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Hey, Are We Having Fun Yet?

WEESIE WALKER, ATS, CRTS®
NRRTS President
BRANCH MANAGER, NATIONAL SEATING & MOBILITY

I ONCE TOOK A ride on something called the "Scrambler" at a fair. After I got into the seat, I was strapped in, and as soon as the ride started up, I was going around and around. Then, the seat I was in started spinning around and around, too. (I bet you know where this is going.)

I got so sick on the ride that, to this day, I still feel queasy just thinking about it. It was the worst torture I had ever endured. I remember trying to brace myself, but I was never quite sure which direction we were going. But, oh the relief when the ride finally and mercifully came to an end. And this was supposed to be fun?

Working in the field of assistive technology is somewhat like taking a ride on the Scrambler; I don't really know which direction we're going.

Working in the field of assistive technology is somewhat like taking a ride on the Scrambler; I don't really know which direction we're going.

We're fighting competitive bidding, so write your congressman. No, we're being given a 9.5 percent cut, so write your congressman. We are ATSs. No, we are all ATPs. I have to get all my CECs. No, I have to get my CEUs. All of our costs of doing business are going up. All of our reimbursements are going down. We see new innovations in technology, but how can we get them funded?

Assistive technology is its own sort of Scrambler, and that sick feeling is starting to come over me again. I want to be prepared. I want to stay informed. I want to be proactive. And, I must empower my clients to speak up.

NRRTS is more critical to our profession and industry now than any other time I can remember, and I've been around for quite a while. I can deal with almost anything if I just know the facts. After all, my profession is helping people adapt to their environment, so I, too, must be adaptable in this new environment. That's why I'm glad I can rely on the NRRTS staff to keep the information coming. I know where to go to get the facts and then I'm prepared to share them with therapists and consumers.

NRRTS continues to bring due recognition to the professional RTS by partnering with NCART, RESNA and the University of Pittsburgh, just to name a few. We set the standards for our profession and we're making a difference in the way funding agencies look at the provision of complex rehab.

But, are we having fun yet?

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Surviving The Squeeze: Big Lessons From A Small Company

JIM NOLAND, ATS, CRTS®
NRRTS Treasurer
PRESQUE ISLE REHABILITATION TECHNOLOGIES, L.L.C.

I HAVE A SMALL pediatric-focused custom-rehab company in Erie, Pa., and over the last couple of years, my staff and I have faced challenges trying to make a profit. Changes in reimbursement and legislation leave us less profit on a fewer number of compensable items, and more than 60 percent of our clients have medical assistance as either a primary or secondary payer instead of more flexible private insurers.

The excellent service offered by our pleasant, upbeat staff — who always offer straight answers and extra help — is the best growth tool we have.

Negotiating price reductions and exception pricing with manufacturers only took us so far, especially when they had volume-structured pricing. So, we were forced to look inward; if we were going to continue to serve our community, we had to change.

I knew there was a great deal I could do to get my company moving in the right direction. Fortunately I've worked with strong leaders before, like Doug McDaniels and others, who taught me a lot about the bottom line and accountability in the DME process. Change for us meant making the bottom line count. Cost cutting, efficiencies and growth were how we categorized the elements necessary for change.

Cost cutting was the simplest place to start tightening things up. Gas prices and labor costs forced us to shrink our service area and group clients in outlying areas. We reduced our staff dramatically, choosing to implement efficiencies in our business process and software solutions. We changed our employee vehicle policies and chose to buy only used vehicles.

Our public showroom was not profitable, so it was closed except by appointment. If a customer couldn't wait, then we politely gave him/her our competitor's phone number and even driving directions if needed. Very few opted to go somewhere else, because they'd usually came to us for a reason in the first place.

The retail segment of our business was not profitable and often took key people away from their core duties to the showroom to sell bath equipment or a walker. We looked at the tradeoffs and decided this was an area outside of our focus, so it had to go.

All contracts and outside services were rebid and a comprehensive review of our insurance policies was undertaken. We reduced cost in this area and found a more comprehensive, two-tiered health plan for our staff, which ensured the employee cost share was not increased. With the money saved, we're considering a long-term disability insurance plan to add value to the benefit package and help retain key employees. We even came up with a basic energy conservation plan that includes reduced air conditioning use and nighttime lighting.

One mistake we made was withdrawing from our state organization of medical suppliers, PAMS. We missed out on a lot of information and failed to support an important part of our industry. We will not make the mistake of not participating in state- and national-level lobbying and forums again.

Developing efficiencies was more challenging, because it required taking a hard look at our whole business practice. But this is where our greatest gains were made. Reducing the time between an initial evaluation and receipt of payment, and standardizing our back-office process into a predictable and consistent model were our goals.

We've discovered one of the most important keys to reducing back-office cost and expense is to have the frontline staff focus on performing complete intake assessments so that we're fully informed and know what a consumer's options are before the RTS hits the road.

A hard stop for profit with standardized indicators is now utilized to give management control over each piece of equipment and predictability in cash flow. It's always okay to provide a piece of equipment at a lower profit if it's an informed choice.

CONTINUED ON PAGE 8

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CONTINUED FROM PAGE 6

Surviving The Squeeze: Big Lessons From A Small Company

Pre-scheduling client deliveries based on ship dates forces us to meet time goals. We keep logs of promised ship times versus actual ship times for each manufacturer so we can predict with greater accuracy the fastest delivery date possible after our fabrication and assembly process. Now very few deliveries are rescheduled because of shipping delays. The controller and fabrication staffs have also learned to coordinate their efforts, efficiently saving time on every order. Everyone always works better with established time frames, after all.

Seating clinics were developed at large facilities and outlying areas. In-house appointments are strongly encouraged and clients are given incentives to come to "the shop" for a tune-up or a growth check while they're here. We even have a bottle of Turtle Wax® in the repair area!

Software was written to manage back-office tasks and auditing procedures. We chose Brightree as our client and inventory software package, partly because it's Web-based and we cannot afford the updates, IT headaches and local storage costs associated with many other software packages. We leave specification sheets for our therapists on lmnbuilder.com to facilitate complete and accurate letters of medical necessity. GIDB (get it done by) dates are assigned to pending medical documentation with concise rules for early contact with clinicians and families for help getting required documentation. We can always use free help!

Cost cutting and process efficiencies make us leaner and more effective with the limited resources we have, but without growth, we would be missing the target. Growth can be expensive, but it doesn't have to be. Marketing happens every day whether you realize it or not. The excellent service offered by our pleasant, upbeat staff—who always offer straight answers and extra help—is the best growth tool we have. Plus, transparent back-office time frames and limited delays for processing of paperwork will push you to the top of the pile.

Consider sending a personal thank-you note or making extra follow-up phone calls to your referring clinicians; these gestures are often more appreciated and effective than sending tape measures or pens. Marketing in the form of community education and in-services improves relationships, and everyone benefits from more product or clinical knowledge. Getting your customers excited and interested in rehab technology is a great way to grow and serve your community.

Ultimately, we lined up our goals with our payers and consumers. We all needed a more efficient process with lower costs and a better service product/model. I'm doing what I can to help fight reimbursement cuts through supporting NCART, NRRTS and RESNA, but cuts are going to be a part of life for a while.

We have to persevere. Our community needs us because we're valuable. To keep doing this great work we have to be smart, prepared and efficient. We must fearlessly attack the flabby and sloppy aspects of our businesses. It not only helps assure that we'll be around for a few more years, but our customers will inherit a better service product.

Surviving is not enough. We can adapt and excel. Lawmakers set the rules, but we make great things happen. Envision your enterprise after it's tuned up and slimmed down, and then go make that vision a reality. If we can do it in Erie, Pa., you can do it, too.

Keep the faith!

ABOUT THE AUTHOR
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Our Mission: "To Explore Strange New Worlds... To Boldly Go Where No Man Has Gone Before"

JERRY KEIDERLING
President
U.S. REHAB

I MAY NOT BE a diehard Star Trek fan, but it sure feels like we've been stuck in some sort of a time/space anomaly. It seems the harder we try to return to any semblance of normalcy, the deeper we fall into oblivion—like a big black hole sucking us in deeper and deeper until the light at the end is so dim it seems light-years away.

Taking a deep look at your costs, purchasing habits and profit/loss margins from the available product offerings will provide you with an outlook of where you are today and what you need to do for tomorrow.

It may not feel that bad all the time, but it's been a long journey for all of us—especially since CMS, the media and a few elected officials seem to suggest that caring for and providing special services to those in need results in excess reimbursement, and perhaps a direct path toward fraud and abuse.

All our efforts to positively reinforce our image in the eyes of the "controllers" seem to go unnoticed or misunderstood, resulting in a black-cloud attitude that frequently implies we're all in it for the money.

If only they could spend a day or two walking in the shoes of a rehab-technology provider! Maybe then they would get a better picture of what we do, how we do it and why we do it. Maybe then they would understand what hurdles we have to overcome, the level of pain we incur to do our jobs correctly and professionally ... and with only hopes of being paid for our services.

Lately our industry has done a much better job of getting involved and helping when help is needed. This sense of awareness and willingness to be involved needs to continue. I'm positive that it will.

Several of our missions have been met with success. Our recent rallying and communications on the Hill have awarded us with the preservation of the first-month purchase option and a carve-out from the competitive-bidding program for complex rehab. Unfortunately, this success also brings about a 9.5 percent cut in reimbursement that will send us deeper into the abyss. We'll keep up the good fight with continued industry efforts, such as operations surveys, cost studies and real data, that will support the devastating effects of further reimbursement cuts on our industry and, just as important, on the clients we serve.

With active participation by many of us in several industry associations including NRRTS, NCART and RATC, we are beginning to explore new worlds of opportunity within the walls of Congress. Working relationships have been formed and a mutual understanding of values has been established. It appears that Congress and CMS are finally beginning to recognize that complex rehab is a specialty niche within the broad spectrum of DMEPOS. However, that belief needs to be constantly reinforced, or it could easily fade into outer space.

On the other side of the spectrum, mounting pressures from regulatory changes and reduced reimbursement have turned our focus from strictly being a quality rehab provider to also looking at new ventures in product lines and different operational strategies in order to simply keep our businesses afloat. So, we find ourselves contemplating major changes:

- purchasing management and billing software that will streamline our operations and make us more efficient
- offering innovative products to entice additional cash/retail business opportunities
- eliminating certain services, or initiating a fee for services, to counter the dwindling revenue flow
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CONTINUED ON PAGE 12

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CONTINUED FROM PAGE 10

Our Mission...

Every provider will be searching for changes in business strategy, not only to maintain a status quo, but also to succeed and prosper.

What's best for you and your operation? Even though we're all rehab technology providers, each company is unique in its operations. Taking a deep look at your operational costs, purchasing habits and profit/loss margins from the available product offerings will provide you with an outlook of where you are today and what you need to do for tomorrow.

We're navigating into uncharted territories. Numerous proposals in regulatory and reimbursement are currently being discussed that will likely affect your future operations. Stay informed on all issues and get involved! Your voice, your opinions and your suggestions do matter. Take a bold step and think outside the box. You may just find others thinking the same way.

ABOUT THE AUTHOR
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IT'S DIFFICULT TO BELIEVE how fast time goes by, and it's even more difficult to believe how fast it goes by when you have a spinal cord injury. Maybe it's because I'm just so fast in my wheelchair that it makes time go by quicker, but probably not. I'm 32 years old and have used a wheelchair as my means of mobility for the past the 15 years because of a spinal cord injury.

When first injured, there is so much to learn that it's overwhelming for the person injured and for his or her family.

I had a car accident at the prime age of 17, and on July 18, 1993, the last place I ever walked on this earth was a McDonald's in Epping, N.H. I got my license the day I turned 16 years old and was the only one out of all my friends who had their own car, and I was very proud of it. It was a 1983 Chrysler LeBaron, dark blue inside and out. The tape deck was on the floor and it had a blue velvet interior, but that didn't matter. I had freedom. I named this car the Blue Bomber and drove it into the ground. By my junior year of high school I got a 1990 Chevy Beretta, which was a better fit for me. It was a reddish color and in good condition. It went faster and was even kind of sporty. I was happy with my Beretta.

Then, I totaled it when I rolled my car over three times in the median of a highway. I lost control while going 75–80 mph. A bee was in my car, so I was distracted and wasn't paying attention to the road as it curved. I went off the road and that's when the car flipped, throwing me from the vehicle. I remember looking up at the blue sky and hearing some voices. And all I knew was that I couldn't get up.

After that I had all the routine tests. The results? A complete break of the 5th and 6th thoracic vertebrae. I was paralyzed. The next few months were a blur between surgeries, rehabilitation and learning everything all over again. It was a whirlwind of major life changes in such a very short period of time.

Now it's 15 years later, but to me it seems like it was just yesterday that I was running around the soccer field and even walking on the beach or driving the Blue Bomber. I have such vivid memories of the last three weeks of my life as an able-bodied person. I can tell you what I was doing and who I was with from July 1 through July 18. I hold onto those memories because it was not only a very happy time in my life, but also a time I never want to forget—my life as an able-bodied person. In a couple of years, I will have spent half of my life as an able-bodied person and half of my life as a wheelchair user. That's just strange to think about, because being 17 seems like it was just yesterday.

Although my life turned out completely different from what I had imagined, I've done some of the most amazing things and met some of the most amazing people due to my spinal cord injury. It was something that changed my life forever.

As a wheelchair user, I don't feel any different emotionally, but there are times when it's very obvious that I use a wheelchair. Over the years my wheelchair has become more and more a part of who I am—how I "roll," so to speak. When I picked out my first car, it had to be affordable, practical, and despite the blue velvet interior, it grew on me. The Blue Bomber actually reminds me of my first wheelchair, and coincidentally my first wheelchair was also blue. And like my first car, it was also affordable, bulky and very generic. But, what did I know about wheelchairs? I was only shown a couple of wheelchairs, and because everything happened so fast throughout the rehabilitation process, the medical staff really wanted me to have my own wheelchair when I was discharged from the hospital. (It's even crazier how short the average hospital stay is for someone with my level of a spinal cord injury.) So, there I was in my second blue bomber, but this time it wasn't my first car, it was my first wheelchair.

CONTINUED ON PAGE 16

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Founder and President
of Logan Magazine

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CONTINUED FROM PAGE 14

Wheelchairs: Functional Yet Fashionable!

Once I started getting active in disability organizations and adaptive recreation, all of a sudden I saw I was the one in the room who had the dorky wheelchair. And just like in my first car, I felt a little awkward. I saw many different types of amazingly sporty-looking wheelchairs, and I was so mad I didn't know I had more choices when I was in the hospital. I really started hating the way I looked in my wheelchair. After a while I accepted it and knew I would be eligible for a new wheelchair sooner or later, but I wanted it to be the next day.

When first injured, there is so much to learn that it's overwhelming for the person injured and for his or her family. A wheelchair is someone's mode of transportation and there is so much that needs to be evaluated when picking out wheelchairs: wheels, cushions, backrests, straps, casters, tippers and the list goes on and on. But a wheelchair can also be an extension of the person sitting in it. If only I had known now what I didn't know when I was first injured, I wouldn't have left that rehab hospital with a second blue bomber in my life; I would have had at least the BMW of wheelchairs. There has been so much progress and growth in the industry of wheelchairs and options for wheelchairs, which are both for function and a little bit of fashion.

In the last 15 years I've gone from a blue bomber to a sporty little wheelchair (like a Honda Civic) to many other upgrades. Now I have a wheelchair that's an extension of who I am. I've learned a lot over the years and now I have my choice of "wheels" for my wheelchair. As far as the size of my wheelchair, I've downsized over the last five years or so. Now I'm more confident in myself. Right after I was injured I always felt as though people weren't looking at me; they were looking at my wheelchair. Now it's completely different. Now people see me first, and then the wheelchair.

Another thing that has changed is that when someone comments on my wheelchair I get fewer and fewer of people saying "Want to race?" or "Don't get a speeding ticket." Now when people see me, they compliment me on my wheelchair, whether it's about the light-up casters, the fancy design I have on my wheels, the color or just the sleek frame. In the last 15 years times have changed. Instead of a blue bomber, I have a wheelchair I'm proud to ride around in; it's functional and yet still fashionable. Maybe one day I'll have a different wheelchair to match my outfit every day. Yeah, that'll be the day. (I would need a very large garage!) Now I just need a real BMW to match my "Beemer" of a wheelchair.

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Hop On The Social Marketing Train

JACKIE KAUFENBERG
Marketing Manager
ALTIMATE MEDICAL

SINCE ALTIMATE MEDICAL DEVELOPED its first website in 1996, Internet marketing has changed tremendously. Back then, our website consisted of maybe a dozen pages; now, it's a dynamic multimedia site with hundreds of pages, and our content changes daily.

With the goal of making our website the center of all our marketing communications, we've shifted our trend from printed catalogs, CDs and DVDs to web-based electronic formats that we can update and post online instantly. Fresh website content keeps both the search engines and visitors happy. Now, enter Web 2.0.

With the goal of making our website the center of all our marketing communications, we've shifted our trend from printed catalogs, CDs and DVDs to web-based electronic formats that we can update and post online instantly.

In the past year or so, we've also dipped our toes into social online marketing (part of the Web 2.0 phenomenon) by making contacts through social networks like Facebook and MySpace, by uploading educational and entertaining videos on YouTube, most recently, by writing a corporate blog.

As rehab technology suppliers, you're probably wondering why this Internet stuff is relevant to you. Maybe one idea presented in this article will strike you as a way you or your marketing team can build business and/or network. If not, you'll at least get some insight into the websites your kids are using!

FACEBOOK/MYSPACE

Before you jump to the conclusion you're too old to be on Facebook, you should be aware that the fastest growing segment of people on Facebook are aged 35–54. In a nutshell, Facebook and MySpace are social networks that allow people to become friends, network with others, share photos and information and, ultimately, develop relationships. MySpace is thought to be edgier and attractive to a younger audience, and Facebook is commonly known as more mainstream for the mature crowd.

One of the cool things about both platforms is you can create "groups" for like-minded individuals. For instance, there are groups for people with different disabilities, for wheelchair athletes, for parents of kids with special needs, etc. Facebook also allows you to create a "page" for a business or brand, which is similar to a group, but allows a person to "become a fan" of the page. When someone becomes a fan of your business or brand, it's basically a product endorsement. Fans' "friends" will see they support your business, and those friends may become fans themselves.

LINKEDIN

LinkedIn is a more business-orientated social networking website that allows you to summarize your professional accomplishments. Similar to Facebook and MySpace, you build a network of "connections" made up of people in your industry or people you've worked with in the past.

LinkedIn highlights your education, career history and current job summary, and it allows others to "recommend" your product or services. It's basically an online resume and networking tool in one, which can be beneficial when looking for new clients, business opportunities, new hires or new jobs. Again, any user can form or join a "group" with like-minded individuals.

YOUTUBE

YouTube is a video-sharing website that's exploded over the past couple years. Anyone who has a video camera or webcam can share his or her videos with the world in a matter of minutes. Viewers can subscribe to your videos, comment on them or mark them as favorites.

You may be familiar with our "Life After Spinal Cord Injury" videos that we send out free of charge to rehabs, suppliers and consumers. Last year, we posted short clips from the videos at ***www.youtube.com/easystand*** and placed an

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Hop On The Social Marketing Train

EasyStand logo splash at the end of each clip. It's resulted in tens of thousands of video views and dozens of comments. Recently, we added EasyStand customer story videos that have become equally as popular.

BLOGGING

In August, EasyStand started a blog at ***blog.easystand.com*** that consists of posts from employees and guest contributors. Our blog topics have ranged from legislative updates to personal stories, product updates and more. The word "blog" is short for web log, which can be thought of as a journal or a collection of articles.

Unlike a static website, blogs usually have new posts each day or several times a week. Most blogs allow readers to leave comments, which encourage interaction and the forming of a community. Anyone can start a blog for free with online blogging software like ***www.wordpress.com*** or ***www.blogger.com***. All you need to do is register, choose a template and start blogging.

Why blog? First of all, if you have a company website, it's fantastic for search-engine optimization, especially if you're blogging about topics that are relevant to your business and you include links back to your main website. We noticed within minutes of making a post on the EasyStand blog, we can Google key words related to that post and find it at the top of that Google search.

Besides the benefits of search-engine optimization, a blog also allows you to provide announcements in a timely manner. As soon as you're done writing a post, going live is as simple as clicking a "publish" button. Blogs can attract new customers, develop better relationships and help make your company an expert in the field. Plus, if readers leave comments, blogs can be a great way to get feedback and interact with current or potential customers.

The value of social online marketing can be immeasurable. We know by extending Internet marketing beyond our website, we've increased our site visitors, built up EasyStand brand recognition and developed relationships with current and potential customers. The evolving Internet has changed the way many of us are doing business and communicating. People are sharing their ideas, experiences and opinions in new ways. Could you be reaching out to your customers or colleagues through social online marketing? Take some time to check out these social media website to find out.

ABOUT THE AUTHOR
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Victory?

GARY J. GILBERTI
President of NCART
President, CHESAPEAKE REHAB EQUIPMENT, INC.

WHEN H.R. 6331 BECAME law, many proclaimed victory although the legislation left us with as many questions as answers. Was this really a victory for rehab? What do we do about the 9.5 percent reimbursement cut? What short- and long-term legislative strategies are left?

We've all become tiresomely familiar with the legislative process. Providers, consumers and clinicians spent hours in congressional offices touting the value of the process, products and services that make up complex rehab technology. There were fly-ins, legislative days, CELAs and passionate arguments surrounding the pitfalls of competitive bidding and the damaging effects they would have on consumers. The good fight was fought.

It's time for the rehab industry to show Medicare the benefits provided justify the costs.

H.R. 6331 ensures rehab-technology companies won't have to face competitive bidding for Group 3 power wheelchairs and accessories when it rears its ugly head in the next 18–24 months. Oh, by the way, did we tell you it's going to cost you 9.5 percent of your reimbursement? Yes, we need to be appreciative for the "carve-out," but what's claimed as a monumental victory for the HME industry is a marginal one for rehab.

Some say the 9.5 percent cut is the price we must pay for not having to deal with competitive bidding. Others argue the 9.5 percent cut will cause the same problems for consumers, clinicians and providers as competitive bidding. Where one stands on this can depend on a number of factors and beliefs about what really would have happened had competitive bidding continued.

It seems logical the industry should go back to the Hill and fight the 9.5 percent cut. A "parallel exemption" makes sense, and the extent of the cut appears to be a disproportionate price for the rehab industry to pay for the delay and exemption when compared to the savings that were expected from competitive bidding in the 10 initial CBAs.

Throughout and after the legislative process that brought us H.R. 6331, NCART and others lobbied heavily for relief from the cut. While many want the fight to continue, the political climate for such an effort isn't favorable. Those congressional champions for complex rehab have been very clear that the industry should be content with the exemption, and that discussion about the 9.5 percent cut is a "non-starter." Some mention has been made of interest in the Senate, but that's a long shot at best. For the short term, it looks like rehab providers will need to adjust to the cut and brace for its Jan. 1 implementation.

What's the next step?

Any hope for changes to H.R. 6331 would require a strong case for a technical amendment and a legislative vehicle to carry it. Neither seems to be likely in the short term. There's a very small window of opportunity between now and the elections, and another window isn't likely to present itself until after the new administration is in place in January. Given the caution suggested by Hill staff, the industry may be better off using the time to assess the damage, make the necessary operational and product changes, and collect information that can support any strategy to rescind or modify the cut when the earliest opportunity arises.

As the Jan. 1 implementation nears, clinicians and consumer groups must monitor changes in services and products. These folks should be educated and empowered to let their representatives know they're having issues and consumer choices and options are disappearing. This will be a challenge, because many consumers won't always know what they could have had if they're not told or if they haven't had previous experience with a better product. This is no longer just a reimbursement or payment issue, and providers simply can't continue to absorb reimbursement

cuts without changing the products and services they offer.

As the legislative landscape becomes clearer after the elections, the industry can continue the dialogue on the Hill and begin to deliver the information that's been gathered. At the same time, it's critical the clinical and consumer advocates continue to educate Congress about their experiences in a post-cut environment.

And then what?

Long-term strategies are already in the works. One involves the collection of more detailed data on the costs and benefits of rehab technology. Another strategy includes moving complex rehab technology into a separate payment category within the Medicare program.

Numbers talk on Capitol Hill. It's time for the rehab industry to show Medicare the benefits provided by complex rehab technology justify the costs. Data should be collected and processed independently by those who don't have a financial stake in the results. The industry has historically relied on anecdotal information that suggests there are positive outcomes. As compelling as the story is, it won't gain the traction it needs until supporting studies carried out by clinical and academic facilities are completed. The money and time needed to produce these studies should be seen as a small investment in the future of rehab.

During the fight for exemption, it was clear complex rehab continues to be painted with the broad brush of HME. In spite of compelling arguments otherwise, it's impossible to establish any degree of separation given the current structure. This made it even more difficult for Congress to enact legislation that was favorable to this sector.

There's a growing sentiment that one solution might be to move complex rehab into a separate benefit category within the Medicare program, not unlike orthotics and prosthetics. Even with product overlap between HME and rehab, it's arguable the application of those products and the processes to provide them differ enough to establish different payment and coverage criteria.

As 2009 approaches, more will unfold on these projects. One thing is for sure: there will always be a battle for us on Capitol Hill until we can once and for all prove our value. The goal now is to arm the complex rehab industry with the information and structure that's needed to win the real victory.

Keep up the fight!

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Why I Work In Rehab

THANA A. FRANCE, ATS/P, CRTS®
NRRTS Review Chair for DMERC A
BROWNING'S PHARMACY & HEALTH CARE

I'VE BEEN IN THE medical equipment industry since 1984. Actually, you could say I fell into it. My background was in technical parts identification and customer service for the power pumps industry. I was a technical writer for a new company, Penox Technologies, where I wrote manufacturing and quality-control procedures. That experience led me to regulatory affairs, which was pretty interesting, or at least I thought so then. My husband and I wanted to move to Florida, so when there was a sales opening there with Penox, I asked for it. I eventually left Penox and went to work as a regional sales manger for another manufacturer.

I'd rather be involved in fighting for my own destiny than allowing others to do it for me.

My first exposure to rehab happened when I went on a business trip to visit Jay McGinn, my company's North Carolina sales representative. He asked if I minded making a stop to help a therapist he worked with on a regular basis; her name was Barbara Levy. I watched as she and Jay did a wheelchair evaluation for a young boy with Duchene's, and it was fascinating.

That experience never amounted to anything further for me until George Browning asked me to join Browning's Health Care a couple of years later. During my interview, as we were exploring different contributions I might make, George uttered the words that we still occasionally laugh about: "I've always wanted to do rehab." And that was how it began. I told him my story about Jay McGinn and Barbara Levy, and said if he were willing to help me get started, I'd love to do it.

I'm very fortunate to work for George Browning, because he's from the old school of thought that believes quality and service begets sales—so am I. He's always enabled his employees to become educated in their areas of practice. We agreed early on this was the only way we would succeed at adding rehab to Browning's repertoire.

Being as green as I was to rehab, I relied upon our sales representatives to get me pointed in the right direction. Greg Stowell, our Invacare rep, helped me order my first six cushions and a power wheelchair. Paul Parparian was able to get me into LaBac School, even though it was a pretty advanced class. Stephanie Tanguay taught it, and I'll never forget the experience. I was a fish out of water, but she was a great instructor and, eventually, it all came together for me.

Browning's main office is in Melbourne, Fla., and since I lived 77 miles away in Orlando at the time, I commuted back and forth every day. (Gas was much cheaper then!) My first therapist-mentor was Ann Street from Health South/Sea Pines Rehabilitation Hospital. She invited me to attend wheelchair clinics with a couple of my competitors. I watched, listened and learned. Eventually, she stopped inviting the competitors and I worked with all the therapists to help their patients get into the custom wheelchairs they needed.

I became a NRRTS registrant after a year of doing rehab, and earned my ATS after two years. Just before the sun went down on the ATP prequalification of having "four years' experience without a Health Sciences degree," I took and passed the exam. There was a great deal of industry confusion about the two credentials then, just as there is now, and I didn't want to miss an opportunity that could arise from having both ATS and ATP certifications.

I decided to become a NRRTS board member because Michele Gunn told me she was going to ask one of our competitors to if I didn't do it. Beyond that, though, I knew this was a very critical time for our industry; this was do or die time. So, for me it was "do" time. I'd rather be involved in fighting for my destiny than allowing others to do it for me.

I've always been a "closet activist." I enjoy jumping out there and sticking myself in the middle of

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Why I Work In Rehab

things I think are wrong and need to be fixed. We all know our industry is in serious trouble, and we've worked together to get the changes, reprieves and considerations we've achieved. But we also know there's much more work to be done. I don't want to sit back and gripe if I'm not willing to work for what I believe is right.

Those of us who've joined NRRTS have done so because we believe we make a difference to those we serve. We all have success stories that make us feel warm and fuzzy, and that's what keeps us coming back for more despite the frustrations of ever-constricting funding. What better time is there than now to add your voice? We must find ways to push forward and become more seriously recognized as a powerful force in the industry.

For two years, I spoke to a woman who was suffering from MS about power mobility. If she spent one day out of bed, she would have to spend the next two days back in bed to recover from it. When she finally got her first power wheelchair, her husband bought her a van. That woman hasn't been home since!

Then there was the kid with Duchene's, whose friends had to push him around because he'd lost the ability to push himself. When he got his first power wheelchair, he tore through $400 worth of 14x4 flat-free tires within three weeks! His mom found out the friends who'd pushed him before were now riding on the back of the wheelchair with him.

But there are sad stories, too. I'll never forget the day we lost my first patient. And, there was a young man named Brandon we lost just this past year. He was young and bright and social and caring—despite the huge challenges he faced. These are the people who drive me to keep working through these hard times.

Next time you feel like you just can't take anymore, dredge up a few of these memories. Laugh or cry, but don't give up. What we do is important on so many levels and to so many people. We all need to push hard for the people who need our help.

Becoming a RTS was the best decision I've made in my professional career. We're going through some pretty tough times right now, but I still think taking the high road is the only way to go. Our most significant obstacle is getting funding and regulatory agencies to recognize the real value of the services we provide. I hope we're all going to push, and push hard, for eventual licensure, because it's in achieving licensure that we'll finally be recognized as serious professionals, separating ourselves from the stigmatism of "wheelchair sales."

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BACK TO THE FUTURE

Predicting the future of business, especially for a particular industry, isn't the easiest thing to do. We can look at trends, traditions and the forecasts for population, technology and funding sources, but at the end of the day we really don't know what will happen. To use a sports analogy, "that's why they play the game." So let's tip off.

THE CONSUMER

Modern-day end users are changing how they think when it comes to deciding what product is best for their circumstances, and this transformation is happening right before our eyes. Product information is everywhere, be it on the Internet, in consumer groups or even through direct advertising. Consumers are starting to wrestle with the responsibility of choice.

The idea that consumers are stronger together than we are apart is taking shape. Soon, there will be a battle before the health-care industry over who controls the information. The medical model will start to erode, stripping away the controlled information from the professional and giving it instead to anyone who chooses to access it. Prescription drug companies have been doing it for years. I personally never heard of any of the drugs mentioned on television until the prescription drug companies took information out of the physician's control and put it out on cable. To make this happen in our industry, we'll all need to work together—health-care professionals, social workers, consumers and funding sources, whether public and private.

Are there really enough consumers out there to make a difference? I know numbers aren't always an interesting read, but try and stay with me for a moment. We cannot always rely on the trends of the past. For instance, in 2000, 35 million people 65 years of age and older were counted in the United States. This represented a 12 percent increase since 1990, when 31.2 million older people were counted. Although the number of people 65 years and older has increased between 1990 and 2000, the proportion of them to the total population dropped from 12.6 percent in 1990 to 12.4 percent in 2000. These numbers DO NOT represent the next ten years and should not be relied on as a forecast.

Why? Enter the baby boomers, hundreds of whom are turning 50 years old every six to seven seconds. Unfortunately, if you're younger than 50 years old right now, Medicare is projected to run out of money by the time of your retirement, all because we're on the verge of a virtual explosion of adults aged 65 years and older. It's projected that the population of people age 65 years and older will reach 40.2 million in 2010, in 2015 it'll reach 46.7 million and by 2020 nearly 55 million.

These baby boomers aren't your everyday consumers, however. This generation invented the saying, "get more bang for your buck." They're a consumer group that demands the best, and they're willing pay for it. Speaking of bucks, next year the boomers can start cashing out their 401(k)s. My point is lots of people with lots of money are going to demand lots of customer service. There'll be no tolerance for cheap products, no need for self-service gas stations and no acceptance of a "wink and a nod—this chair was made for you." Research and questions will follow this consumer during the transaction, and the provider better be well versed in all products and have an answer that will satisfy all questions.

DARREN JERNIGAN
Director of Government Affairs
PERMOBIL

EDUCATION

In our current environment, there's a push for educating the end user. Education will occur naturally when those who are 65 years and older bring their wisdom to the dance. Not only is this group the most active voting block, but they'll be the smartest and most educated seniors ever, demanding to be involved in their health-care decisions and expecting the government will be accountable to them when funding earned benefits. I forecast when the time comes, AARP will be taking up industry issues; sooner than later, it'll be the most important and vocal voice in the health-care industry.

Caregivers are largely unorganized, and they still struggle to be recognized as professionals. What they do for the everyday life of a senior, or for any person with a disability, is immeasurable. Caregivers will be playing a larger role in the next ten years as boomers request to stay at home and utilize community-based services. Two educated minds are better than one, and if product and service information is provided for all to absorb, greater access to products, methods and customized care can be provided.

The voting power of senior citizens, coupled with the voices of 54 million people with disabilities, will force Congress to get educated and shift away from the traditional medical model to provide greater access to information and technology. Evidence-based research and practice will dominate the complex-rehabilitation category.

THE PROVIDER

Great opportunities lie ahead for the industry, and for the provider in particular. Currently, and reporting on 2007 Medicare numbers only, a little more than 5,000 providers furnished millions of end users with power mobility, and the government handed out just more than a billion dollars. In the near future the government will be pouring out billions (that's right, with an "s") into an industry that will desperately need to keep up with the aging population.

At the end of the day, government involvement in our business may not be as bad as one would think. What!?! Really? Regulation can be good? Sure! It can curve fraud and abuse, provide structure (like officially recognizing a category such as complex rehabilitation) and keep a finger on the pulse of the industry's growing technology in specific categories.

The role of the provider will start to diminish in the medical model, but begin to flourish in the consumer market—maybe not so much in the category of complex rehabilitation, due to the involvement of clinics and the detailed service component found in maintaining complex equipment, but definitely in markets that include adults 65 years and older who require sit-and-go mobility. Business and marketing plans will need to be adjusted and new partnerships formed, but the payoff will be through the roof!

Shows, such as Medtrade®, will become less relevant with easier access to information. Manufacturers will offer you a show's "deals" regardless of if you attended. A provider can actually log on and watch live streaming of some shows. It's not like it was in the 80s, when providers had to send half their staff across the country to remain on the cutting edge, get a great deal and see the latest and greatest products. Networking is still an advantage, and these type of shows can be a place to take classes for CEUs, or even the RESNA exam, but if you miss the show this year, you can get caught up on all the highlights plus read an opinion or two on Medtrade blogs via the Internet, or by catching up with your local rep over dinner.

THE FUNDING SOURCE

Traditionally, the government has had a difficult time keeping up with technology; however, adults 65 years and older are quite comfortable with technology and will wish it to be a covered item. Unfortunately, the nation's largest health insurance program is in danger.

A report released by the Medicare and Social Security trustees stated that the Medicare program will go broke by 2019. With the rapid decline in the number of workers per beneficiary, a rise in national health-care spending and an aging baby boomer generation, Congress will be forced to make some really tough decisions regarding Medicare soon. Reform will need to occur on a couple of fronts. Expectations of government, health-care professionals and providers will increase.

First and foremost, Congress will have no choice but to face the music; they'll be forced to raise taxes, increase premiums, cut money from the federal budget or confront the restructure of Medicare and the outdated medical model. Without a public outcry, the manipulation of funds will continue. Ah, but there will be an outcry, which leads to point number two.

The shear number of adults who are 65 years and older will dictate reform. Reform of the medical model, prices and quality of care and product will be necessary. Free information and education, customer service and absolute control over health-care decisions will be demanded. Election years are the time to enact such a battle cry, and there will always be a candidate ready and willing to listen to the concerns.

MY POINT IS LOTS OF PEOPLE WITH LOTS OF MONEY ARE GOING TO DEMAND LOTS OF CUSTOMER SERVICE.

Now for the best part: cash ... right out of the consumer's pocket and in to your account. But not so fast—as mentioned before, these educated consumers will want to look at specific models, and they'll have questions: "Does this come with tilt?" "How about financing?" We'll see such a big difference between consumer sit-and-go power and complex rehabilitation, and the everyday Joe looking to put his parent in a product will know the difference between the two.

CONCLUSION

If you thought about getting out of the business due to recent events, think again. A change here, a tweak there, and suddenly you're prepared to meet a market demand that will be starving for quality products and services, and people will be ready to hand over money without even thinking about it. You'll be the driver of a bigger, better and more effective business.

Partnerships will prosper between consumer organizations, businesses and the government. New leaders will emerge, embracing the changes of the future, and paradigm shifts in thinking will occur as they did when tilt-and-recline hit the market. But the best part is, and this is why most of us got into the market to begin with, you'll be providing a service to humanity, providing everyday quality of life that only politicians can promise to deliver. Create change, make money and someday you might retire with a smile on your face. I've never been one to get on the bandwagon, but when the bandwagon came by my house, I got on it!

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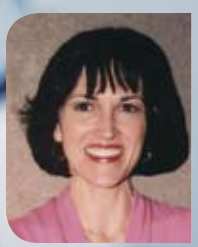
The opinions expressed in this article are those of the individual author and do not necessarily represent the opinions of the NRRTS Staff, board of directors or registrants.

REHAB
in the Future



RITA HOSTAK
Vice President Government Relations
SUNRISE MEDICAL

There are several aspects of the rehab industry that must be considered to gain perspective for predicting the future. You cannot merely sit in the moment and guess how it will turn out. However, you can look at history and expect certain outcomes absent of external forces. Consider the rehab industry like a jigsaw puzzle. Only in this case, the pieces can be moved around to result in different options for your final picture.

Without external forces, rehab will rapidly decline. It'll decline in the number of rehab companies and in the size and scope of technologies. Without external forces, rehab will become like a commodity and the last 20 years of innovation will be unavailable. That's an easy prediction to make; all you have to do is look at the number of companies that have already stopped providing rehab equipment and the manufacturers that are focused on standard technologies.

Why are they doing this? It's because reimbursement has been on a steady decline while the cost to manufacture, purchase and provide products has increased. It's because the same pricing methodology is used to create the Medicare fee schedules for standard products and rehab technologies. Therefore, the same percentage of reimbursement is there to cover the services provided with standard, commodity items as there is to cover the broader services that rehab companies provide. In layman's terms, you can make more profit selling standard products, albeit less than what it was a year ago. This is the same whether the service is for a Medicare beneficiary or any of the other payers that adopt Medicare reimbursement, or some percentage of it.

However, as tired as people are from fighting the many issues the rehab industry has faced over the last 10 years, I believe there are external forces with the potential to change the picture of the future. These forces will ultimately determine what the picture will look like next year, three years from now, five years from now and so on.

I consider the external forces to be consumers, clinicians, payers, policy makers, suppliers and manufacturers. Any one of these groups has an ability to change the picture for the future, directly or indirectly. Ultimately, it's who applies the pressure and how it's applied that will determine the future.

The need for rehab products won't go away. And, rehab technologies, selected to meet the specific and unique needs of individuals for the purpose of improving their function and therefore their lives, are worth fighting for. The real questions will be: how will the equipment be provided, how much service will accompany the products and will the equipment provided truly meet the functional needs of the individual?

CONSUMER

Consumerism is defined as the protection of the rights and interests of consumers, especially with regard to price, quality and safety. In the case of rehab technology, usefulness should be added to the definition. Consumers should be fighting to protect their rights to access the technology they require to meet their daily needs. I believe many advocacy groups have organized around the need to have a strong consumer voice in Washington for this very purpose.

These groups are numerous and growing in strength and commitment; they have the ability to be a powerful eternal force. The question for consumers and advocacy groups is how much do they know about the barriers that will deny access to the most appropriate technologies? For individuals replacing equipment, it may be easier to recognize what's happening as product choice is reduced and lower quality products delivered. But for individuals requiring equipment for the first time, it's much more difficult for them to know what they're missing when they don't know what all their options could have been. The best people to educate consumers are their suppliers and clinicians. However, suppliers and clinicians are inadequately reimbursed for the services they provide as it is, and I've heard many say they just don't have time to educate consumers about the equipment they should get but can't because of coding, coverage or pricing issues.

Ultimately it'll be important to spend some time educating consumers, because if they don't know what they're being denied, they won't see a need to use their voice. Moreover, their voice is the strongest external force for shaping a positive and stable future for rehab.

CLINICIANS

This group is another one that can apply powerful external force. Unfortunately, they have reimbursement issues of their own. Documentation requirements, billing issues, funding issues, and let's not forget, many are working in environments where they are expected to generate revenues. Does this mean they don't care about their patients? Absolutely not! But, clinicians have been told they shouldn't recommend equipment that can't get paid. So, after years of hearing this from suppliers, many clinicians find they're recommending equipment based on

payer parameters, i.e., coverage policies or pricing limitations. This may mean the consumer receives less technology than the clinician would have recommended based strictly on the individual's functional and medical needs.

Groups like RESNA, the Clinician Task Force, APTA and AOTA are engaged and applying forces to effect positive change. Top clinicians involved in seating and wheeled mobility from around the country are engaged and knowledgeable about the issues. They're willing to voice their concerns on Capitol Hill and in the conference rooms at CMS and HHS. In addition, we need more clinical evidence, more case studies and more data to support our requests for positive change.

PAYERS AND POLICY MAKERS

For the purpose of this article, I'll group these two groups together, because the dynamics are similar. Whether we're talking to CMS, a Medicaid program or a member of Congress, their goal is to meet medical necessity at the lowest cost. As a tax payer, this isn't a bad goal, at least not on the surface. And, unless there's a real access issue, payers are likely to continue implementing reimbursement cuts until they believe they're paying the least amount possible for the goods and services provided.

Whether competitive bidding moves forward, fee schedule freezes continue for another decade or some other means for reducing reimbursement is used, the bottom line is payers want to pay the lowest amount necessary for goods and services, and they want to ensure that these goods and services are only being provided to individuals with a true medical need. We need compelling evidence regarding the cost of the service component of rehab, including its clinical value. Efforts are underway to gather this information, and the results could clearly change the future of rehab.

I consider the external forces to be consumers, clinicians, payers, policy makers, suppliers and manufacturers. Any one of these groups has an ability to change the picture for the future, directly or indirectly. Ultimately, it's who applies the pressure and how it's applied that will determine the future.

SUPPLIERS

This group can apply a great deal of external force. Some of it is direct force: meetings with their members of Congress and communication with CMS or Medicaid staff. But, this group can also impact the future of rehab in an indirect way. I've heard a number of suppliers state that they are developing formularies, mandating the products that their RTSs can provide and implementing other business decisions that will reduce their costs and thus allow them to keep their doors open and provide some level of technology to their customers. It's hard to argue with survival—the need to pay the bills and meet payroll.

However, there's a slippery slope that everyone must consider. As suppliers reduce the quality and/or features available on the products they provide, and the level of service to consumers, these reductions must be disclosed. If not, they'll be accepted as standard. Unless someone is willing to share that what is being provided is less than what would have been provided a year ago, six months ago or yesterday, the lesser products and supplies will soon be the standard. The powerful voice of the consumer won't be heard, but not because they aren't willing to speak; they just didn't know they had something to complain about.

Equally as dangerous are the well-meaning and compassionate RTSs who continue to find ways, even if it ultimately results in the demise of their companies, to provide the most appropriate technology despite funding and coverage barriers. This group of suppliers, while serving their immediate customers exceedingly well, is, without knowing it, telling payers that providing a high level of technology and service at the allowable is doable. It's hard for some to see that this paradigm puts the needs of a few before the needs of the majority. Ultimately, access will be denied, but more suppliers will leave the industry and many consumers will receive less than adequate technology before the problem is recognized and change occurs.

The right strategy is to provide the best product and services based on the existing level of reimbursement and current policies. If that doesn't truly meet the needs of individuals, let them know and arm them with as much information as possible to fight for their rights.

Suppliers also have the ability to track their costs and track the impact of reimbursement or coverage changes on the goods and services they provide. This type of data is invaluable. Valid and reliable data, along with the voice of the consumer, are the strongest forces to result in a better picture for the future of rehab.

MANUFACTURERS

This is a group that can apply a great deal of external force, too. This force, too, can be direct or indirect. Manufacturers have their own needs, and they want to support every other stakeholder in the equation—their supplier customers and their consumer customers, as well as the clinical community that prescribes and recommends their products. The external forces of manufacturers have been extremely important in creating the current picture of rehab. There's no doubt that this will continue to be the case. However, indirect pressure from manufacturers also shapes the future.

One product development strategy that's been applied a number of times through the years takes place when a manufacturer builds a standard product and adds rehab features. This results in two key problems. First of all, it blurs the line between standard and rehab (the impact of that is another article). Then, since most payers lack knowledge regarding the features and options of the various

technologies and their clinical application, this may cause payers to down-code from a rehab product to a standard product, referencing "least costly alternative" policy language.

This product development strategy might be implemented with all the best intentions. It happen due to the fact that justifying rehab technologies can sometimes be difficult, causing suppliers to provide standard products. The manufacturer may believe that offering some of the rehab features on standard products provides better function for the consumer who really needs the rehab product. Or, the strategy might be to corner a market by using the "least costly alternative" policy to gain market share.

Even when the strategy is benevolent, it can have dangerous consequences. This strategy may cause payers to adopt coverage policies that make it exceedingly difficult to obtain the higher-level technology—technology that may have enhanced function for many individuals. Keeping the light bright between standard and rehab allows clearer policy development, facilitates the collection of rehab data and makes conclusions clear and relevant. It makes it easier to demonstrate access issues, and it makes it much easier for clinicians to justify the medical need for products.

THE FUTURE PICTURE

Regardless of the external pressure, the picture won't change overnight. Year one may only result in stopping the bleeding—stabilizing the marketplace. But, if there's a bright line drawn between rehab and standard products, and if the right standards are developed and enforced for each category, the rehab industry can begin to obtain strong data regarding clinical outcomes and the associated costs.

There can be a solid strategy developed to segment rehab, and this could lead to reimbursement that covers the services that accompany these products. It could also lead to better coverage policies for rehab technologies. With this progress, innovation will be stimulated and improving people's lives will once again become the focus. Young, energetic and compassionate people will once again be drawn to this industry not for the money—that was never what attracted people to the rehab industry—but because they can earn a living while improving people's lives. I'm confident that this can be the future of rehab if the right external forces are applied.

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The opinions expressed in this article are those of the individual author and do not necessarily represent the opinions of the NRRTS Staff, board of directors or registrants.


Our job now is to
reach our goal of
greater recognition
for the services
we provide.

CARA C. BACHENHEIMER
Senior Vice President of
Government Relations
INVACARE CORPORATION

The Future of Rehab and RTSs

RESNA's decision to consolidate the designations of assistive-technology supplier and assistive-technology practitioner into a single certification is important; the designation will no longer be tied to a role, but rather, it'll be knowledge-based. As RESNA officials announced, the new designation "recognizes professionals who have reached an internationally accepted standard of knowledge in assistive technology and who adhere to RESNA's code of ethics and standards of practice." The change is effective Jan. 1, 2009.

This change enables us to actively pursue greater recognition (and payment) for the services provided by the new ATPs. I would expect an increasing number of payers (particularly state Medicaid programs and private payers) to require the new ATP credential for the following product areas: Group Two power wheelchairs with powered seating, and Group Three and higher power wheelchairs, as well as seating and positioning products above the general-use categories.

On the other hand, the ATP credential should be buttressed by more rigorous educational requirements. We often look at the success of the orthotics and prosthetics professionals and consider how they successfully achieved recognition and payment for the services they provide. We must remember their certification programs have more stringent educational requirements. Similarly, we need to strengthen the educational requirements for the ATS credential.

On a positive note, Congress' decision to permanently exclude high-end rehab for any and all future competitive-bid programs allows rehab the opportunity to further distinguish itself from the rest of the industry. Our job now is to reach our goal of greater recognition for the services we provide. To do this, we must develop objective quantifiable data that sufficiently differentiates us and demonstrates the real value we provide to consumers and to the overall health-care system.

Given the increasing budget pressures (that will only increase in the next few years), it is more imperative now than ever before that we develop this data, or payers simply won't recognize (or pay for) our value. Any services that don't have demonstrable value won't be supported.

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UPCOMING OPPORTUNITIES FOR HEALTH-CARE REFORM

JULIA PIRANO, PT, ATP
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PRIDE MOBILITY PRODUCTS/
QUANTUM REHAB

HEALTH-CARE AND MEDICARE REFORM are going to continue playing a significant role in shaping the face of rehab businesses, of the rehab-technology supplier and of the provision for mobility-assistive equipment in 2009, which will lay the foundation for years to come. Working together as an industry, we have an opportunity to influence, impact and direct change from a legislative and regulatory perspective, but we need to know what the threats and opportunities are to succeed.

A 9.5 PERCENT PAYMENT reduction for all products bid in round one of competitive bidding is the first change the industry will see, beginning Jan. 1, 2009. This will be difficult for providers to absorb when furnishing power wheelchairs to the growing number of senior citizens who require this type of intervention. At the same time, the industry will need to stave off the application of this reimbursement reduction in state Medicaid programs and commercial insurance fee schedules.

While the application of a 9.5 percent payment reduction for complex-rehab power wheelchairs and related accessories shares the same challenges and opportunities as standard power mobility, the stakes are higher for the complex-rehab product category. The preliminary information from a survey of the complex-rehab industry indicates that pretax profits of a complex-rehab company are between 3.44 percent and 6.87 percent, which doesn't leave room to absorb a 9.5 percent reduction without significant restructuring.

An industry survey designed to identify what changes companies that provide the uniquely configured, labor-intensive complex-rehab power wheelchairs will be making indicates there will be significant changes to the products companies offer, a reduction or elimination of the services they provide and a reduction in staff who are necessary to process an order in a timely manner.

Of particular concern is the fact some companies indicated they'll no longer be able to provide complex-power wheelchairs for the severely disabled beneficiaries in their area. The industry provided sound, rational arguments as to why this product category should be removed from the competitive bidding program, and we succeeded in that effort. Now we have an opportunity and obligation to let our legislators know of the impact a 9.5 percent reduction will have on our business and on the beneficiaries we serve to secure a parallel exemption from this payment reduction.

We may also see the competitive-bidding contracting process restart in 2009, with changes and improvements required by MIPPA. The program is expected to include all Group Two power wheelchairs, including single- and multiple-power option wheelchairs, which are considered complex-rehab power wheelchairs according to medical policy. Most power wheelchairs are uniquely configured to meet the physical, functional and environmental needs of the individual; therefore, it will be imperative for companies that submit a bid in the power wheelchair category to do a thorough evaluation

of all costs associated with providing the products and services covered by the bid amount for each HCPCS code.

The Office of the Inspector General (OIG) and CMS firmly believe significant savings can be realized through the competitive bidding program based on Internet and other pricing models. If companies don't take the time to factor in their operating expenses and the cost of the "services" they provide during the bid submission process, the essential services that support the inclusion of power mobility products in the continuum of medical care will be lost, and the way mobility-assistive equipment is provided for all product categories under Medicare reform will likely change.

If companies are mindful of the essential services they provide throughout the algorithm of mobility-assistive equipment, there will be an opportunity to influence the direction homecare takes in health-care reform.

Funding sources have traditionally set fee schedules for products based on antiquated methodology, with little to no regard for the services required to dispense the product. In 2009, the PDAC (Pricing, Data Analysis and Coding) contractor, Noridian Administrative Services, is expected to look at manual wheelchair coding, coding of additional repair and replacement parts, and the possible expansion and/or redefinition of current HCPCS codes.

They may pick up where the SADMERC left off with a project, use a portion of the SADMERC information and move forward, or scrap the SADMERC information altogether and begin a new project. In any case, it's also expected there will be new timelines, guidelines and coverage criteria for the provision of many of the products that fall under the policies for manual wheelchairs, wheelchair options and accessories, and wheelchair seating, which will impact the business operations of a rehab company and the responsibilities of the certified rehab-technology supplier.

In addition, the topic of fraud and abuse will be at the forefront of every discussion regarding Medicare and health-care reform. While the industry is threatened by the companies that continue to make headlines, providers have an opportunity to put action into words by becoming accredited in early 2009, long before the Sept. 30 deadline. They have an opportunity to lead by example, to take an active role in the legislative and regulatory process, to highlight homecare as the most cost effective method of delivery for medical care and to come together and make recommendations for Medicare and health-care reform that may be very different from the "the way we've always done it."

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The opinions expressed in this article are those of the individual author and do not necessarily represent the opinions of the NRRTS Staff, board of directors or registrants.

Delayed But Not Dead: MIPPA And The Future Of Dmepos Competitive Bidding

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Attorney
BROWN AND FORTUNATO, PC

ON JULY 15, 2008, Congress passed H.R. 6331, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). In addition to delaying competitive bidding by 18 months, MIPPA imposes other changes on the HME industry.

Overview: Competitive bidding was created by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). On May 18, 2008, CMS announced the contract winners for Round One. The competitive bidding program went into effect on July 1, 2008. Two weeks later, Congress overrode a presidential veto and enacted MIPPA.

In addition to delaying competitive bidding by 18 months, MIPPA imposes other changes on the HME industry.

MIPPA's Effect on Suppliers: 18-Month Delay

MIPPA terminates contracts awarded under Round One and delays competitive bidding for 18 months. Suppliers must rebid for contracts in the 10 CBAs in 2009. Additionally, MIPPA delays Round Two until 2011.

Reimbursement: According to MIPPA, supplier reimbursement for DMEPOS reverts back to the fee-schedule amounts applicable prior to July 1, 2008. To the extent possible, CMS will automatically reprocess claims that were (1) paid under competitive bidding and (2) denied solely due to competitive-bidding rules.

9.5 Percent Reduction in Fee-Schedule Payments: To finance the delay, MIPPA will cut fee-schedule payments for DMEPOS items covered by the 10 product categories in Round One by 9.5 percent nationwide, beginning Jan. 1, 2009. The fee schedule reduction also applies to diabetic supplies, but only if furnished through mail order.

Items not subject to competitive bidding will receive an inflation update of five percent for 2009, which is the percentage increase in the consumer price index for all urban consumers (CPI-U) in the 12-month period ending June 2008. For 2010 through 2014, fee schedules will be increased annually to reflect the CPI-U increase. In 2014, fee-schedule payment amounts for the items that were subject to the 9.5 percent cut in 2009 will receive an additional two percent increase, except where CMS has adjusted those amounts based on the competitively bid prices for the same items.

Repeal of Transfer of Ownership of Oxygen Equipment: The Deficit Reduction Act of 2005 (DRA) imposed a "rent-to-buy" requirement on oxygen equipment. According to the DRA, beginning in 2006, title to oxygen equipment would automatically be transferred to beneficiaries after 36 months of renting. MIPPA eliminates the title transfer, but the rental cap remains.

Under MIPPA, after the 36th continuous month during which payment is made for rental equipment, the supplier retains ownership of the equipment but must continue to furnish the equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment. CMS will continue to pay suppliers for oxygen contents and delivery during the period of medical need. However, payment for maintenance and service is not guaranteed. Maintenance and servicing payments will be made for parts and labor not covered by the supplier's or manufacturer's warranty, but only if CMS determines such payments to be reasonable and necessary.

Postponement of Accreditation Requirement: As a result of the delay, MIPPA cancels the accreditation deadlines previously established for Round Two. However, the previously established Sept. 30, 2009, accreditation deadline for all DMEPOS suppliers is still in effect.

Restitution for Damages: MIPPA establishes a method to compensate suppliers that sustained monetary damage as a result of the termination of contracts from Round 1. According to MIPPA,

CONTINUED ON PAGE 42

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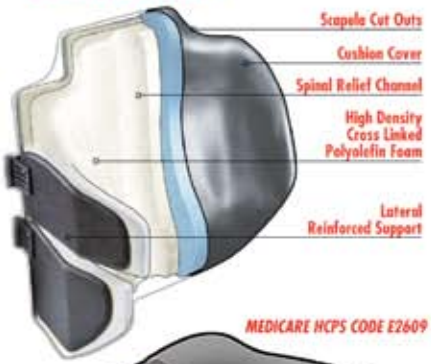

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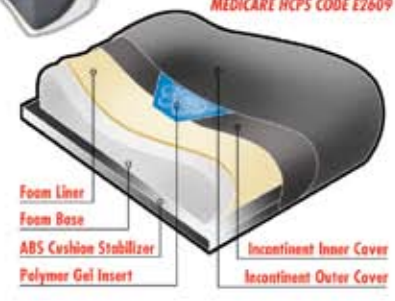

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Delayed But Not Dead...

the federal government will make available $20 million for the fiscal year 2008 and $25 million for each of fiscal years 2009 through 2012 for this purpose. To the extent they can prove damages, suppliers will receive compensation from the CMS Program Management account.

MIPPA Reforms to Competitive Bidding

Round 1: According to MIPPA, Round 1 of competitive bidding will begin in 2009. Round 1 will include all of the same MSAs named before MIPPA's enactment, except for Puerto Rico. Furthermore, all product categories will be the same as before MIPPA's enactment, except that negative wound pressure therapy items and services will be excluded.

Round 2: MIPPA indicates that Round 2 will include the same MSAs originally selected for Round 2. MIPPA gives the Secretary of the Department of Health and Human Services (the "Secretary") authority to subdivide MSAs with populations of at least 8 million into separate areas for competitive bidding purposes.

Subsequent Rounds of Competitive Bidding

In implementing subsequent rounds of competitive bidding before 2015, the Secretary will exempt the following: (1) rural areas; (2) MSAs not selected under Rounds 1 or 2 with a population of less than 250,000; and (3) areas with a low population density within a selected MSA.

Elimination of Items from Product Categories

For all rounds of competitive bidding, MIPPA exempts complex rehabilitation wheelchairs and related accessories and negative pressure wound therapy devices and related accessories. Certain off-the-shelf orthotics are exempt if furnished by a physician or practitioner to his or her own patients. Off-the-shelf orthotics and HME, and supplies furnished by a hospital to its patients during an admission or on the date of discharge, are also exempt.

Supplier Feedback on Missing Financial Documentation

MIPAA establishes safeguards for suppliers that do not submit all required financial documentation when bidding for a contract. Specifically, as long as a supplier submits financial documents with its bid before the specified document review date, CMS must notify the bidder of all missing documents not later than 45 days (for Round 1) or 90 days (for subsequent rounds) after that date. CMS may not reject a supplier's bid on the basis that a document is missing or untimely as long as the supplier submits all missing documents within 10 business days after the supplier receives notice. This provision does not require CMS to notify a supplier of the accuracy or completeness of the covered documents it has submitted.

Disclosure of Subcontractors

According to MIPPA, no later than 10 days after the date a supplier enters into a competitive bid contract, the supplier must disclose all of its subcontracting relationships to CMS, and must inform CMS whether each subcontractor is accredited.

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Jeffrey S. Baird, Esq., is chairman of the Health Care Group at Brown & Fortunato, P.C., a law firm based in Amarillo, Texas. He represents home medical equipment companies, pharmacies and other health-care providers throughout the United States. Mr. Baird is board certified in health law by the Texas Board of Legal Specialization. He can be reached at 806.345.6320 or jbaird@bf-law.com.

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On Board The Electronic Train: Are You Taking Advantage Of The Opportunities Available To You?

ANDREA STARK
Consultant
MIRAVISTA, L.L.C.

TODAY'S ELECTRONIC WORLD PRESENTS DME companies with more and more opportunities to increase reimbursement efficiencies. In light of the inevitable reimbursement cuts and competitive bidding challenges, it's increasingly important providers explore new approaches to streamlining operations.

Virtually every provider is using electronic software to create claims, that's a given. Recent estimates for Medicare claims processing indicate more than 97 percent of all claims processed by the contractors are received electronically. The question on the table is: Are we this successful as an industry at sending the same percentage of electronic claims to our other payers? Unfortunately, I find most businesses are underserved in this area.

By expediting your claims processing protocols, you'll see an increase in revenue flow and find your staff has more time to spend on other important issues within your business.

Paper claims take a lot of time to process; they must be matched to prescriptions and paper EOBs, stamped, addressed, stuffed into envelopes and then signed, among other tasks. Additionally, we have to wait for weeks or months to find out if there were any problems with the claim's address or with the formatting of the claim forms. All of this time spent waiting results in money down the tubes.

Providers can experience a much greater success rate and accountability by sending these claims electronically. When is the last time you analyzed your payer list? At a minimum, you would be well served to identify your top five to 10 payers and contact them to see if they accept claims in the 837 format. Because your software already produces electronic claims in this format, it's the most efficient way to bill your claims. If the payers don't accept claims directly via a Web portal, FTP or modem-type connection, ask if they work with any preferred clearinghouses.

Filing claims electronically offers some obvious perks with regard to reducing production time, but it also allows for more accountability to both billers and the payers. For example, for every batch of electronic claims sent, a 997 report is produced, which can assure you the batch was accepted without critical errors. Often another report will detail the acceptance or rejection of each individual claim, giving you the opportunity to correct rejected claims and reduce costs associated with claim filing. For example, you may quickly catch the patient's ID is not valid or recognized, you did not send the right modifier for the product or you didn't format the dates correctly. The delay in finding out this same information from a returned paper claim can create its own set of problems.

Another perk that comes with filing electronically is faster payments. When you file electronically, the claims that are accepted are typically "dumped" into the claims processing system, whereas paper claims have to be scanned, sent through an OCR program or manually keyed into the system—processes that can increase the risk of keying errors on the payer side.

With a clearinghouse, you can use your software to create a single batch of claims for multiple payers that gets uploaded to one site. The clearinghouse then takes care of getting the claims to the appropriate destination. Just think: you could be sending thousands of claims to thirty different payers in less than a minute!

There are some clearinghouses that don't charge any fees for this service, while others charge a per-claim fee. What's most important is to determine which clearinghouse(s) has the greatest number of payers on your list, so you can then use it for those payers. Some clearinghouses

also offer added services such as a rejected-claims module to easily identify and resubmit claims that don't make it to the final destination, the stuffing and mailing out of patient statements, and eligibility verification for multiple payers. Because of these added benefits, it's worth your time and investment to look into using the services of a clearinghouse. A simple Google or Yahoo search for the words, "professional claims clearinghouse," will provide you with numerous options to consider.

By expediting your claims processing protocols, you'll see an increase in revenue flow and find your staff has more time to spend on other important issues within your business.

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Andrea Stark is a Medicare consultant and reimbursement specialist for medical equipment suppliers and pharmacies. She founded MiraVista LLC after working for the Region C DMERC, and now provides consulting and education services throughout the country. She also operates a medical equipment billing company, ClaraVista LLC, for outsourced DME billing.Andrea can be reached via e-mail: andrea@miravistallc.com.

CELA 2009

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Tuesday, April 21, 2009

7:00am
Breakfast and Orientation to Capitol Hill visits

8:30am
Buses depart for Capitol Hill

5:00pm
Buses depart Capitol Hill

Wednesday, April 22, 2009

7:00am to 8:30am
Breakfast and Capitol Hill Visits Debriefing

8:45am to 9:30am
Saying No: A Survival Skill for Complex Rehab Providers and Therapists
Gerry Dickerson, CRTS®, Director of Rehab Technology, Medstar, Inc.

9:30am to 11:00am
Doing More With Less: Making Appropriate Seating and Wheeled Mobility Clinical Decisions in the Face of Funding Cuts, Part 1: Manual Wheelchairs and Seating
Moderator:
Joni McGhee, OTR, Clinical Coordinator, TIRR/Memorial Hermann
Panelists:
Foster Davis, Freedom Designs
Tom Whelan, Global Vice-President, Seating, Sunrise Medical
Tina Roesler, MSPT, ABDA, Director of Sales & Education, TiLite

11:00am to 12:30pm
Doing More With Less: Making Appropriate Seating and Wheeled Mobility Clinical Decisions in the Face of Funding Cuts, Part 2: Power Wheelchairs and Seating
Moderator:
Joni McGhee, OTR, Clinical Coordinator, TIRR/Memorial Hermann
Panelists:
Mike Babinec, OTR/L, ABDA, Product Manager: Power Wheelchair Electronics, Invacare Corporation
Julie Piriano, PT, ATP, Director, Rehab Industry Affairs, Quantum Rehab
Ann Eubank, OTR/L, Director of Education, Permobil

Thursday, April 23, 2009

8:00am to 9:00am
Looking Back: Lessons for the Future
Hymie Pogir, Vice President of Product Planning, National Seating and Mobility

9:15am to 10:45am
Powered Mobility Training for Children with Complex Needs
Karen Kangas, OTR/L, Seating and Positioning Specialist, Shamokin, Pa.

9:15am to 10:45am
Fixed Postures? Flexible Opinions
Tom Hetzel, PT, ATP, CEO, Ride Designs/Aspen Seating

11:00am to 12:30pm
Bariatric Seating: Challenges, Techniques and Technology
Pat Meeker, MS, PT, CWS, The ROHO Group

11:00am to 12:30pm
Stable, Not Static: Dynamic Seating to Improve Movement and Function
Allen Siekman, Siekman Consulting

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Margaretville, NY 12455
Office:845-586-4720
Toll Free: 800-952-5868
Fax: 845-586-4716
Registration Date: 8/18/2008

Mary S. Sepulveda, RRTS®
GMA Assistive Technologies
Office:626-399-6278
Fax: 626-628-3946
Registration Date: 8/7/2008

Dustin Silveri, RRTS®
Choice Healthcare
500 North 56th Street, Suite 20
Chancler, AZ 85226
Toll Free: 888-250-5003
Fax: 775-201-0130
Registration Date: 8/18/2008

CRTS® CREDENTIALS

Congratulations to NRRTS Registrants recently awarded the CRTS® credential. A CRTS® receives a lapel pin signifying CRTS® or Certified Rehabilitation Technology Supplier® status and guidelines about the correct use of the credential. Names listed are from July 19, 2008 through October 16, 2008.

Michael Bavaro, ATS, CRTS®
Hudson Home Health Care, Inc.
Newington, CT

Alan F. Bettencourt, ATS, CRTS®
Premier Medical Supply, Inc.
Ceres, CA

Shannon Lee Cook, ATS, CRTS®
Glass Seating & Mobility
Huntsville, AL

Jason Duewel, ATS, CRTS®
Doctors Equipment Service, Inc.
Kansas City, MO

Richard Friedman, ATS, CRTS®
Independent Mobility Services
Hialeah, FL

Margaret Galaska, COTA, ATS, CRTS®
Agnesian Healthcare Enterprises
Fond du Lac, WI

Joseph Gilkerson, ATS, CRTS®
Chesapeake Rehab Equipment, Inc.
Salisbury, MD

Efrain R. Guerrero, ATS, CRTS®
Border Mobility, Inc.
McAllen, TX

Christopher Liquori, ATS, CRTS®
Hudson Home Health Care, Inc.
Newington, CT

Nathan Lyon, ATS, CRTS®
Acute Rehab Equipment
Valdosta, GA

Warren R. Oliver, ATS, CRTS®
ATG Rehab
Mountain View, CA

Richard E. Olson, Jr., ATS, CRTS®
Beaumont Home Medical Equipment
Southfield, MI

Loretta Pender, ATS, CRTS®
Advanced Rehab Technologies
Urbandale, IA

Richard Petersen, ATS, CRTS®
Reflection Medical, Inc.
Temperance, MI

Randall Scott Powell, ATS, CRTS®
A Plus Medical
Evans, GA

Kendall Richards, ATS, CRTS®
LTC Providers, Inc.
Sullivan, MO

CRTS® CREDENTIALS

Debra Robinson, ATS, CRTS®
Choice Medical Billing and Supply
Rogers, AR

Daniel P. Swain, ATS, CRTS®
National Seating & Mobility, Inc.
Chicopee, MA

Bill Wilson, ATS, CRTS®
U of M Wheelchair Seating Services
Ann Arbor, MI

Manuel Yzquierdo, ATS, CRTS®
South Texas Monitoring Systems
McAllen, TX

ATS CREDENTIALS

Congratulations to NRRTS Registrants who earned the ATS credential. Depending upon their registration date, they will be awarded CRTS® upon completion and approval of the renewal following fulfillment of required registration. Names included are from July 19, 2008 through October 16, 2008.

Efrain R. Guerrero, ATS, CRTS®
Border Mobility, Inc.
McAllen, TX

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

FORMER NRRTS REGISTRANTS

The NRRTS Board determined RRTSTM and CRTS® should know who has maintained his/her registration in NRRTS, and who has not. Names included are from July 19, 2008 through October 16, 2008. For an up-to-date verification on Registrants, visit www.NRRTS.org, updated daily.

Paul Amsterdam, ATS	Bethpage, NY
Robert P. Bechtel, ATS	Ann Arbor, MI
Lee E. Bowman, ATS	Albuquerque, NM
Chad Carman	Fife, WA
Clint Chester	Tampa, FL
F.L. Douglass	Bakersfield, CA
Michael S. Duda, ATS	Indian Trail, NC
Rick Formanek	Mason City, IA
Sydney Gubin, ATP, ATS	Palm Springs, CA
Regena Hawkins	Augusta, GA
Cheryl D. Hunter, ATS	Seattle, WA
Dennis M. Layton, ATS	Collinsville, IL
Hugh O'Neill, ATP	Berkeley, CA
Brent E. Parker, Jr.	Idaho Falls, ID
Brent Pedigo	Albany, GA
Rick Pedigo	Cookeville, TN
Roberta Powell	Corpus Christi, TX
Scott Ray	Greenville, SC
Tracy L. Smith, ATS	Seattle, WA
Pamela K. Westhoff	Kansas City, MO

[NRRTS] 08-09 TeleSeminar Series

.2 CEUs FOR EACH TELESEMINAR WILL BE PROVIDED

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

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

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

TeleSeminar Series Registration Fees

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

Individual TeleSeminar Registration Fees

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

Register on-line at www.nrrts.org or by phone at 800.976.7787.
Long distance charges may apply and .2 CEUs have been applied for.

Cancellation Policy: No refunds will be provided.

Thursday, November 20, 2008 • 5:00pm to 7:00pm Eastern

PELVIC STABILITY TECHNOLOGY AND CLINICAL APPLICATIONS

Michelle Lange, OTR, ABDA, ATP & Dave Hintzman

This course will present strategies for positioning the pelvis for stability, function, orthopedic alignment and comfort. Seating challenges, including pelvic posterior tilt, anterior tilt, obliquity and rotation will be presented in the context of user and wheelchair causative factors. Strategies to address each seating challenge will then be discussed in the context of the goals of the intervention. These goals also can be used for funding justifications. Dave is president of Bodypoint Designs, and Michelle evaluates children and adults in the areas of positioning, mobility, access to communication devices and computers, and electronic aids to daily living. She is a frequent author and speaker.

Thursday, December 11, 2008 • 5:00pm to 7:00pm Eastern

KEEPING UP: AN OVERVIEW AND COMPARISON OF NEW POWER WHEELCHAIR ELECTRONICS

Michelle Lange, OTR, ABDA, ATP

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

Thursday, January 22, 2009 • 5:00pm to 7:00pm Eastern

DESTRUCTIVE POSTURAL TENDENCIES, IDENTIFICATION AND TREATMENT

Tom Hetzel, PT, ATP

This workshop provides advanced principles for the evaluation and treatment of destructive postural tendencies in sitting and intervention strategies relative to specific postural tendencies as they relate to seating and wheelchair configuration. Out-of-wheelchair strategies directed at reduction of destructive tendencies in sitting will also be understood. Tom is CEO of Ride Designs, Inc.

February 19, 2009 • 5:00pm to 7:00pm Eastern

BARIATRIC SEATING

Pat Meeker, PT

Participants in this session will be able to identify the scope and problems associated with obesity and bariatrics, identify the causes and dynamics of bariatric clients medical management, demonstrate various safety issues associated with the bariatric client, describe the solutions for choosing appropriate equipment and caring for the bariatric client's skin, understand the challenges faced in seating and wheeled mobility and will discuss the multidisciplinary team efforts to plan the bariatric client's care. Patrick is Director of Sales and Clinical Specialist for the East Region and also manages sales in Australia/New Zealand for the ROHO Group. He has been with ROHO for ten years.

March 19, 2009 – 5:00pm to 7:00pm Eastern

WASHINGTON UPDATE

Gary Gilberti

This presentation will review what has happened in the last 12-18 months and the opportunities available in the next 12 months. Questions that will be answered include. What strategies can be employed in DC for the benefit of complex rehab? And what can NRRTS, NCART, etc. do? Gary is president of NCART and president of Chesapeake Rehab Equipment in Baltimore, MD.

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PRM The Power of Precision
Quantum Rehab Innovative Rehab Solutions A Division of Pride Mobility Products Corp
Aspen Seating
Ride
Stealth Products
Sunrise Medical Quickie
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Guy Henningsson

GUY HENNINGSSON
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