THE OFFICIAL NEWSLETTER OF THE NATIONAL REGISTRY OF REHABILITATION TECHNOLOGY SUPPLIERS

NRRTS news

inside

VOLUME 1 WINTER 2007

president's update | MIKE SEIDEL

EXECUTIVE DIRECTOR SEARCH ENDS!

As you may be aware, the board of directors reached a decision on an executive director and an associate executive director for our organization. Our new executive director is Simon Margolis, and Simon officially took the helm of NRRTS on January 8, 2007. Our new associate executive director, Valerie Nehl started on February 1, 2007.

Simon has 30 years of experience in the field of complex rehab seating and wheeled mobility. He was a founding board member and past president of NRRTS. He has also served the industry as president of RESNA, the Rehabilitation Engineering and Assistive Technology Society of North America, and as an executive committee member and founding member of NCART, the National Coalition for Assistive and Rehab Technology. He comes to NRRTS directly from his seven-year tenure as vice president for clinical and professional development for Tennessee-based National Seating and Mobility, Inc.

Our organization has grown, so we must take a more active role in issues involving our industry.

Valerie has more than 15 years of experience in the finance and business administrative field. She is a non-paid board member on the American Red Cross and serves on the John Deere Community Credit Union Advisory Council. She comes to NRRTS directly from her position as a regional director with Senator Charles E. Grassley.

I want to elaborate on what hiring Simon and Valerie means to NRRTS and how we reached the decision to make them a part of our team. Because the board of directors consists of volunteer NRRTS registrants who are also working RTSs, we have a limited amount of time to devote ourselves to special projects, etc.

This lack of time has become more

CONTINUED ON PAGE 16

rehab forum

COMPLEX REHAB POWER MOBILITY CHANGES:
SOMETHING FOR EVERYONE TO LEARN

With the last release of fee schedule changes, the industry finally has all the pieces of the puzzle regarding Medicare's coverage of power mobility. But, in many ways, the change is just beginning. Everyone tried to learn the changes as they were released and educate their staffs and referral sources on the incremental changes. However, the unfortunate reality is it took having all of the pieces to totally understand the change the industry was facing.

I feel blessed to have been one of many in the industry to have a front row seat to all the changes. I have had the fortunate position of following the changes, talking with decision makers, understanding their intent and being able to focus a tremendous amount of time reading and understanding each element of change. I cannot imagine trying to understand all of the details impacting power mobility without this level of focus. Yet, most people in the industry have had much more to focus on over

CONTINUED ON PAGE 19

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contents

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REHAB AND COMPETITIVE BIDDING

CARA C. BACHENHEIMER
Vice President, Government Relations
Invacare Corporation

Later this year, the Centers for Medicare and Medicaid Services (CMS) is slated to begin implementation of competitive bidding for certain DMEPOS items, possibly including power wheelchairs and high-end rehab items. In the Medicare Modernization Act of 2004, Congress required CMS to implement "competitive acquisition" for durable medical equipment, prosthetics, orthotics and supplies, beginning in 2007. Competitive bidding will begin in ten of the largest metropolitan areas in late 2007, and an additional 80 large metropolitan areas will begin competitive bidding in 2009. In 2009, CMS has the authority to use prices established in a competitive bid area across the country. Clearly, the impact will likely be widespread and dramatic.

At press time, CMS was scheduled to soon release the final regulation implementing the competitive bidding program. Documents issued subsequent to the final rule, particularly the Request for Bids (RFB), are expected to have significantly more substantive information to enable us to better understand how CMS will administer the program, exactly which products and HCPCS codes will be included in which geographic areas, how suppliers must submit bids, how the payment rates will be calculated, how "winning" bidders will be selected and numerous other important details. In August 2006, CMS issued the final Quality Standards, and in late November 2006, CMS announced the accreditation organizations that have received "deemed status" from CMS, meaning that a supplier's compliance with those organizations standards would be deemed to meet the CMS/ Medicare Quality Standards for DMEPOS suppliers. Eventually all suppliers will have to meet the Quality Standards, and suppliers that submit bids in the competitive bid areas will have to meet those standards to submit a bid.

Under its statutory mandate, CMS is to include in competitive bidding the items that will yield the most savings to the Medicare program. In addition, the new power mobility device (PMD) codes implemented November 15, 2006, that categorize power wheelchair technology from low to high CMS has the administrative capability to include only a subset of codes in the PMD benefit in a competitive bid, if it so chooses. CMS could, therefore, make a determination that including high-end rehab PMD codes in a competitive bid would not likely result in "significant savings" (the statutory directive) to the Medicare program. Therefore, CMS does have the authority not to include these items. That does not mean, however, CMS will make that decision. It is difficult to see how the Medicare program would achieve "significant savings" by including high-end mobility devices in competitive bid programs, given their relatively limited utilization among the Medicare population. Once CMS issues the final regulation, CMS will announce the product categories and the specific items by HCPCS code, which will be included in the initial ten areas.

On the legislative front, there are even better opportunities this year to ensure high-end rehab items are not subject to competitive bidding. A new Congress and a new session mean bills introduced in previous years must be reintroduced. Therefore, the Hobson-Tanner and Hatch-Conrad bills that would make significant improvements to competitive bidding, as well as H.R. 4994, the bill that would exempt high-end rehab from competitive bidding, will need to be reintroduced early in the year. Importantly, the near seismic shift in the House to a Democratic majority and a slight Democratic majority in the Senate present real and positive opportunities to get these bills passed into law.

The Hobson-Tanner and Hatch-Conrad bills include a number of provisions that would specifically address the needs of the high-end rehab community. First, one provision would require CMS to define and demonstrate the probability of achieving savings of at least ten percent before it could include a product in the bidding process. Second, there is a provision that would allow any provider defined as small business that meets the quality standards and submits a bid below the current allowable to provide the items and services at the final bid rate, reducing the possibility that a large number of small providers would be eliminated from the market. A third important provision would require CMS first to conduct a "comparability analysis" before implementing competitive bid rates in non-bid areas, effective January 1, 2009, to ensure that it is appropriate to apply bid rates in non-bid areas.

Clearly, competitive bidding will present unprecedented challenges for the rehab industry. For those many reasons, I urge all in the rehab community to engage politically on this issue. It is up to all of us to educate our respective senators and representatives about the ill effects of this program on the consumer. The political dynamics in Congress will likely be receptive to the modifications the above bills would achieve. If we are successful in obtaining serious legislative modifications, we can be assured beneficiaries will continue to have appropriate access to this important benefit. ■

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GRASSROOTS EFFORTS VS. NATIONAL COMPETITIVE BIDDING (NCB) IN THE 110TH CONGRESS

JOHN E. GALLAGHER
Vice President, Government Relations
VGM & Associates

Two thousand and seven (2007) is shaping up to be an opportunistic year for the rehab/DME industry. Regardless of your party affiliation, now that Democrats have taken control of both houses of Congress for the first time in more than a decade, the debate over the healthcare agenda will change.

The first area of interest is one the Democrats pushed throughout the 2006 election—"lobbying reform." At first glance this sounds good. However, part of this reform includes new tax cuts and spending to be paid for (pay as you go), meaning the Democrats in control of the 110th Congress—just as the Republicans before them—will be looking for offsets to pay for any entitlement program increases they are planning. Within the health care segment, these offsets could be bad news for all.

The second area of interest is the Senate's desire to have stronger restrictions on earmarks. No one can agree on the precise definition of a congressional earmark, but in general, the word "earmark" refers to any element of a spending bill that allocates money for a very specific thing—a given project, location or institution. Transparency and stronger restrictions on earmarks would be good news for our industry, with the main advantage being committee chairman would not be able to add on legislative earmarks at the last minute, such as the DRA (oxygen cap). It remains to be seen if the tougher Senate version makes it through conference with new committee chairmen at the helm of Ways & Means (Charlie Rangel, D-NY) and Energy & Commerce (John Dingell, D-MI) commissions.

The third area of interest is a question of how soon the industry can motivate members of Congress to reintroduce **HR.3559 / S.3920 Medicare Durable Medical Equipment Access Act of 2005; HR.5513 / S.3814 Home Oxygen Patient Protection Act of 2006 & HR 4994 - Medicare Access to Complex Rehabilitation and Assistive Technology Act of 2006.** These proposed pieces of legislation are each important to rehab in its own specific way. Although individually proposed and introduced by different entities within our industry, they are tied together by an attempt to keep CMS from destroying rehab, as we know it today, by utilizing congressional support and action to affect our goals. The quicker we can capture our champions for legislations such as **HR 4994** and get bills passed, the better our chances for surviving the dreaded bidding nightmare.

Several industry organizations are doing everything they can to combat the implementation of National Competitive Bidding (NCB). But to truly and effectively defeat NCB, the DRA oxygen cap and drastic changes to PMD policies and reimbursement, we as an industry must unite with the Medicare beneficiary to develop a Triple Track Approach:

- **Legislative** – Develop legislative "champions" in the 110th Congress for the industry.
- **Grassroots** – Coordinate grassroots activity at the provider level—BECOME THE "PROVIDER LOBBYIST."
- **Legal** – Develop legal efforts to delay, impede and or defeat NCB.

To meet this end, LAST CHANCE FOR PATIENT CHOICE (LCPC), a 527 non-profit organization, was formed. Members include beneficiaries, HME/rehab providers and manufacturers. LCPC believes Medicare beneficiaries will become victims of a two-tier health care system if provisions of the current Medicare Modernization Act stay in place.. The goals of Last Chance for Patient Choice are focused on four areas:

- **Conducting public information campaigns** in selected congressional districts through a multi-media effort designed to educate the electorate about their legislators' support of selective contracting for HME/rehab, and informing Medicare beneficiaries about how their freedom to choose providers and equipment are adversely affected by selective contracting.
- **Filing a federal lawsuit** to strike the selective contracting sections within the MMA on constitutional and other grounds. The lawsuit will include Medicare beneficiary patients who are referred by local providers in areas selected for the first bidding and who volunteer to assist in this cause.
- **Partnering with other organizations** that are likely to be the next targets of selective contracting and those beneficiary groups most likely to be adversely affected if the scheme is implemented.
- **Facilitating an increased informational campaign** for members of Congress to explain why selective contracting is bad public policy because it will create a two-tier health care system in the U.S.

Opportunities to effect change in our industry are readily available for any and all who are willing to participate and get involved. Remember, as a NRRTS registrant, you have the advantage of a large support network behind you. Yes, it takes a great effort on your part, but an investment in promoting the inherent value of your services is time well spent. ■

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A LOOK BACK

WAYNE GRAU
Director of Rehab Industry Affairs
SETH JOHNSON
Vice President, Government Affairs
Pride Mobility/Quantum Rehab

The year 2006 will be recalled as the first time in the history of the rehab industry providers, consumer groups and manufacturers finally stood in solidarity and said, "I'm mad as hell, and I'm not going to take it anymore."

Competitive bidding, the Interim Final Rule, the Local Coverage Determination, and multiple versions of the PMD fee schedules created the perfect storm that forced all members of our industry to join together and fight.

The beginning of a new year is a good time to reflect and evaluate what happened in the previous year and plan for the upcoming year. We learned a lot this past year, including what worked, what did not work and what is the best approach to working with our legislators.

The industry made some new friends, and we will need to work to strengthen these new relationships. With the recent elections, there are many new representatives and senators we'll need to work with as well. Just as we built our companies one relationship at a time, we must take the same approach to building our relationships with our legislators.

WHAT DID WE LEARN?

1. **Legislative support is needed** - When the LCD was first introduced, the stand and pivot provision to qualify for a Group 3 power chair was a major concern for complex rehab providers. While a patient's ability to stand and pivot to transfer should have some bearing on the type of power chair a patient qualifies for, this should not have been the only qualifying issue. The stand and pivot provision along with automatic down coding to the least costly alternative would force some of our patients into Group 1 power chairs, which were totally inappropriate for rehab patients. After a number of meetings with CMS, it was apparent that CMS would not listen to our concerns about patient safety and the appropriateness of the Group 1 chairs for all rehab patients. The industry started to call on legislators to educate them about the inappropriateness of the LCD. Meetings, phone calls and teleconferences were conducted to show how the proposed LCD would harm patients (voters). The effort paid off and with political pressure from numerous members of Congress, CMS revised the LCD in favor of a more appropriate coverage policy.
2. **Congressional Education** - Simply calling your legislators does not work as effectively as meeting with them directly. The majority of congressmen and their staff have no idea how involved rehab equipment is and how it creates independence for the people using it. We must educate our legislators and their staff members. A number of congressional visits were scheduled at providers' locations. This is the best opportunity to educate our representatives and senators, so they can see first hand what we do and how our companies help their constituents. The legislators not only heard from the providers, but also from consumers of the equipment who provided a first-hand account of what the equipment did for them and how it allowed them to continue their active independent lifestyles. It is very important these activities continue in 2007.
3. **Consumer Advocates** - A special thanks goes out to the ITEM Coalition, American Association of People with Disabilities and United Cerebral Palsy Association, along with hundreds of other consumer groups who took action and fought to protect their members. The rehab industry worked very closely with consumer groups both on the national and local levels to educate them on how the LCD would affect their members. The consumer groups mobilized and complemented the industry's efforts to educate legislators about the devastating consequences of the LCD. Teaming up with the consumer groups raised the issue to a new level and greatly assisted in getting Congress to weigh in, for support of the industry's positions.
4. **Industry Membership** - Our legislators understand the power of numbers. The individual who tries to fight city hall will lose, but the group who takes on Congress has a much better chance of success. Registration in NRRTS and membership in AAHomecare, your state association and NCART is something all rehab providers should strongly consider. It is amazing how much a dedicated group of motivated, caring individuals can do to impact national politics. When we first started, naysayers said we could not do anything; we would just have to learn to live with it. The above-mentioned groups did not listen, and because of their efforts, the LCD was changed to protect the industry and our patients.

While we fought a number of battles in 2006, the upcoming year will pose other issues, including competitive bidding, new manual wheelchair codes and fee schedules, final PMD codes and fee schedules are expected to be implemented January 1, 2008. The fight is not over, but with a few wins under our belt we can move into 2007 feeling as if we can change the world. If we work together, we can succeed. We simply have no other choice. ■

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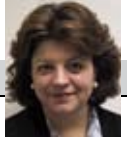

FEDERAL COURT DECISIONS

ASELA CUERVO
Attorney
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Given this newsletter takes a comprehensive look at the changes in the power mobility benefit that took effect last year (as well as those that are ahead), it is worthwhile to examine recent federal court decisions addressing medical documentation requirements to support claims for payment under the Medicare program. The cases are relevant not only because they deal specifically with the nature of the medical necessity documentation that CMS can require to support claims for power wheelchairs, but also because medical necessity documentation issues will continue to be important as suppliers incorporate the new power mobility device (PMD) coding and coverage policies into their operations.

Most providers are aware of a 2004 decision issued by the federal court for the Eastern District of California holding that CMS contractors could not require a PMD supplier to submit medical necessity documentation beyond what is otherwise required on the certificate of medical necessity (CMN). For many suppliers of PMDs, this decision, ***Maximum Comfort v. Thompson,*** provided a basis for challenging the power wheelchair audits that have been commonplace in recent years. The DMERCs were finding large overpayments and sometimes extrapolated from those amounts to demand repayment of even larger amounts. Even though the immediate impact of the decision would be limited to the Eastern District of California, the *Maximum Comfort* decision could be "persuasive" in ALJ appeals or before other federal district courts.

Citing *Maximum Comfort* as precedent, suppliers in two separate cases argued that CMS and its contractors lack the authority to require medical necessity documentation for PMDs beyond what is required by the CMN. Interestingly, both courts declined to follow the *Maximum Comfort* decision. In ***Mackenzie Medical Supply, Inc. v. Leavitt,*** the court reviewed the Social Security Act provisions pertaining to CMNs. Unlike the *Maximum Comfort* court, the *Mackenzie* court concluded that the statute did not unambiguously preclude CMS from requiring medical necessity documentation beyond what was required in the CMN. The court went even further in its analysis, stating that CMS has discretionary authority under the law to determine what is "reasonable and necessary." This would include the discretion to require medical necessity documentation beyond what is furnished via the CMN. Otherwise, the secretary would lack the authority to determine whether an item was reasonable and necessary in any case where there had been a physician's prescription for the item.

As you know, CMS has eliminated the CMN as a requirement for a number of items of DME.

Similarly, in ***Gulfcoast Medical Supply Inc. v. Department of Health and Human Services,*** the Eleventh Circuit Court of Appeals held that the Social Security Act does not limit CMS' discretion to require evidence of medical necessity in addition to the CMN. The *Gulfcoast* court's analysis followed closely the analysis in *Mackenzie*. Both courts reasoned that inherent in the secretary's power to administer the Medicare program is the discretion to require medical necessity documentation in addition to the CMN. Importantly, like *Mackenzie*, *Gulfcoast* held the Social Security Act does not unambiguously establish the CMN as the exclusive vehicle for documenting medical necessity. Moreover, the *Gulfcoast* decision applies throughout the Eleventh Circuit, a geographic area that includes many of the states that make up Medicare DME region C.

As you know, CMS has eliminated the CMN as a requirement for a number of items of DME. Consequently, it is tempting to question the relevance of these decisions. The decisions are important because they affirm that CMS has broad discretion to administer the Medicare program's statutory mandate that items and services must be "reasonable and necessary." The courts were very reluctant to find a statutory limitation on this discretion. It is important to keep this in mind over the course of the coming year because documentation issues will continue to be a large part of the discussion on how the new coding and coverage policies are implemented. The information on a form—whether one generated by the supplier, or officially sanctioned by CMS—may not be prove conclusive on the issue of medical necessity under the analysis in these recent cases. Consequently, suppliers should be cautious about relying exclusively on such forms. While this should not stop stakeholders from working toward more specificity in what is required to support medical necessity for PMDs, there will be no shortcuts for properly educating your referral sources or collecting medical record information when necessary. ■

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WHAT HAPPENED TO BUSINESS AS USUAL?

JERRY KEIDERLING
Vice President
U.S. Rehab

For quite some time now, "Business As Usual" in rehab has been more like "Business As It Needs To Be Today!" With CMS making adjustments and alterations to its entire system in an effort to gear up for mandatory accreditation, competitive bidding and numerous cuts and revisions, it has been difficult for the rehab community to keep up with constant changes.

Keeping up with the continuous regulatory and policy changes is just one part of the difficulties suppliers face. The most important task is adjusting your business practices to stabilize profitability while maintaining the high levels of quality in service and product offerings your clients and referral sources have come to expect from your company.

Our professionalism is key, but it comes at a stiff price.

Our industry has always dealt with not only the many changing faces of CMS, but private payer sources as well. We've handled them well and have been able to adapt fairly quickly to maintain a status quo within our companies. The reason for our ability to cope and recover is, historically, changes and updates were typically somewhat singular in nature (e.g. either a fee schedule, a modifier fix or billing criteria of some nature). These were relatively easy to manage and slight modifications to systems and daily business practices did the trick, and all was okay for the time being.

All of that changed with the onset of the Medicare Balanced Budget Act (BBA) of 1997. Since then, it has been as if someone opened the gates and let the lions in the ring. With a new Local Coverage Determination (LCD) plus revisions, 64 new Power Mobility Device (PMD) billing codes, several new fee schedules and adjustments, National Competitive Bidding (NCB) and an accreditation and supplier standards mandate, it has simply been one battle after another, fought by many in the industry. Many conflicts between CMS and rehab providers emerged from these radical changes, along with efforts made on both sides to somewhat alleviate the damages to all involved. These efforts to facilitate a change for the better were given a real boost by the increasing involvement from providers across the nation. Those who were quiet in the past saw the real need to get involved. They attended DC fly-ins, wrote letters to CMS and elected officials, held meetings with their elected officials and got involved with their state, national and industry associations to lend support in any way possible. There are many more battles to be fought on the horizon. I believe CMS now knows we mean business, and more importantly, we are genuinely concerned about the beneficiaries and the level of care they deserve.

So what can we do to insure not just survival for our companies, but profitability and growth in an industry that's under constant scrutiny and attack? Part of the answer is to remain committed to your company's core values: providing medically and functionally necessary products to those in need at a fair price, with a keen sense of quality and at a level of service unmatched by others. This is a difficult task, but one of most importance. If we allow ourselves to stray from these values, then we become our own worst enemies, and the bureaucrats win.

Our professionalism is key, but it comes at a stiff price. Operating our businesses in a legal and ethical manner takes time, people, software, education and marketing—all of which are expensive, yet necessary. With our margins being whittled away by payer sources, our standard operating procedures are being challenged every day. It's a balancing act, if you will, of complying with all the new updates while keeping a watchful eye on the bottom line.

There are a few elements that should be considered as key components to a winning combination of business strategies in today's world:

ABN
The Advanced Beneficiary Notice is probably one of the most under-utilized and valuable tools we have at our disposable. Although put into effect in early 2002, its use and intent still remains somewhat of a mystery to many providers. This tool gives consumers the freedom to choose the products that are best for them without paying the entire up-front cost of products not traditionally covered by Medicare.

For reimbursement purposes, Medicare identifies which home medical equipment and supplies are "medically necessary." The definition of "medically necessary" usually applies to less advanced or "stripped-down" products. In the past if beneficiaries wanted to upgrade to a product that better met their clinical and personal needs, they were responsible for paying the whole up-front cost of the product and waiting

CONTINUED ON PAGE 14

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continued from page 12

BUSINESS AS USUAL?

for Medicare to reimburse them for 80% of the allowable fee. Under the new guidelines, however, beneficiaries can upgrade by paying the difference between Medicare reimbursement and the price of the equipment they prefer. This new process benefits Medicare recipients, and it enables DME providers to function within a realistic business model when offering their customers higher quality services.

When a supplier believes Medicare may not reimburse for some or all equipment and services provided, the supplier must have the beneficiary complete the ABN form. By completing the form, the beneficiary acknowledges responsibility to pay for equipment and services denied by Medicare. When the form is used properly, it protects suppliers from financial liability.

GPS tracking technology has proven itself to be of great value to providers.

As is evident, properly used ABNs can make a dramatic impact on your bottom line. They are a way of taking CMS's "least costly alternative" and turning it into a sale that greatly enhances your margins.

TECHNOLOGIES

When thinking about technology and software, our minds quickly turn to billing, inventory management and tracking programs. All are an important part of running a rehab company, and each provider should choose wisely the programs suiting individual operations best. The technologies that demand attention for today's market are add-on programs designed to enhance your service capabilities and product offerings, thus increasing sales and market share.

GPS tracking technology has proven itself to be of great value to providers. The capability of knowing where your delivery people, your RTSs or your service technicians are at any given time is invaluable to streamlining your cost of operation. The ability to alter schedules and handle new business now rather than later with reduced travel time is a great asset for you and your clients. This technology also allows your drivers to quickly correct bad directions or being lost. Fuel savings and response time are both greatly increased, along with possible reductions in insurance premiums. The intent of GPS is to save time and money, not to be confused with a fear of "big brother" watching.

Another piece of technology being researched by many for revenue generating purposes is aimed at client follow-up and fulfillment. The idea is any given rehab provider has a broad enough client base built up over the years that several or many of these individuals are simply lost or forgotten over time. They are evaluated and assessed for specific needs, provided

equipment, trained and possibly re-fitted to some extent and when all is well, seldom is contact ever made again. These are individuals who may, over time, have either outgrown their equipment or had changes in condition that demand attention. These clients equate to losses in maintenance opportunities, upgrade sales and products and thus revenue. There are legal and regulatory issues surrounding the marketing to Medicare beneficiaries, but it is acceptable if approached as a standard follow-up program to all clients within these parameters.

Lowest acquisition cost is not always the best route to take.

PRODUCT OFFERINGS

Lowest acquisition cost is not always the best route to take. Many times, we get caught up in the margin percentage of the initial purchase, and we lose site of service costs coming down the road. Make sure your RTSs have correctly assessed the potential usage of the equipment prescribed. Supplying the lowest cost equipment is fine to those clients whose total usage will be light and in the home, but many will use their equipment outdoors and often to a great extent. Even though Medicare does not recognize "out of the home" as criteria for coverage, providers need to pay serious attention to real-life daily activities. Most PMD manufacturers have several product offerings within each respective code grouping, and all models deliver a given level of performance and durability. It's far more important to provide the product most suited to the client up front. Equipment with a high-quality factor and carrying a slightly less margin up front will pay more in the long run with fewer service calls and repairs.

Rehab and assistive technology has been around for many years and despite everything the world has thrown at us, we still survive, grow and prosper. Advances in technology, improved educational opportunities and a willingness to get involved have been key to our success. As you prepare your company for the future, please keep a few things in mind:

- Profit is not a dirty word! Look for it in creative ways and make it work to your advantage.
- The work you do and the services you provide are an important and integral part of our society. Without it, disabled Americans would be bed ridden and out of site rather than living their lives as independently as possible.
- Operational and reimbursement changes will continue to happen. Keep yourself informed and be as involved with industry efforts as much as you possibly can. ■

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continued from page 1

SEARCH ENDS

obvious in the past year through activities surrounding issues with the PMD, LCD, etc. Larger organizations in our industry have the resources to employ individuals who specifically work on these and other activities. Due to our limited manpower and financial ability, we were not able to devote necessary resources to this and other issues affecting the industry. Because the board feels NRRTS should be represented and become more vocal about the issues facing our industry and profession, we have called on the expertise of Simon and Valerie to help us do so.

Our organization has grown, and we must take a more active role in issues involving our industry and profession. We as NRRTS registrants need to own our profession. For far too long, RTSs have sat back and allowed manufacturers, rehab companies, allied healthcare professionals, etc., to dictate what we do and how we do it.

Until recently, NRRTS has operated with Administrator Judy Vance, part-time Administrative Assistant Tom Vance, and Marketing Coordinator Amy Odom. Judy's pending retirement led us to the decision to hire Valerie. NRRTS will miss Judy, as she has been the lifeblood of our organization. We wish her and Tom all the best! Amy plans to remain on staff.

The board strives for the representation of NRRTS registrants outside of our employers and manufacturers to ensure our professional standards and consumer rights are upheld.

The placement of Simon and Valerie does not change how NRRTS is operating. The bylaws of our organization are set up to allow for such positions. The duties of the daily operation of the organization will be laid out and separated between Simon, Valerie and Amy to perform.

The board of directors will remain in place, and elections will be held as always. The president, vice president, treasurer, secretary, etc., will all remain in place and they will continue to carry their duties. The 2007 election is coming, and I HIGHLY encourage you to consider being placed on the ballot.

We sincerely hope these changes will allow NRRTS to become more vocal on the issues affecting each of us by allowing dedicated people to represent us on a consistent

basis. The board strives for the representation of NRRTS registrants outside of our employers and manufacturers to ensure our professional standards and consumer rights are upheld.

As my presidency is ending, I have gained a deeper understanding of what is required to represent our organization and am confident the current board has made it easier for those who follow us to serve this organization and help guide NRRTS into the future. The board is charged with setting the mission and goals with which the executive directors have been hired to perform.

This is truly a new and exciting time for NRRTS and our profession as we proceed with unprecedented representation. More than ever before, we ask for your support and commitment as a RRTS™ and CRTS®. Again, I ask you to reach out to fellow RTSs and encourage them to join us in our efforts to raise the bar—not just for their individual commitments to professionalism, but also for our industry.

I encourage you to read this newsletter from cover to cover. We have the most up-to-date information concerning the LCD with some of the top industry professionals represented. Thanks to all of the writers for their positive contributions to NRRTS! ■

Mike Seidel, CRTS®, can be reached at 913/541-0205 or mseidel@nsm-seating.com.

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continued from page 1

COMPLEX CHANGES

the last three years than power mobility changes. So now it becomes critical to make sure everyone understands the policies and how to implement them successfully. By successfully, I mean your businesses remain sound, you get to keep the money Medicare initially allows and consumers continue to get the level of technology they require.

To focus on all of the changes, I will segment the various changes into categories: ***Coding, Medical Necessity, Advanced Determination of Medicare Coverage (ADMC), Other Conditions for Coverage,*** and ***Payment.*** Finally, in this article, I will address what happens next.

CODING

Coding is the foundation for all other change. Don't allow yourself to be overwhelmed by the number of codes. I remember a time when the medical directors thought six HCPCS codes for power wheelchairs were too many. Now we have 64 PMD codes! The truth is, for Medicare purposes, there are only five groups you need to be concerned with: One POV and four PWCs. The various codes within each group are merely configurations based on patient weight, seat type (sling or solid v. captain style), or powered seating options. For complex rehab specifically, your focus will be even narrower.

This represents a paradigm shift in coding in which we should pay attention. The industry needs to understand this is a trend. The structure moved from a base code plus add-on codes for options such as seat width and depth, and accessories such as footplates, seat belts and casters. The former coding scheme required billing and processing multiple line items on each claim. The new coding scheme bundles commonly provided options and features into the base code. This structure is more streamlined, will require less time and presumably cost less to submit and to process.

MEDICAL NECESSITY

I find it easier to hone in on the coverage requirements by breaking coverage apart and focusing on the medical necessity criteria separate from other conditions of coverage. The National Coverage Determination (NCD) for Mobility Assistive Equipment (MAE) expanded access to power mobility by removing the "bed or chair confined" policy and replacing it with a focus on mobility limitations that impair an individual's ability to perform mobility related activities of daily living. A mobility limitation is one that:

1. Prevents the beneficiary from accomplishing the MRADLs entirely. OR
2. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to participate in MRADLs. OR
3. Prevents the beneficiary from completing the MRADLs within a reasonable timeframe.

The second and third criterions, in my mind, represent the increase in access. It is extremely important CMS acknowledges that even though an individual may be able to perform an ADL, if it places him/her at heightened risk or it takes an unreasonable length of time to complete the task, the individual has a medical need for an assistive device.

The local coverage determination (LCD) contains the medical necessity criteria for qualifying for the various groups and codes. There are many "interpretations" within the industry right now about this important policy. Unfortunately, several are incorrect. While the policy is lengthy and fairly complex, the policy is clear. I recommend you read the policy and the policy articles. If you can't find something written in the policy or an accompanying policy article and you have questions, do some research; submit a question to the Advisory Council in your region. It is going to take a while for everyone to be as knowledgeable regarding the new policies as we were with the previous ones.

I continue to hear ongoing debate regarding how an individual qualifies for a Group 3 device. Some people claim

CONTINUED ON PAGE 20

continued from page 19

COMPLEX CHANGES

that the documentation must "justify" why a Group 2 device won't meet the individual's needs to qualify for a Group 3 device. This is not the case. The real answer is based on the individual's diagnosis. If the individual has a diagnosis that is the result of a neurological condition, myopathy or congenital orthopedic deformity and meets the overall criteria for power mobility, the individual qualifies for Group 3. The medical directors understand and acknowledge individuals who require power mobility have diagnoses that fit one of these three conditions, then they require the performance of devices in Group 3. The supplier is not required to provide any further proof or evidence as to why a Group 2 won't meet the individual's needs. This is true for all Group 3 devices.

ADVANCED DETERMINATION OF MEDICARE COVERAGE (ADMC)

The ADMC eligibility has been expanded. This is very important. If you have not routinely utilized this process in the past, I encourage you to now. I especially encourage you to use the ADMC process when the individual has a neurological condition that is progressive and you are providing a base that accommodates single or multi-power option seating system, but were not not providing the seating system at the time of initial issue of the power wheelchair. I also encourage you to use this process if you are not quite comfortable with the documentation you are receiving. The ADMC process provides you an opportunity to have a manual review of your documentation. The ADMC process also gets you an automatic extension on the delivery of the equipment. As opposed to the regular 120-day requirement, when a claim goes through ADMC, you are allowed six months. For dual eligible clients, if you have to file a prior authorization with Medicaid, this extra time may be important.

OTHER CONDITIONS OF COVERAGE

I group requirements regarding the physician face-to-face, comprehensive evaluations by therapists, SADMERC code verification, and delivery timelines in the category of "other conditions of coverage." These are regulatory requirements not necessarily tied to the medical necessity of the individual, but nevertheless impact coverage.

These are the devilish details that require process change. These policy requirements must be understood and incorporated into your businesses. This takes education, training and time. I continue to be asked whether the physician has to see the patient if he/she refers the patient to a therapist for an evaluation. I continue to be queried about when the clock starts ticking for the 120-day delivery by the supplier or the 45 days for delivery of the documentation to the supplier.

I also continue to hear people say the beneficiary doesn't have to see his/her physician if it is a replacement chair. Be very careful with this one. This applies only if the replacement is during the useful lifetime of the chair; a replacement must be due to the original product being lost, stolen or destroyed and must be replaced with the same or similar equipment. This exemption does not apply when it is time to replace the chair, because the original chair has exceeded its useful life or the individual's needs have changed due to a change in condition. In these circumstances for replacement, a face-to-face evaluation by the physician is still required.

PAYMENT

During the pricing of power mobility, many people learned more about how Medicare establishes the fee schedules than they ever wanted to know. I hope this will allow more people to be actively engaged in CMS' efforts to establish new methodologies for developing payment. The presence of fair and equitable payment is a non-event. But, let payment fall below a certain threshold and it becomes paramount; coding and coverage no longer matter—access is denied.

Payment was the final piece of the

power mobility puzzle for Medicare. However, the release of the PMD Medicare fee schedule is far from the end of change. In fact, the release of the fee schedule (all of the releases) has or will cause a ripple effect across all payers. The industry worked very hard to ensure reimbursement allowed access to this important technology to continue. I believe everyone agrees the level of reimbursement for some codes still challenges suppliers to find appropriate products they can continue to provide. Additionally, I think most people would agree the current levels of reimbursement for rehab power mobility are at subsistence level. Any effort by other payers to discount off the Medicare fee schedule has the potential to eliminate access.

Medicare establishes the model for all payers. CMS takes the lead in coding, coverage and payment. This is why what Medicare does is so important, even for rehab suppliers that "don't do Medicare." NCART worked very hard to ensure coding, coverage and payment took into consideration the needs of individuals with disabilities; to protect access to complex rehab mobility devices. If other payers are going to model their policies around Medicare's, the Medicare policies must accurately reflect and protect the needs of these individuals.

WHAT HAPPENS NEXT?

The battles move to the states and to other payers. As other payers begin to implement the new HCPCS codes, they will also require new fee schedules as well as coverage policies. The easiest thing for other payers to do is to adopt Medicare's policies. This raises several concerns.

Medicare requires a device be necessary for use "in the home." This can mean the device Medicare allows will not meet the individual's needs outside his/her home—the device that allows an individual to access his/her community and community services. In fact, the LCD policy states Group 4 devices have features primarily for use outside the home and therefore Medicare will reimburse for these devices based on the least costly device that meets the individual's needs inside his/her home.

If Medicaid, for example, adopts the LCD in total, the in-the-home restriction becomes extremely problematic.

In addition, many Medicaid programs currently reimburse at a percentage off the Medicare allowable; some discount as much as 30% off Medicare. Discounts off Medicare for power mobility will block access for Medicaid recipients.

Moreover, the criteria stipulating the patient must have a specialty evaluation performed by a licensed/certified medical professional such as a physical therapist (PT) or occupational therapist (OT), or by a physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features could cause problems if adopted by other payers. Actually I believe this sort of specialty evaluation is very positive. It is access to the individuals who can perform these evaluations that could be problematic. Access problems typically result from a lack of payment or insufficient payment for these services.

Another problem can be the availability of someone with the knowledge and expertise required to perform the evaluation. This is especially true in very rural areas.

Therefore, before Medicaid programs or other payers begin to adopt all of Medicare's policies or decide to discount off the Medicare fee schedule, they must understand the impact of these decisions. The industry must continue to work together to ensure all payers adopt policies, including payment policies, which will continue to provide access to complex rehab power mobility.

COMPETITIVE BIDDING

NCART is continuing efforts to achieve an exemption from competitive bidding for rehab and assistive technology. Representative Lewis of Kentucky introduced legislation last year that, if passed, would have achieved this goal. This legislation will be introduced again in 2007. It is critical we achieve an exemption this year through regulation or

CONTINUED ON PAGE 23

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continued from page 21

COMPLEX CHANGES

legislation. Everyone must stay focused and work together to ensure success.

MANUAL WHEELCHAIRS

Keep in mind everything we have learned over the past three years regarding coding, coverage and payment. We will repeat some of this when the SADMERC develops a coding proposal for manual wheelchairs. The timing is not yet firm on a new code set for manual wheelchairs. However, it is not unrealistic to anticipate a new code set for implementation before fall of 2007.

When new HCPCS codes are implemented, it usually necessitates a new LCD and new fee schedules. This is when it is so critical not to forget lessons learned with power mobility. It will be critical for the industry to be proactive regarding coverage and pricing. We must provide recommendations and information early on in the process rather than responding to a crisis. It requires focus and coordination with CMS and its contractors upfront. It requires evidence to support our recommendations.

NCART has already submitted a coding recommendation for manual wheelchairs, and there are already plans to meet with the medical directors to discuss coverage and clinical indications for use of the various levels of technology. The industry will also need to gather pricing data and be prepared to work closely with CMS officials as they develop fee schedules—potentially with new pricing methodologies.

SUMMARY

There is so much to learn and so many policy changes to implement. There is something new in every aspect of the delivery model from order intake to delivery of the product. In industry efforts to implement all of the change, we need to keep in mind the clinical community. Physicians and clinicians have a lot to learn as well. The clinical community is your greatest ally. You will depend on this team of individuals to deliver the documentation you need to support medical necessity for power mobility devices. The changes in the NCD and LCD dictate these professionals alter the way they document the need for specific levels of technology.

There are many opportunities right now for suppliers to gain education regarding the myriad policies impacting the delivery of power mobility. We need to ensure these opportunities exist for the clinical community as well. After all, the goal isn't just to be paid! It is to stay paid. Good documentation is the key to staying paid!

The new power mobility policies brought with them many changes. Some of the changes are policy details that must be implemented. Others are broader changes that will impact how the industry operates going forward. Either way, there is something for everyone to learn. ■

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MARK R. SCHMELER, PH.D., OTR/L, ATP

CLINICAL REQUIREMENTS FOR MOBILITY ASSISTIVE EQUIPMENT:

The new Local Coverage Determination (LCD) for Mobility Assistive Equipment (MAE) certainly has everyone spinning on all levels. The new powered mobility codes make more sense clinically, but the allowables are a challenge I will let other (more qualified) people address in this issue of *NRRTS News*. I do want to take a look at what the policy means clinically. There are three main themes I see in the new policy: getting back to best practice, building and rebuilding the interdisciplinary team approach, as well as challenges and opportunity for NRRTS as a Registry and individual registrants.

Everything related to clinical coverage in the LCD relates back to commonly accepted best practice in health care; a physician face-to-face, referral to a Licensed Certified Medical Practitioner (i.e. Occupational and/or Physical Therapist), ruling out lower cost alternatives, verification of home accessibility and good documentation are things we all know should have been taking place all along. Unfortunately, some were not following best practice and we needed CMS to remind everyone. Criterion as to who qualifies for Group 1, 2 or 3 power bases also makes a little more sense clinically. So those who have applied this type of practice should be fine and will only likely have to educate clinicians on the new language so the need can be clear based on the new coverage policy.

Obviously, what still does not make sense is CMS will not cover Group 4 power wheelchairs—or any Mobility Assistive Equipment (MAE) for that matter—if it is only to be used outside of the patient's home. Hopefully this problem will be fixed sometime in the future given our growing population of people with mobility impairments.

Perhaps it is time to go one step beyond these credentials when it comes to wheeled mobility and seating.

About ten years ago, most of the mobility devices provided involved a team approach with at least a therapist and supplier working with the client under a physician's referral. Over the last ten years, we've watched this relationship dissolve for many reasons: closure of wheelchair clinics as they were not profitable, some suppliers who became ATS/CRTS® certified assumed they could now work independent of other team members, payers not requiring an interdisciplinary team, vague coverage, outdated coverage policies and suppliers who found an opportunity to exploit the powered mobility benefit. The new LCD is steering us back to the interdisciplinary model. Yes, you are preaching to the choir when you tell me there aren't enough clinicians out there to meet the demand, but we all need to do our share to start promoting the team approach, and I have provided strategies for this at the end of this article.

The LCD further states the supplier must document the patient's home has adequate space to operate and maneuver the recommended MAE. This is an acknowledgement to suppliers as it is the first time we have seen where the supplier can officially contribute to the assessment and documentation. Another testament to suppliers is the mention of the ATS involvement in the provision of certain Group 2 and Group 3 power wheelchairs starting April 1, 2008. Personally, I would like to see a "competent" supplier involved in all powered mobility and manual wheelchair prescriptions – we could essentially do away with all the inappropriately prescribed wheelchairs we see out there everyday.

Therefore more responsibility and more recognition will come once suppliers can demonstrate a consistent standard of practice based on a valid and standardized credentialing process reflecting the knowledge and skills competent suppliers demonstrate. Ten years ago, the RESNA ATP and ATS credentials were established as a starting point but were only intended to demonstrate general entry-level competence in the provision of assistive

DO THEY MAKE SENSE AND HOW CAN WE MEET THE DEMAND?

technology. The credentials have also served their purpose in identifying people with general knowledge and skill in AT. However, perhaps it is time to go one step beyond these credentials when it comes to wheeled mobility and seating, from both practitioner and supplier perspectives. This would be a natural challenge and opportunity for NRRTS.

Clinically, the LCD makes more sense, but NRRTS now has to show consumers, payers, policy makers and other clinicians that NRRTS certification truly represents the only type of suppliers qualified to provide wheeled mobility and seating technology to ensure the best possible outcome. Another clinical concern is the consumer power or light rehab industry has infringed on this area of practice. There is no such thing as consumer medicine or light therapy, physicians and therapists won't allow it and state practice laws prohibit it. Only a competent supplier working within an interdisciplinary team should determine who needs less-involved mobility devices versus more-involved interventions.

So what steps must be taken to get to this point as well as meet the clinical requirements of the LCD? There is no one simple solution. National organizations and each of us has a role and a responsibility.

RESNA is making efforts to increase the number of ATP/S examination sittings over the next year to increase the number of credentialed practitioners and suppliers. Go to www.resna.org for a complete listing of dates and locations.

The University of Pittsburgh in partnership with other entities is putting materials together to assist people in preparing for the exams, including review courses and an online Assistive Technology Training Program. Go to www.rstce.pitt.edu for current information. RESNA is also in the process of investigating and potentially developing a specialty certification in Wheeled Mobility and Seating above the ATP certification.

Individually as a NRRTS registrant, there are several activities you can get involved in if you haven't already. You've addressed the first one, which involves joining your registry. The other involves finding strategies to further promote your profession and build relationships with the rest of the healthcare community as follows:

- Provide in-services that only share objective information about products, including the indications but more importantly the contraindications of products. Present your role as part of the team. Explain who NRRTS is. Never bash your competitor. Show you are a professional and not just a wheelchair salesman. Many clinicians still perceive RTSs as just salesmen.
- Learn a little about how clinicians get paid for their services and give them examples of how the newer CPT code structure makes it more financially feasible for them to perform MAE assessments and how it might open new business opportunities. Many clinicians are still under the impression wheelchair assessments are complete money losers.
- Share the new coverage policy and documentation requirements. Explain how most of their existing documentation procedures might already address a good part of the LCD requirements and where more emphasis needs to be given.
- Show this technology is really not intimidating on the surface and you, as a supplier, will handle the intricate technical support in conjunction with support from the manufacturers. Many clinicians still believe it is their responsibility to know all the technical aspects of equipment and support it.
- Finally, show them how much fun this area is—especially when you see immediate responses from clients—as compared to more traditional therapy interventions. ■

Look for the Q&A session with CFONS over similar issues on page 38!

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MANAGING THE NEW PMD CODES

DON CLAYBACK
Senior Vice President
The MED Group

You heard it here first. CMS has completed a three-year analysis of power mobility devices (PMDs) and issued new codes and allowables. What…you say you knew that already? Well, if that's so then what have you done about it?

It's a brand-new-world if you're in the business of providing PMDs. The arrival of the November 15, 2006 codes and allowables has dramatically changed the landscape of the power wheelchair market. You need to be sure you are making the necessary changes in your business. Here are some suggestions to be sure you are doing what's required to operate in this new environment:

KNOW THE NEW STUFF

There's a variety of new information to know, much of which is covered in the other articles in this newsletter. Some is very apparent, while some is subtler. You need to know the codes and allowables. You need to know the specific wheelchair models that have been classified under each code. You need to know what is still separately billable and what is now included in the base code. And you need to know the related coverage and documentation changes that came along too. All this detail is available for access and downloading at the SADMERC and DMERC sites.

EXAMINE THE SPECIFIC IMPACT ON YOUR BUSINESS

The new product groups, equipment classifications and documentation requirements have a significant impact on most rehab businesses, including those who don't do much Medicare. Take a close look at your product mix and how it fits under the new product categories and reimbursement. This is for both scooters and power wheelchairs. Estimate the annual revenue impact on your company. You need to quantify the financial impact and determine what changes will be needed to offset this.

ANALYZE YOUR PRODUCT OFFERINGS

You need to take a fresh look at the power products you are offering. With the reductions in allowables come reductions in the gross profit dollars that run your business. Develop a "Best Picks List" for each of the new codes. Those products that provide a realistic gross profit should populate this. Print this list and share it with all staff who are involved in the evaluation and recommendation process. Today more than ever, you need to carefully analyze your product recommendations.

EDUCATE AND INVOLVE YOUR STAFF

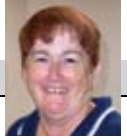
Be sure everyone in the company is aware of the changes and their significance, since these changes impact more than just Medicare beneficiaries. Encourage staff suggestions on how the business can reduce costs in light of these revenue reductions.

EDUCATE YOUR PAYERS

This is critical as the Medicaid agencies and other payers implement these new codes. And remember: while they must adopt the new codes, each payer sets his/her own allowables. Meet with payers and ask about what their implementation plans are. Be proactive; don't wait for them to make an announcement. Let them know about the unique aspects of providing rehab technology and the need for appropriate reimbursement levels. You can access a Power Point® presentation designed for payer education at http://www.medgroup.com/pmd.htm.

Lastly, you've heard it before but it bears repeating...you need to be smart in the overall management of your business. Sound business practices, measurements and reporting are critical. This isn't unique with the arrival of new codes and pricing, but the changes make these even more important. Like it or not, we have a new environment to work within. Make sure you and your company are fully informed and have made the required changes to operate successfully. ■

Don Clayback also oversees MED's National Rehab Network. He can be reached at dclayback@medgroup.com.



POWER MOBILITY AND NEW CODES

PEGGY WALKER, RN
US Rehab/VGM
Billing & Reimbursement Advisor

The fog is slowly lifting, and we can see some light. On November 15, 2006, the final policy for the new power mobility codes became effective. We now have 64 new codes, which include two groups for scooters/POVs and five groups for power wheelchairs. Documentation must be specific to item provided.

Let's see if I can help make this simpler for your company by throwing some bridges over the quicksand in which we are now floundering.

The documentation required includes making sure we, as suppliers, educate the physicians on how to write their progress notes. UGH. (This is my favorite expression now!)

What does this mean and how can we accomplish it without causing all of our staff to use up all their mental health benefits?

If the patient NEEDS IT, Medicare will pay for it. However, if the patient WANTS IT, the patient should pay the difference between what he/she wants over what he/she needs.

The ordering practitioner should understand (family members and patients as well) the first thing he/she needs to acknowledge is the patient is there for an evaluation for a power mobility device. He/she needs to state why the patient is unable to ambulate (related to what?) and why a cane, walker or manual wheelchair will not meet the patient's needs. He/she will then be able to order a POV/scooter or a power wheelchair. It is acceptable to go with the patient for this visit and explain what is needed up front. A simple letter explaining the rules will help with some, but of course, not all. Supplier generated "forms" would not be acceptable as documentation on a post-pay audit.

Once all of the paperwork from the physician is in order, how do we decide the proper base for our clients and make sure we get paid for what we provide?

We need to begin by understanding the groups and what is required for each. The POVs/Scooters have two groups which also have subgroups related to weight capacity (standard (up to 300lbs), heavy duty (301 to 450lbs) or very heavy duty (451 –600lbs).

A POV is covered if the patient cannot ambulate with a cane, walker or use a manual wheelchair to complete MRADLs within the home. The patient must have postural stability, must be willing to use the POV and have the cognitive ability to do so. The patient's weight must be recorded. Group 1 codes (K0800, K0801, K0802) are covered if needed within the home and if documentation supporting the need is "in you files." The KX modifier is required, and the code is all-inclusive. No accessories are billed separately.

The Group 2 POVs (K0806, K0807, K0808) are not covered as they have features that are basically needed outside the home.

ABNS
Remember you still have the option of using the ABN within all POV and Power Wheelchair codes as long as the basic criteria has been met for the standard item. You can do beneficiary-requested upgrades or free upgrades.

The basic package for power wheelchairs includes the seat belt, battery charger, all tires (including flat frees), controller and input devices. If a code specifies an expandable controller as an option, but not a requirement at the time of initial issue, it is billed as an E2399, legrests (except ELRs) footrests including adjustable angle, armrests (except adj. height), upholstery and weight-specific components.

Power wheelchairs are broken out by weight capacity as well as seating components (Sling/sold seat type or Captain's seat types) Standard sling/sear or captain's seat – heavy duty, very heavy duty and extra heavy duty for each group and seat type.

Group 1 standards are covered if they meet criteria for power and the patient is unable to use a POV in the home. The Group 2 standard has exactly the same criteria as the Group 1 standard, but the Group 2 cannot down code to a Group 1. Remember since a KX is required on each base and all MAE has to follow a step wise (decision tree) format you must have documentation in your file to reflect need of any higher-level base over the lower level base.

A basic consideration (not written rule) would be the length of time the patient is up in the chair. CMS would expect a low-end, low-functioning person who may just use the PWC intermittently to only need a Group 1 power wheelchair. The patient who is in the chair for

CONTINUED ON PAGE 30

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continued from page 28

NEW CODES

longer periods of time (6-8 hours and longer) and is more active would go into a Group 2 standard (according to weight capacity). **This is just a general statement and is not written in policy.**

NOTE
Group 2 single power and above requires a PT/OT evaluation. This level and above can go to ADMC, if the patient currently does not need a tilt or recline, but has a progressive disease that will require alternative drive controls, tilt or recline in the future.

A Group 2 single power option type of base would be needed for a patient who requires a power tilt or recline for adequate pressure relief or for an alternate drive control. The Group 2 multiple power option is covered if all criteria for the lower level base are met, and both tilt and recline are needed.

The Group 3 power bases have additional criteria relating to diagnosis of a progressive neurological disease (ALS/MD), myopathy or skelator deformities (spina bifida). The Group 3 bases also fall into standard/single power/multi-power (HD/VHD/XtraHD). The Group 3 single power options are covered if all criteria for power are met, if the patient has one of the diagnoses required and if the patient has a need for alternate drive control, tilt or recline.

The Group 4 power chairs are not covered and if billed with a KX modifier, will down code to a comparable Group 3 power wheelchair. The pediatric bases fall into the Group 5 and are covered on an individual bases.

All power wheelchairs must be coded by SADMERC, and the product classification list is updated on its web site. If your manufacturer states it has a specific code, and you cannot find it on the SADMERC web site, ask the manufacturer for a copy of its verification letter stating it has received the specific coding.

For billing purposes, the power wheelchairs require a purchase option letter. For first month, you must bill with the new (NU), purchase (BP), first month (KH) and the medical necessity has been met (KX) modifiers. NUBPKHKX – When you put a KX modifier on a claim, you are telling the DME MAC you have "ALL" documentation proving criteria has been met for the base you provided "IN YOUR FILE." This documentation SHOULD NOT BE in the physician's or the hospital's files, but actually in the file you have at your billing site! This MUST BE DONE prior to sending the claim.

The main thing to remember is if the patient truly needs the base you provide to complete MRADLs within his/her usual environment, Medicare will pay for it. If the beneficiary "WANTS" a mobility device to go shopping, to go outside, or travel for leisure activities, the mobility device is not covered.

If the patient NEEDS IT, Medicare will pay for it. However, if the patient WANTS IT, the patient should pay the difference between what he/she wants over what he/she needs.

The down coding is carefully explained within each area. A Group 2 PWC can down code within the Group 2 but not to a Group 1. A Group 3 can down code to a Group 2 or a lower level Group 3; the Group 4s will always down code to a "comparable" Group 3.

Be careful and make sure you fit the patient to the wheelchair and not the wheelchair to the patient. Know the specific code in which the patient meets criteria, review the manufacturers' base for coding, provide what is needed, bill correctly and hope for the best.

If you have questions or concerns, please contact me. *Please make sure to refer to this article in your email or phone call.* ■

Peggy Walker can be reached at 803/754-2090 or walkerp321@aol.com.

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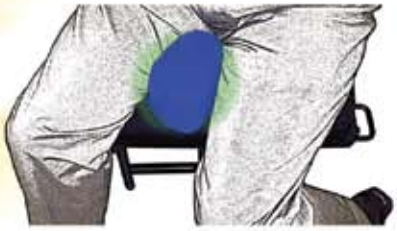
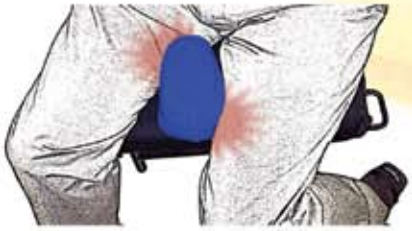


RIGHT!

The pad is angled to fit the lower extremity asymmetries. In turn this creates 'best case' outcomes for effective abduction while reducing pressure points and discomfort! FSC Technology 'encourages' compliance!



WRONG!

The pad cannot accommodate lower extremity asymmetries. This reduces effective abduction, creates pressure points and discomfort and discourages compliances!

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SO EXACTLY WHAT DOCUMENTATION IS REQUIRED?

CLAUDIA AMORTEGUI, President
ELIZABETH COLE, MSPT, Senior Consultant
The Orion Group

November 15, 2006 has passed the dust has settled, but exactly where are we with the PMD documentation requirements? As much as the industry wanted an exact detailed list of what would be needed, we received only a portion of that request. Truth be told, it makes sense why it is not exactly what we asked for. When it comes down to it, if it was, not everyone would be happy. CMS created certain standards, but then left the door open for the referrals to provide what information they had. What we do know for certain is the following items are required:

- Physician's written order
- Face-to-face physician exam report/notes
- Detailed product description
- Home evaluation

So what does CMS define as the requirements for each of these documents? Let's review.

WRITTEN ORDER

The following items must be included in the written order:

- Patient name
- Description of the item ordered (could be just "PMD" or could be the specific product)
- Date of the face-to-face exam
- Pertinent diagnoses/conditions that relate to the need for a PMD
- Length of need
- Physician's signature
- Date of physician's signature

FACE-TO-FACE REPORT

For most PMD orders, the patient must have a face-to-face evaluation with a physician, physician's assistant, nurse practitioner, or clinical nurse specialist. The report must include documentation that indicates the need for the PMD, including:

- History of the conditions/related diagnoses that require a PMD—in other words, how long has the client had this condition? What has the progression been?
- Description of the mobility limitation and how it interferes with the mobility-related activities of daily living (MRADLs)
- Past interventions that have been tried and why they did not resolve the limitation
- Why a cane, walker, manual wheelchair (or POV) cannot meet the patient's needs
- Documentation that the patient has sufficient cognitive and physical ability and can willingly and safely operate the PMD
- Physical and functional exam findings that support the need for the PMD

So in layman's terms, what does this mean? Does the documentation have to cover each of the above bullet points word for word? In Medicare's eyes, the report from the face-to-face examination is generally enough to document need. However, previous notes from the medical record should be included to document progression if the physician has treated the patient for an extended time. It may also be necessary to include diagnostic test results or reports from other practitioners.

As a provider or a referral source, you need to be certain your documentation "draws a clear picture" of your client. Remember, the medical review staff people do not know the patient in person; they only know what they can read. We have found a good test is to give the documentation to a staff member who does not know the client or his/her situation. Have the person read through the notes and see what can be gathered. Obviously, be sure the person has enough knowledge of the rehab indutry to know what to look for or what clinical terms may actually mean.

Also, if a PT/OT report is part of the face-to-face evaluation report, the supplier cannot employ the clinician.

Per Medicare, supplier-generated forms and OT/PT evaluation reports can be added to the medical record documentation, but the physician's progress notes must still be included and must document medical necessity. Also, if a PT/OT report is part of the face-to-face evaluation report, the supplier cannot employ the clinician. In fact, there must be a signed and dated attestation by the supplier indicating it has no financial ties with the clinician. The only exception is when the supplier is owned by the hospital and the clinician works in the hospital's inpatient or outpatient department.

Don't forget to be "smart" about your documentation requirements. If you have a high-level quadriplegic, Medicare will not need to know why he/she cannot use a cane or walker. However, if you have an obese client with COPD, Medicare will want to see how his/her condition has progressed over time, what has been tried and why it does not meet his/her needs.

The supplier must receive the physician's written order and his/her medical report/notes within 45 days of the face-to-face examination or the date of discharge from a hospital

CONTINUED ON PAGE 34

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continued from page 32

SO EXACTLY WHAT?

or nursing home. Remember in certain situations the "clock" for the 45 days may not start ticking until the therapist evaluation is completed, sent to the physician and then signed and dated verifying his or her concurrence with the evaluation.

An important key that cannot be forgotten is to conduct ongoing trainings for both the provider staff and referral sources.

DETAILED PRODUCT DESCRIPTION

The supplier must also have a detailed product description, which includes:

- HCPCS codes for the base to be provided and all separately billed options
- Manufacturer name and model (or a general description of the codes) for each of those codes
- Supplier's charge
- Medicare fee schedule (not applicable if there is no fee schedule)
- Physician signature and date of signature

The supplier may complete the detailed product description, however the physician must sign and date the form prior to delivery to indicate agreement. In essence, this form is Section C of the old CMN.

HOME EVALUATION

Per Medicare, the home evaluation needs to be completed by either the provider or the referral/practitioner and must take place at the patient's home. The report must verify the beneficiary can maneuver the PMD within the home, considering the physical layout, doorway width, thresholds and surfaces. This report must also be completed before or at the time of delivery and be kept in the patient file.

So when it comes down to it, Medicare did give us the guidelines. Quite honestly, some details were provided. Is it an exact science? No, but it can't be. The CMNs did not work, because in reality rehab cannot be so cut and dry. Each client is different, even many of those with the same diagnoses and conditions. Medicare has started to understand this and therefore did not create a "form" to be completed.

As time goes on, you will feel more comfortable with your review of the documentation received. An important key that cannot be forgotten is to conduct ongoing trainings for both the provider staff and referral sources. Without this, everyone on all sides will continue to scramble and all—from the patient to the providers—could be hurt. ■

You may contact The Orion Group to ask any billing or Medicare questions at 303/623-4411 or info@orionreimbusement.net.

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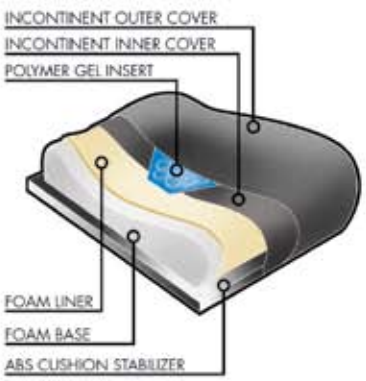

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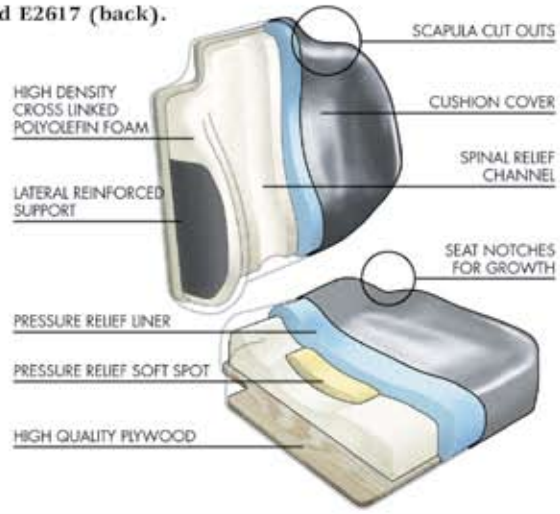

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MARK SULLIVAN
Invacare

NRRTS posed the following questions to Corporate Friends of NRRTS. Wayne Grau, Director of Rehab Industry Affairs and Paul Komishock, Reimbursement, both from Quantum Rehab; Julie Jacono, Global Vice President of Power Mobility, Sunrise Medical; Darren Jernigan, Director of Government Affairs, Permobil; Brad Peterson, Vice President of Sales and Education, Motion Concepts; and Mark Sullivan, Vice President of Product Management-Rehab, Invacare Corporation all graciously responded to the questions below.

NN: THE ALLOWABLES HAVE BEEN SET FOR THE EQUIPMENT; HOW DOES A REHAB PROVIDER GET PAID FOR THE SERVICES REQUIRED TO PROVIDE THAT PRODUCT?

Paul Komishock: Medicare expects the allowables cover delivery, set up and training on the equipment. For the rehab provider, this can be much more extensive in many cases. For this reason, we continue to advocate for higher allowables for higher-end chairs. It is important to remember that while some components are now considered part of a Basic Equipment Package, most rehab accessories are separately reimbursable. The allowables for rehab chairs in fact have generally been increased as compared to the old K0011 allowables.

Julie Jacono: The current thinking of CMS is the service the supplier must expend to evaluate, deliver, train and set up the consumer in his/her new power wheelchair is paid for through the profits of the initial issue of the product. Through this reengineering of the codes, Sunrise along with many industry partners, has worked to demonstrate to CMS the extent of the services and their cost. It is our hope this dialog remains open with CMS to ensure qualified suppliers can provide the service needed and the product needed to the consumer while remaining financially whole.

Darren Jernigan: Theoretically, the allowables for power mobility devices have the service factor included in the price of the equipment, as the service factor is not currently broken out. As an industry, the next step is to get these services broken out and coded. Providers are professionals who have been trained, are on call and are dependent on when an end user is vulnerable, much as professionals who offer a service such as firefighters or policemen. They may show up at your door at anytime when their expertise is called upon.

Providers also must become proactive with their congressional members.

Mark Sullivan: In our industry, the government pays for product, not protocol, which is unfortunate because of all of the great services rehab providers have given over the years, including in-the-home assessment, fittings, delivery, refitting, etc. It is a knowledge base that should be paid for much as a PT or OT gets paid for his/her time, but will require continued effort through certification and educating congress on the benefits of these services.

NN: DOES CMS TO APPRECIATE WHAT IS REQUIRED TO PROVIDE REHAB? IF NOT, HOW DO WE GET CMS TO APPRECIATE OUR EFFORTS?

Wayne Grau: CMS does not have a complete understanding of what it takes to supply rehab equipment to beneficiaries. The service, the travel time and the evaluation time are not compensated for, and this is what causes most rehab providers to operate on a 1-3% net margin. What can we do about it? We must all join together and become members of organizations such as NCART and AAHomecare. We need to have a unified industry that must have one voice representing providers, manufacturers and patients. Providers also must become proactive with their congressional members.

Julie Jacono: The best course of action is to work with NCART on the industry communications being provided to CMS on these issues.

Darren Jernigan: I believe they are evolving just as we are as an industry. For example, the grouping of the codes and the LCD language attempts to address the difference from consumer power and complex rehab. There have been many revisions to the power wheelchair codes,

CONTINUED ON PAGE 38

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CONTINUED FROM PAGE 36

local coverage determination and fee schedule over the past two years to get it right. The revisions are proof of their efforts not to "stay the course" and to try to listen and understand what the industry is relaying, and to understand the process of providing rehab equipment is not as simple and easy as it was in the 60s.

Brad Peterson: The rehab profession and the unique tools required being proficient as a provider or clinician are still not completely comprehended by CMS or other funding sources. In the past five plus years, we have begun to see a tacit recognition of the specialized nature of these skills and the hard work and knowledge required to properly dispense specialized equipment. While progress is slow, it is still progress. Continuous education of funding sources is a must. We must also implore consumers to have a louder voice in this discussion, as they are ultimately the people who will suffer from poor service and further cuts. It would also be interested to see some sort of independent study that looks at the long-term cost of providing inappropriate, low-cost equipment. How many times have we seen a funding source pay for more than one system or mobility base, because the first one provided was so woefully incorrect? Rather than talking about the age-old adage "an ounce of prevention is worth a pound of cure," we should have some empirical evidence backing it up.

Mark Sullivan: CMS understands to a degree, but it does not have a complete understanding of the process. One way to help is to establish industry units of measure as they have in the clinical setting. For instance, obtaining a powerchair for a CP client may take more time than obtaining a powerchair for a Para or a geriatric. A manual chair may take less time than a power chair. Therefore, the billable hours should not be the same.

NN: DO YOU AS A MANUFACTURER NOTICE MORE DEALERS USING YOU TO HELP WITH CODING?

Julie Jacono: Yes, as a partner in the rehab industry, we want to support, educate and help manage all these

changes in coding. In addition, we will continue to work with industry groups such as NCART to further our industry for the benefit of our consumers.

Darren Jernigan: Sure. It is difficult to keep up with an industry changing at such a fast pace concerning accreditation, certification, coding, competitive bidding, changing LCDs and reimbursement. That's just Medicare. There are also funding sources such as Medicaid and private insurance. As a manufacturer, we must be a resource, and Permobil understands the importance of working with suppliers to ensure the funding of our product. The manufacturer knows its products best, so we have committed resources to assist our supplier network to help keep their head above water.

Paul Komishock: We have seen a fairly substantial increase in requests for assistance with coding. Any significant change to a particular product's codes or medical policy usually generates an increase at least in the short term.

Brad Peterson: Yes. While we do not have our own funding experts on staff, we do point providers in the direction of the larger manufacturers and our own consultants. We do our best to expedite and simplify the order and quotation process by coding our order forms and quotations. In addition, we try to provide specific funding help with the more customized, unique systems that we manufacture.

Mark Sullivan: Absolutely. The providers are having a difficult time understanding which code or group to use for the various disabilities, and they are also dealing with difficult documentation requirements. ■

nrrts' rebuttal

LESLIE RIGG
Vice President of NRRTS

"NRRTS is celebrating 15 years of commitment to raising the standards of the seating and mobility industry," writes Lori, Physical Therapist and Editor of October's *Rifton Rapport*. Lori's article provided an excellent description of the NRRTS organization and its registrants. The growth of our organization to near 800 is quite an accomplishment by any standard. But NRRTS didn't do this alone. Generous assistance and support from our registrants, Corporate Friends of NRRTS and Friends of NRRTS have made this organization what it is.

The *Rifton Rapport* goes on to describe the qualifications and standards by which a NRRTS registrant must comply. Rifton knows the value of doing business with NRRTS registrants and wants to help others understand the expertise of these dedicated professionals.

Organizations sometimes forget to acknowledge the small deeds done by supporters. I want to acknowledge this deed and thank our friends for helping to spread the word. NRRTS has often been given feedback that we "do not put ourselves out there enough." We do not tell therapists, case managers and physicians they are working with a CRTS® and then explain to them the benefits.

Generous assistance and support from our registrants, Corporate Friends of NRRTS and Friends of NRRTS have made this organization what it is.

Lori's article is a great example of what can be done to help make people aware of the benefits of working with a CRTS®. We all need to follow this example. Do something today. Tell someone about NRRTS and our mission.

However, keep in mind that as visibility and communication increases for our organization, we will also find misinformation and erroneous statements. We can look at these statements as opportunities to once again get our name and mission in the minds of payers and other medical professionals.

Rehab companies rely heavily on experienced caring individuals to carry out their mission.

Probably the most common confusion relates to the difference between the ATS, ATP, NRRTS registrant and CRTS®. I appreciate the *Rifton Rapport* for spelling this out quite clearly. A CRTS® credential indicates the individual has demonstrated exceptional knowledge in two areas. One is educational knowledge through the ATS exam and subsequently maintaining that credential. The second is experiential knowledge as documented by OTs and PTs who work directly with the individual in the prescription and delivery of mobility equipment. The CRTS® combines both the educational knowledge of an exam and the functional knowledge of experience.

NRRTS has worked hard to differentiate its registrants from individuals providing standard home medical equipment. We have worked hard to create titles and descriptions that reflect the work and expertise of rehab companies and their rehab specialists. It was brought to our attention that Rifton's newsletter referred to rehab companies as "dealers" and the individuals as "technicians." NRRTS received some feedback regarding these designations. Feedback is always appreciated, and I hope we can learn something each time an idea such as this is presented.

Is the company a supplier or a dealer? I would support the term "supplier" over "dealer." Most would agree our mission is to SUPPLY the most appropriate medical equipment, versus making a DEAL on a wheelchair. If we wish to set ourselves apart, we must choose our words carefully. Even with this designation we might agree that we do more than supply wheelchairs. A rehab company is a complex group of specialized individuals who can work with case managers, insurance companies, medical professionals and individuals with complex mobility needs to provide a mobility device that best brings functional mobility back to the client. This is quite a responsibility for the rehab company. Rehab companies rely heavily on experienced caring individuals to carry out their mission.

Is the individual a "technician?" Typically the word "technician" refers to the person who works on the equipment.

CONTINUED ON PAGE 42

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rebuttal

CONTINUED FROM PAGE 40

The technician is the individual with the skills to repair the wheelchair and perhaps install seating accessories. Experience as a technician is possibly how many rehab technology suppliers acquire experience to become a NRRTS registrant or CRTS®. However, the NRRTS registrant and CRTS® demonstrate skills, knowledge and abilities above and beyond that of a technician. The registrant or CRTS® provides assistance with equipment selection. He or she understands physical challenges associated with various disabilities and takes these into consideration when suggesting wheeled mobility and seating. The registrant or CRTS® is an active participant in evaluations with other medical professionals to determine the best mobility solution for their clients. This involvement reaches far above a technician. As we spread the word, it is important people understand this expertise and think of this individual as a professional in the area of wheeled mobility and seating.

Thanks to our friends for spreading the word. Thanks to the written word for making us think about how we want to be perceived. And thanks to individuals concerned enough to take notice and make comment.

That being said, I would like to provide a challenge for all NRRTS registrants and CRTS®s. We are a professional organization and expect all registrants to present themselves as such. Professionalism goes beyond your daily work; it extends to your community service and even to your involvement in your professional organizations. NRRTS was founded because a group of individuals wanted to be recognized as having a unique set of skills. We created standards of practice, ethics and membership criteria. We did this to protect you, our registrants. We did this to give you a mechanism to set yourselves apart in your knowledge and experience. This is your organization.

As registrants, we must each be responsible for maintaining our professional titles. This not only means your daily work, but also the requirements for registration and renewal.

As registrants, we must each be responsible for maintaining our professional titles. This not only means your daily work, but also the requirements for registration and renewal. The registry has reached a level that we can no longer call individuals three or four times to get necessary documentation for renewals. We can no longer call new registrants five or six times for documentation and hold their applications for six months. NRRTS has set forth specific guidelines for new registrants and renewals. Please respect your fellow registrants and CRTS®s who donate their time to maintain the integrity of this registry. Be professional in supporting your registry and credential.

Leslie can be reached at leslie@atswheelchair.com or 208/672-1500 x24.

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OBSS software has been improved to make the client digitizing and cushion ordering process easier, faster and more accurate. Courses are being offered now for current OBSS-certified customers to learn and receive the new software. To learn more, go to our website at

www.ottobockus.com/education/course_descriptions.asp.

If you would like to learn more about the Otto Bock Shape System, please contact your Otto Bock sales representative at **800.328.4058**.

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ROHO RECOGNIZES PROVIDERS WHO EMPLOY NRRTS REGISTRANTS!

The ROHO Group added a search option to its retail locater so the consumer can find an approved provider who employs a NRRTS registrant. Consumers may choose from a full listing of providers, but the NRRTS registrants are listed first. This is to emphasize the importance of certified rehab professionals, RRTS™ and CRTS® when ordering and fitting ROHO Group products. "We feel this is a winning solution for our customers. They can be confident the provider chosen employs a NRRTS registrant with the experience and knowledge to supply the most appropriate product," said Melissa Keim, Vice President of Marketing for ROHO.

ALTIMATE MEDICAL RECOGNIZES NRRTS REGISTRANTS ON NEW WEBSITE

Altimate Medical Inc. (AMI) highly recommends suppliers employing NRRTS registrants, because of their commitment to customers in need of rehabilitation products. Now, EasyStand suppliers who employ NRRTS registrants are recognized in the Supplier Locator section of the new Altimate Medical website.

The EasyStand Supplier Locator lists companies that employ NRRTS registrants at the top of each Zip code search marking each with the NRRTS logo.

Understanding and Applying the New PMD Coverage Criteria

TELESEMINAR - MARCH 21, 2007 @ 5:00 - 6:30 PM EST

Presented by NRRTS and NCART exclusively for NRRTS registrants

PARTICIPATION IS LIMITED TO THE FIRST 100 REGISTRANTS - ACT NOW!
There is no charge to NRRTS registrants to participate
(however, long distance telephone charges will apply)

Are you still confused by the new power wheelchair coverage criteria? Are the physicians and therapists you work with having trouble with "The Algorithm" and documentation? NRRTS and NCART are here to help.

The primary presenter for this exclusive 90-minute teleseminar will be Rita Hostak, president of NCART and vice president for government relations for Sunrise Medical. Rita is the #1 authority on everything having to do with coding and coverage criteria. Her information comes from the source - the PSC Medical Directors, the SADMERC Medical Director and senior CMS staff. She will share her knowledge and answer your questions.

To register please go to
freeonlinesurveys.com/rendersurvey.asp?sid=mldwuschm07fl50260358

former registrants

The NRRTS Board determined RRTS™ and CRTS® should know who has and has not maintained his/her registration in NRRTS. The following is a list of non-renewals. For an up-to-date verification on registrants, visit www.NRRTS.org.

FROM 10/1/2006 THROUGH 1/15/2007

Curt Anders	Plymouth, IN
Jessica Arms	Cleburne, TX
Scott Bland, ATS	Martinez, CA
Armand Borel	New Orleans, LA
Jim Brown	Holt, MI
Randy Bullock	Gallatin, TN
Mike Burnett	Huntsville, AL
Ray Cearley	Danielsville, GA
Luc Cole	Holt, MI
Carlos Collazo	Whippany, NJ
Trish Crandall, ATS	Maumee, OH
Felix Crisostomo	Hanover, MD
Frank Drake	Stockton, CA
Jeff Fischer, ATS	High Point, NC
Darren Fontenot	Washington, LA
Wayne Getty	Haslet, TX
Gary Gilberti	Timonium, MD
Mark Gingles	Sun Lakes, AZ
Mark Hamman, ATS	Arlington, TX
David Hornback	Evans, CO
John Irving	Lewisville, TX
Zane Jacobs	Greenville, MS
Ray Lawder	Perry Hall, MD
Geoff McMillion	Boise, ID
Mike McNeill	Beaverton, OR
Joseph Nassef	Highland, CA
Ken Nelson	Scappoose, OR
Brad Nichols	Portland, ME
Bob Nolan	Signal Mountain, TN
Ted O'Neill, Sr.	Kennett Square, PA
Steven Petersen	Snellville, GA
Jeff Polkinghorn	Omaha, NE
Angela Reed	Colbert, GA
Stan Rehn, ATS	St. Louis, MO
Tom Rogers	Erie, PA
Charley Ruckstuhl	Plantation, FL
Sam Sumner	Wilsonville, OR
Terry Thompson	Cedar Park, TX
Carl Trahan-True, ATS	Havana, FL
Peter Webb, ATS	Syosset, NY
Margaret Whitworth	Mustang, OK
Richard Wood	Lake Jackson, TX

new registrants

POLLY ALLEN
Advacare
938 S. Oliver Street
Wichita, KS 67218
Phone: 316-440-5550
Fax: 316-440-5552
pfallen@advacare.com
Registrant since: 2/1/2007

JEFFREY R. AUSHER
Progressive Mobility & Medical
320 Cameron Rd.
Washington, PA 15301
Phone: 724-228-4568 x.4
Fax: 724-228-7090
Toll Free: 800-487-9568 x.4
jausher@progressivemobility.com
Registrant since: 2/1/2007

CORY BRANT
Barnes Healthcare Services/
Optioncare
1700 N.W. 80th Blvd.
Gainesville, FL 32606
Telephone: 352-333-2525 x.2752
Fax: .888-276-7934
Email address:
coryb@barneshc.com
Registration Date: 1/18/2007
ID: 1005239

WAYNE CARROLL
Mobility Medical
101 Flowood Dr.
Flowood, MS 39232
Telephone: 601-932-1001
Fax: 601-932-2130
Email address:
wcmobimed@bellsouth.net
Registration Date: 1/8/07
ID: 1005240

DEBRA CORNELIUS PT
Frontier Home Medical
304 West 8th
Cozad, NE 69130
Telephone: 308-784-3040
Fax: 308-784-3061.
Email address:
deb.c@frontierhomemedical.com
Registration Date: 12/1/06
ID: 1005247

BILL DICKERSON
Care Medical
1242 Prince Ave.
Athens, GA 30606
Telephone: 706-354-4136 x.103
Fax: 706-548-7140
Email address:
billd@caremedga.com
Registration Date: 1/8/07
ID: 1005245

MICHELE A. FROEHLICH, ATS
R & R Discount Medical, Inc.
304 W. Wayne St.
Dowagiac, MI 49047
Telephone: 269-373-1753
Fax: 269-226-9834
Email address:
randrdiscount@aol.com
ATS Date: 10/29/04.
Registration Date: 1/8/07.
ID: 1005487

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Ability Medical Supply, Inc.
4654 N. Hiatus Rd.
Sunrise, FL 33351
Telephone: 954-572-7603
Fax: 954-572-7604
Email address:
jed@abilitymedicalsupply.biz
Registration Date: 1/3/07
ID: 1005324

BRIAN GOUGH
Hometown Medical
814 Belmont St.
Vicksburg, MS 39180
Telephone: 601-634-6363
Fax: 601-634-6380
Email address:
bmgough@yahoo.com
Registration Date: 1/2/07
ID: 1005317

RAFAEL GUTIERREZ
Wheelchair Center Inc.
1840 Fulton Avenue
Sacramento, CA 95825
Phone: 916-489-3651 x.4032
Fax: 916-489-5949
r.gutierrez@atgwci.com
Registrant since: 1/24/2007

ROBBI K. HAASE
Handi Medical Supply
2505 University Ave. W
St. Paul, MN 55114
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Fax: 651-644-0602
Email address:
rhaase@handimedical.com
Registration Date: 12/19/06
ID: 1005251

MITCHELL R. HILLIER
Meriter Home Health
2180 W. Beltline Hwy.
Madison, WI 53713
Telephone: 608-327-3700 x.3742
Fax: 608-327-3747
Email address:
mhillier@meriter.com
Registration Date: 11/13/06
ID: 1005082

JULIE IVERSON
AAA Medical Sales, Inc.
936 Cottonwood Drive
Fort Collins, CO 80524
Telephone: 303-781-1474
Fax: 303-762-9612
Email address:
jiverson@aaamedical.com
Registration Date: 11/17/06
ID: 1004938

BENNIE G. JONES
Rehab In Motion, Inc.
8666 Huebner Rd., Ste. 200
San Antonio, TX 78240
Telephone: 210-696-1084 x.24
Fax: 210-696-1085
Email address:
bennie@rehab-in-motion.com
Registration Date: 11/20/06
ID: 1005153

JAMES L. KEATING ATS
Accucare, Inc.
130 King St.
Roswell, GA 30075
Telephone: 770-512-0090
Fax: 770-512-0190
Email address:
jameslkeating@hotmail.com
ATS Date: 6/24/03
Registration Date: 10/16/06
ID: 1004868

DAVID M. LEWIS
Carolina Medical Equipment
4787 Sunset Blvd.
Lexington, SC 29072
Telephone: 803-356-4983 x.115
Fax: 803-356-9246.
Email address: dlewis@sc.rr.com
Registration Date: 12/18/06.
ID: 1005325

JUSTIN LOOK
All-U-MED, Inc.
1103 W. Adams Ave.
Temple, TX 76504
Telephone: 254-773-1226 x.110
Fax: 254-773-1227
Email address: jlook@allumed.com
Registration Date: 1/19/2007
ID: 1005482

SCOTT S. MCCALLUM
St. Vincent Healthcare H.O.M.E.
2245 Hyacinth Dr.
Billings, MT 59105
Telephone: 406-237-8900
Fax: 406-237-8905
Email address: e1s1t1@bresnan.net
Registration Date: 11/6/06
ID: 1005084

LESTER MILLER
National Seating & Mobility, Inc.
3930 South Perkins
Memphis, TN 38118
Telephone: 901-362-9880 x.107
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Email address:
lmiller@nsm-seating.com
Registration Date: 12/19/06
ID: 1005397

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316 Bluebird Drive
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Telephone: 615-851-1400
Fax: 615-851-9447
Email address:
dmunroe7@yahoo.com
Registration Date: 12/1/06
ID: 1005072

SIOBHAN MURPHY
National Seating & Mobility, Inc.
1517 W. North Carrier Parkway,
Ste. 110
Grand Prairie, TX 75050
Telephone: 972-206-7345
Fax: 972-522-0103
Email address:
smurphy@nsm-seating.com
Registration Date: 10/25/06
ID: 1004994

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1024 A Andrews Highway
Midland, TX 79701
Telephone: 432-570-5079
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Email address:
lniem007@sbcglobal.net
Registration Date: 11/17/06
ID: 1005249

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4320 U.S. 19
New Port Richie, FL 34652
Telephone: 727-849-0262
Fax: 727-849-1380
Email address: mpisano@aol.com
Registration Date: 1/3/07
ID: 1005151

new registrants

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A Plus Medical
1225 Walton Way
Augusta, GA 30901
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Email address:
scott@apmedical.com
ATS Date: 10/22/01
Registration Date: 11/27/06
ID: 1005250

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1103 W. Adams Avenue
Temple, TX 76504
Telephone: 254-773-1226 x.111
Fax: 254-773-1227
Email address: kriffel@allumed.com
ATS Date: 11/1/2002
Registration Date: 1/19/2007
ID: 1005481

DEWEY L. SEAGRAVES
Care Medical
1242 Prince Avenue
Athens, GA 30606
Telephone: 706-354-4136 x.121
Fax: 706-722-0279
Email address:
dseagraves@caremedga.com
Registration Date: 1/8/07
ID: 1005246

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947 Woodland St.
Nashville, TN 37206
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Registration Date: 12/1/06
ID: 1004991

MR.ERIC SORVILLO
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211 E. Broadway
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Fax: 330-545-4080
Email address:
eric582@sbcglobal.net
Registration Date: 1/18/2007
ID: 1005332

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AS CORPORATE FRIENDS OF NRRTS, THESE COMPANIES RECOGNIZE THE VALUE OF WORKING WITH NRRTS REGISTRANTS AND SUPPORT NRRTS' MISSION STATEMENT, CODE OF ETHICS AND STANDARDS OF PRACTICE.

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