a co-investigator in research with the Center for Rehabilitation Outcomes

Research (CROR) at the Rehabilitation Institute of Chicago (RIC), is a native of Wisconsin. She completed her bachelor's degree in occupational therapy at the University of Wisconsin-Madison in 1986. The following year, Hammel relocated to Palo Alto, Calif., where she accepted a position as an occupational therapist at the Palo Alto Veterans Affairs Medical Center, specializing in the development and evaluation of assistive technologies to support community living and work.

During this time, Hammel also began the Master of Education program at San Francisco State University, where she focused her energies on understanding how people learned and how technology could be made more accessible to people with disabilities as a learning and survival tool.

"I was working with people who were trying to return to community living after a spinal cord injury," said Hammel. "That made me aware of technology that was available, but also where it fell significantly short. People were experiencing a lot of isolation and depression and, through my exposure to disability activists and places like Centers for Independent Living in Berkeley and San Francisco, I became much more aware of the environmental barriers people were facing – that is what got me involved in disability studies and asking, 'How does society respond to and modify itself based on people with disabilities and their needs, versus how we try to change the person in rehabilitation?'"

Following the completion of her master's degree, Hammel remained in northern California and began a Ph.D. in educational psychology at the University of California at Berkeley. She was at Berkeley during a watershed moment in disability rights – the 1990 passage of the Americans with Disabilities Act – and Hammel described it as a "perfect time" to become involved in the disability rights movement to enact equal rights, including the right to participate in the community. This event shaped her future research trajectory.

Hammel completed her Ph.D. in 1994, along with a doctoral dissertation that examined environmental barriers to returning to community living and work after a spinal cord injury. Finally, she explained, she ended up in Chicago, drawn to the city by the Occupational Therapy and Joint Doctoral Program in Disability Studies at UIC, and the vibrant and growing disability activism community.

"The doctoral program at UIC is the first of its kind in the country within the field of disability studies," Hammel said. "That is how I became very interested in how the environment can oppress people's choice and control, and going beyond studying impairment and moving toward participation and citizenship in society."

An article co-authored by Hammel, summarizing the results of the focus groups mentioned in our cover story, is in press.

Dr. Anne Deutsch (Continued From Page One)



her a full-time position. She accepted and spent two years working in the hospital's rehabilitation unit. Then, explained Deutsch, she made the decision to get a master's degree.

State University of New York at Buffalo. Her duties while director of education included serving as a liaison between UDSMR and the Centers for Medicare and Medicaid Services (CMS), teaching classes on functional assessment, and providing training for the Medicare Inpatient Rehabilitation Facility Prospective Payment System. During that time, Deutsch also began work on her PhD in Epidemiology and Community Health.

While living in Buffalo, Deutsch's husband was offered a new position and they relocated to Chicago where she began the arduous task of finishing her doctoral degree from several states away.

"I was finishing up my degree via email," she said. "My son was only two years old and I had to travel back

on Disability and Rehabilitation Research (NIDRR), and we recruit patients with a spinal cord injury to participate in a national database to look at immediate and long term outcomes."

In addition, Deutsch said, within that grant, she is also working on a research project with Heinemann to examine access to and outcomes of patients with spinal cord injury who have Medicare and Medicaid coverage.

Deutsch lives in Naperville, Illinois with her husband, Steve, and their six-year-old son, Adam.

Anne's primary research interests include post-acute rehabilitation care and health policy. She lives in Naperville, Illinois with her husband, Steve, and their son, Adam.

The master of science program at the State University of New York at Buffalo's School of Nursing was one of the few available for rehabilitation nurses at that time, so Deutsch relocated to Buffalo. While completing her master's degree, she also worked as a staff nurse – first at Buffalo General Hospital, and later at Mount Sinai Hospital in Toronto.

"I remember driving through the U.S.-Canadian border at midnight one night after work, telling the U.S. Customs Officer that I had to drop off a paper by 8 am," Deutsch said, laughing.

Deutsch finished her degree in 1992 with a master's project entitled, "Predicting the Amount of Human Assistance Needed by Persons with Spinal Cord Injury to Complete Activities of Daily Living."

She then accepted a position as the director of education at the Uniform Data System for Medical Rehabilitation (UDSMR) at the

to Buffalo from Chicago to defend my dissertation."

Deutsch completed her PhD in 2003, with a dissertation that examined outcomes and reimbursement for patients with stroke and hip fracture. She then accepted a post-doctoral fellowship at Northwestern University. During that fellowship, Dr. Allen Heinemann, director of the Center for Rehabilitation Outcomes Research at the RIC, was one of Deutsch's mentors. In May 2005, he invited her to join CROR's research team.

Anne's primary research interests include health services/health policy research in post-acute care. She is currently working on a CMS contract to develop a Uniform Patient Assessment Tool.

"Another project I am working on is the Midwest Regional Spinal Cord Injury Care System," Deutsch explained. "It's a grant that is funded by the National Institute

CROR Staff Part of "Model System" Research Team

RIC has been designated a "Model Spinal Cord Injury Care System" by the National Institute on Disability and Rehabilitation Research (NIDRR), Department of Education. The Midwest Regional Spinal Cord Injury Care System is a collaboration of acute care and rehabilitation services, provided jointly by RIC and Northwestern Memorial Hospital (NMH). This honor differentiates RIC as an elite center of care, one of only 16 institutions designated nationwide. As a model program, RIC will support clinical and research projects to establish innovative planning for the delivery, demonstration, and evaluation of comprehensive rehabilitation care.

Dr. David Chen, medical director of both the spinal cord injury rehabilitation program at RIC and the spinal cord injury acute care program at NMH, leads this project. The Midwest Regional Spinal Cord Injury Care System team also includes RIC clinician Diane Rowles, NP; CROR employees Allen Heinemann, PhD, Anne Deutsch, PhD, Holly DeMark and Annelouise Tookoian; and research staff George Hornby, PhD, Jessica Pedersen and Marianne Kaplan.

Measuring Community Participation (Continued From Page One)

individual capacity rather than limitations, utilizes a neutral language, and describes consequences along a continuum.

However, there are considerable problems with using the ICF to draw conclusions about individual levels of participation, Heinemann said. The ICF provides a taxonomy with components such as Activities and Participation, and Environmental Factors, but the system has not been translated into a measurement tool.

Other attempts to measure participation fall short as well.

“There is a real lack of good instruments,” Heinemann said. “They tend to have difficulty measuring more able individuals and they don’t consider input from all of the different stakeholders involved.”

Goals of the study

In order to address the need to measure the longer term outcomes of rehabilitation, Heinemann, along with a project team that includes members from the University of Illinois at Chicago and Craig Hospital, began a three-year-long study aimed at gathering data from the various stakeholders and using it to develop an instrument to accurately measure individuals’ participation in the community.

The study, which is funded by the National Institute on Disability and Rehabilitation Research (NIDRR), is one of four projects of the Rehabilitation Research and Training Center on Measuring Rehabilitation Outcomes and Effectiveness.

As Heinemann explained, this project’s goal – incorporating stakeholder perspectives of community participation with the existing ICF – has three main objectives:

1. Describe indicators of participation from the perspectives of the various stakeholders: rehabilitation consumers, caregivers, health care providers, payers and policy makers.
2. Write items that will eventually comprise an instrument, that will guide measurement, and will inform the community.
3. Evaluate the participation item bank using representative samples of people with disabilities.

“What we really wanted to do is get in contact with all of the stakeholder groups and hear what they had to say,” Heinemann said. “We also wanted to make sure that people with brain injury, stroke and spinal cord injury – the rehabilitation consumers – were actively involved in the study.”

Developing an instrument

One of the first tasks of the study, which began in December 2004, was to find members of the different stakeholder groups and obtain their perspectives on participation. Project staff conducted focus groups in Chicago, Illinois; Englewood, Colorado; and Washington, D.C.

The project team tried to include input from as many different parties in the focus groups as possible. The consumers were made up of people who had sustained a traumatic brain injury, stroke, or spinal cord injury, while the payers’ focus group included members of private insurers, members of the Insurance Research Group, and state Medicaid staff in Illinois. The policymaker focus group included aides from the U.S. House Subcommittee on Health, Energy and Commerce Committee, and finally, the rehabilitation providers’ focus group included physicians, occupational and physical therapists, psychologists, vocational therapists, speech language pathologists, and social workers. The total number of participants was 138 across 18 focus

groups.

“We partnered with disability activism groups and organizations,” said Joy Hammel, Associate Professor in Disability Studies at the College of Applied Health Sciences at the University of Illinois at Chicago, and a member of the project team. “We talked to people coming out of rehabilitation facilities, to people living in the community long term, and policy makers. The whole idea was to get a very well-rounded group.”

Sample questions asked in the focus groups included “What does the word ‘participation’ mean to you?” “Why is participation important to you?” and “What barriers affect participation?”

“The advantage of focus groups is that you get active involvement,” Heinemann said. “We used a captioner so we could document people’s exact words, and it also served as a reasonable accommodation for participants” Team members then coded these transcripts using a method that identifies the major themes and ideas. From this analysis, the team, which included people with disabilities from the community, wrote sets of participation items that reflected these ideas. The focus groups revealed three basic community participation indicators, which helped shape the instrument: domains, aspects, and values.

The domains -- that is, where participation takes place -- are: social, community, and economic/productive settings. Participation aspects were split between performance and satisfaction components. In addition, they noted that participation values mentioned by the respondents generally fit within eight themes: mobility, opportunity and choice, active engagement, control, having an impact, supporting others, citizenship, and inclusion.

“That series of eight value statements was something new,” Hammel said. “It wasn’t well developed in current literature. For us, different values come into play for each person as opposed to some universal participation norm or societal expectation.”

Findings and the future

With less than one year of the study remaining, Heinemann says the project team has begun preliminary analysis of the data and hopes to complete it within the next few months. In addition to pilot testing the participation items with consumers at the three study sites, the group is collecting additional population data from 1000 people – 500 with disabilities and 500 without – from the Colorado Behavioral Risk Factor Surveillance System to supplement the existing data.

Among their findings so far, Hammel said, was the conclusion that participation cannot be evaluated without fully considering the interaction of the social, physical, sociopolitical, and cultural environment as well. “Participation, more than anything else, is embedded in environment,” she said.

In addition, Hammel said, participation needs to be thought of as more than just the act of “doing,” or functional performance. Part of the goal of the study is to reconceptualize it to include more aspects of social inclusion and “being a part of” communities and society, such as being a valued member of a community group or being able to fully engage in community environments and citizenship opportunities. In other words, participation doesn’t have to involve physical activity, but rather a sense of inclusion, respect and dignity.

The project team’s goal is to complete all pilot tests, refine the instrument, and complete data analysis by next fall, at which point, they hope to have a measurement instrument that can be used successfully in the field to assess all of the community participation indicators.

“This is a great example of cost-effective, consumer-focused research with a focus on insider perspective, and a community context to evaluate participation,” Heinemann said. RIC will evaluate the utility of the instrument as part of its routine monitoring of patients after they are discharged.



Winter 2007 Welcome (Continued From Page One)

International Classification of Function and Disability provides a valuable taxonomy to characterize participation, but has not been translated into a measurement instrument. Working with collaborators at Ohio State University, the University of Illinois at Chicago, and Craig Hospital, we have developed and pilot tested an instrument as part of the Behavioral Risk Factor Surveillance Survey in Colorado.

Our second feature article discusses Local Coverage Determinations (LCDs). Based on Medicare regulations, LCDs are regional decisions made by fiscal intermediaries and specify what medical treatments and services are reasonable and necessary for patients admitted to inpatient rehabilitation hospitals. Our article includes interviews with a range of industry leaders who discuss how LCDs impact access to rehabilitation care, regional variation in guideline interpretation, and issues related to administrative burden and cost. Understanding LCDs is important for understanding access and outcomes in IRFs and post-acute care in general.

Finally, our Rehabilitation Research and Training Center-sponsored State-of-the-Science Symposium on post-acute

rehabilitation is scheduled February 12 and 13, 2007 at the Hyatt Regency Crystal City Hotel in Arlington, Virginia. As the title "Setting a Research Agenda and Developing an Evidence Base for Practice and Public Policy" suggests, the symposium aims to develop a research agenda to support an evidence base for post-acute care rehabilitation policy and practice. The program is co-sponsored by several professional and provider organizations. Keynote speakers include Senator Bob Dole; Laurence Wilson, Director of Medicare's Chronic Care Policy Group; and Steven Tingus, Director of the National Institute on Disability and Rehabilitation Research and Chair of the Interagency Committee on Disability Research. We have commissioned five plenary speakers to address symposium themes related to population and technology issues driving demand for rehabilitation services; measurement and methodology issues; access to post-acute rehabilitation; organization of rehabilitation services; and effectiveness and outcomes of post-acute rehabilitation. Four authors are providing state-of-the-science summaries of the relevant literature, and 24 speakers will provide work-in-progress summaries of recently completed or currently underway research projects. Small group discussions will lead to the formation

and synthesis of recommendations for future research with consideration of policy issues.

The goals of the symposium are to:

- describe the current state of the knowledge regarding utilization, organization and outcomes of post-acute rehabilitation care;
- identify methodological and measurement challenges to conducting research in this area;
- foster the exchange of ideas among researchers, policymakers, industry representatives, funding agency staff, consumers and members of advocacy groups; and
- identify critical questions related to setting, delivery and payment of rehabilitation services that are of the highest priority for investigation.

Additional information about the symposium is available at <http://www.foundationforpmr.org/programs/postacuterehab.html>.

*Allen W. Heinemann, PhD
Director, CROR*

State-of-the-Science Symposium

Dr. Allen Heinemann is chairing a State-of-the-Science Symposium on Post-Acute Rehabilitation to be held on February 12 - 13, 2007 in Crystal City, Virginia. Attendance is limited to 250 participants.

The goal of this two-day invitational conference is to develop an agenda for research that will support an evidence base for post-acute care rehabilitation, including issues related to measurement and research design, access to post-acute care rehabilitation services, organization of rehabilitation services, and outcomes attained by beneficiaries of Medicare and other insurers.

To register, or for more information, please visit <https://www.firminc.com/symposiumregistration.asp>

Sponsoring Organizations

In addition to the Center for Rehabilitation Outcomes Research at the Rehabilitation Institute of Chicago, other sponsors include: American Academy of Physical Medicine and Rehabilitation; American Congress of Rehabilitation Medicine; American Hospital Association; American Medical Rehabilitation Providers Association; American Psychiatric Education Council; Association of Academic Physiatrists; Commission on Accreditation of Rehabilitation Facilities; Federation of American Hospitals; Foundation for Physical Medicine and Rehabilitation; Fowler Healthcare Affiliates; HealthSouth; Johns Hopkins Hospital; MetroHealth Rehabilitation Institute of Ohio; Moss Rehabilitation Hospital; and Rehabilitation Institute of Chicago.

LCDs In Review (Continued From Page Three)

expensive and a huge administrative undertaking. You have to review all of the documents, interview everyone involved in the case, and make the decision to appeal. Then you write a rebuttal to the denial, explaining why the fiscal intermediary was wrong. It's a tremendous amount of time, copies, telephone calls – it has to be done very carefully with attention to deadlines or it's all for nothing. It's an overwhelming situation that providers really don't want to be in."

Not surprisingly, most inpatient rehabilitation providers, rather than risk denials and the extensive, costly appeals process, have chosen to dramatically change their admitting process and severely limit the type of patients they

about whether a patient who is denied inpatient care will receive comparable benefit in a skilled nursing facility (SNF) or a home health agency. Unfortunately, there isn't enough research, as of yet, to determine which patients need intensive, inpatient care and which patients can fare equally well in other settings, said Whitener and Zollar.

"One insurance carrier representative said he believed that much of the care provided in IRFs can be equally provided in SNFs," they said. "The problem with this generalization and similar assertions is that no one has accurate data to support such a policy direction at this time," they said.

Although sufficient data is not yet available to make definitive judgments about which conditions necessitate inpatient rehabilitation care, Irma Fiedler, associate clinical professor of physical medicine and rehabilitation at the Medical College of Wisconsin, is currently assessing ten regional LCDs to determine whether their medical necessity guidelines are consistent with the accepted standards of patient admissions for rehabilitation facilities, known as the "Standards for Assessing Medical Appropriateness Criteria for Admitting Patients to Rehabilitation Hospitals or Units."

Fiedler is analyzing the standards, which were adopted by the American Academy of Physical Medicine and Rehabilitation (AAPM&R), and comparing them to the LCDs to see if FIs are consistent with accepted admissions criteria, and to demonstrate the need for more substantive research. The data derived from her analysis will be presented in February at the State-of-the-Science symposium on Post-Acute Rehabilitation, sponsored in part by the Center for Rehabilitation Outcomes Research at the RIC.

Another potential problem for patients facing denials is the high degree of variation among SNFs. As Gans explained, one skilled nursing facility could have a strong rehabilitation focus and perform the same as an IRF, while others could be much different in their level of care and available rehabilitation treatments.

"That is a real problem for Medicare," Gans said. We need more research."

**"Denials are extremely harsh on providers."
Rather than risk denials, many IRFs severely
limit the type of patients they admit.**

*Carolyn Zollar, VP for Government Relations
American Medical Rehabilitation Providers Assoc.*

admit. In order to comply with regional LCDs and with the 75 percent rule, IRFs are seeking "acceptable" patients, such as those with strokes, and denying those cases that have proven difficult for reimbursement.

"Facilities are understandably in a very difficult position," Gans said. "They are having to deny large numbers of patients, and the recruitment of patients with acceptable conditions has really heated up. This year, there were 8 percent fewer rehabilitation beds. That's partly because of the 75 percent rule but also because of this auditing and denial process."

Which rehabilitation setting is best?

A foremost reason for concern about inpatient LCDs is the uncertainty



CROR Staff, 2006 - 2007. Back Row (left to right): Allen Heinemann; Kendall Stagg; Jillian Dworak; Annelouise Tookoian; Holly DeMark; Trudy Mallinson; Nora Wenthold; Patrick Semik.
Front Row (left to right): Susan Magasi; Johnnie Berry; Anne Deutsch; Linda Ehrlich-Jones; Joyce Siragusa.

Free Seminar

An archive of a CROR seminar on "Planning, Conducting, and Funding Rehabilitation Research" is available online. Registration fees are currently being waived for our readers. To register, visit <http://www.ricacademy.com/displayresource.aspx?resourceid=94485> Use "researchconf" for the coupon code.

The seminar consists of five presentations: (1) Research Utilizing Single Subject Designs: Evidence-Based Decisions for Evidence Based Practice; (2) Budget Development: Planning for Staffing, Equipment, Supplies and Indirect Costs; (3) Patients as Subjects: Ethical Issues in Informed Consent; (4) Funding Sources and Application Requirements; and (5) Developing Researchable Questions.

CEUs are not currently offered for this particular seminar.



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Winter Issue...

Three months ago, we unveiled the inaugural issue of CROr Outcomes, the quarterly newsletter of the Center for Rehabilitation Outcomes Research (CROr) at the Rehabilitation Institute of Chicago. This quarter, we offer our newsletter for the first time in electronic format, which allows us to share our progress and research results with you in the most cost effective manner possible. As always, we hope you will find the newsletter of benefit and provide insights into measurement, policy, and rehabilitation outcome issues... *More on Inside Cover.*

LCDs in Review...

Researchers at CROr are studying the impact of Local Coverage Determinations (LCDs). In this edition of CROr Outcomes, we feature an article summarizing interviews with other researchers and industry leaders who discussed LCDs with us and shared their perspectives on the issue... *More on Page 2.*

Measuring Participation...

Along with collaborating researchers at Craig Hospital and the University of Illinois at Chicago, CROr is utilizing feedback from people with disabilities and other stakeholders in an attempt to develop an instrument that will accurately measure individuals' participation in the community... *More on Inside Cover.*

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