

# DIRECTIONS

Formerly *NRRTS News*



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# DIRECTIONS

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EDITOR *Amy Odom*

EDITORIAL ADVISORY BOARD  
*Simon Margolis*

DESIGN *Amanda Sneed,*  
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P.O. Box 863  
Trinidad, CO 81082-2712  
800.976.7787 or 719.846.4229  
Fax 719.846.4462  
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For all advertising inquiries, contact Amy Odom at 806.722.2322, Fax 806.783.9984 or aodom@nrnts.org

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FOR ETHICAL, CLINICAL AND BUSINESS PRACTICES

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## Just Prove It



WEESIE WALKER, ATS, CRTS®  
President, NRRTS  
Branch Manager, NATIONAL SEATING & MOBILITY

WORKING IN THE FIELD of assistive technology has never been more challenging. How did we get to this point? We created a professional registry and a certification exam. We educated and in-serviced payers, referrals and consumers at every opportunity. We went to Washington. We talked to state Medicaid programs. And now, here

we are, struggling and frustrated. The delay in competitive bidding was a “good news, bad news” scenario.

No, we don’t have to worry about bidding for now, but

we’re taking a significant cut in reimbursement. We’re still lobbying for the complex rehab carve out. And, we’re gaining momentum. We have to keep writing letters and e-mails to our senators and representatives.

So, what is the deal? It isn’t lack of passion for what we do. It isn’t lack of importance for what we do. It isn’t lack of need for what we do. What is it? We don’t have the outcome measurement to prove that

working with a certified supplier saves precious health-care dollars in the long run. We just know it. We don’t show the hours it takes beyond the evaluation—the many hours spent collecting the documentation, filling out order forms, getting quotes, doing home evaluations, assembling the equipment, etc.

We can all agree that we’re under much scrutiny from CMS and the OIG. This is what they need to see: documentation of all the steps and the time it takes to deliver a complex system.

While meeting with a program analyst for the OIG, I realized we weren’t documenting all the time spent on the processing of each order. She was truly interested in all aspects, from start to finish. She visited our shop and saw chairs being assembled. We showed her files that were two inches thick. She accompanied me to a seating clinic to observe an evaluation. She saw all the equipment available at clinic for trial. She talked to the patient and heard her experience of getting a powered wheelchair she could not use.

As each process is completed, I send an e-mail to inform her of the steps taken and the time involved.

She would see the same thing with any CRTS®. There are no shortcuts. Each process must be carefully completed, checked and rechecked. As they gather more of this information from many different suppliers, there will be a better understanding of what it takes to go through the entire process.

It’s difficult to look at the amount of time and resources spent on each mobility system, but doing so is certainly an eye opener. This is the type of information we can provide to our senators and representatives to prove our case. This information is vital to demonstrate the essential functions of the certified supplier.

With this data, it will be clear for anyone to see why our profession is referred to as “complex” rehab.

ABOUT THE AUTHOR  
Weesie may be reached at 770.452.1450 or [wwalker@nsm-seating.com](mailto:wwalker@nsm-seating.com)

*We’re still lobbying for the complex rehab carve out.*



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# The Vision of Users First™ Alliance Evolves: A United Voice is a Strong Voice



ANN EUBANK, OTR/L, ATP  
Executive Director  
USERS FIRST ALLIANCE

CURRENT REIMBURSEMENT POLICIES CREATE great challenges when recommending and providing rehabilitation equipment. Rehabilitation equipment suppliers and manufacturers have mobilized and made considerable efforts to educate elected officials and legislative bodies about reimbursement issues, specifically complex rehab.

Yet, a very important voice is missing: the voice of the consumer. The absence of this voice weakens reimbursement efforts for providers, and most importantly, for the consumer. As an industry we have not done enough to include,

mobilize, unite and empower citizens who use wheelchairs.

The vision of Users First Alliance has evolved to meet this critical need, to create a united and strong consumer voice.

Users First Alliance is a means for wheelchair users and advocates to come together as a collective force and demand products

that meet real-life, everyday functional needs. Yes, funding rehabilitation equipment is challenging, and without a strong consumer voice, our governmental efforts are severely weakened even with six-figure lobbyists involved. To change policy and create better reimbursement for quality products, consumers and advocates must unite. We are all advocates: clinicians, family members, equipment suppliers, manufacturers and caregivers. Users First Alliance seeks to unify and mobilize all people who believe in consumer choice.

An example of a successful advocacy group is the American Association of Retired Persons (AARP). AARP was founded in 1958 by Dr. Ethel Percy Andrus, a retired high school principal. At that time, private health insurance was virtually unavailable to older Americans; in fact, it was not until 1965 the government enacted Medicare, which provides health benefits to persons over age 65. Dr. Andrus approached dozens of insurance companies until she found one willing to take the risk of insuring older persons.

Can you envision wheelchair users having a strong and influential advocacy group like AARP? I can see it now—an annual conference held in Washington, D.C., with two or three thousand members

on the Hill wearing bright green T-shirts and delivering a message of independence. Currently there are approximately twelve thousand members who have joined the Users First Alliance. Soon there will be links on [www.usersfirst.org](http://www.usersfirst.org) to include all advocacy groups, such as the ALS Association, who also works with people using wheelchairs. Together, we can be as strong or stronger than AARP.

Using an inclusive, empowering message, Users First Alliance envisions membership growing to a point in which our elected officials can no longer dismiss the mobility needs of people who use wheelchairs.

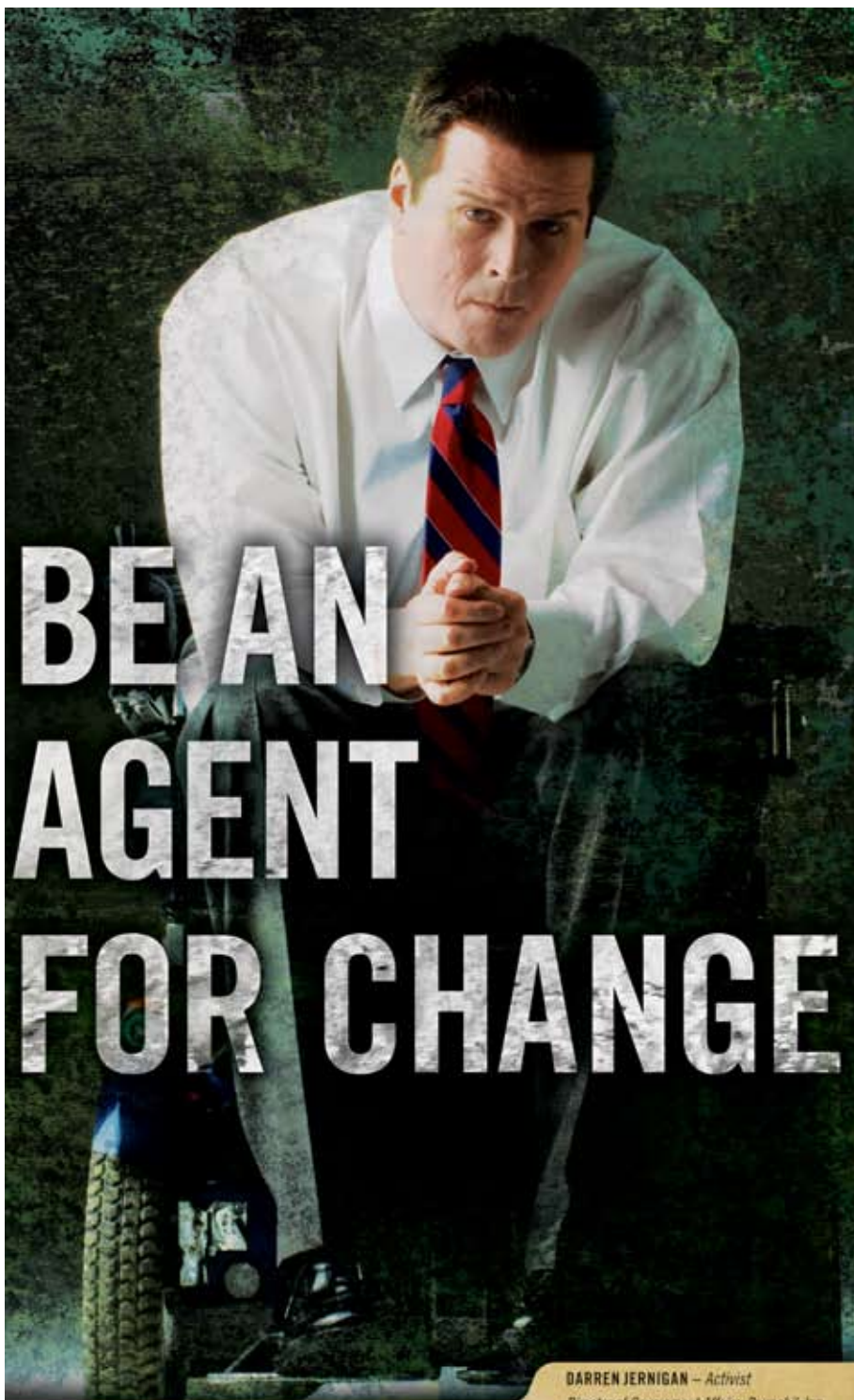
Historically, it has been difficult to mobilize the disability community, especially to address mobility needs, even though the community is diverse with various advocacy groups. To empower consumers, Users First Alliance will offer education materials to clinicians and providers, directing them to appropriate resources.

A non-profit organization, Users First Alliance invites you to be an agent for change! Make your voice heard by joining the Alliance today at [www.usersfirst.org](http://www.usersfirst.org).

ABOUT THE AUTHOR  
Ann can be reached at [anneubank@usersfirst.org](mailto:anneubank@usersfirst.org).

*To change policy and create better reimbursement for quality products, consumers and advocates must unite.*





DARREN JERNIGAN – Activist  
Director of Government Affairs, Permobil, Inc.

# BE AN AGENT FOR CHANGE



**I LIKE TO TAKE CHARGE.** I am a lobbyist, a mediator and an advocate. As the Director of Government Affairs for Permobil, Inc., I want to improve the quality of life for all wheelchair users. That's why I joined the Users First™ Alliance. This organization of individuals, corporations and providers

strives to ensure you have the state-of-the-art products that you deserve and that companies continue to develop solutions for your specific mobility needs. Users First seeks to empower all wheelchair users through education and information. Join us today and demand what is rightfully yours!

[www.USERSFIRST.org](http://www.USERSFIRST.org)

## Ethics and Competitive Bidding



SIMON  
MARGOLIS  
Executive  
Director, NRRTS

Sometimes it seems these two ideas don't come up in the same sentence.

Our industry and profession seem to have won a minor battle – the very temporary delay in the implementation of Competitive Bidding. Industry pundits are totting this victory as assuring consumer access to appropriate equipment.

We may have won the “access” skirmish, but we seem to have lost the “quality” war. A short while ago, rehab had a 20% plus decrease in the Medicare fee schedule. Our purported victory in Congress has gained us another 9.5% cut. It will, in short order, be difficult if not impossible to provide consumers with the right equipment – we will need to settle for providing them with the most affordable.

In the face of these cuts, NRRTS believes a re-emphasis on ethical business and clinical practices is critical. NRRTS believes regardless of the funding available there are lines that cannot be crossed and consumers must be afforded equipment and services in a timely and professional manner.

Please see Rich Salm's article “NRRTS Tightens Ethics Policy” on page 23.

### ABOUT THE AUTHOR

Simon may be reached at [smargolis@nrrts.org](mailto:smargolis@nrrts.org).



# Nothing Short of a Miracle



TERESA ACAMPORA  
Director of Marketing  
ATG REHAB

THERE HAS ALWAYS BEEN something mystical about the relationship between animals and humans—especially humans who are ill or in need of special care or assistance. Many hospitals and care centers use visits from furry, four-legged domestic creatures to boost morale and increase the “spirit” of healing. However, one such relationship—of horses and humans—is unique and often

“magical,” especially as it pertains to the therapeutic benefits realized as a result.

Herein lies both the mystique and the reality of therapeutic riding. The value of therapeutic horseback riding and its benefits have been documented for many years, as early as 600 B.C. by Orbasis of Ancient Lydia.

However, it was not until 1875 the first systematic study of therapeutic riding was reported. The French physician, Chassaing, came to the conclusion that riding was helpful in treating a variety of conditions.

Chassaing noted improvements in posture, balance and joint movement. He also noted a striking improvement in morale in many of his patients.

Riding therapy and its benefits were introduced in Scandinavia following two outbreaks of paralytic polio in 1946. Liz Hartel, an accomplished rider who became ill with polio, was the brave and inspirational woman behind this movement. Able to walk with crutches after surgery and traditional physical therapy, she became determined to ride again. Daily riding restored her muscle strength and coordination. Liz Hartel went on to win Denmark’s 1952 Olympic Silver Medal for dressage—a true testimony to the benefits of riding and equestrian-related activities.

While riding a horse can be exhilarating for anyone, it provides a special freedom for those with disabilities. It is and can be especially liberating for an adult or child to get out of a wheelchair and onto a horse. The stride and gait of a horse is inherently therapeutic.

The benefits of therapeutic riding are physical, sensory, emotional, cognitive and social. The horse’s walk stimulates the rider’s pelvis and trunk in a manner that closely resembles a human’s walk or gait while also improving muscle tone, especially in one’s core muscle group. As a form of therapy, horseback riding is helpful in developing

balance, coordination and strength in people with disabilities.

Horseback riding is not only fun, but it also provides emotional value by helping the rider overcome fear and anxiety while increasing self-esteem. Some parents with autistic children have noted speech-impaired children have started speaking for the first time after they started therapeutic riding. Some parents reported although their children had been in speech therapy for many years and had yet to say, “mom,” “dad,” or their own names gained the motivation and ability to use their voices for commands like “walk on” and “whoa” after they began riding in this type of program.

Manes & Motions is a non-profit therapeutic riding center located in Central Connecticut and a member of the Hospital for Special Care community. Also a member of the North American Riding for the Handicapped Association (NARHA), this program offers individuals from 4 years of age through adulthood living with physical, cognitive and/or emotional disabilities the opportunity to enjoy equine-assisted activities for therapeutic, recreational, sport and education purposes.

One of its greatest success stories is of a charming, personable and animated 7-year-old boy with spastic diplegic cerebral palsy named Kyle. Kyle and his twin brother Connor

CONTINUED ON PAGE 10

*Many hospitals and care centers use visits from furry, four-legged domestic creatures to boost morale and increase the “spirit” of healing.*



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### *Nothing Short of a Miracle*

were born prematurely at 33 weeks and one day. Connor is healthy, but due to oxygen deprivation to his brain, Kyle struggled to walk with leg braces and a Crocodile Gait Trainer walker only one year ago. His mother, although aware of the tremendous benefits of therapeutic riding, was hesitant to commence this type of program with Kyle due to his general dislike for animals—especially horses!

Although the benefits of therapeutic riding for Kyle were obvious, how to overcome the anxiety of even the close proximity to these animals was almost insurmountable. Due to Kyle's issues with balance, sporadic movements and hypersensitivity to noise, combined with the size of these animals, horseback riding was not at the top of Kyle's to-do list!

Against all odds, Kyle's mother took him, literally kicking and screaming (not to mention crying), to the Manes & Motions facility for his inaugural lesson. Within minutes, the transformation after arriving at the facility and meeting the staff, instructors and Rosie (his horse) was the stuff that dreams are made of ... magical to say the least! Kyle rode for one hour, a smile beaming from ear to ear, and he has been riding ever since.



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Just one year later, Kyle is able to walk using only Lofstrand forearm crutches—always a goal but never considered a reality this early in his plan of care or treatment. This “miracle” is due largely in part to the benefits of the Manes & Motions therapeutic riding program and its people. Tremendous improvements have also been achieved in all aspects of Kyle’s quality of life. Increased muscle tone has translated into improved gait, balance and posture—even radiating to fine motor skills, ease and clarity of writing and thus, improved academic performance!

Riding since only March of 2007, the changes in Kyle have been dramatic to say the least. So inspired by and passionate about this program and its benefits, Kyle’s mother organized an annual charity motorcycle ride, the Freedom Ride (“We ride so they can ride too”), to benefit Manes & Motions, as the organization relies completely on donations and grants. It was her way of giving back to a program that gave her son, and their family, so much.

As quoted by Jonathan Swift and realized by so many handicapped riders and their families, “Upon the whole, the behavior of these animals [horses] was so orderly and rational, so acute and judicious, that I at last concluded they must be magicians.” Certainly if they are not, the gift they give so many disabled riders is magical and, for some like Kyle, is nothing short of a miracle!

**ABOUT THE AUTHOR**  
Teresa is the director of marketing for ATG (Assistive Technology Group) Rehab and a mother of four children, one of whom has spastic diplegic cerebral palsy. For more information on Manes & Motions or the benefits of therapeutic horseback riding, she can be contacted at [tacampora@comcast.net](mailto:tacampora@comcast.net), or visit [www.hfsc.org/Programs/Manes](http://www.hfsc.org/Programs/Manes).

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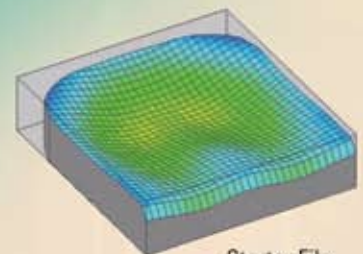
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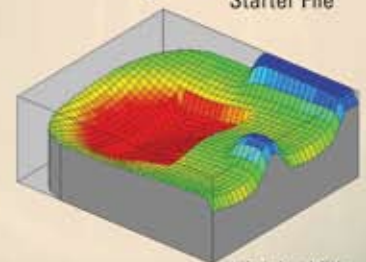
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# Advocacy: What Is It and Why Do It?

JULIE REISKIN  
Executive Director  
COLORADO CROSS-DISABILITY COALITION

WE HEAR REGULAR COMPLAINTS about changes in the rehabilitation industry—CMS has done this, Medicaid has done that. And let's not even talk about working with private insurance companies—\$2,000 limits? Please! Do these people have any clue what we are talking about? The answer is no, they don't, and the reason they don't is because we need to be much more aggressive about

our advocacy approaches. The good news is that advocacy works! In Colorado we have made it work on several occasions. We

have done this by teaming up complex rehab equipment providers with disability rights advocacy groups. By working together we can win, because when the clients or end users are calling policymakers they cannot accuse us of greed. When we need technical answers, we can get them from providers so the government cannot accuse us (the end users) of not having technical expertise. In Colorado we have accomplished this on a few occasions by having rehab vendors refer clients who have been denied equipment to the Colorado Cross Disability Coalition (CCDC), a statewide advocacy organization.

When Medicaid decided they were going to just go along with the new Medicare codes and refuse prior authorization payments of group-four chairs for dual-eligible clients, we teamed up and filed numerous appeals. Any time the government (Medicaid) denies a request (prior authorization, claim for payment, etc.), a client has the right to appeal that decision and go to an administrative law judge. Our state regulations have a good definition of medical necessity, so we filed appeals on all cases where the state was denying appropriate chairs. The state finally got so sick of answering to the appeals it changed its policies. Now we are working on getting it to understand a ten-year-old court decision that rules it cannot have exclusive lists and cannot simply deny an item because it is "not a covered DME item." Already we have convinced it to pay for certain items it has previously not covered. Most recently, an administrative law judge mocked the state agency for claiming a sleep-safe bed was not covered because it "is furniture, not DME," and overturned the state denial on this necessary bed for a severely disabled young man.

What advocacy takes are a few ingredients:

**1)** You need a willing and well-trained disability advocacy organization. This organization should be able to use non-attorneys

to file basic appeals. In Colorado we train volunteers to be the non-attorney advocates. And if appeals end up in court (about four steps into the process), the organization should have an attorney or access to an attorney (perhaps through legal aide or a group like National Health Law Program). However, it is rare an attorney is actually needed, because the laws are already on our side.

**2)** You need a DME provider community that will do a few things, such as refer clients who are denied rather than just telling the clients, "sorry Medicaid won't pay;" make sure the client signs necessary releases for advocates (HIPAA); and be willing to work with advocates to make sure documentation is correct for the hearing.

**3)** Most important, you need clients who are willing to fight and go through the hearing process; they will almost always do this with just a little encouragement.

**4)** Finally, it helps if providers make donations to the advocacy organization to offset their costs. Most true advocacy organizations truly struggle for funding.

If the technology you are asking for is new, complex rehab or the state will argue the client can make do with something less expensive, so you may need to send your people to the hearing. The advocate should be able to prepare them and question them, but they might need to testify

*The good news  
is advocacy  
works!*

# Rehab.

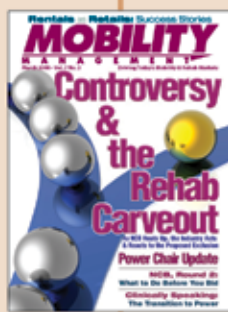
*It's what we do.*

as to why they recommended a specific piece of equipment. This could take up to an hour, not including travel time. We often don't need them to actually show up, because they can phone in if they are in a remote location.

Margaret Mead said, "Never say that a few thoughtful committed citizens cannot change the world, indeed it is the only thing that ever has". We need to stop taking the collective "no" from the government, insurance companies, lawmakers and others, and start fighting back. This is only one of many ways to accomplish this, but all involve a team effort between rehabilitation professionals and end users of equipment.

#### ABOUT THE AUTHOR

Julie may be reached at 303.839.1775 or [jreiskin@ccdconline.org](mailto:jreiskin@ccdconline.org)



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# Just Sales?



ELAINE STEWART, ATS, CRTS®  
NRRTS At-Large Board Member  
Branch Manager, NATIONAL SEATING & MOBILITY

EVEN BEFORE COLLEGE I was interested in science and health, so it came as no surprise that I went on to earn a BS in biology with a minor in athletic training from Manchester College in North Manchester, Ind.

I've been in the industry since 1986 and first began working with the disabled in 1982. The first job I had out of college was working in an ICF/MR facility, assisting the 200 in-house residents with their

daily activities and equipment needs. Two people who really helped me during that time were Lynn and Kerry Marschand. They provided assistance to the residents also, and they taught me about adjusting and fitting equipment to clients' specific needs in order to optimize their function.

I had been working as a PT aide for a year and a half when a position opened with a DME company—Indiana Home Health, located in Indianapolis, Ind, now known as Clarian Health. The position offered

more pay than my \$4-an-hour job, so I jumped at the opportunity. Besides, I knew I wanted to stay in the health-care field.

I was hired as a customer service representative, responsible for submitting prescriptions, prior authorizations and LMNs to doctors for review and approval. I also secured coverage for private insurances, Medicare and Medicaid.

While working with clients at the ICF/MR facility, I assisted with the seating and wheelchair clinic. It gave me the ability to work with a unique population of people, and I felt I made a difference in their lives. That's why I became a RTS. The reason I remain a RTS is I still love providing clients with function, either positional or mobility, which allows them independence within their abilities. It also allows me to be creative, and to learn new things daily.

During a normal day, I generally begin 6 a.m. and hope to finish by 5 p.m. This rarely happens, however; realistically, I usually finish by 10 p.m. I manage two offices—one in Fort Wayne, Ind., and the other in South Bend, Ind. I split my hours between both locations and am on the road approximately 90 percent of the time. I am also involved yearly with our MDA camp, insuring the power chairs are operational and safe. I evaluate, set up and deliver most of what I spec out, so my day is never boring or static.

In addition to work, I've been married to my husband Michael for 14 wonderful years and I also have two children: Sam, 9, and Aubrey, 7. My children and husband are involved in martial arts, and I play soccer and volleyball when my schedule allows.

Mike Seidel asked me to run for the board about two years ago while we were in Scottsdale, Ariz., at an NSM symposium. He felt I would do a good job.

The NRRTS board is important because it allows the opinions that surround our profession to be discussed and acted upon. The board was established for RTSs, and it offers us a code of ethics and a description of the conduct expected of us to provide the best outcomes for the clientele we service. It provides us with accountability.

I hope each of you will consider running for the NRRTS board, because it is an opportunity to be exposed to what's going on outside of our everyday RTS roles, and it provides insight into how our industry has developed over the years and helps us understand the hurdles we still need to jump over to be an established profession.

The obstacles of the NRRTS board include the proposed change of the ATS credential to ATP only. I believe the supplier and the practitioner play two distinct roles in the health-care

CONTINUED ON PAGE 16

*The reason I remain a RTS is I still love providing clients with function, either positional or mobility, which allows them independence within their abilities.*





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*Just Sales?* model for our clientele. The bar of advancement needs to be raised, but we must also maintain our identity. The future of competitive bidding and its ramifications will take affect on many suppliers who aren't awarded bids, and the services our clients have access to will suffer unless we, as suppliers, play an active role to make a change.

Rather than being seen as just salespeople, the RTS profession is headed toward being recognized as a contributor to the betterment of the clients we service. We do so much more than make the sale to our clients; we provide evaluations, set up, delivery and education without passing on the cost to anyone. I don't know of any other profession that provides this type service. We provide so much more to our clientele than just equipment.

The primary obstacles in this profession are having what we do

be belittled by our funding sources, by being seen as unimportant to anything other than the bottom line.

To close, I'd like to leave you with one of my favorite stories: I was contacted to assist with evaluating a young boy named Anthony for power mobility. He was a non-verbal client with spastic cerebral palsy and constant movement in all extremities. At the time, he was in a manual wheelchair with linear seating, was not able to actively participate in class and required full-time assistance for all of his daily needs.

His therapist, Carrie, felt he could contribute to his education, but that he had no tool to allow the pursuit of it. Though the school was not supportive at first due to fear he would hurt himself and others because of his inability to control his movements, we proceeded with our plan. We configured a power chair and trialed numerous drive options:

joystick, foot control, scanning, switches and head array.

To our elation, Anthony was able to operate the head array well on his first attempt. He was provided a loaner system to use at school and has since become very active in his learning. His concentration has improved and he's now able to get to all of his classes independently. He has also been set up with a talking devise that enables him to express his needs.

I get rewarded when I can be a part of a process like this, and providing Anthony with an open door to his education, future and independence is the reason I continue to work in this field.

#### ABOUT THE AUTHOR

Elaine may be reached at 866.450.5630 or [estewart@nsm-seating.com](mailto:estewart@nsm-seating.com).



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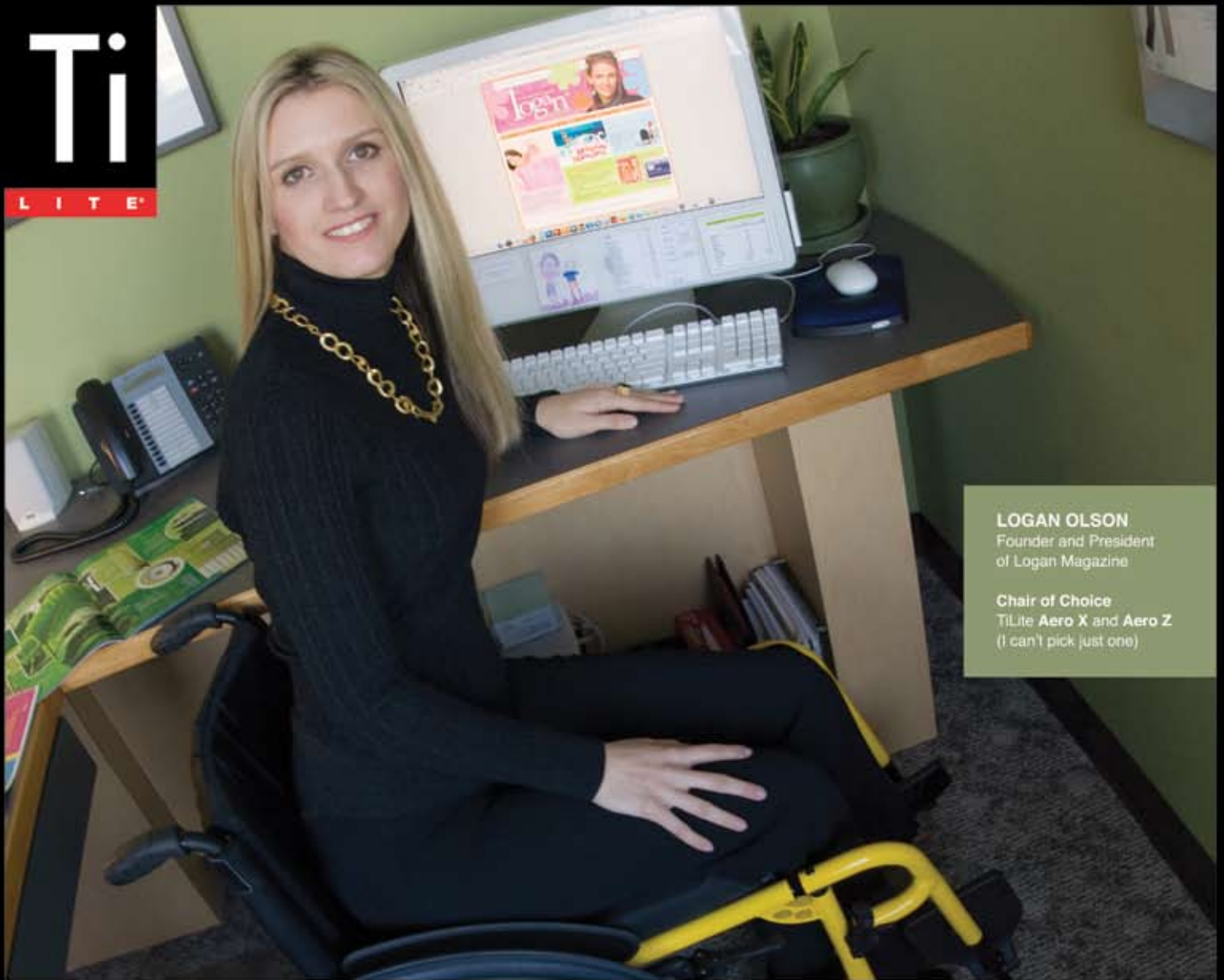
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Founder and President  
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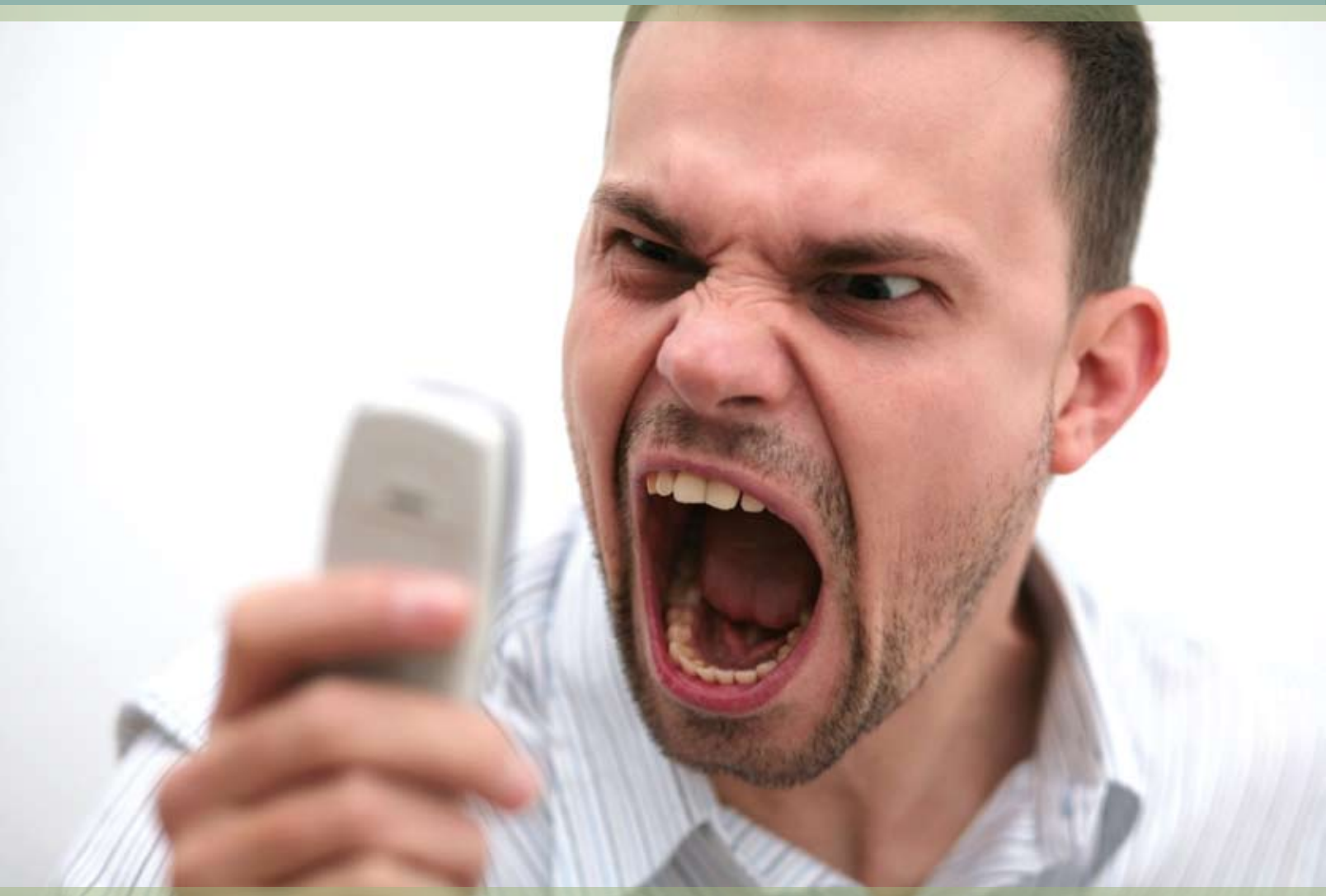
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# Getting Equipment Gets Harder



TIM GILMER

Wheelchair users in the United States are finding out that getting the durable medical equipment they need—and getting it when they need it—is becoming more difficult and costlier. Restrictive documentation policies as well as outdated “in-the-home” language that governs claims decisions in the Centers for Medicare and Medicaid Services are creating hassles for DME providers and consumers. What’s worse, power wheelchair reimbursements made by Medicare, already reduced by 27 percent in January 2007, will be reduced more. Since private insurance companies follow CMS’ lead, these new policies portend a growing nightmare of denials, delays, red tape and economic hardship for DME providers and end users alike. Following are just a few stories that demonstrate these issues.

## Medicare Unresponsive

When Abbie Freedman of Santa Rosa, Calif., was paralyzed at age 39 due to a T5 spinal-cord injury, she was immediately covered by MediCal. A year and a half later, because MediCal does not allow beneficiaries to have anything more than subsistence funds in the bank, she was switched to Medicare. She used three wheelchairs in the next 22 years, and Medicare picked up the costs. Now in her early 60s, with deteriorating shoulders, Freedman was advised to have corrective surgery, but her personal physician, knowing how difficult recovery can be, advised against it. Instead, he prescribed specialized physical therapy and a new power-assist wheelchair.

Freedman ordered an iGLIDE, manufactured by Independence Technology (IT), and was told by IT that Medicare would cover it. Anxious to get on with saving her shoulders, she paid for it out of her own pocket, then filed a claim for reimbursement with Medicare. She received the chair in September 2004 but was surprised when her claim for reimbursement was denied. “I’m not sure I would have ordered it had I known Medicare wouldn’t pay,” she says. “\$6,320 is a lot of money.”

The Medicare denial stated: “This item cannot be paid without a new, revised, or renewed certificate of medical necessity.” Freedman then resubmitted a new CMN and her appeal was approved in March 2005, but no reimbursement was issued. Later she received a letter dated June 28, 2005 from a Medicare administrator in response to her appeal, stating, “If you paid any amount to this provider for this service, Medicare will pay you back the amount you paid. To get this payment, bring or send to this office three things: 1. A copy of this notice; 2. Your supplier’s bill; 3. A receipt or other proof you have paid the bill.”

“At that time, I submitted the three required documents,” says Freedman. “Since then, I have made several

attempts to get this reimbursement from Medicare, both written and by phone, only to get a runaround, no response or one that is irrelevant,” she says.

The latest runaround occurred in August 2007, when she was told by CMS that she would receive reimbursement from CMS’ contracted carrier, Noridian Administrative Services of Fargo, N.D.—but she would have to contact them directly. She did, and was told she had to fill out another form. “It was an original claim form!” exclaims Freedman. “After nearly four years, they sent me back to square one. The system is a joke, but it’s not funny.”

In December 2007 Freedman received another letter from Medicare stating that her iGLIDE would not be covered. “I’m getting worn down. If it were less money, I would just give up. I can’t tell you how many phone calls and letters I have sent, and you never get the same person. But I’m not giving up. It’s not only the money, it’s the principle. They keep telling me I’m entitled to reimbursement, but it’s going on four years, and I haven’t seen a dime.”

## Ultralight Titanium Chair: Document Need!

On May 15, 2007, Sue Montgomery met with her local durable medical equipment dealer and ordered a Quickie Ti ultralight as a replacement wheelchair. Six weeks later, Montgomery, of Knox, Pa., called and discovered the person handling the order had accidentally misplaced the paperwork, so it was re-sent. On July 17, Montgomery learned her insurance company had denied her claim; the wheelchair was deemed “not a medical necessity.”

Montgomery, who has severe bilateral osteoarthritis, had filed documentation of medical need by her orthopedic surgeon along with her need as an active-lifestyle wheelchair user with a full-time job. Her medical records established that she had undergone 11 failed

reconstructive surgeries and had used a wheelchair for 15 years. Understandably upset, she appealed the denial, which set in motion a series of appeals and denials—she appealed three times—until she finally received a letter of approval on Oct. 9, followed by shipment of the wheelchair on Nov. 14. But the wheelchair that arrived had no brakes, no cushion, no anti-tip bars and had the wrong seat depth. Montgomery refused the chair. A different chair arrived on Dec. 7 but still had the wrong seat depth. Finally, on Jan. 4, 2008, the seat depth issue was resolved. The list price of Montgomery’s Quickie Ti was nearly \$5,700—definitely on the high side.

In her research, Montgomery discovered that had she been covered by Medicare (or if her private insurer would have allowed it), she might have been able to sign an Advanced Beneficiary Notice (ABN) giving her the option of paying the difference between what Medicare codes allow for a given type of wheelchair and the actual cost of the product. Under an ABN, she would have been allowed \$2,986, and she would have paid \$2,641 out of pocket. However, Montgomery’s private insurance did not allow an ABN (see [www.wheelchairjunkie.com/abn.html](http://www.wheelchairjunkie.com/abn.html) for an article on ABNs). Fortunately, since Montgomery won her appeal on the third try, she got a much better deal, paying only an out-of-pocket deductible of a few hundred dollars. Although the overall purchase price was high, her payment portion was minimal. Not all insurance companies would have covered as much.

“The most important thing I did in the final appeal was document my need for an ultra lightweight chair. The insurance guidelines require a medical statement that I could not propel the standard or the lightweight, and that I required the ultra lightweight. I documented 29 years of stress on elbows, wrists and shoulders from using crutches and wheelchairs. We also stressed the



need to maintain my independence not only in my active lifestyle, but in my daily living skills in the home,” says Montgomery.

### **All-Terrain Chair: Pushing Coverage Limits**

Walter Reynolds, 57, injured at the T9 level in 1970, feels fortunate to be able to live on acreage in central California. He moved to the Santa Maria area in 1980 and not long after landed a good job, where he has been promoted over the years, enabling him to purchase property in a secluded canyon-like area. His lifestyle would be physically demanding for anyone, but for a wheelchair user, appropriate adaptive equipment is critical. He has a long gravel driveway to maintain, a well, a septic system and several outbuildings—and he tries to do as much as possible himself.

Problems with shoulder wear and tear from decades of wheeling resulted in rotator cuff surgery, so now he tries to preserve what he has. “There comes a point where you want to use a power chair to save your shoulders,” Reynolds explains. But not just any power chair works with his lifestyle. He needed a chair with all-terrain capabilities, so he ordered an OmegaTrac by Teftec.

His admittedly hopeful plan was that his insurance company, Blue Cross, which up to that point had provided excellent service, would be able to see his unique need. To make certain they understood, he engaged an occupational therapist to do an exhaustive 20-page summary/

the “in-the-home” language to their benefit in order to deny equipment and save money.”

What galls Reynolds most is in rehab he was taught to do as much as he can possibly do, and now his insurance company, following CMS’ lead, is doing its best to restrict his lifestyle choices.

### **What About Top-of-the-Line Standers?**

While lifestyle restrictions imposed by insurance companies may be understandable to some, how can restrictions placed on our health needs be justifiable? James Parsons, 27, a T6 para for five years, took time off from his job in Portland, Ore., to travel to Detroit for a three-week intensive rehab program at the Rehab Institute of Michigan last year (see “Stem Cell Gamble,” from March 2008 at [www.newmobility.com](http://www.newmobility.com)). He wanted to maximize the potential of his core muscles and stay in shape for future breakthroughs in SCI restorative therapies.

His father, Roger, had met with Dr. Wise Young in China while researching olfactory ensheathing cells treatment options, and Young had told him the best piece of equipment that James could buy would be a stander, to keep his bones strong, among other health benefits. James ordered an EZ Stand Evolv Glider because it combined exercise with standing and stretching, fully expecting that his insurance company, United Health Care (UHC), would see the health benefits and cover the cost. They even knew of

appeal, which was denied, and moving on to a second internal appeal, also denied, and, finally, an external appeal, just denied in April. During this process the Parsons have sent untold numbers of letters and have provided documentation of the benefits of the stander for James’ particular condition based on applicable clinical trials, but UHC, playing the role of institutional ostrich with head-in-sand, stubbornly refuses to acknowledge those benefits.

The irony of all this is UHC paid for James’ intensive three-week therapy at RIM, where he used the exact same model of stander and where he obtained letters of support from physical therapists who worked with him. Still, UHC would not approve the same stander for use in his home.

Not only does the insurance company’s position not make logical sense, it does not make monetary sense. UHC was willing to pay \$5,000 or more for three weeks at RIM, but they refuse to pay for a stander/exerciser that Parsons would be able to make effective use of for years. And what are the benefits of this particular model of stander? Strong bones, enhanced circulation, improved urinary tract and bowel function, less chance of pressure sores and even some cardiovascular benefit.

Apparently, even though the principle of preventive medical care is universally praised, cost-effective treatment is not high on the list of some insurance companies. The Parsons fully intend to seek help from their state legislators.

**“But I’m not giving up. It’s not only the money, it’s the principle.”**

analysis of his ADLs and rural lifestyle. Nice try, but it didn’t work.

“They should be deciding these cases on a case-by-case basis, but they were unwilling to negotiate,” he says. He feels that Medicare policy, specifically the outdated “in-the-home” restriction, is responsible for his insurance company’s denial. “Insurance companies are falling back on Medicare policy and using

someone else who had succeeded in getting UHC to cover this model.

But UHC denied Parson’s initial claim, which set in motion a campaign of letter writing between a very determined father and son and an extremely unresponsive insurance company. The Parsons have been careful to document everything in their seemingly endless appeals process, beginning with an internal

### **Expect Human Error and Delays**

As unresponsive as Medicare and insurance companies are, there are other potential flies in the ointment. Janet Nordgren, 34, feels most of her problems with getting a new TiLite wheelchair can be traced to an equipment providers that was less than competent. To be fair, part of

the blame is Nordgren's, and part is due to the nightmare of paperwork that providers face in getting the right equipment in the first place.

she realized she had made a mistake in ordering. The chair wasn't right for her. So this time she went to her local DME providers to re-order. Oddly,

These stories and hundreds of others like them drive home the point that today, getting the chair you need is more complicated than ever.

## Getting the chair you need is more complicated than ever.

Nordgren's history of wheelchair purchases is a lesson in itself. When she sustained an SCI at the T12 level at the age of 22, her first chair was a Quickie, which served her well, but she opted for a TiLite replacement several years later. Although she lives in Massachusetts, a physical therapist at Craig Hospital in Denver helped with ordering her chair, and to date, this is the best experience Nordgren has had in purchasing equipment. "They were awesome; they knew exactly what to do," she reports.

When it came time to replace the TiLite, she called someone she knew at TiLite who helped her fill out all the measurements and specifics over the phone. When her chair arrived,

the same thing happened again. On the third try, the order went through without problems, but the protracted three-part process, mired in paperwork and delays, took 1.5 years to run its course. And, she ended up having to pay significantly more than the insurance company allowed.

"I'm very fortunate I have a good job and can afford to get what I need," she says. "I can't even imagine what it is like to have to deal with all this without the right support or enough money to get the right equipment. Maybe it was just this particular situation, but the people I dealt with [at the local level] did not know what they were doing, and this always complicated the process."

Medicare and insurance companies are restructuring the process and narrowing windows of approval. Longer delays are the norm. DME providers are squeezed by lower reimbursement allowables and more complex and time-consuming documentation. Buyer be vigilant! Buyer beware!

**ABOUT THE AUTHOR**  
Tim may be reached at 215.675.9133 or tim@newmobility.com

*Reprinted from the disability lifestyle magazine New Mobility: 888.850.0344 and www.newmobility.com.*



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NFRTOR





JONI MCGHEE, OTR  
Clinical Coordinator  
TIRR/MEMORIAL HERMANN

# ETHICS AND PRINCIPLES: "Or You Got It or You Ain't"

Andreas Voutsinas, the elusive Greek actor once described talent to famed actor and movie producer Mel Brooks, saying, "or you got it or you ain't."

This timeless adage bodes well to ethics and principles as well: or you got 'em, or you ain't. Ethics is character and integrity, fidelity and justice, beneficence and duty, morality and veracity. (See the American Occupational Therapy Association's 2005 Occupational Therapy Code of Ethics, found in the American Journal of Occupational Therapy, volume 59, pages 639-642.) Principles are the actions and behaviors associated with ethics.

Ethical behaviors are inherent in all human beings; from the time we are born, our character develops and we begin the journey of an ethical existence, or not. Ethics is about choice—choosing to do the right thing for yourself and all parties involved. Principles are also a choice of doing the right thing. However, "principles only mean anything when we stick by them when it's inconvenient," as once stated by Rod Lurie, director of the 2000 movie, "The Contender."

The impact of the choices we make in our own lives pale next to the choices we make on behalf of our patients and clients. During any given seating evaluation, a therapist and supplier will make numerous choices relevant to a person's function and positioning, and much consideration is given to the person's caregiver, environmental factors and financial picture.

Is it ethics or government that is the driving force behind these choices? Are we allowing LCD policy, a diagnosis, a reimbursement rate or limited access to drive our decisions? Are we choosing what is convenient, or a sure shot for authorization?

Our professional ethics guide us and tell us to stand by our choices, and also to stand by the choices of our patients and clients.

Choices we all must consider: Are we standing by our decisions and justifications for our patients and clients? Are we working in concert with one another to ensure that our patient's choices, and ultimately their independence, are not compromised? Are our seating specialists qualified and competent? Are our providers qualified and competent and adhering to CMS guidelines for submitting claims? Are our physicians educated on referral and documentation requirements?

We are ethically responsible for making the right choices in these situations. In this day and age of competitive bidding, limited access, DRGs and PPS, our patients' choices are vulnerable and on the endangered list.

Now, more than ever, patient advocacy is of the highest order and it is the ethical responsibility of health-care professionals to insure that beneficiary rights to appropriate products and services remain at the heart of our endeavors.

Patient advocacy is educating our patients and clients in accessing appropriate products and services. Advocacy is educating physicians, providers and colleagues about current policies and regulations. Advocacy is educating our legislative bodies on the impact that our products and services have on the lives of the disabled. And it's protecting the patient's right to

choose. The right to choose is fundamental to all Americans, able-bodied or disabled. Fundamental to ethics, is choice.

We have chosen

professions that allow us the opportunity to change the lives of those around us. We must ensure that we, and those around us, are choosing to act responsibly and ethically.

Or you got it, or you ain't. The choice is ours.

#### ABOUT THE AUTHOR

Joni may be reached at 713-797-7386 or [memorialhermann.org](http://memorialhermann.org).





# For most of us,

Fortunately, complaints are rare, but NRRTS does receive them from time to time. Usually, we receive complaints from consumers, but sometimes we also receive them from other NRRTS Registrants or clinicians. Some complaints are even lodged against individuals who aren't NRRTS Registrants. Most of those complaints involve misuse of our RRTS® or CRTS® credential.

One such case involved a man who was handing out business cards that listed CRTS® after his name when he wasn't a CRTS® or even an NRRTS Registrant. We issued a stern warning and a demand that he cease and desist. However, a few months later he was caught again, this time turned in by a therapist who was angry because he was traveling

around looking for ramps in front of homes and then leaving his cards and brochures on the front doors of those homes. Since he was not a registrant, our options were limited, but we did decide to make him ineligible, permanently, for NRRTS registration.

Complaints from consumers many times are found to be the result of issues outside the control of the RTS, such as funding problems. Or sometimes the RTS has just fallen behind in his or her workload. In these cases we work to help resolve the problem by examining the facts of the case and determining whether action against the registrant is warranted or not. In such circumstances, the RTS is usually eager to take care of the customer

and resolve the problem. Either way, we'll discuss it with the consumer. Frequently, just getting NRRTS involved has the effect of getting the RTS to focus on that client more intently and resolve the issue.

Until recently, complaints were handled by the Ethics Chair. The chair usually was a NRRTS Board Member who volunteered and was approved by the board. That lone individual would handle the investigation and communications among the consumer, RTS and therapist to sort out the facts from allegations. (Oh the times I've heard an earful from a consumer only to call the RTS and get another earful as well as a completely different story from the consumer's.) The chair would then meet with the



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# ethics simply means doing the right thing.

board to discuss the facts of the case and then decide on a resolution. For the most part, the whole process was left to the discretion of the Ethics Chair and Board, with little structure to guide them.

With increased passage of policies and legislation requiring certification and/or the NRRTS CRTS® credential in order to provide complex rehab, there is more at stake for an RTS who could stand to lose his or her CRTS® certification.

It became imperative to make our procedure for handling ethics complaints “bulletproof” so we can best defend our Code of Ethics, Standards of Practice and trademarked credentials.

Moreover, we wanted to add some “teeth” to the program so it would be meaningful not only to us, but also to the communities we serve. To that end, NRRTS has worked in the past year to further develop an ethics policy and procedure for handling complaints. This policy is an important part of NRRTS registration, as it outlines not only how NRRTS will handle the complaint, but also the Registrant’s rights within the process.

One of the major changes made was the creation of an Ethics Committee that consists of three individuals who jointly investigate, discuss and adjudicate a complaint. Having this committee has several advantages. The most obvious is the ability to share workload, but the most important is the ability to excuse one or more committee members from the process in cases of conflict of interest. Changes made to the NRRTS Bylaws by the Board have empowered the Ethics Committee to adjudicate complaints and mete out punitive actions

against a registrant found to be in violation of the Standards or Code. The current Ethics Committee members are Mary Beth Kinney,

and desist, to a simple reprimand, censure or supervision requirement, to suspension or even full revocation of registration. To add validity to the system, records of complaints are



ATS, CRTS®; John Zona, ATS, CRTS®; and me.

Another important change is the development of a process consisting of a series of steps designed to ensure that we notify the Registrant of the complaint and conduct an investigation as well as provide a process for the registrant to respond with additional information. Each has an attached timeline that helps keep the complaint moving forward in a timely manner. A complaint processing worksheet was also added as a useful tool to help keep the whole process on track. An appeals process was added to allow a registrant who disagrees with the decision of the ethics committee to have the decision reviewed by the NRRTS Board of Directors. In the event of an appeal, the Board may either uphold or overturn or modify the decision of the Committee.

Depending on the nature of the violation, a variety of measures are possible. They range in severity from requiring the registrant to cease

kept on file with certain information available upon inquiry. Information regarding the actions of the Ethics Committee may even be posted on the NRRTS website.

For most of us who are trying to do the right thing everyday, a complaint filed against us results in no action. But for those who really are operating outside of our ethical standards, we stand ready to deal with them. Of course, our greatest hope in developing these rules is that we’ll never have to put them to use, but given the complexities of serving our clientele and the oftentimes convoluted funding process we are forced to work within, opportunities for problems with orders and communications abound. And that fact alone places all of us at risk of having to deal with a complaint at some time or another.

#### ABOUT THE AUTHOR

Rich may be reached at 303.666.5150 X 101 or rsalm@peakwheelchairs.com.



# Together, We Can Turn a Bill Into a Law



**JOHN GALLAGHER**  
Vice President Government Relations  
US REHAB

FOR A NUMBER OF providers across the United States, March 20, 2008, was the start of a long road toward combating the seriously flawed program known as competitive bidding. On that day, the 1,000-plus providers who participated in the first round of competitive bidding received a letter from the Centers for Medicare and Medicaid Services (CMS) that would decide the fate of their businesses. While some received

program that has taken us to where we are today.

### **The Birth of a Bill**

In the United States Congress, a bill is the most common form of legislation used and may originate in either the House or the Senate. A bill begins with an idea that may come from anybody. However, only a member of Congress may introduce the bill.

For the DME industry, the start of a bill to delay or defeat the competitive bidding program began when the industry started making noise about the several procedural flaws that were coming to light in the program. Almost immediately after receiving their denial letters, providers started contacting their legislators, informing them of the flaws and how providers were improperly and unfairly disqualified. The industry created enough rumble to gain attention throughout Congress, including getting the attention of the Ways and Means Health Subcommittee chairman, Fortney “Pete” Stark (D-Calif.), who eventually introduced a bill in the House that would delay competitive bidding.

### **How a Bill Becomes Law**

When a bill is introduced in the House, it’s designated by the letters, “H.R.,” which stands for “House of Representatives,” and followed by a number. The bill will keep the designated letter-

number combination for the entire duration of its parliamentary stages. Any member of the House may introduce a bill at any time while the House is in session. The member who introduces the bill is known as the sponsor.

At the time of introduction, the bill is referred to a committee where its members will debate over any changes. After they have marked up the bill with any changes, the committee will vote to accept or reject the bill. If the bill makes it through the committee vote, it will either be sent to a subcommittee for more study or reported to the House Floor. If the bill is reported to the House, the committee staff writes a committee report for the bill that details the purpose of the bill and provides a section-by-section analysis. All of the text must be reported, even the text being repealed. The bill is put on one of the House Calendars and is sent to the House Floor for consideration.

One of the fastest and most commonly used ways that a bill is considered is by the “Consideration of the Whole.” The Committee of the Whole allows the House to act with a quorum of 100 members, instead of the requisite majority of 218 members. Both sides are allotted an appropriate amount of time to debate the bill after the bill is read, and the debate is terminated after the time allotted is used. The bill is then read

*A bill is the most common form of legislation used and may originate in either the House or the Senate.*

a letter awarding them a contract to bill Medicare for competitive-bid items in the first round of the program, many more were denied contracts for reasons that could not be justified.

“Losing” providers were told contracts would not be offered for reasons such as missing financial documents or for supposedly not meeting accreditation requirements. In both cases, however, providers could prove the missing information was, in fact, sent. Meanwhile, “winning” providers only had ten days from the date of the letter to evaluate both the pricing impact and the contract terms before they had to either accept or reject the contract. Thus began the battle to defeat the

a second time, which is a section-by-section reading where amendments may be brought up when a specific section is read. The Committee of the Whole then reports the bill to the entire House. The bill is read a third time in the House, and then it's ready to be voted on once again.

When the House votes, the bill is read by title only. Members of the House will then vote electronically to either approve the bill ("yea") or disapprove the bill ("nay"). House members may also indicate they are "present" if they were in attendance but chose not to vote on the bill. If the majority of the House votes to pass the bill, the bill must then pass through the Senate. Once in the Senate, the bill may be debated and marked up again, unless the Senate motions to cloture. If cloture is invoked, debate on the bill is ended and the Senate may choose to vote on the bill without making changes. If the majority of the Senate passes the bill, the bill is finally sent to the president, who will take one of three different actions. The president may choose to:

1. take no action, automatically turning the bill into law ten days after the bill passed through both the House and the Senate.
2. veto the bill, sending it back to the floor where both the House and the Senate may vote to override the veto. (A two-thirds vote is necessary to override the veto.)
3. sign the bill into law.

### Passing H.R. 6331 and Delaying Competitive Bidding

On June 12, Chairman Stark introduced H.R. 6252, "The DMEPOS Competitive Acquisition Reform Act of 2008," to delay the competitive bidding program. The bill was referred to the House Ways and Means Committee, but about a week later, the text of the language was incorporated into H.R. 6331, "The Medicare Improvement for Patients and Providers Act of 2008."

H.R. 6331 was introduced to the House Ways and Means Committee on June 20, and under a suspension of the rules, the bill went to the floor

on June 24. "Suspension of the rules" happens when the House limits debate and bars amendments to the bill. In order to pass, however, the bill will require a two-thirds majority vote. Much to the industry's delight, the bill passed overwhelmingly by a margin of 355-59, which was far more than the required two-thirds vote.

The bill was then sent to the Senate where the democratic leadership announced the Senate would vote for cloture on H.R. 6331. While the motion to invoke cloture failed on June 26, upon the Senate's return from their Independence Recess, the cloture vote passed by a margin of 69-30. Based on a ruling, the Senate moved forward with H.R. 6331, choosing to pass the bill.

While both the House and the Senate passed H.R. 6331 by a veto-proof margin (at least two-thirds of the vote), on July 15, President Bush vetoed the bill, sending it back to the floor. Within hours of the veto, the House overturned it by an overwhelming margin of 383-41.

The Senate followed about an hour later with a margin of 70-26. The Congress' override of the president's veto put the bill into the law, delaying the competitive bidding program for at least eighteen months.

What started out to be a long, uphill battle ended in a monumental victory for the DME industry. On March 20, much of the industry was in dismay, fearing beneficiaries would suffer the consequences of a flawed system and providers would lose their businesses. But thanks to providers who rallied together to contact their legislators, an idea turned into a bill that became a law. As providers across the nation rejoice in the delay, they are reminded the fight continues. The next step is to defeat competitive bidding. And thus, the process of turning a bill into a law begins again.

### ABOUT THE AUTHOR

John can be reached at  
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# Staying on Top of NSC Enrollment Guidelines



CLAY STRIBLING  
Attorney  
BROWN & FORTUNATO, PC

WITH THE REHAB INDUSTRY facing significant changes related to competitive bidding, documentation guidelines, reimbursement woes and other serious concerns, it is easy for suppliers to lose focus on the more basic elements of their business. For rehab providers billing Medicare, the most basic and fundamental part of their businesses is compliance with the Medicare supplier standards enforced by the National Supplier

Clearinghouse (NSC).

### STATE LICENSURE

Most rehab suppliers are aware of the need to have state licensure for their primary location, and in many cases, for satellite locations set up in other states. However, the requirement for licensure is not only related to physical locations. Often,

merely providing services for a beneficiary residing in a state will require that the rehab provider be licensed in that state. The NSC has become increasingly aggressive with enforcing state licensure requirements. In many cases,

suppliers have been caught unaware and have been asked by the NSC to verify licensure status in 20 to 30 states at one time.

Failure to maintain a state license in a state where you provide services could lead to revocation of your Medicare billing number. Since Medicare reimbursement is a primary source of revenue for most rehab providers, this outcome could be catastrophic. For this reason, it is vitally important suppliers stay on top of all state licensure issues.

### MULTIPLE LOCATIONS

A very common question regarding the NSC involves the need to enroll multiple locations of a supplier's business. Many companies believe they can operate multiple locations and bill services provided in each of those locations through a single centralized Medicare supplier number.

The determination of whether or not a location must be enrolled with the NSC depends on whether or not the location is considered a retail outlet or a warehouse location. Warehouse locations do not need to be enrolled and obtain their own Medicare billing numbers. However, merely calling a location a warehouse will not, by itself, resolve the issue. A warehouse location is a location where beneficiaries do not receive products or services. If your company advertises a certain location to physicians, patients or other members of the

health-care community as a location where beneficiaries can come for assistance, then the location is almost certain to be one that requires its own enrollment through the NSC.

### MISSING FORMS

Given the history behind the supplier standards and the familiarity of most suppliers with these guidelines, it is surprising to see many companies cited for failing to maintain certain basic forms required under the standards. The NSC continues to be aggressive in requiring the supplier maintain all appropriate forms to continue its enrollment.

Among the forms most commonly cited by the NSC as missing from suppliers' files include:

- a capped rental notification letter
- evidence of warranty coverage provided to the beneficiary
- proof of delivery documentation
- existence of a complaint resolution protocol
- evidence the supplier is providing beneficiaries with copies of Medicare supplier standards

Samples of all of these forms should be readily available for the NSC if it conducts a site inspection, and all personnel should be educated and instructed on the location of these forms.

### BUSINESS HOURS

The most frustrating situation for suppliers involves violations

CONTINUED ON PAGE 30

*For rehab providers billing Medicare, the most basic and fundamental part of their businesses is compliance with the Medicare supplier standards.*

A man with glasses and a white polo shirt is sitting in a wheelchair on a porch. He is smiling and looking towards the camera. The background shows a house with a window and some greenery.

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## Staying on Top of NSC Enrollment Guidelines

of standard No. 8. According to this standard, a supplier must permit CMS to conduct an on-site inspection to ascertain the supplier's compliance with this standard. In addition, "The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation."

One of the most certain ways to get a supplier number revoked is for a supplier to be absent during posted hours. If an NSC official comes to a supplier's location to conduct an inspection and the location is closed during posted hours, revocation of the supplier's billing number is virtually guaranteed. During posted hours, the supplier must have an employee present and available to allow the NSC to conduct an on-site inspection. Although there are certainly emergencies that arise which may require personnel to

be absent from the office for brief periods of time, the NSC's position on posted business hours is clear. For this reason, it is strongly encouraged for suppliers to maintain a "no exceptions" policy to staffing the locations.

### REPORTING CHANGES

According to supplier standard No. 2, a supplier must report any change to the information contained in the NSC application within 30 days of such change. Although this information is clear and straightforward, many suppliers fail to report such changes and are caught unaware when the NSC inquires.

It is advisable for most rehab suppliers to pull a copy of their Medicare 855S application on a quarterly basis to verify all the information in their most recent applications remain complete and accurate. The most common examples of changes not reported include:

- changes in management personnel
- changes in ownership
- changes in product mix
- changes in insurance coverage

Of special concern to those suppliers located in the demonstration project areas of California and Florida is the requirement that any change of ownership requires 30 days advance notice. Therefore, suppliers in those demonstration areas should provide ample time prior to the change of ownership to notify the NSC of their intended acquisitions.

### CONCLUSION

Given the immense pressures on rehab suppliers in today's market, it is easy to allow the "little things" to slip while trying to address larger issues. However, the consequences of failures to comply with the supplier standards can be catastrophic in a business highly dependent on Medicare revenue. Suppliers should set aside time on a quarterly basis to review the supplier standards, implement new compliance guidelines and review their 855S applications to verify that they not only achieve compliance with the supplier standards, but they maintain such compliance moving forward.

### ABOUT THE AUTHOR

Clay Stribling, Esq., is an attorney with the Health Care Group at Brown & Fortunato, P.C., a law firm based in Amarillo, Texas. He represents pharmacies, infusion companies, home medical equipment companies and other health-care providers throughout the United States. Mr. Stribling is Board Certified in Health Law by the Texas Board of Legal Specialization. He can be reached at 806.345.6346 or [cstribling@bf-law.com](mailto:cstribling@bf-law.com).

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## Does It Keep Moving?



CLAUDIA AMORTEGUI  
President  
THE ORION GROUP

THESE DAYS I FEEL like the rehab industry has a target aimed right at its heart. Unfortunately, we as providers have been caught in the crossfire. We can easily say this wasn't our fault, however, we must also recognize it wasn't the fault of all consumer power providers. It's like the old saying goes: One bad apple can spoil the whole bunch. In this case it was more than one just one bad apple, but at the same

time, it certainly was a smaller percentage of the total. At the end of the day, it still leaves us exactly where we are. Unfortunately, with all the changes in our industry, there has been confusion and many unknowns. We have new

contractors processing our claims, which means not only do we have to learn the new rules, but our new contractors are also starting from step one.

So what does this mean for the rehab provider? In my opinion, your bottom line is affected by your knowledge and ability to be detail oriented. You need to be on your toes. Understand that just because you learned something yesterday

doesn't mean that your new knowledge won't change again in the very near future. As mentioned, the contractors are in a learning process themselves.

By being certain your staff and referral sources are trained, your success in reimbursement will be favorable. You may have great RTSs, but if they don't know and understand the rules, it doesn't matter how much they sell. Sales are important, but being capable of collecting your payments is key. Therefore, spend the time (and the money if needed) to train everyone appropriately. Don't forget the staff responsible for deliveries, intake or documentation collection. Each person who has any type of responsibility tied to proper payment (this could even be a person who simply attains signatures on required forms) must be involved with the training. Don't be shy when evaluating your staff; give them "tests" to find out what they really know.

It's our bad luck that most Medicare contractors also need training—more in the form of product training and knowledge of their specific clinical benefit. Our hands are tied in most cases, however with some of your private insurers and state Medicaid offices, you can be of help. With many of these other funding sources adopting the Medicare coverage guidelines, even

more assistance is needed. It has been found that numerous insurers are misinterpreting the guidelines or simply misunderstanding how to process the new codes. If you don't have a strong relationship with your processor, develop one. Keep in mind this is not your time to "sell," though. Educate them; be a resource.

When it comes to your claims, be smart. Don't just accept a denial as the last word. In the same breath, be realistic. Does what you submitted truly meet all the coverage guidelines for that insurance policy rather than just reflect what you know by heart? I always say to take a step back and ask yourself if you would pay the claim based on the rules. Also, don't forget it's easy to get paid; the difficult part is keeping your payment during an audit. With all the new rules (and the moving target), are you certain you have everything you need—and within the timeframe required? How are you managing the process? Who is accountable?

At the end of the day, complex rehab claims are truly easier to qualify than a consumer power wheelchair claim. The qualifying documentation should be easily found in the patient charts. When it comes to PMDs, the key for providers is to be sure they have what will qualify the entire claim, not just the base. True rehab claims have many parts and pieces; you

CONTINUED ON PAGE 34

*Complex rehab claims are truly easier to qualify than a consumer power wheelchair claim.*



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### Does It Keep Moving?

cannot forget about these when reviewing documentation.

As for manual wheelchairs, it's still a waiting game for the new codes; and as always, we have been given a new obstacle to overcome. At this point, we are to continue as is. Surprisingly, I still consistently find many providers forget the "algorithmic approach" does not only apply to power wheelchairs; don't forget these same rules apply to manual wheelchairs, too. So once again, documentation is key. And trust me, this documentation will be reviewed during a post-pay audit.

No matter what you sell, how much you sell or where your business comes from, we come back to the beginning. Your success comes down to knowledge and understanding of the full picture before you even order a product.

You must be thorough. Be sure you have everything you need and be sure to actually read materials so you can understand the content. Many providers believe they have no issues in this area; unfortunately, this is not always the case. Remember the documentation requirements are for all of your claims, so your thought process of "oh, it's just one claim; we'll be okay" needs to be thrown out the window. That one claim may be the one chosen for an audit, and it's just not worth it. Do it right from day one.

#### ABOUT THE AUTHOR

Claudia may be reached at 303.623.4411 or [info@orionreimbursement.net](mailto:info@orionreimbursement.net).



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# Postural Care Around the Clock



TAMARA KITTELSON-ALDRED, MS, OTR/L, ATP  
Director for Access Therapy Services

Is it possible to help control or even reverse contractures, improve sleep patterns, relieve pain, ease wheelchair positioning, decrease self-abusive behaviors and simplify activities of daily living like dressing and hygiene without medications or surgery? Anecdotal evidence from my practice and other sources suggests that 24-hour postural care, implemented by committed families and caregivers, can offer these benefits.

*We spend hours evaluating, justifying, fitting and modifying proper seating systems.*

and nighttime positioning systems to implement at home; the families provided feedback about their experiences and the results they observed. It seemed eminently practical. I already had personal experience providing 24-hour postural care for my youngest daughter, who had cerebral palsy. For me it was second nature to provide a variety of well-aligned positions for activities and for rest. Yet I knew from my experiences as an occupational therapist as well as the mother of a child with disabilities, that rolled blankets and pillows did not always do the trick.

What is 24-hour postural care? In 2001 an article was published describing the Mansfield Project, a postural-care service in England. Thirty-one families with disabled children up to the age of 19 were given training

In 1976 Fulford and Brown described the development of severe deformities in children with cerebral palsy as being caused by the effects of immobility and gravity on the body of a growing child. While a child with cerebral palsy is born with a body that is shaped like any other child, gravity and immobility take their toll over time and result in windswept deformity, asymmetrical flattening of the rib cage, hip abduction contractures and flattening of the head on one side. The good news is that careful attention to supporting well-aligned, symmetrical positions for all activities (including sleep) can pay off with the benefits I listed at the beginning of this article.

Individuals with significant motor disabilities frequently sit in static, asymmetric positions unless they are provided with seating systems to promote well-aligned, functional posture. While the average able-bodied person changes position every ten seconds, many of our clients are unable to do the same. If they can, their movement repertoires are often limited to habitual postures influenced by muscle tone, weakness and other factors. Thus many people take the path of least resistance when out of their seating systems and assume (or fall into) the asymmetric, poorly aligned positions that gravity dictates. When we consider wheelchair seating and function, do we think about what happens to a person who spends hours lying in a destructive position when he or

she is not in the wheelchair? What happens is distortion of body shape, which has significant implications for health and function.

We spend hours evaluating, justifying, fitting and modifying proper seating systems for kids and adults with complex postural needs, yet many of them spend as much or more time out of their seating systems than in them. With 8,760 hours in a year, approximately 3,640 hours are spent in bed. Ask questions, do the math and you will see that most people spend at least one-third of their time out of their seating systems—most of it in bed. With education and support, families and caregivers can transform this time into therapeutic intervention.

Nighttime postural care is effective, because while sleeping, a child is less affected by tone, spasticity and the activity demands of waking hours. He or she is more likely to tolerate the gentle orthotic effect of corrective positioning. If the body is lying flat and supported in a symmetrical position, gravity helps mold the body symmetrically rather than distorting it. This is really just expanding on the idea of nighttime splinting, a well-accepted approach.

Allow me to share a few stories about young people with cerebral palsy who have benefited from the use of nighttime positioning systems:

- Cliff is a young man who crawled out of his bed and wandered in the house at night until he was fitted for a sleep system that cradled him symmetrically in bed.

CONTINUED ON PAGE 38



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### Postural Care Around the Clock

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• Jackie is a young adult who experienced severe pain when she was bed bound for more than a year. A bed-positioning system to support her body symmetrically and relieve strain on her joints was implemented, and her pain level was reduced so drastically that she cried when the system was removed for cleaning.

• Billy was 9 years old and had never slept through the night. He (and his parents) awakened at

least five times per night, he hated going to bed and his father had to “unfold” and stretch him out in the morning before Billy could sit in his wheelchair. He slept through the night for the first time after implementation of the sleep system, and began going to bed happily. His father found that Billy could be easily positioned in his seating system right out of bed, without the customary morning stretching routine. This family has slept better and remained committed to nighttime positioning for the past two years.

I highly recommend working as a team with clinicians and families in exploring sleep-positioning options to protect the body shape of individuals with significant motor disabilities. Such programs can only be carried out by committed caregivers who believe in the approach. While funding may be a challenge, the health benefits can be huge.

If you are interested in learning more, following are a few resources you might find helpful:

\* “The Mansfield Project: Postural care at night within a community setting,” found in the October 2000 issue of *Physiotherapy* (volume 86, issue 10, pages 528–534)

\* “Position as a cause of deformity in children with cerebral palsy,” found in the June 1976 issue of *Developmental Medicine and Child Neurology* (volume 18, pages 305–314)

\* “PM&R Update: 24 Hour Postural Management,” found in the summer 2004 issue of *The Children’s Hospital Physical Medicine and Rehabilitation Newsletter* (Denver, Colo.)  
The Postural Care Skills Programme,  
[www.posturalcareskills.com](http://www.posturalcareskills.com)

#### ABOUT THE AUTHOR

Tamara Kittelson-Aldred may be reached at 406.549.9521 or [tamaralka@gmail.com](mailto:tamaralka@gmail.com).



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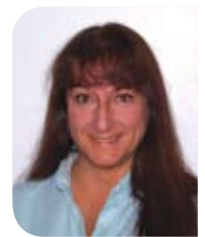
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Registration Date: 5/20/2008

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Ed Medical, Inc.  
742 Freeland Station Rd.  
Nashville, TN 37228  
Office: 615-242-9988 x.2  
Fax: 615-242-1782  
Registration Date: 6/3/2008

**Robert Harry, ATS, RRTS®**

AABON Home Health Care Supply  
136 E. Reynolds Street  
Ozark, AL 36360  
Office: 334-774-7535  
Toll Free: 800-835-2266  
Fax: 334-445-1736  
Registration Date: 6/2/2008

**Craig Kulus, RRTS®**

Preferred Home Care  
2628 W Birchwood Cir  
Mesa, AZ 85202  
Office: 480-446-9010 x.371  
Toll Free: 800-636-2123 x.371  
Fax: 480-505-9091  
Registration Date: 6/2/2008

**William C. Mattern, RRTS®**

A & A Home Health Equipment, Inc.  
1009 N Flowood Dr  
Flowood, MS 39232  
Office: 601-932-9185  
Toll Free: 877-440-5691  
Fax: 601-932-9327  
Registration Date: 5/30/2008

**Mike Schleppebach, ATS, RRTS®**

Michael's Medical, Inc  
4724 Prescott Ave  
Lincoln, NE 68506  
Office: 402-488-3411  
Fax: 402-488-6535  
Registration Date: 5/28/2008

**Mark Sheldon, ATS, RRTS®**

Romar MedEquip  
3833 US Hwy 29N  
Danville, VA 24540  
Office: 434-836-1824  
Toll Free: 866-766-2722  
Fax: 434-836-2525  
Registration Date: 6/2/2008

**Curt Simonds, RRTS®**

Allumed Medical  
2004 E Randol Mill Rd, #503  
Arlington, TX 76011  
Office: 817-299-8012  
Fax: 817-299-8095  
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## ATS CREDENTIALS

*Congratulations to NRRTS Registrants who earned the ATS credential. Depending upon their registration date, they will be awarded CRTS® upon completion and approval of the renewal following fulfillment of required registration. Names included are from May 16, 2008 through July 18, 2008.*

Jay Krusemark, ATS, RRTS®  
Benton Medical Equipment, Inc.  
Mountain View, CA

Mike Schleppenbach, ATS, RRTS®  
Michael Medical, Inc  
Lincoln, NE

## CRTS® CREDENTIALS

*Congratulations to NRRTS Registrants recently awarded the CRTS® credential. A CRTS® receives a lapel pin signifying CRTS® or Certified Rehabilitation Technology Supplier® status and guidelines about the correct use of the credential. Names included are from May 16, 2008 through July 18, 2008.*

Marjorie Ard, ATS, CRTS®  
Family Home Health  
Valdosta, GA

Brett Barnett, ATS, CRTS®  
Columbus Medical Equipment, Inc.  
Columbus, OH

Rick Blanchard, ATS, CRTS®  
Prescriptions Plus-DME America  
Pico Rivera, CA

Damon Bradley, ATS, CRTS®  
Majors Medical Supply  
Johnston, RI

Steve Carnes, ATS, CRTS®  
Wright & Filippis, Inc.  
Madison Height, MI

Kimberly A. Martin, OTR/L, ATS, CRTS®  
Wilpage, Inc.  
Pompton Plains, NJ

Brian Matthews, ATS, CRTS®  
Progressive Mobility & Medical  
Washington, PA

Rob Matuszeski, ATS, CRTS®  
Total Respiratory & Rehab  
Omaha, NE

John McCarble, ATS, CRTS®  
Custom Healthcare, Inc.  
Beaumont, TX

Betsy K. McKone, ATS, CRTS®  
ATG/Rehab Specialists  
Mountain View, CA

## CRTS® CREDENTIALS

Cody Murphy, ATS, CRTS®  
Trucare Medical  
Mt Pleasant, TX

Michael Pitifer, Jr., ATS, CRTS®  
ACE Medical Equipment, Inc.  
Lubbock, TX

Thomas C. Powell, IV, ATS, CRTS®  
Powell Medical Equipment, LLC  
Raleigh, NC

Mary A. Ray, ATS, CRTS®  
Home Health United  
Madison, WI

Gary A. Thompson, ATS, CRTS®  
Meriter Home Health  
Madison, WI

Deborah White, ATS, CRTS®  
Majors Medical Supply  
Deland, FL

## FORMER NRRTS REGISTRANTS

*The NRRTS Board determined RRTS® and CRTS® should know who has maintained his/her registration in NRRTS and who has not. Names included are from May 16, 2008 through July 18, 2008. For an up-to-date verification on Registrants, visit [www.nrrts.org](http://www.nrrts.org), updated daily.*

Richard M. Andrade, ATS	Cerritos CA
W. Troy Cole, ATS	Monroe, LA
Craig Dieter, ATS	Garden City South NY
Mark E. Locklear, ATS	Baltimore MD
Jerry Morgan, ATS	Fairmont WV
Beth Plaisance-Hill, ATS	Appleton WI
Debbi Smith	Centralia WA
James Spencer	Colden, NY
Tim Stockton, ATS	Redmond OR
Mike Thompson, ATS	Vancouver WA

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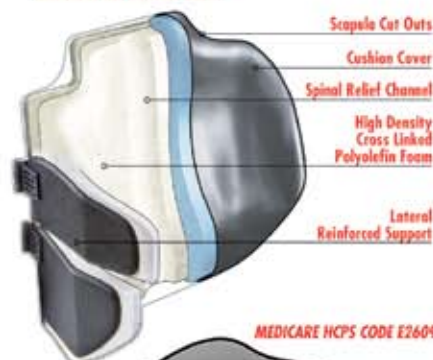
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# [NRRTS] 2008 TeleSeminar Series

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This unique educational opportunity is designed with three criteria in mind: to provide quality continuing education in seating and wheeled mobility, to meet the annual CEU requirement for ATS and ATP renewal, and to provide this programming in an extremely, cost-effective manner - as low as \$75 per CEU.

The TeleSeminars' faculty members are among the most well-known and talented people in our industry and profession. They will present state of the art information and answer questions from participants. Prior to each TeleSeminar the presenter's Power Point presentation and other course material will be uploaded to a special section of the NRRTS website ([www.nrrts.org](http://www.nrrts.org)). Registered participants may download and print these or follow along during the TeleSeminar.

Audience: ATSS, ATPs, physical therapists, occupational therapists (intermediate to advanced)

## TeleSeminar Series Registration Fees

NRRTS Registrants	\$75
Friends of NRRTS	\$100
All Others	\$150

## Individual TeleSeminar Registration Fees

NRRTS Registrants	\$20
Friends of NRRTS	\$25
All Others	\$35

Register on-line at [www.nrrts.org](http://www.nrrts.org) or by phone at 800.976.7787.

Long distance charges may apply and .2 CEUs have been applied for.

**Cancellation Policy: No refunds will be provided.**

### *Thursday, August 21, 2008 • 5:00pm to 7:00pm Eastern Time* **EVIDENCED BASED PEDIATRIC MANUAL WHEELCHAIRS**

**Lauren Rosen, PT, ATP**

This session will focus on the evidence available for the provision of pediatric wheelchairs with a focus on manual wheelchairs. The course will discuss previous research in pediatrics as well as adult wheelchair research that relates to pediatrics. A discussion of the limitations of the current research will be included. Lauren Rosen is a Physical Therapist and an Assistive Technology Provider at St. Joseph's Children's Hospital in Tampa, Florida. She is the Program Coordinator for the Motion Analysis Center, a three-dimensional motion analysis lab. Additionally, she runs a seating and positioning clinic.

### *Thursday, September 18, 2008 • 5:00pm to 7:00pm Eastern Time* **STANDING: ADVANCED PRINCIPLES, PRACTICES AND CLINICAL APPLICATIONS**

**Ginny Paleg, PT**

This exciting course moves expert rehab providers to the next level. Bone density, bowel, bladder, spasticity and range of motion benefits of passive and dynamic standing (including vibration) programs will be highlighted. This session will conclude with a rousing session on funding that will leave you shouting "show me the money." Ginny Paleg is a pediatric PT from Silver Spring, MD. She works in a 0-3 (Early Intervention) program for Montgomery County Public Schools. She serves children in their homes and daycare centers. She is the Reimbursement Chair and listserve monitor for the pediatric section of the APTA. She is on the editorial board of Rehab Management and PT Products Magazines, and is on the consumer advisory board of VTech toys.

### *Thursday, October 16, 2008 • 5:00pm to 7:00pm Eastern Time* **POWERED MOBILITY: FROM COGNITION TO TECHNOLOGY TO CLINICAL APPLICATION**

**Kevin Phillips, ATS, CRTS® and Anna Edwards, PT**

This session will offer participants the ability to match features of a powered mobility system with the consumer in mind. Ms. Edwards has been a practicing physical therapist for over 30 years. She has clinical experience in a variety of settings: acute, ambulatory, rehabilitation, home health, psychiatric, school and private practice with pediatric, geriatric, orthopedic and neurology patient populations. She also has experience in health care management and service operations.

She continues to practice in pediatrics and consults in the evaluation and selection of assistive technology and power mobility systems for persons with developmental disabilities across the lifespan. Kevin Phillips has been a RTS for several years. He has been a NRRTS Registrant since 2002 and is also a member of RESNA. Kevin speaks at national conferences such as the International Seating Symposium and Canadian Seating and Mobility Conference, on seating and mobility topics, specializing in seating for function.

### *Thursday, November 20, 2008 • 5:00pm to 7:00pm Eastern Time* **PELVIC STABILITY TECHNOLOGY AND CLINICAL APPLICATIONS**

**Speaker TBD**

### *Thursday, December 11, 2008 • 5:00pm to 7:00pm Eastern Time* **KEEPING UP: AN OVERVIEW AND COMPARISON OF NEW POWER WHEELCHAIR ELECTRONICS**

**Michelle Lange, OTR, ABDA, ATP**

Participants will have the opportunity to increase their knowledge about power mobility and develop a better understanding about what to provide their client population. Specific issues to be discussed include the comparison and contrast of the four new power wheelchair electronics packages. Michelle evaluates children and adults in the areas of positioning, mobility, access to communication devices and computers, and electronic aids to daily living. She is a frequent author and speaker.

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