THE OFFICIAL NEWSLETTER OF THE NATIONAL REGISTRY OF REHABILITATION TECHNOLOGY SUPPLIERS

# NRRTS news

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from the nrrts' office

## SURVIVAL

If you don't like something, work to change it. If you can't change it, figure out new ways to deal with it. But whatever you do, don't sit around and complain about it.

Things look pretty bleak. Changes in policy, changes in reimbursement, competitive bidding, the high price of gasoline and many other factors are making it harder and harder for you to serve, in the manner you desire, the clients who need your help and expertise.

> NRRTS will once again plan and facilitate the Rehab Track at Medtrade® this fall.

At least there is one bright light out there: NRRTS.

Thanks to your efforts, NRRTS has become a highly visible, impactful force in our industry and profession both in the educational, policy, regulatory and legislative arenas. Here are just a few accomplishments over the last few months:

- Over 200 NRRTS Registrants have participated in two NRRTS-sponsored *TeleSeminars: Competitive Bidding and its Impact on Complex Rehab* and *Understanding the PMD LCD and NCD*. Many thanks to Rita Hostak and NCART for their help in facilitating these presentations.
- NRRTS sponsored a clinically-oriented educational track for RTSs at the International Seating Symposium in Orlando.
- NRRTS will once again plan and facilitate the Rehab Track at Medtrade® this fall.
- In response to a call for action from NRRTS, at least ten local site visits with Members of Congress and their staff have been scheduled and hosted by NRRTS Registrants and Friends of NRRTS. (Please read Michele Gunn's article, *"You Can Do It!"* on page 42.)
- More than 100 NRRTS Registrants have called and/or emailed their Members of Congress about supporting the Complex Rehab and Assistive Technology Carve-Out from Competitive Bidding. This effort was in

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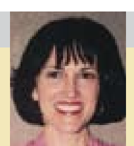
rehab forum



## RECYCLING:
## THREAT, OPPORTUNITY OR OBLIGATION?

**RITA HOSTAK**
Vice President Government Relations
Sunrise Medical, Inc.

When you think about recycling of rehab and assistive technology, you undoubtedly have a visceral response. It is important to understand the facts regarding recycling of technology—also referred to as re-use, refurbishing, redistribution and re-issue. With real facts and data, each person can decide for himself/herself whether this growing trend is a threat to the industry, a business opportunity or possibly an obligation, as it offers access to technology that uninsured or under-insured individuals otherwise may not have.

It is important to understand the magnitude of recycling currently taking place in this country. In a study conducted by RESNA in April 2005, 30 states reported

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# LATERAL THINKING

**BRADFORD C. PETERSON**
Vice President of Sales and Education
Motion Concepts

A quick check of the dictionary reveals a term whose definition seems to be custom-made for our industry. Lateral thinking is defined as, "a way of solving problems by unconventional or apparently illogical means rather than by a traditionally logical approach." How many times have you been presented with a challenge that could only be solved through engaging in a little lateral thinking?

It is no secret product development is often the result of lateral thinkers taking matters into their own hands and moving our industry forward. A quick review of the last 25 years reveals a dizzying array of new technology to choose from, including new support surfaces for seating and positioning, exciting lightweight materials for manual wheelchairs, software-based programming and different drive-wheel positions for power wheelchairs. However, when it comes to power positioning systems, we are still stuck with the same old, same old: movement forward and back (in the sagittal plane) with tilt and recline.

It has been said that we, as human beings, are dynamic in nature—constantly moving, constantly searching for comfort and function. Ponder for a moment how often you move—how often you bend, twist and laterally flex your body to stretch, yawn, breathe deeply or perform some functional activity. Simply put, we were not designed to sit for extended periods of time without constantly repositioning and redistributing our weight in more than one plane.

Not too long ago, recline was the only game in town and tilt-in-space, or orientation in space, was new and unproven. We have come a long way since then, and now tilt and combination tilt/recline systems are the norm. So isn't it time to look at a "new" way to position people? Based on the interest we are seeing, the answer is yes.

**Funding for lateral tilt continues to be a challenge... don't let this scare you away!**

Lateral tilt, while not new, has become an increasingly popular solution for many clinicians looking to augment the functional benefits of traditional posterior tilt and tilt/recline systems. The addition of a lateral tilt module to a power positioning system allows up to 15 degrees of lateral tilt to the left and/or to the right, in conjunction with posterior tilt and recline. The amount of each movement is dependent upon several factors, including the power base used and the weight of the consumer.

Why lateral tilt? Well, that is the most common question we answer when showing a system or explaining what it does. It seems the only limit to the use of lateral tilt has been the imagination and creativity of the people prescribing the system. We have observed many clinicians and providers doing a little lateral thinking with this tool, finding new and effective ways to use 15 degrees of tilt in a different plane. Common applications for lateral tilt have been pressure reduction, accommodation/reduction of postural deformities, transfer and independent repositioning for comfort and function.

Studies have shown a small percentage of consumers prescribed traditional tilt and/or recline systems actually perform a full pressure relief as needed. Most will reposition themselves in about 15-20 degrees of tilt or tilt/recline, for comfort, without truly accomplishing the needed weight shift. I am sure we can all think of several consumers who are less than compliant with their pressure management because they do not want to look at the ceiling. A combination of lateral tilt with posterior tilt and/or recline may provide pressure reduction without completely limiting their visual field and environmental interaction like full posterior tilt and/or recline can.

Lateral tilt may also be useful in finding a comfortable and functional position for people with postural deformity. While comfort may not meet the criteria for medical necessity, when it comes to funding and justification, I think we can all agree most people who are uncomfortable in their systems will move to find a position of comfort. More often than not, this movement to seek comfort can actually compromise many of the goals of the seating and positioning system. Seating discomfort may also impair daily function, in addition to creating secondary positioning problems subsequent to the adoption of poor sitting posture.

Recently prescribed lateral tilts, used in concert with posterior tilt and/or recline, have enabled consumers to independently reposition themselves more effectively than they could in previously prescribed, traditional power positioning systems. This ability to independently adjust their position, without caregiver assistance, increased their time out of bed and overall quality of life.

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## LATERAL THINKING

Beyond being uncomfortable, postural deformity can also effect physiological functions such as digestion, respiration, swallowing and gastric emptying. In addition, rotated and asymmetrical postures can place pressure on bony prominences other than the weight-bearing surfaces of the pelvis, such as the trochanters, ribs and scapulae. A lateral tilt module has been effective in reducing pressures on these bony prominences while also relieving internal pressures and tensions created due to misalignment.

As with any seating intervention, lateral tilt may lead to secondary complications based on how the consumer reacts to the system. Careful attention must be paid to redistribution of pressure to other areas, as well as the effects gravity may have on tone, head position and postural stability. While lateral tilt may accomplish one goal, it may also lead to concerns in other areas.

Funding for lateral tilt continues to be a challenge; the success of each submission hinges on the documentation provided to the funding source. Don't let this scare you away! Objective measures such as pressure mapping, pulse oximetry, video fluoroscopy and barium swallow tests may show how a laterally tilted position can improve physiological function and decrease pressure.

This short article is no more than an overview of lateral tilt—a subjective observation of cases that I hope will whet the appetite and stir your creative juices. Documentation of the long-term effects and benefits of lateral tilt is scarce, as are studies on most other power positioning solutions. That shouldn't stop us from exploring, experimenting and engaging in a little lateral thinking while striving to find the best possible solution for the consumer. ■

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# A SAILING ADVENTURE

**MANYVONE CHAMPAVANNARATH**

Not long ago, I did something that I never thought would be possible in a million years: I went sailing! That's right. I actually went sailing all on my own. You see, sailing was something I'd always wanted to do, but I never thought it would be possible due to the fact I'm confined to a wheelchair. As it turned out, however, there was a way. And going sailing became one of the best experiences of my life.

It all began about a year ago when I went to Custom Mobility for some wheelchair repairs. While waiting, some pictures from across the room caught my eye. I went to take a closer look and discovered they were pictures of people sailing. The owner of the wheelchair company, Bruce Bayes, happened to come into the room where I was looking at the pictures, so I asked him to tell me about them. That's when I learned that Bruce was on the board of Sailability, an organization that facilitates sailing for everyone—regardless of age or ability (www.sailability.org).

Bruce explained to me how the program worked, and I asked him if he thought I could do it. He said yes. He then told me what I would need to do and gave me the phone number of a woman named Sandy.

The next morning, I called Sandy and told her I wanted to sail. She said I was welcome to come and sail with someone, but that I would not able to control the boat on my own until I took a special class and passed it for certification. Sandy invited me to go out and see if I liked it or not, so I signed up for a Saturday sailing trip scheduled for April 1, 2006.

On the morning of April, a friend drove me to Clearwater, where this amazing adventure was to take place. My friend and her husband dropped me off, made sure I was okay and then went their own way.

After waiting a short time, it was finally my turn to sail; I was very excited. The staff let me try the chin control so I could see how it worked. Because I didn't know what the heck I was doing, the instructor, Alder, sat in the boat with me and instructed me on what to do. Needless to say, I had no clue about what part of the boat was what, and Alder was throwing new words at me left and right—words I had never even heard. I was totally in the dark and realized I had much to learn before sailing on my own.

As we left the dock, I discovered something strange about the chin control: it took the boat in the opposite direction of my chin movements. So, not only did I not know what the heck I was doing, I had to keep in mind that if I wanted to turn the boat to the left, I had to push the control to the right and vice versa! It was very confusing at first, but once I got used to it, I found the boat easier to control. I really enjoyed my first sailing adventure and decided it would be my new hobby.

Because I wasn't certified, I couldn't yet sail on my own—someone else was always required to be with me, controlling the boat. Though it was fun sailing with someone, I really wanted to do it by myself. I decided it was time to take the class for certification.

I applied for a class scholarship in December 2006, and by January I was on my way to certification. My sailing instructor, Alder, came to my home once a week for three weeks and gave me one-on-one instruction. I then took my final exam and passed it. I was finally certified to sail on my own, and I couldn't wait to get out on the water!

The day finally came for my inaugural solo sailing adventure, and I was very excited! The staff put me in the boat and gave me a push; Alder told me to sail to the two buoys. I was not prepared for this at first, because I thought Alder would at least be in the boat with me. Surprise! I was in the boat ALONE! My motto for the next hour was, "Whatever happens, happens!" (This is my motto for everything!) I thought to myself, I'm sailing on my own and I'm really enjoying being out on the water. It felt as though I was free of all restraints. It was amazing! The best part of the whole experience was being able to sail on my own: I accomplished my goal!

This past year, I've gone sailing once a month. When I tell people about this awesome experience, I usually hear the astonished response, "That's amazing! How were you able to do that?" Or, "Are you crazy!?" And one of my favorites: "Were you scared? You wouldn't find me out there doing that!" I just laugh and think about my next adventure out on the water. ■

Manyvone Champavannarath can be reached at crazymany94@verizon.net .

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# COMPETITIVE FINAL BIDDING

**SHARON HILDEBRANDT**
Executive Director
NCART

The DME industry and complex rehab providers were hit with more than a double whammy when CMS finally released the competitive bidding final rule and product categories on April 2. Not only did CMS establish a timeline that called for the bidding process to open that same month, but CMS included in its products to be bid "complex rehabilitative power wheelchairs and related accessories." According to CMS, the complex rehab product category includes not only Groups 3, 4 and 5 power wheelchairs and accessories, but also seating and positioning products. Certain provisions of the final rule were equally disturbing. For example, the awarded payment amount for each item must be less than the current fee schedule so CMS can achieve the savings required by the statute. This means complex rehab providers, to be considered, must submit bids less than the current fee schedule amount for the particular item.

Complex rehab providers will be hard pressed to bid for complex rehab products. An NCART- commissioned study that took place last year about the effects of CMS' new power wheelchair fee schedule indicated complex rehab companies had one–two percent margins and therefore would have great difficulty absorbing the fee schedule reductions. With CMS' requirement that the awarded payment amount be less than the fee schedule, it is difficult to see how complex rehab companies can bid without reducing services or eliminating the highly configurable products from their inventory.

Medicare beneficiaries needing complex rehab products stand to be the losers if complex rehab products are bid. Current complex rehab clients will be unable to continue receiving the products and services that help them function, and new clients may never know there are products that will maximize their potential and allow them to live independently.

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## FINAL BIDDING

There is recourse, however, in legislation to exempt complex rehab and assistive technology from competitive bidding and legislation that changes the structure of competitive bidding to help those DME companies that decide to bid. It is imperative the DME industry and complex rehab providers, their clients and their referral sources contact their elected representatives to ***demand*** they sponsor these critical pieces of legislation.

By the time you read this article, legislation will have been introduced into the Congress to exempt complex rehab and assistive technology from the national competitive bidding program. This legislation is similar to the legislation introduced into the 109th Congress by Rep. Ron Lewis (R-KY). It defines complex rehab and assistive technology products as "medically necessary adaptive seating, positioning and mobility devices and speech generating devices that are evaluated, fitted, configured, adjusted, or programmed to meet the specific and unique need of an individual with a primary diagnosis resulting from injury or trauma or which is neuromuscular in nature." To further define the population needing complex rehab products and services, the legislation identifies those diagnoses as including spinal cord injury, traumatic brain injury, cerebral palsy, muscular dystrophy, spinal muscular atrophy, spina bifida, amyotrophic lateral sclerosis, multiple sclerosis or any other disease or disability identified by the Secretary as requiring the use of such devices.

The Medicare Durable Medical Equipment Access Act of 2007 (H.R. 1845) was introduced by Reps. John Tanner (D-TN) and David Hobson (R-OH) in March and is intended to benefit the DME industry as a whole by modifying the competitive bidding program by adding protections for beneficiaries and providers. This legislation includes the provisions that would:

- Protect patients by requiring competitive bidding not begin until quality standards are in place;
- Exempt smaller rural areas with populations under 500,000;
- Allow all qualified providers to participate at the selected award price;
- Restore the rights of participating providers to administrative and judicial review and
- Exempt items and services unless savings of at least 10 percent can be determined.

There is support on Capitol Hill for these two pieces of legislation, but it is up to complex rehab providers and the DME industry to generate and increase that support. Call, e-mail or fax letters to your congressional representatives, urging them to sign these bills. If you are a complex rehab provider, explain to them what complex rehab is all about. They don't know. Be specific and give them examples of clients who have received the wrong equipment and explain to them the amount of time you spend assessing, fitting and programming equipment to meet an individual client's medical and functional needs. Demonstrate to them why complex rehab must be excluded from the competitive bidding program.

Regarding the Tanner-Hobson bill, tell them structural changes are needed to the competitive bidding program to protect beneficiaries as well as small providers. Let them know if a significant portion of small suppliers are eliminated through competitive bidding, competition will diminish, quality will erode and beneficiary-provider relationships—many of them long term—will be disrupted.

We can prevail. But it will take the collective efforts of NRRTS Registrants and their clients to convince Congress that changes need to be made in the competitive bidding program as put forth by CMS. **Now is not the time to despair, but to *act*.** ■

Sharon Hildebrandt can be reached at 202/776-0652 or sharonh@ncart.us.

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# RTSs AND NRRTS: A POWERFUL PARTNERSHIP FOR THE INDUSTRY

**KATHY FALLON**
Majors Mobility
NRRTS Review Chair for DMERC B

Years ago, I was a pharmacy technician for a family-owned pharmacy where I "helped" with DME needs as necessary. I found myself liking the DME side of the business more and more, so I decided to look into the industry.

I was lucky to have a good contact already working in DME—Jeff Randall, who was the general manager for a provider. He ended up hiring me as a full-time CSR and showroom attendant in 1995 for a local provider in Maine. After about four years of serving in that capacity, I moved into an RTS position. (As an interesting side note, Jeff is now my Invacare® territory representative.)

As a RTS, I enjoyed learning new things and meeting people, and found each day presented new challenges and opportunities to learn. Since I don't like stagnancy, RTS and I were a good fit. Though there were times when I wanted to throw in the towel, I kept my RTS position because it seems once you get into this industry so far, you can never really pull yourself out—it just becomes a way of life.

Today, I am the RTS for a small company, and I find myself wearing many hats. My days are filled with responsibilities such as performing all evaluations for manual, power and custom seating in client homes or at either of our locations, which are 40 minutes apart; working with therapists on everything from products they are looking for to required changes to Medicare documentation; answering questions that come in from physician offices concerning coverage and criteria for coverage; referring sources for educational workshops that take place at either physician locations or at one of our locations; entering data into billing systems and working with Kathy, our billing specialist, to make sure everything leaving the store will be paid for—hopefully; placing most of the orders for equipment that I

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## A POWERFUL PARTNERSHIP

have spec'd out and explaining to Dan, our service technician, exactly how I want each chair to look before it is delivered; delivering equipment (luckily, Dan does most of my deliveries though); and sitting in on a two-hour conference call one or more times a month so the NRRTS Board can give input on current issues and review applications of potential new Registrants. As you can see, my days are usually very full—as are those of most RTSs.

And on top of my job obligations, I'm a wife and proud mother—yes, I do carve out time for my family at the beginning and end of each day! I am married to Tom, a wonderful man who lets me vent about CMS, competitive bidding and the rest, and I have two lovely daughters: Heather, who is 17, and Olivia, who is six. As you can imagine, I am very busy, even when I am not at work!

Back in 2001, I joined NRRTS after stumbling upon it while looking for mentoring opportunities that might expand my skills. I later became a CRTS® in 2003, when I finally hit a wall and needed to decide whether to stay in the industry or leave it for good. Obviously, I decided to stay and take my involvement to the next level. In fact, I became a board member thanks to the encouragement of Mike Seidel.

The main attraction I have to NRRTS is the fact it provides me with a support network of others who are just like me—we are all fighting the same insurance battles, and we are all willing to give guidance and suggestions for difficult seating issues. I needed a connection to others in this profession, and I found it through NRRTS.

Furthermore, the NRRTS Board is important for bringing a cohesive voice and set of rules to the organization. The board also provides Registrants with people they can contact with specific issues. We are not a club, but a professional organization that lives by a code of ethics and bylaws, and the board ensures others understand our cause.

If you are considering running for the NRRTS Board, I highly recommend following through. As a board member, I've been able to give back to the organization that gives me a voice to express my opinions to CMS and a means to connect with others in the group and with other organizations like the National Coalition for Assistive and Rehab Technology (NCART) and Rehabilitation Engineering & Assistive Technology Society of North America (RESNA). I think everyone should consider running for the board and give back to the organization that's made such a positive difference for our industry.

The obstacles of the NRRTS Board are time and money. There are many things the board would love to institute: more education or mentoring programs, the ability to lobby state and federal

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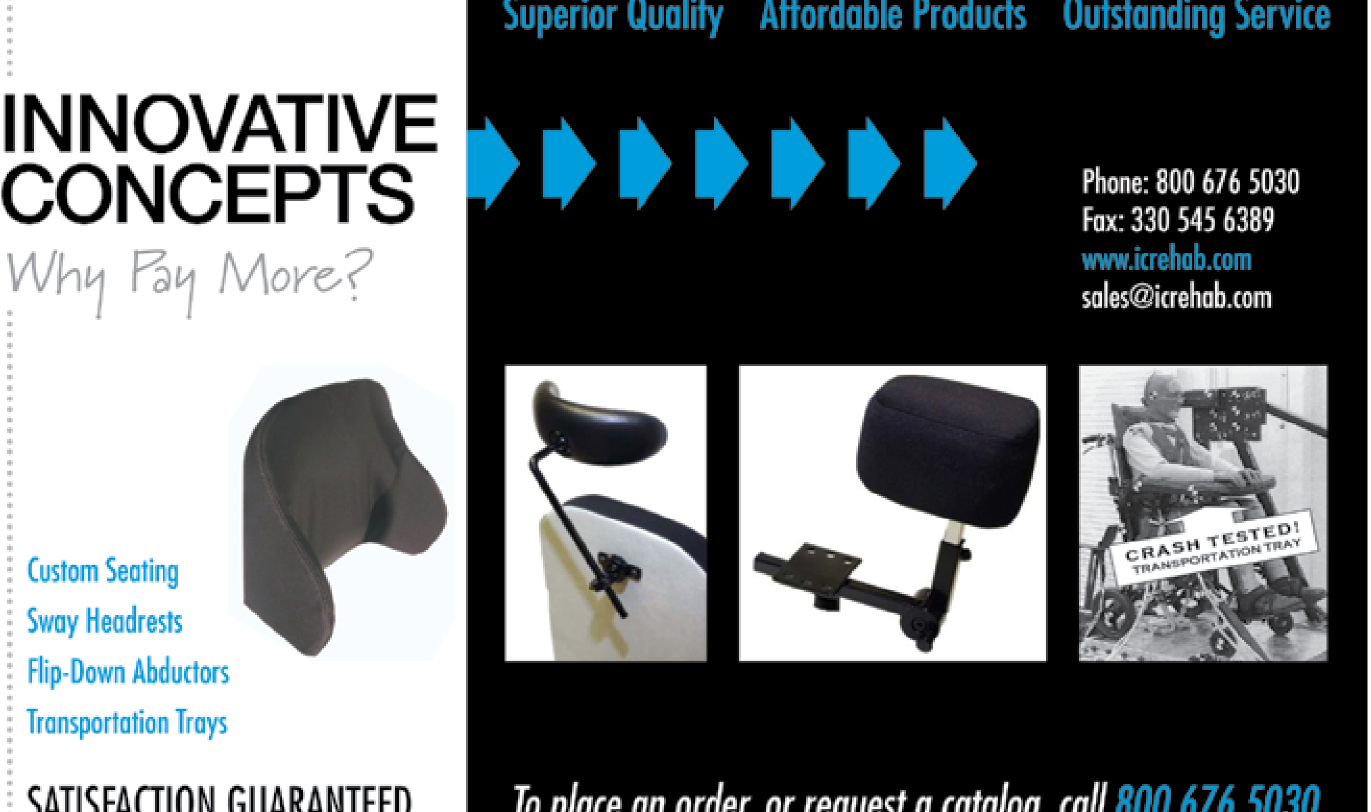

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## SURVIVAL

conjunction with NCART's Capitol Hill Fly-In.

- Twenty NRRTS Registrants responded to a request from the Clinical Task Force to provide detailed information about if and how their State Medicaid addresses issues surrounding the "In-the-Home" restriction.
- NRRTS submitted written testimony to the House Ways and Means Committee opposing the President's budget proposal to eliminate the day-one purchase options for power wheelchairs.
- NRRTS has signed on as a subcontractor with the University of Illinois at Chicago for a grant proposal submitted to NIDRR, the National Institute for Disability and Rehab Research, to develop and conduct a pilot program in conjunction with the Rehab Engineering Research Center (RERC) on Emergency Management.

Theses activities are in addition to maintaining the NRRTS Registry for RRTS™ and CRTS®.

The bad news is only 15% of the NRRTS Registrants are involved in these efforts. We can only surmise the rest of you don't care to take the time, don't understand the seriousness of the situation and/or don't care about the quality of care provided to your clients in the near future and in the long term.

To all the NRRTS Registrants and Friends of NRRTS who have supported our initiatives, thank you and congratulations on taking your fate into your own hands. To everyone else, we strongly urge you to step up and get involved now. ■

If you have questions about NRRTS and its industry efforts, please contact Simon Margolis at 763/559-8153 or smargolis@nrrts.org.

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## A POWERFUL PARTNERSHIP

organizations, etc. But as volunteers who are also full-time RTSs, there just are not enough hours in the day, or so it seems most of the time.

The most significant obstacle in the RTS profession is the fact it is not yet even recognized as a profession! As NRRTS Registrants, we should each be out there recruiting new NRRTS applicants—and yes, that even includes competitors. More Registrants means more voices and the power to create a single louder voice that can push legislature requiring licensure as well as create better policing of the profession.

I believe the RTS profession will become a more respected area of the healthcare industry if all current RTSs will stand up and show end users and payer sources why we are important. We all must remember that complaining about the current situation without having the willingness to do something to change it doesn't help anyone. Obviously, we are all busy, but every single one of us needs to make our congress people aware of what we do daily and of the constraints CMS/other payers place on us that prevent us from doing the best "job" possible for the end user.

My family has been personally touched by the advancements in DME, as my mother-in-law used a manual wheelchair for more than eight years. She just recently moved into a power wheelchair that allows her to remain as independent as possible while in her home. Watching her quality of life improve with the advancements in DME is more than enough motivation to remain an active member of the industry and the organizations, like NRRTS, that support it. Together, RTSs and NRRTS can make a powerful partnership. ■

Kathy Fallon can be contacted at 207/729-6990 x13 or kfmaine@hotmail.com.

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## RECYCLING

operating equipment exchange and/or recycling programs. In more recent efforts to determine the current number of recycling programs operating in the U.S., 120 facilities have been documented to date.

In 2006, A Federal Register notice, the Office of Special Education and Rehabilitation (OSERS), announced efforts to expand recycling and a request for grant applications. The notice stated two priorities: Proposed Priority 1 is to support projects that will develop models of statewide assistive technology (AT) device reutilization systems to meet the AT needs of individuals with disabilities. The purpose of Proposed Priority 2 is to support the establishment of a National Device Reutilization Coordination and Technical Assistance Center to assist grantees funded under Proposed Priority 1 with the establishment or expansion of their statewide AT device reutilization systems.

**Recycling is not a new concept in other countries, and the models are extremely diverse.**

The Center would disseminate information about best practices and successful models for AT device reutilization systems, facilitate information exchange among grantees and address AT device reutilization issues such as building relationships among AT device vendors and manufacturers and working on liability and reimbursement issues at the national level. While funding for projects under Proposed Priority 1 is for a three-year period only, the Center will be funded for five years in order to conduct follow-up activities.

Twelve grants were recently awarded to applicants who responded to the FR publication:

- Assistive Technology for Kansas - www.atk.ku.edu
- Easter Seals Wisconsin - www.wi.easterseals.com
- OK-Sooner AMBUCS, Inc. - www.soonerambucs.org
- VA Tech Project - www.vats.org
- Idaho AT Project - www.idahoat.org
- Deleware AT Project - www.dati.org
- New Mexico AT Project - www.nmtap.com
- MO Paraquad - no website
- DC AT Project - www.atpdc.org
- MS AT Project - www.msprojectstart.org
- TX Project Mend - no Web site
- GA AT Project (Tools for Life) - www.gatfl.org

The PASS IT ON National Task Force on AT Reutilization and Coordination has also been established.

In addition to increased recycling efforts by state AT programs, Medicaid programs are considering recycling as a way to balance increasing costs and shrinking budgets. Many in the industry witnessed problems associated with a recycling program implemented by New Jersey Medicaid. Recycling is not a new concept in other countries either, and the models are extremely diverse. The impact of these programs on individuals that need equipment also varies.

In May 2006, RESNA coordinated a two-day conference on recycling: *Pass It On! A National Conference on the Reuse of Assistive Technology.* Participants heard presentations regarding best practices and discussed barriers about the reuse of AT that needed to be addressed. Barriers were identified as:

- Storage
- Transportation/distribution
- Labor
- Tracking and managing inventory
- Collection of data (i.e. number of people served, equipment reused)
- Marketing and public awareness
- Appropriate disposal of devices

Other issues that focused on program quality were:

CONTINUED ON PAGE 23


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## RECYCLING

- Finding and maintaining qualified staff
- Training staff and volunteers
- Determining the acceptability of devices (i.e. age, condition and type)
- Collection data on consumer outcomes
- Collection data on cost savings
- Standards for cleaning and repairing
- Cultural barriers

Many more topics were discussed at the conference and action items were established in an effort to provide clear guidance and policies to help recycling programs be successful and to ensure long-term stability. Reissuing devices is not a simple program to establish and the barriers, as listed previously, are not small. However, the concept is appealing to many and efforts are definitely being made to develop standards, policies and manuals to assist programs in laying the right foundation for success.

If a program partners with suppliers of rehab and DME in its area, there can be upsides for both parties. For suppliers, having access to refurbished devices can provide an opportunity to serve individuals with insufficient funding or no funding, helping them obtain the equipment they need. In addition, for individuals who want back-up wheelchairs or secondary chairs that aren't covered by insurance, recycling offers a lower-cost solution. Suppliers could also use recycled devices as loaners while waiting for an individual's specific technology solution to be delivered. The recycling program benefits in this model as well; it receives revenue from selling refurbished equipment to suppliers, thus reducing the need for grant money and fundraising. Also, by partnering with the supplier community, individuals receiving recycled equipment have an opportunity to be evaluated to ensure the technology meets their medical/functional needs. Moreover, suppliers may be needed for technical expertise in evaluating and repairing complex electronic devices.

Without question, there are legitimate reasons why the rehab and DME industry feels threatened by recycling programs. Clinical and consumer groups should also be concerned. Not all of the programs are set up in a way ensuring positive clinical outcomes. Current models range from web-exchange only, where equipment is sold as is, to full-service refurbishing and re-distribution that follows a medical model and tracks consumer outcomes. The fact remains recycling is being given a lot of focus and attention, and new programs are being implemented at a growing rate. The momentum is growing, and there is no question when done properly, recycling offers some viable solutions to funding problems. The time has come for the entire community of people, who serve individuals with disabilities to pay attention, get involved and help develop models that work for all stakeholders. ■

Rita Hostak can be reached at 704/846-4096 or rita.hostak@sunmed.com.

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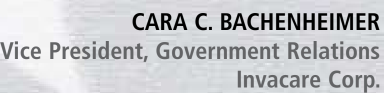

**CARA C. BACHENHEIMER**
Vice President, Government Relations
Invacare Corp.

# Understanding CMS' Final Rule on Competitive Bidding

On April 2, 2007, CMS released the long-awaited Final Rule on Competitive Acquisition for DMEPOS on its website, and then published it in the April 10, 2007 Federal Register.

The following summary provides highlights of the final rule, particularly as it will impact rehab providers. It is important to know while the final rule provides some clarity, many issues remain unresolved. Some of these issues are addressed in the recent release of the CMS Request for Bids. To stay up to date, providers should check the CMS website daily on DMEPO competitive bidding, and the new website of the Competitive Bidding Implementation Contractor (CBIC) — **www.palmettogba.com/cbic/cbic.nsf/(pages)/Suppliers**. The final rule is complex and long, making it all the more necessary for providers to understand the fine details.

CMS announced the initial ten metropolitan areas, Competitive Bid Areas or CBAs, in which it will begin competitive bidding and the ten product categories that will be included. Detailed descriptions, searchable by ZIP codes and maps, are available at the CBIC website.

**First 10 Metropolitan Areas**

- Charlotte-Gastonia-Concord, NC-SC
- Cincinnati-Middletown, OH-KY-IN
- Cleveland-Elyria-Mentor, OH
- Dallas-Fort Worth-Arlington, TX
- Kansas City, MO-KS
- Miami-Fort Lauderdale-Miami Beach, FL
- Riverside-San Bernardino-Ontario, CA
- Orlando-Kissimmee, FL
- Pittsburgh, PA
- San Juan-Caguas-Guaynabo, Puerto Rico

**Product Categories for First 10 Cities**

CMS is including two separate categories for power mobility devices: one for consumer mobility and one for high-end rehab. Also included in the categories are a long list of accessories and seating options. Details regarding which HCPCS codes are included in each product category are on the CBIC website.

- Standard power wheelchairs, scooters and related accessories
- Rehabilitative power wheelchairs and related accessories
- Oxygen equipment and supplies
- Respiratory assist devices and CPAPs
- Diabetic supplies (mail order only)
- Enteral nutrition
- Hospital beds and accessories
- Walkers
- Negative pressure wound therapy devices
- Support surfaces, Group 2 and 3 mattresses and overlays (only to be bid in Miami and San Juan)

**Timing:** CMS expects to issue the Request for Bids in late April, and bids will be due 60 days later (late June 2007). CMS plans to announce winning (contract) suppliers in early December. Suppliers must register on the CBIC website in advance to receive a user ID and password that will allow them to submit bids electronically/on-line. Suppliers must also be accredited or have accreditation pending before they can submit bids. CMS expects to announce winning suppliers in early December and the bid programs will go into effect in the 10 CBAs in April 2008.

**Supplier Eligibility:** Suppliers must meet current Medicare eligibility rules, meaning they must be enrolled in Medicare with good standing and no current sanction; must disclose any previous legal actions, sanctions or disbarments of any employees, officers or affiliated companies or subcontractors; comply with all relevant state and local licenses and agree to terms of the supplier RFB and contract.

### SUMMARY OF WINNING SUPPLIER SELECTION PROCESS, PIVOTAL BID SINGLE PAYMENT AMOUNT CALCULATION

CMS will select contract suppliers as follows: (1) CMS will establish a composite bid for each supplier (a composite bid is the sum of a supplier's weighted bids for all items within a product category); (2) suppliers' composite bids are ranked in order from lowest to highest; and (3) one of the composite bids is selected to be the pivotal bid (the pivotal bid is the lowest composite bid based on bids submitted by suppliers for a product category that will include a sufficient number of suppliers to meet beneficiary demand for the items in that product category). The rule establishes a capacity limit for purposes of calculating the pivotal bid such that no supplier's capacity can be considered to meet more than 20 percent of the total beneficiary need. Suppliers whose composite bids are less than or equal to the pivotal bid are selected as winning suppliers if they meet all other program requirements. Thus, selection of the pivotal bid is used to determine the number of contract suppliers.

CMS will determine the single payment amounts for individual items by using the median of the supplier bids at or below the pivotal bid for each item within each product category. The individual items will be identified by the appropriate HCPCS codes. The median of the bids submitted by the contract suppliers for a particular item will be the single payment amount CMS will establish under the competitive bidding program for the HCPCS code describing that item. In cases where there is an even number of winning bidders for an item, CMS will use the average of the two bid prices in the middle of the array to set the single payment amount.

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**Small Business:** CMS has reduced the definition of a "small supplier" to mean a supplier that generates gross revenue of $3.5 million or less in annual receipts, including Medicare and non-Medicare revenue. CMS is setting a target number for small supplier participation in each product category, for each CBA. The target number is equal to 30 percent of the number of "winning" or contract suppliers for each product category. If there are not 30% of small suppliers included in the group of suppliers who are at or below the pivotal bid, CMS will ask small suppliers above the pivotal bid to participate at the bid rate.

**Networks:** CMS will allow small suppliers to form networks if they cannot service the entire CBA independently. Suppliers not meeting the definition of a small supplier or small suppliers that can service the entire CBA independently may not form networks. Any network must comply with all applicable laws, including the federal antitrust laws. Each supplier submits its own claims and receives payment directly. Each member must have statement that it cannot itself cover the entire geographic area. The small suppliers forming the network must have market shares at the time of bidding, when totaled, that do not exceed 20 percent of the expected beneficiary demand for the product category. No more than 20 small suppliers may participate in a network. Networks must form a legal entity that acts as the bidder, and the legal agreement must be submitted to CMS. Each network member must independently meet all the eligibility requirements, and each network member will submit claims to Medicare and receive payments directly from Medicare. A small supplier may join more than one network but cannot submit an individual bid to furnish the same product category in the same CBA as any network in which it is a member. A small supplier may not be a member of more than one network if those networks submit bids for the same product category in the same CBA.

## GRANDFATHERING RULES TO AMELIORATE BENEFICIARY OWNERSHIP RULES

**Capped Rental Items:** For capped rental items furnished on a rental basis, CMS has a new rule for contract suppliers that must begin furnishing a capped rental item during the rental period to a beneficiary who is no longer renting the item from his or her previous supplier (because the previous supplier elected not to become a grandfathered supplier or the beneficiary elected to change suppliers). They will receive 13 monthly rental payments for the item, regardless of how many monthly rental payments Medicare previously made to the prior supplier. At the end of this new 13-month rental period, the contract supplier will transfer title from the capped rental item to the beneficiary. This rule does not apply when a beneficiary who is renting a capped rental item from a contract supplier elects to obtain the same item from another contract supplier, because the grandfathering provisions only apply to those situations in which a beneficiary had been previously receiving the item from a non-contract supplier.

**Oxygen:** For oxygen equipment, CMS has a new rule for contract suppliers that must begin furnishing oxygen equipment after the rental period has already begun to a beneficiary who is no longer renting the item from his or her previous supplier (because the previous supplier elected not to become a grandfathered supplier or the beneficiary elected to change suppliers). They will receive at least ten rental payments for furnishing the equipment. For example, if a contract supplier begins furnishing oxygen equipment to a beneficiary in months two through 26, CMS will make payments for the remaining number of rental months in the 36-month rental period, because the number of payments to the contract supplier would be at least ten payments. However, if a contract supplier begins furnishing oxygen equipment to a beneficiary in month 27 or later, CMS will make ten rental payments.

## PAYMENT FOR ACCESSORIES FOR ITEMS SUBJECT TO GRANDFATHERING

Accessories and supplies used in conjunction with an item furnished under a grandfathering process may be furnished by the grandfathered supplier. Payment would be based on the bid amount established for the accessories and supplies if the item is oxygen, oxygen equipment or one that requires frequent and substantial servicing. For accessories and supplies used in conjunction with capped rental and inexpensive or routinely purchased items, the payment amounts would

be based on the fee schedule amounts for the accessories and supplies furnished prior to the implementation of the first competitive bidding program in an area or on the newly established competitively bid single payment amounts if the items are furnished by a grandfathered supplier that was a contract supplier for a competitive bidding program, but is no longer a contract supplier for a subsequent competitive bidding program in the same area.

This rule will not apply to accessories that are not an integral part of the base equipment. CMS explains: "For example, a standard mattress is an essential accessory for a hospital bed and may be furnished by a grandfathered supplier of a hospital bed if the supplier has elected to be a grandfathered supplier for the hospital bed. However, a special-powered alternating-pressure mattress furnished to prevent decubitus ulcers is not an essential part of the base equipment and is furnished in addition to the general service of furnishing the hospital bed." Assuming the grandfathered supplier for the base equipment is willing to also furnish accessories or supplies for the base equipment, beneficiaries will be able to choose to obtain any competitively bid accessories or supplies from either the grandfathered supplier or a contract supplier. The amount to be paid under the Medicare DMEPOS Competitive Bidding Program will be the single payment amount, regardless of which supplier furnishes the accessories or supplies.

### HCPCS CODE ISSUES

If a new technology item receives a new HCPCS code during a contract period, that HCPCS code will not be added to the contract suppliers' items. Instead, any supplier in the bid area will be able to provide that new technology.

### PAYMENT FOR REPAIRS AND REPLACEMENT OF BENEFICIARY-OWNED ITEMS

CMS will not require repairs of beneficiary-owned competitively bid items be performed by contract suppliers. CMS will pay for maintenance and servicing of competitively bid items, including replacement parts that may be needed, that are performed by any supplier as long as those repairs are made by suppliers with a valid Medicare billing number that enables them to receive payment for covered Medicare services. If the part needed to repair the item is itself a competitively bid item for the CBA in which the beneficiary maintains a permanent residence, CMS will pay the supplier the competitive bid single payment amount.

**CMS must exempt complex rehab from Competitive Bidding. Encourage your Representatives of Congress to support HR2231! Visit www.complexrehab.org for more information.**

### KEY CONTRACT TERMS

**Nondiscrimination Provision:** CMS will include in each contract it enters into with a supplier under the Medicare DMEPOS competitive bidding program a non-discrimination provision meaning contract suppliers must provide the same level of quality items to beneficiaries in bid areas as they do to beneficiaries outside bid areas.

**Furnishing of Items:** A contract supplier must agree to furnish the items included in its contract to all beneficiaries who maintain a permanent residence or who visit the competitive bidding area and request those items from the contract supplier. A contract supplier cannot refuse to furnish items and services to a beneficiary residing in a CBA based on the beneficiary's geographic location within the CBA. The contract supplier must agree to accept as a customer a beneficiary who began renting the item from a different supplier regardless of how many months the item has already been rented. Suppliers should factor these additional costs into their bids.

Clearly, there are many details and complexities with the new competitive bid program. Providers should stay tuned to the CMS, CBIC and industry websites to keep up to date on all the important implementation details. ■

Cara Bachenheimer can be reached at cbachenheimer@invacare.com or 440/329-6226.

# USERS FIRST ALLIANCE

**TOM ROLICK**
Vice President of Business Development
Permobil

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Is funding dictating how we do business in the rehab industry? It's trying. To challenge the trend of reimbursement cuts, reduction of consumer choices and the move to competitive bidding, three independent rehab equipment manufacturers have formed an alliance, simply called the Users First Alliance, to refocus the priorities on users.

The Users First Alliance is an advocate for the consumer, clinician, provider and payer. Consumers must demand products that meet their needs, clinicians must justify those needs, providers need to obtain and deliver the desired products and the payers need to pay appropriately for the equipment and services provided.

The process must begin with the Users First Alliance. The people who depend on assistive technology deserve to know what's out there. There is a trend in our industry to limit the choices to an individual based only on funding. Sometimes this is done prior to an assessment. A goal of the alliance is to educate and empower the user so he/she can demand the products that best suit his/her needs. A major part of this education is exposing obstacles, appropriating needed equipment and involving the user in attaining his/her equipment. Demand for the most appropriate products and services will drive funding and innovation upward, instead of the downward direction in which it is headed.

Let's face it: without this demand, consumers get only what someone is willing to pay the least amount for, and provider services are devalued along with the cost of the product. Lower prices mean lower quality products, reduced services and lowered potential outcomes. Nobody wins.

Some players in our industry have made some mistakes, and we have collectively been battling the consequences. National competitive bidding is a nightmare. We need to refocus on what got us here, and the Users First Alliance will facilitate that. Consumers, clinicians and providers—get what you need and get it paid for. We are in the business of providing what is best for the users, so don't let funding dictate what is best.

The Users First Alliance is a strong supporter of NRRTS, RESNA, NCART and the proposed carve out of complex rehab products from competitive bidding. You can count on us to continue to lead the fight for continued access to quality products and qualified rehab providers for users everywhere. You can learn more about the Users First Alliance by visiting our Web site at www.usersfirst.org. ■

Tom Rolick can be reached at 800/736-0925 x236 or tom.rolick@permobilus.com.

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# REVISIONS TO THE MEDICARE APPEALS PROCESS

**CLAY STRIBLING, ESQUIRE**
Attorney
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## INTRODUCTION

With the passage of the Medicare Prescription Drug Improvement and Modernization Act of 2003, the Medicare appeals process was significantly changed. The most significant impact of these changes involved the reduction of the timeframe for processing a final appeal from approximately three years down to less than one year. In addition, significant changes to the parties determining supplier appeals have had an impact on both the process of appealing a denied claim and the likelihood of success of such an appeal. In reviewing the changes, it is important to review changes to not only the redetermination by the carrier, but also reconsideration by a qualified independent contractor (QIC) and the administrative law judge (ALJ) hearing. While some of the changes have already been put in place, others will be implemented in the next several months. In this article, we will review the new requirements for the most common steps in the appeal process: redetermination by the carrier, reconsideration by the QIC and the ALJ hearing.

## REDETERMINATION

If a supplier disagrees with the initial claim determination, it has 120 days from the date it received the initial determination to file a request for redetermination. This 120-day period may be extended if the supplier files a written request showing good cause as to why the redetermination request was not timely filed.

The request for redetermination must be in writing and filed with the carrier. CMS states the preferred method for filing a request for redetermination is on a standard CMS form, but other written requests will be accepted if they contain the following required elements:

1. The beneficiary's name;
2. The Medicare health insurance claim number;
3. Specific item(s) and/or service(s) and the applicable date(s) of service and
4. The name and signature of the supplier or the supplier's representative.

**When filing the request, the supplier must explain why it disagrees with the initial determination.**

When filing the request, the supplier must explain why it disagrees with the initial determination and should include any additional evidence to be considered by the carrier when making the redetermination.

In conducting the redetermination, an employee of the carrier who was not involved in the initial determination reviews the evidence and findings upon which the initial determination was based and any additional evidence submitted by the supplier or obtained by the carrier, then making a redetermination decision. The redetermination decision must be mailed or otherwise transmitted within 60 days of the date the carrier received the request for redetermination. This 60-day period is extended by 14 days each time the supplier submits additional evidence after filing the request for redetermination.

Redetermination decisions that affirm, in whole or in part, the initial determination must summarize relevant laws and policies, the facts and the rationale for the redetermination decision, as well as inform the supplier of the process to request a reconsideration by the QIC. The notice must also contain a statement explaining that all evidence the supplier wishes to introduce during the appeal process should be submitted with the request for a reconsideration, and that evidence not submitted to the QIC will not be considered at an ALJ hearing or further appeal unless good cause is shown as to why the evidence was not previously provided. This is a significant change from the previous appeal process, which did not preclude the introduction of additional evidence at an ALJ hearing.

## RECONSIDERATION

A request for reconsideration by the QIC must be filed within 180 days from the date the supplier received the redetermination decision. Again, the deadline may be extended if the supplier demonstrates good cause for missing the filing deadline. A written request for reconsideration should be made on a standard CMS form, but other written requests will be accepted if they contain the information required for a redetermination request, plus the name of the carrier that made the redetermination decision.

When filing the reconsideration request, the supplier should explain why it disagrees with the initial determination and redetermination, and present any additional evidence and arguments of fact or law. As stated previously, if evidence is not presented to the QIC,

CONTINUED ON PAGE 32

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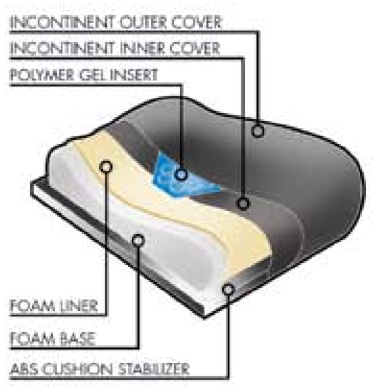


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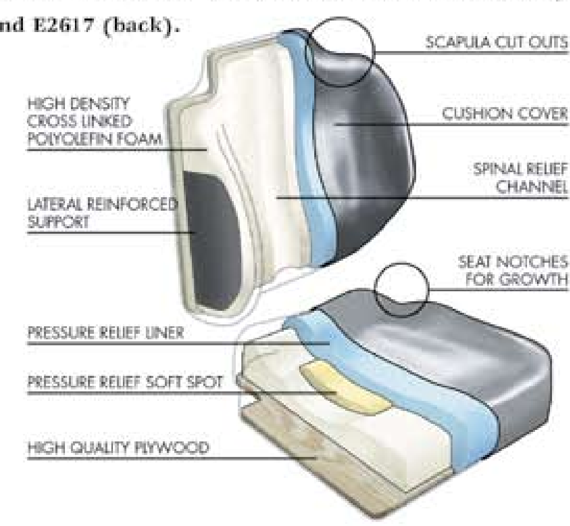



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continued from page 30

## MEDICARE APPEALS

the evidence cannot be introduced at the ALJ hearing or subsequent appeal absent a showing of good cause.

The QIC reconsideration consists of an independent review solely of the written record. The QIC reviews the evidence and findings of the initial determination and redetermination, as well as any additional evidence submitted by the parties or that the QIC obtains on its own. Also, unlike the current carrier hearing process, while QICs must follow national coverage determinations, CMS rulings, applicable laws and regulations, the QICs are not bound by the carrier's local coverage determinations, local medical review policies or CMS program guidance such as program memoranda and manual instructions, although the QIC is instructed to give substantial deference to such policies if they are applicable to the case. Another change from the current process is that if the initial determination involves a finding on whether an item or service is medically reasonable and necessary, the QIC's reconsideration must involve consideration by a panel of physicians or other appropriate health-care professionals, and must be based on clinical experience, the beneficiary's medical records and medical, technical and scientific evidence of record.

The QIC reconsideration consists of an independent review solely of the written record.

The reconsideration decision or other notice must be mailed or otherwise transmitted within 60 days of the date the QIC received the request for reconsideration. This 60-day period is extended by up to 14 days each time the supplier submits additional evidence after filing the request for reconsideration. The reconsideration decision must summarize the facts and other relevant clinical or scientific evidence, relevant laws and policies and the rationale for the reconsideration decision, as well as inform the supplier of the process to request an ALJ hearing. If the QIC is unable to make a reconsideration decision by the imposed deadline, it must notify the supplier of that fact and offer the supplier the opportunity to escalate the appeal to an ALJ without a reconsideration decision. The QIC will continue the reconsideration process until it either reaches a decision or receives written notice from the supplier to escalate the case to an ALJ.

### ALJ HEARING

One of the most significant changes to the ALJ hearing process is the ALJs who hear Medicare cases are no longer under the Social Security Administration, but are under the Department of Health and Human Services.


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To be entitled to an ALJ hearing, the required amount remaining in controversy must be at least $100, and the supplier or other party must file a written request for an ALJ hearing within 60 days after receipt of the QIC's reconsideration decision. A deadline extension may be granted if the party demonstrates good cause. A new requirement is that the party requesting an ALJ hearing must also send a copy of the request to all other parties. The ALJ hearing will be conducted by video teleconferencing if such technology is available. The hearing can also be conducted by telephone if that would be more convenient for one or more of the parties. An in-person hearing will be conducted if video teleconferencing technology is not available or other special or extraordinary circumstances exist, or if a party requests an in-person hearing and the ALJ agrees upon a finding of good cause.

**To be entitled to an ALJ hearing, the required amount remaining in controversy must be at least $100.**

Any additional written evidence to be presented at the ALJ hearing must be submitted either with the request for the hearing or within 10 days after receipt of the notice of hearing, along with a statement explaining why the evidence was not previously submitted to the QIC. If the ALJ determines there was not good cause for submitting the evidence for the first time at the ALJ level, the ALJ must exclude the evidence.

With certain exceptions that extend the deadline, the ALJ must issue a decision no later than 90 days after the date the request for hearing was received. This 90-day deadline is waived if the party requests an in-person hearing.

If a party is not satisfied with the decision of the ALJ, it still has the right to submit an appeal to the Medicare Appeals Council, and ultimately file an appeal in federal district court. ■

Clay Stribling, Esq., is an attorney with the Health Care Group of Brown & Fortunato, P.C., a law firm based in Amarillo, Texas. Mr. Stribling represents durable medical equipment companies, pharmacies and other health-care providers throughout the United States and Puerto Rico. He can be reached at 806/345-6346 or cstribling@bf-law.com.

*This article is not intended to be legal advice or legal opinion on any specific facts or circumstances. The contents are intended for general information purposes only. Attorneys at Brown & Fortunato, P.C. are not Certified by the Texas Board of Legal Specialization unless otherwise noted.*

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# PREPARING FOR THE BID

**MIKE MALLARO**
Chief Financial Officer
VGM Group, Inc.

Those of you in one of the ten competitive bidding MSAs are probably well into the process of formulating your bid. The rest of you should appreciate your reprieve and begin preparing for the day when competitive bidding comes to your backyard. Addressing competitive bidding requires a twofold strategy: (1) building a business model that is not dependent upon Medicare as a payer, and (2) developing a low-cost provider model to serve the Medicare payer.

The portion of your business for which Medicare is the payer will vary, but in virtually every case it is a significant share of your existing business. However, the market for medical and assistive products that help people's mobility and the quality of life in their home is very significant, even excluding Medicare. Furthermore, this market will grow exponentially over the next two decades. Aggressive and innovative entrepreneurs, I believe, can find many ways to build viable non-Medicare businesses related to what you already do. Keep in mind, your greatest competitor in this regard is not a neighboring business or a national chain; you're greatest competitors are nonconsumption and substitute methods. There are millions of Americans out there who could benefit from equipment, products, technology and ideas that you possess or for which you have the capacity to become an expert. You'll need to find this equipment, these products and technologies and then find a way to effectively communicate their value to people who could be helped by them. The answers will not come from the consultants, but from your customers and your fellow entrepreneurs.

The second element of the strategy requires you to become a low-cost provider. Being a low-cost provider, in and of itself, is not a bad thing, but I suspect it is fundamentally different from the way you've been operating. It begins with understanding the payer

CONTINUED ON PAGE 36

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continued from page 34

## PREPARING FOR THE BID

wants to obtain the product for the lowest cost possible price. This is the single most important element for this payer source (Medicare). This is simply a different approach, which places emphasis on minimizing costs. "Low cost" is not synonymous with "bad" or with "junk." I'm fairly sure you think you keep costs to a minimum, but I'm also fairly sure you don't succeed. I have not seen a provider who runs the kind of low-cost operation of which I am speaking. Being a low-cost provider is a culture and an entirely different way of approaching your business.

Becoming a low-cost provider for Medicare will require a rigorous and dispassionate analysis of your current operations. Begin by determining what net profit margin you are willing to accept. Gather all the financial and operational data you can access from the past year, including units and dollars. Try to create two alternatives to your traditional P&L: one by payer source and the second by product line. On product lines you wish to bid for Medicare, you will need to go through an exercise of projecting revenues. Under the bid scenario, if you win you will undoubtedly grow the unit sales in this category of business somewhere between 25% - 75% the first year alone. This is because CMS will greatly limit providers, leaving quite a bit more unit volume for the winners. Adjust the unit sales for a lower fee per unit based on your expectation of where bids will come in. Work through to your gross margin level using the units you projected in the previous step.

Now get into the details of operating expenses. You need to challenge everything on the expense side of your business. Ask questions around what is really necessary in a low-cost provider model? How could things be done differently? What must be done? What is optional? I suggest using a team of key managers and outside advisors to work through this planning process. Outsiders, a CPA or a trusted businessperson, can offer an important perspective. Oftentimes, people in the business are so close to the way things have been done in the past they miss an opportunity to change. This is an iterative process, so plan to go through several iterations of ideas and alternatives. Conclude with a projected P&L showing revenues, cost of goods and operating expenses. Now assess how you think others may bid. Leave yourself time to think over your bid and ample time to prepare and submit your bid packet.

The market for your products and services will grow dramatically in the coming years. But the largest payer, Medicare, will remain problematic. Become a low-cost provider for Medicare while at the same time build a business not dependent upon Medicare. You may find your business can thrive in the future despite the difficult Medicare environment. ■

Mike Mallaro can be reached at 319/274-6682 or Mike.Mallaro@vgm.com.

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# 2007 MEDTRADE® ORLANDO PRELIMINARY SCHEDULE

| TIME | PRESENTATION | PRESENTER(S) | COMPANY | DESCRIPTION | AUDIENCE | SPONSOR |
|---|---|---|---|---|---|---|
| **Tuesday, October 2, 2007**<br><br>8:30am - 10:45am | NCART Manual Wheelchair Coding Update | • Adrian Oleck, MD, Medical Director, Region B, DME PSC<br>• Doran Edwards, MD, Medical Director, SADMERC<br>• Rita Hostak, Vice-President for Government Affairs, Sunrise Medical" | | The SADMERC has turned its attention to developing a new HCPCS code set for manual wheelchairs. The complicated process and outcomes to date will be explained by the individuals integrally involved in this complex undertaking | RTS, OT, PT, payers (all audiences) | NCART |
| **Tuesday, October 2, 2007**<br><br>11:00am - Noon | NCART Complex Rehab and Assistive Technology Competitive Bidding Update | Cara Bachenheimer, Esq. | Invacare | Competitive Bidding is a fact of life. This presentation will focus on how this process will affect the way Rehab Technology Companies deliver Complex Rehab and Assistive Technology products and services. | RTS, OT, PT (all audiences) | NCART |
| **Tuesday, October 2, 2007**<br><br>8:30am - 9:30am | Pressure Mapping When, Who and How to Get Paid For It | Sharon Pratt, PT | Sunrise Medical | This session will review clinical best practices in the use of Interface pressure mapping from around the world as they exist today. Their pitfalls and strengths will be discussed. The presentation will explore the real world concerns of funding this evaluation modality. | PT, OT, RTS (intermediate to advanced) | Sunrise Medical |
| **Tuesday, October 2, 2007**<br><br>9:45am - 10:45am | Providing Pelvic Control Using Static and Dynamic Seating Components | Allen Seikman | Allen Siekman Consulting | Control of the pelvis in seating is complicated by the desire to provide a stable base of support and postural stability. This presentation will explore methods and devices helping to control pelvis and trunk location and allow functional controlled movement. | PT, OT, RTS (intermediate to advanced) | Allen Seikman, Consulting |
| **Tuesday, October 2, 2007**<br><br>11:00am - Noon | Standing Wheelchairs, Mobile Standers, and Sit to Stand Devices | Ginny Paleg, MS, PT | Private Practice | This presentation will review the proposed RESNA Position Paper on Standing. Pediatric and adult research studies will be reviewed. Products from over 15 different manufacturers will be reviewed and compared using case study format. | PT, OT, RTS (intermediate to advanced) | Altimate Medical |
| **Wednesday, October 3, 2007**<br><br>8:30am - 10:45am | Coding & Billing for PMDs | Peggy Walker | US Rehab | The outline will contain the correct way to get coding the product and how to properly bill for what you provide. How to know the difference between coverage from a Group 1 through Group 5. Which chairs are covered and which will deny. | RTS, billing personnel (all audiences) | US Rehab |
| **Wednesday, October 3, 2007**<br><br>9:45am - 10:45am | Evidence Based Pediatric Seating-With What Evidence? | Lauren Rosen, PT, ATP | St. Joseph's Children's Hospital | This session will focus on the evidence available for the provision of pediatric manual wheelchairs. The course will discuss previous and current research in pediatrics and adult wheelchair research relating to pediatrics. | RTS, OT, PT, payers (intermediate to advanced)) | NRRTS |
| **Wednesday, October 3, 2007**<br><br>11:00am - Noon | Minimizing the Risk - Legal Issues in Seating and Wheeled Mobility Practice | • Jeffrey Baird, Esq.<br>• Denise Fletcher, Esq. | Brown and Fortunato, P.C. | There are legal risks in any form of healthcare related service delivery. This presentation will explore the specific risks associated with the provision of DME equipment in general and laser in on Complex Rehab and Assistive Technology in general. | RTS, management (all audiences) | NRRTS |

| TIME | PRESENTATION | PRESENTER(S) | COMPANY | DESCRIPTION | AUDIENCE | SPONSOR |
|---|---|---|---|---|---|---|
| **Wednesday, October 3, 2007**<br>8:30am - 9:30am | Seating and Mobility Medical Terminology From the RTS Perspective | Simon Margolis, ATS, ATP | NRRTS | This presentation, developed by RTS for RTS will focus on the anatomic and functional terminology needed by RTS to perform as a professional member of the clinical team | RTS (entry level to intermediate) | NRRTS |
| **Wednesday, October 3, 2007**<br>9:45am - Noon | Seating and Wheeled Mobility Evaluation and Measurement From the RTS Perspective | Mike Seidel, CRTS® | National Seating and Mobility | This presentation, developed by a RTS for a RTS will focus on the skills, knowledge base and techniques needed to translate physiologic and functional finding of clinicians into final equipment specifications. | RTS (entry level to intermediate) | NRRTS |
| **Thursday, October 4, 2007**<br>8:30am - 9:30am | Hosting a Site Visit with your Member of Congress | Simon Margolis, ATS, ATP Moderator | NRRTS | An important part of the industry's legislative strategy is to enlist help of suppliers and clinicians. This panel presentation will focus on the logistics of setting up and successfully conducting a site visit with members of Congress. | RTS, OT, PT (all audiences) | NCART/ NRRTS |
| **Thursday, October 4, 2007**<br>9:45am - 10:45am | Equipment Recycling: Good, Bad, Voluntary or Mandatory? | Rita Hostak, Moderator | Sunrise Medical | This panel will focus on recycling of used assistive technology equipment including manual and power wheelchairs. The panelists represent the industry, equipment recyclers and the Department of Education. | RTS, OT, PT, manufacturers, payers (all audiences) | NCART |
| **Thursday, October 4, 2007**<br>11:00am - Noon | Seating and Wheeled Mobility Case Studies | Gerry Dickerson, CRTS®, Moderator | MedStar, Inc. | This panel presentation will feature three case studies, presented by a RTS, of complex clinical scenarios and how the client's needs were addressed | RTS, OT, PT (intermediate to advanced)) | NRRTS |
| **Thursday, October 4, 2007**<br>8:30am - 9:30am | The Medical Benefits of Tilt | Jane Fontein, OT | PDG | What are the medical benefits of tilt? The session will include a review of studies about tilt-in-space wheelchairs. Case studies demonstrating benefits will spur discussion from the audience about their experiences with tilt. | RTS, OT, PT (intermediate) | PDG |
| **Thursday, October 4, 2007**<br>9:45am - 10:45am | There's More To Power Seating Than Tilt or Recline | Stephanie Tanguay, OTR, ATP | Motion Concepts | The ability to design a mobility device for maximizing function is the art that seems to be forgotten in the shadows of codes and margins. This session will utilize studies to illustrate what our industry has to offer power mobility users. | RTS, OT, PT (intermediate to advanced)) | Motion Concepts |
| **Thursday, October 4, 2007**<br>11:00am - Noon | Technological Advances and Programming to Improve Successful Children's Powered Mobility | Amy Bjornson, PT, ATP | Sunrise Medical | Facilitated mobility is critical to the development of motoric, cognitive and social skills in the pediatric client. This course will discuss developing technologies and programming strategies to increase successful outcomes. | RTS, OT, PT (entry level to intermediate) | Sunrise Medical |

# recycling?

**SIMON MARGOLIS**
Executive Director
NRRTS

## THE GOOD

Assistive technology recycling and redistribution programs were initially and exclusively designed to place small, used AT devices, speech-generating devices, computers, etc., in the hands of people who need them and who otherwise might not be able to afford them.

## THE BAD

In an effort to provide wheelchairs for uninsured and under-insured individuals, recycling and re-issue has been expanded to include manual and power wheelchairs. This is bad because it does not address the core problem: the hundreds of thousands of under-insured and uninsured Americans.

## THE UGLY

States are looking toward recycling as a way to lower the costs of providing power and manual wheelchairs to Medicaid recipients. This is truly ugly, because it sets up two classes of consumers: one gets appropriate equipment and the other gets used products that may or may not meet his/her needs.

Listed in no particular order, here are a few issues—from the supplier perspective—that need to be understood, explored and addressed before recycling programs are established:

- The loss of revenue for the manual or power base, even though they may cost less than others, will impact the ability of the supplier to meet their fixed, indirect expenses, causing layoffs of technical and support staff.
- Fitting seating products, both manual and power, to used frames will be problematic.
- How will warranty issues (i.e. lifetime frame warranties, etc.) be tracked and transferred?
- Will the recycler be responsible for repairs to the frame they refurbished?
- How will the continuity of FDA requirements for tracking equipment be assured from one consumer to another?
- How will consistent guidelines be established in determining if a chair is suitable for refurbishing due to age and condition?
- How will the supplier be compensated for repair and long-term service for this equipment, as most payers require chairs to last up to five years before a replacement is authorized?
- Who will maintain the liability exposure for the refurbishing done to the base? The recycling program? The manufacturer? The supplier?
- The list goes on!

All this said, well designed and implemented recycling programs may be a good idea. They need; however, to be set up by clinically-oriented business people with a working knowledge of the Complex Rehab and Assistive Technology industry in collaboration with advocacy groups, such as the State Assistive Technology Programs. People who have provided wheeled mobility products and services must be the driving force if recycling programs are to provide the desired outcomes for people with disabilities.

*(Please read Rita Hostak's comprehensive article,* "Recycling: Threat, Opportunity or Obligation?" *on the front cover for more information on this topic.)* ■

Simon Margolis can be reached at 763/559-8153 or at smargolis@nrrts.org.

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**MICHELE GUNN**
Review Chair, DMERC A
NRRTS

A little while ago, NRRTS' new Executive Director, Simon Margolis, asked each NRRTS Board member to contact the U.S. Representatives of our states for an on-site congressional visit. His point was we as a board could not ask the NRRTS Registrants to do things we were unwilling to do ourselves. Well, I'm a firm believer in not asking others to do what I would not do myself, but this was uncharted water for me! I crawl under wheelchairs for a living. The whole political thing pretty much scared me to death. I had been good about going to suggested sites and emailing, as well as mailing hard copies of letters on the various issues that we as an industry have faced for the past couple of years. I was hoping this sort of activity was going to be enough to let policy makers know some of the problems inherent in the decisions they were making. Obviously, I was wrong.

**NRRTS has step-by-step instructions available for conducting an on-site visit.**

While we have had some victories, most of the news in the past two years has been bad and continues to get worse on what would seem a daily basis. When Simon first contacted each of us, he asked we speak with our representatives on two or three pressing issues. By the time we were making our initial contacts, the news that complex rehab was to be included in the first roll out of competitive bidding had hit. At least it made the talking points list smaller and more focused. Other issues pushed aside, we needed to explain why complex rehab should not be competitively bid and the harm it would cause to beneficiaries if it were. We needed support for a complex rehab carve out from competitive bidding.

As an industry, we thought we had been talking to all of the right people. It appears the one thing we can do at this point is organize these grassroots efforts in local districts in order to get our voices heard on a higher level. If you're like I was, you might think you can't do this. YES, YOU CAN. And, you don't have to do it alone, because NRRTS can help.

*Pictured from left to right:* George Browning, Owner/President, Browning's Health Care, Barbara Arthur, Deputy Regional Director, Senator Bill Nelson, John Newstreet, Central Florida Regional Director, Senator Mel Martinez, Linda Westfall, complex rehab consumer, Michele Gunn, ATP, CRTS®, Alice King, OTR/L, ATP, Thana France, ATP/S, CRTS®

NRRTS has step-by-step instructions available for conducting an on-site visit. You will be provided with links to find the senators and representatives you need to reach according to ZIP code, and with letter templates you can modify to your specific needs. After the letters go out, you will need to make phone calls to set up a time and date for the on-site visit. Once you have the visit schedule, talking points will be made available to you, as well as handouts you can give to your representatives as they leave.

I followed these simple steps, and our on-site visit was conducted April 11, 2007, in our Melbourne, Florida location. Real people with only one head each and who did not breathe fire showed up to talk with us. We had an articulate consumer there to help drive the point home about the service we provide with quality products that allowed her to remain independent. The representatives listened, took notes and asked very intelligent questions. At the end, one representative recounted the points back to us, and I joking asked for a copy to share because he had nailed each and every one better than I thought we had explained them. We have since followed up with thank you letters to these folks for spending their valuable time with us.

My point to all of this is, to share my initiation into this arena, assure you it's not that hard and to make sure each of you do this *now*. You will be surprised how easy it is to talk about what you do and explain why it's so important. At one point, I thought: *"Help me! I've started talking and I can't shut up!"* Simon has sent the on-site requests for us over the list serve a couple of times, and those requests can be sent again if needed.

***Please,* if you have not already, start this process now!** We have been hearing about these issues for a while, and saying you are too busy to take action is not going to work anymore. By the time you have the time, ***IT WILL BE TOO LATE!!*** ■

Michele Gunn can be reached at 407/650-9585 or mgunn@brownings.net.

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To ESTABLISH relationships with entities whose functions impact the Mission of NRRTS.

To EQUIP the NRRTS Registrant with an identity and a voice for the RTS.

To EDUCATE the consumer about NRRTS and its goals.

To TEAM with clinicians and funding sources to evaluate a consumer and provide appropriate, cost-effective solutions.

**Visit *www.nrrts.org* to learn more about NRRTS.**

## ats credential

Congratulations to NRRTS Registrants who earned the ATS credential. Depending upon their registration date, they will be awarded CRTS® upon completion and approval of the renewal following fulfillment of required registration.

**WAYNE CARROLL, ATS**
Mobility Medical
Flowood, MS

**DEBRA A. CORNELIUS, ATS**
Frontier Home Medical
Cozad, NE

# new registrants

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**LAURA FREY RRTS™**
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**GREG NEWTH RRTS™**
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**CHUCK VETSCH JR. RRTS™**
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Registration Date: 2/5/2007

## 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 1/15/2007 THROUGH 5/1/2007

| Name | Location |
|---|---|
| Brandon Arab | Santa Monica, CA |
| Lynn Bates, OT, ATP | Madison, AL |
| Kenneth Byerley | Hixson, TN |
| Enrico Cartei | Miami Beach, FL |
| Kevin Clement, ATS | Duluth, GA |
| Shannon Cook, ATS | Scottsboro, AL |
| Kyle Cornell, ATS | Chico, CA |
| Chris Doster | Hull, GA |
| Lori Fons | Windsor, WI |
| Craig High, ATS | Austin, TX |
| Kevin Howe, ATS | Hyde Park, NY |
| Darren Hulbert | Anaheim, CA |
| Rich Kistler | Littleton, CO |
| Kristi Lafrenz | Bismarck, ND |
| Debbie LaRue, COTA/L | Rocky Mount, NC |
| Ed Linser, Jr. | Hilliard, OH |
| John Lowery | Montgomery, AL |
| Nathan Lyon, ATS | Valdosta, GA |
| Leona McGinty | West Melbourne, FL |
| Charlie Moreno | North Port, FL |
| Joel Muska | Phoenix, AZ |
| Jonathan Okpalaezecha | Atlanta, GA |
| Bill Pierce | Bristol, CT |
| Kelly Powell, ATS | Charlotte, NC |
| Michele Rahn, ATS | Allentown, PA |
| Chad Ramee | Pembrook Pines, FL |
| Gary Salazar | Huntington Beach, CA |
| Lonnie Schultz | Gardner, KS |
| Scott Scobey, ATS | Savannah, GA |
| Jeff Sestrich | Vail, AZ |
| Jeff Swift | Midland, GA |
| Emily Williams | Montgomery, AL |

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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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