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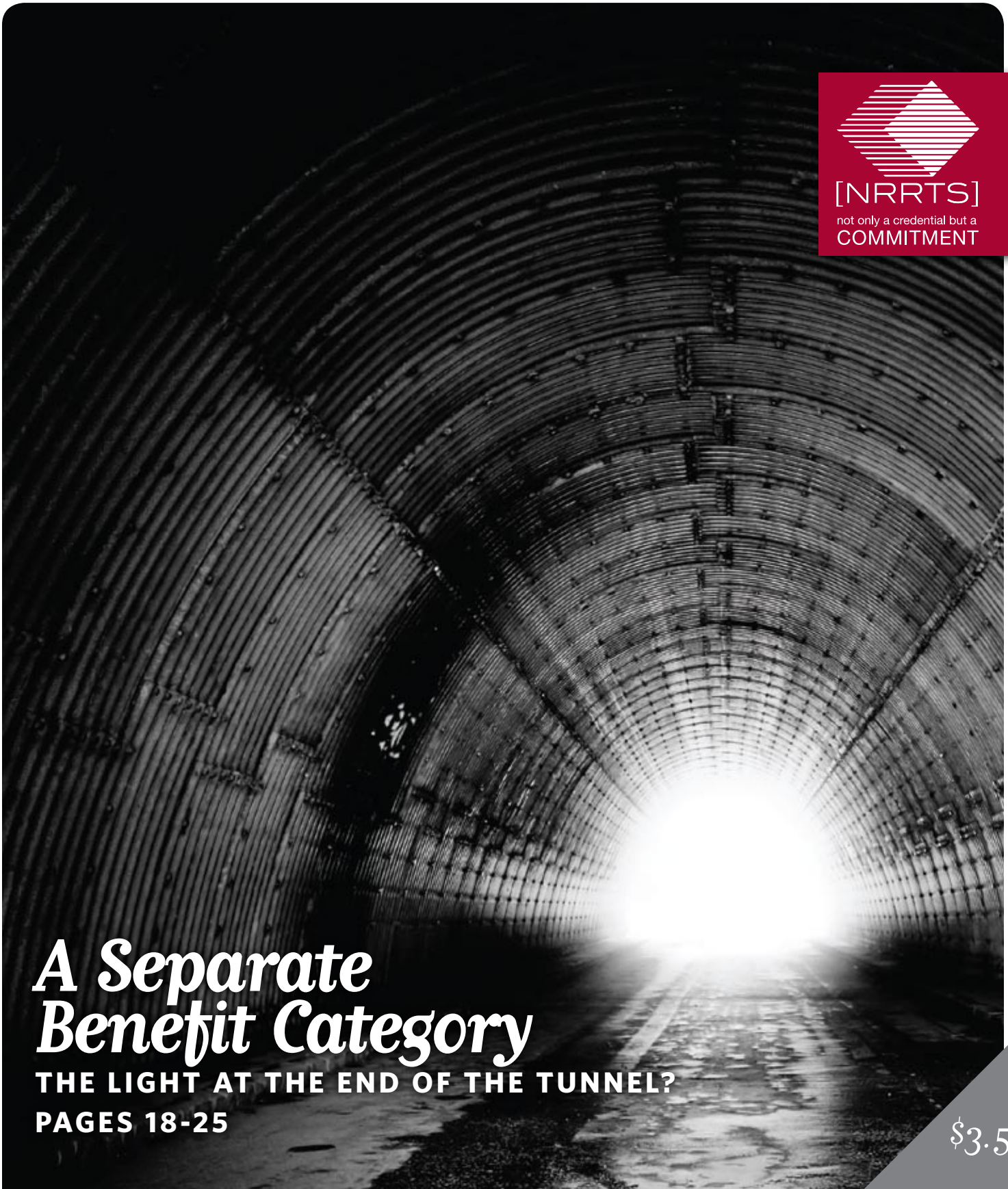
VOLUME 3 | EARLY SUMMER 2009

DIRECTIONS



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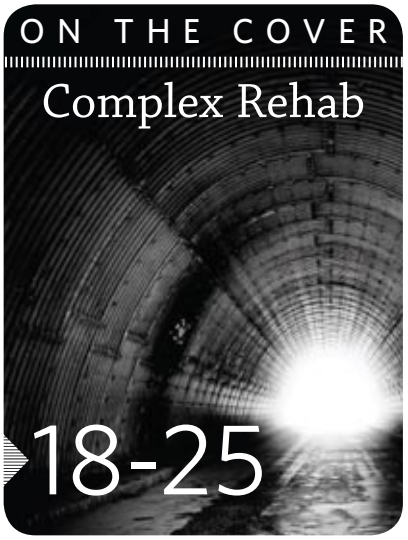


NRRTS & THE INDUSTRY

NRRTS TELESEMINARS 2009
TeleSeminar Series
[MORE INFO ON PAGE 56 & 57]

FEATURES

NRRTS DIRECTIONS is readily available for download off the NRRTS website: **www.nrrts.org**

$60 Billion

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

RECENTLY, ONE OF THE nightly news programs aired a segment on Medicare fraud. They interviewed a convicted operator of a Medicare scam who related how easy it was to set up a shell business that billed millions of dollars a year. He went on to explain how he had used props to support the shell business for rare visits from inspectors. Actually, he only remembered one inspector visit in the first year.

Why is it necessary to fight for fair allowables when clearly there is enough money to adequately fund complex rehab?

For just one year, the estimated amount Medicare spent on fraudulent claims is $60 billion, and some think that could be a very conservative estimate.

This is the response from CMS to address the recent reports of fraud: "HHS and CMS continue to aggressively target DME fraud on several levels, and it remains a top priority. It is appalling that some seek to steal from a program intended to help millions of people, including some of our country's most vulnerable citizens."

Well, this certainly makes me feel better. I guess they have forgotten all they learned regarding fraud in Harris County, Texas, just a few years ago. Do the words "wheeler dealer" ring a bell?

Isn't it ironic that somewhere in South Florida, a guy was driving around in a Rolls-Royce paid for with our health-care dollars while I got a denial because an ABN was filled out using the wrong font size? Apparently, I have a lot more questions than answers. Nothing amazes me anymore.

In April, CELA participants spent a day on Capitol Hill visiting legislators and their staff. The mission was to test the waters for granting complex rehab a separate benefit category and to restore the 9.5 percent cut to allowables. It was estimated that adding the 9.5 percent back to complex rehab would cost some $8 million a year—just chump change to Medicare.

I do wonder why we aren't hearing more about efforts to get this runaway system under control. Wouldn't $60 billion a year go a long way to fund complex rehab? Okay, what about half of that amount? Even $30 billion would be a good start for funding.

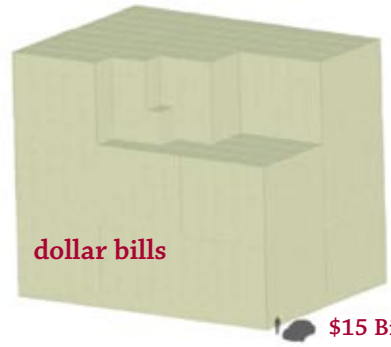
We were only asking for $8 million. Let's look at it this way: $8 million equals .01 percent (one hundredth of one percent) of the money wasted on fraud.

What's wrong with this picture?

How much is $60 billion? It is difficult for most people to truly understand this huge amount. According to the Forbes Report, $60 billion could:

- put $9.19 in the pocket of every person on the planet;
- fund the American Cancer Society for the next 103 years;
- If earning 8 percent annually, indefinitely pay the salary of 104,753 public school teachers (average pay: $45,822 a year).
- cover the American Red Cross' annual operating expenses for the next 17 years.

It takes four of these stacks to equal $60 billion!



Just how much is $60 billion? Each pile of one dollar bills is 60 feet high, 150 feet long, and 62.5 feet deep. It would take four of these piles to equal $60 billion.

Enough fun facts about $60 billion. Why is it necessary to fight for fair allowables when clearly there is enough money to adequately fund complex rehab?

I wish I had all the answers. I do know that as we gain more information we must share it with consumers. Arm them with knowledge. Give them the tools to speak up. Not just some of us, but all of us must contact our representatives and senators and ask these questions. Got the picture? Are you mad yet? D

ABOUT THE AUTHOR
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Keep Access for Consumers with Disabilities

ANDREW DAVIS
Consumer

FORTY-ONE YEARS AGO, I was born with spina bifida myelomeningocele. You may have heard it referred to as "open spine;" there was an opening in my spine and the nerves from the spinal cord were on the outside of my back and encased in a fluid-filled sac. A neurosurgeon performed surgery on me, pushed the nerves back inside and closed my spine. (Those nerves had to be put back inside, or I would have suffered from more paralysis, infection or even death.)

Disabled consumers shouldn't have to wait a year and a half from the time the doctor writes them the prescription to get what they need.

The first 20 years of my life were filled with 20 operations and years of physical therapy, as well as the battle to be mainstreamed into the school system. Things then were much different than they are today. However, I was able to attend regular neighborhood schools, go to college and achieve a bachelor's degree.

More recently, I have been a volunteer at the Shepherd Center in Atlanta, Ga., and worked to get a bill passed in Georgia regarding handicapped parking. I have mentored other people who are patients in rehab hospitals and taken part in fundraising activities for Shepherd Center, which required me to push myself over uneven ground at a farm where a fundraiser took place.

I can participate in sports including snow skiing and white water rafting. I go to a local nature trail once a week and to the gym three times a week. I live in my own home, drive a hand-equipped regular car and perform all the everyday chores around the house. I'm also active in my neighborhood association.

As you can tell, I am a very busy, active person. I am not only a participating member of the community; I am a contributing member of the community.

My life was very different before I got my lightweight wheelchair and a good cushion. I used to have one of those heavy wheelchairs seen in hospitals and nursing homes. I couldn't lift it myself, and my parents could hardly lift it to put it in the trunk of the car. Because of the heavy wheelchair and its construction, I didn't get to take part in many activities and had to get someone to push me up ramps and over curbs.

When there were no ramps, I would get out of the chair and crawl up the steps to a person's house. Once inside, I would crawl to a chair and pull myself up into it. That old wheelchair was too heavy for most people to lift and carry up steps and into their house, but I wanted to go places and visit in people's homes so much that I crawled.

After Medicare paid the rehab provider what it was going to pay for my new lightweight chair, I had to pay $400 out of my pocket to cover the remaining balance. To me, $400 is two months' worth of food or a month's worth of bills. It's not pocket change!

It took a year and a half for Medicare to pay the provider for my current wheelchair. When I finally called to ask what the hold up was, the person I spoke with said, and I am quoting, "These things just take time." In other words, it wasn't his problem that I didn't have my new chair.

I told him that the frame on the wheelchair I was using was cracked and eventually it would break, which meant I would be crawling on the floor. If that happened, skin breakdown would probably occur, which would lead to surgery (skin graft). There was dead silence on the other end of the phone line, but I got my new wheelchair within a month.

Disabled consumers shouldn't have to wait a year and a half from the time the doctor writes them a prescription to get what they need.

The chair I have today is lightweight—only 22 pounds. If there is no ramp at a house where I visit, two people can get on each side of the chair and lift me up the

CONTINUED ON page 8

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CONTINUED FROM PAGE 6

Keep Access for Consumers with Disabilities

steps; then I can go on the visit with dignity. Most people who ask me to go somewhere with them can pick up my chair and put it in the trunk of their car; it's also light enough that I can lift it with one arm and put it behind the driver's seat of my car and go wherever I want.

I can be independent. I don't need an assistant; I don't have to live with my parents; I don't have to live in group housing; I don't have to have a specialized van. I can live on my own and be in control of my own life!

I can be independent. I don't need an assistant; I don't have to live with my parents; I don't have to live in group housing; I don't have to have a specialized van. I can live on my own and be in control of my own life!

Another aid that has changed my life for the better is the cushion that I sit on each and every day. Two reasons life is better with my new cushion:

1) Because of a dislocated hip, my body leans to one side, and because of that, my hip pushes up into my diaphragm and my diaphragm pushes up into my lungs. I was having some problems breathing as there was compression of my lungs and heart. With my new cushion, I no longer have breathing problems, as I am able to sit up straight and alleviate pressure from my diaphragm.

2) I had many, many problems with skin breakdowns. Sores would go so deep that I was in danger of having to undergo skin grafts. Deep sores would have to be packed with gauze and then the gauze would have to be pulled out every day to clean out the dead skin so new skin could grow. A paraplegic does not form a scab over a sore and heal like other people; a paraplegic forms no scab and the healing starts at the lowest point in the sore and builds up in rings of new skin until it finally fills in the "hole." I had to spend weeks in bed to take the pressure off the sores on my hips and buttocks and to let them dry out. I missed a lot of school and a lot of time with friends and family. Since I've had my new cushion, I never have sores, which means I don't have to spend time taking care of one!

So that's a little bit of my story as a person with a physical handicap, and that's how having the best equipment has changed my life. I could not afford this kind of wheelchair or cushion on my own. That's why I am urging funding sources to continue paying and even expand the funding for medical equipment. Being mobile allows people like me to develop to our highest potentials and enjoy participating in our communities.

Besides the positive aspects to our lives, think of the money the government would save by not having to pay more for health-related problems. These problems include hospitalization for pressure sores, skin grafts and pulmonary care for problems caused by pressure on lungs. If a person is just sitting around the house because he or she cannot get out due to a heavy wheelchair, then he or she is going to be physically out of shape, won't get the exercise needed and will develop more health issues—obesity, cardiovascular disease, diabetes, high blood pressure, etc. Providing people with disabilities with the proper medical equipment is a win-win situation!

We come to the aid of people in other countries; surely we are not going to fail to come to the aid of people in our own country. I feel it is our responsibility to help those less fortunate than ourselves and help people of all abilities and disabilities develop to their highest potential. There are 54 million disabled people in the United States. Surely our government is not going to turn its back on all those people. Without financial aid from our government in purchasing necessary equipment, our quality of life will be drastically reduced. D

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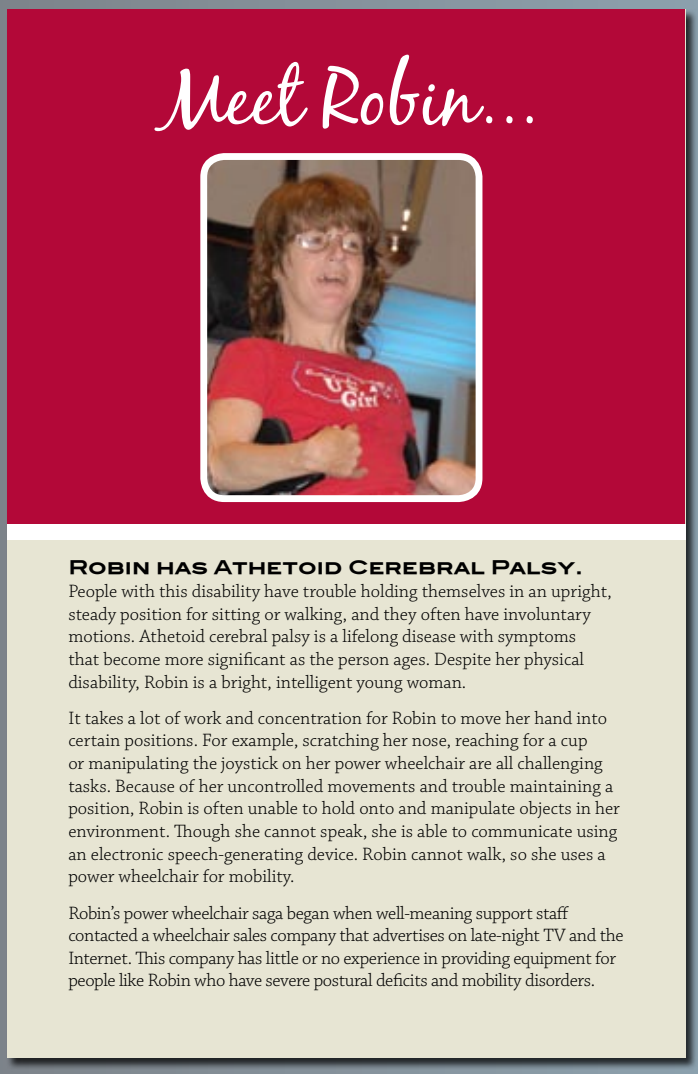
Educate referral sources, case managers, clinicians, consumers, and fellow colleagues about the professionals who make up NRRTS by using the new NRRTS brochure!



This newly designed brochure, based on the feature story in NRRTS DIRECTIONS, Vol II of 2009, is a first-rate tool for education. "Robin's Story" encourages all parties to insist on the services of a NRRTS Registrant.

Brochures are available for $20 per 50 copies plus shipping charges.

To order, contact Judy Dexter at 800-976-7787 or jdexter@nrrts.org.

The Right Place

CHRIS DAILEY, ATP, CRTS®
CAROLINA MOBILITY AND SEATING, INC.

I'VE ALWAYS BEEN INTERESTED in working with people. And, living as a paraplegic myself since 1988, I also have a strong interest in the goings-on of the complex rehab industry. Combining these two interests and making a career out of them happened by pure luck; I was simply in the right place at the right time and took an opportunity that was presented to me.

NRRTS' Registration is important simply because it serves as a network of professional support and a source for sharing ideas and concerns among peers.

After starving for three years on commissions in the mortgage banking industry, the local complex rehab supplier in Norfolk, Va., who supplied my equipment had a position opening in sales and offered me a job. It sounded like a great opportunity.

Not only would I be able to jump directly into sales where I could work with people, but I'd also be able to relate with my clients in a very personal way. Plus, after the turmoil of working in the mortgage banking industry, having a constant paycheck certainly helped my decision to take the job. So, complex rehab became my career of choice in 1995.

While I started on this path in Norfolk, Va., and the surrounding Hampton Roads area, I now work for Carolina Mobility and Seating Inc., and manage its Chesapeake, Va., office. Before all this, I graduated from Nansemond-Suffolk Academy in Suffolk, Va., in 1986 and went on to earn a Bachelor of Arts in Psychology at Randolph-Macon College in Ashland, Va., in 1991.

The main obstacles I see in this profession are the 1-800 companies that constantly blemish our industry and sabotage our efforts of earning respect and professionalism from Medicare and other payer sources. I also see the competitive bidding process to be a possible hurdle for many suppliers who will be at risk of losing much of their business. Being able to overcome obstacles like these can seem overwhelming, and that's why NRRTS is so important to our industry's survival.

NRRTS' Registration is important simply because it serves as a network of professional support and a source for sharing ideas and concerns among peers. The CRTS® certification plays an important role in distinguishing us as professionals in the eyes of clients, insurance companies and the physicians and therapists with whom we work daily. The support NRRTS offers our industry is unmatched in leading the constant battle to bring integrity, professionalism and a decent image to our industry.

Annual continuing education requirements also ensure NRRTS Registrants are current with the most recent complex rehab items on the market and can solve any seating problem in this sometimes "trial and error" industry. Lastly, the NRRTS Code of Ethics brings relief to me, because I know all clients will be treated appropriately with respect, professionalism, expertise and care, no matter what their color, gender or financial background.

In respect to complex rehab industry providers and RTSs, the threat of competitive bidding is ominous. It places our pride and joy in the hands of unqualified DME providers who are more focused on profits than clinical outcomes. Competitive bidding will handcuff beneficiaries to bid winners based on price as opposed to allowing beneficiaries the freedom to choose the supplier who provides them the best service.

The outcome of NCB will be inappropriate and ill-fitting equipment for the disabled community. I believe this program, designed to save money, will instead cost far too much when measured by the standard of care our complex rehab clients need and deserve. However, our profession can head in a positive direction if Medicare will see us as the professionals we are and prevent any unfit provider from

CONTINUED ON page 12

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CONTINUED FROM PAGE 10

handling complex rehab clients.

As for my personal story of how I became a paraplegic, it begins in 1988, when I was in my family's grocery store near closing time during my second year of study at Randolph-Macon College. As I walked up front, there was a robbery in progress, and I found myself in the middle of a very bad situation.

I was within an arm's reach of the door before I realized the crime was in full force and a "gentleman" approached me violently with a lock-blade knife. I was left with four stab wounds and a paralyzing gunshot wound in my back. Within about 7 seconds, I went from living the life of a happy, carefree college kid with food for the week at Mom and Dad's expense to a life bound for wheelchair confinement.

Back at the scene, I was in and out of consciousness and have few memories of being awake immediately after the incident. After the rescue squad arrived, I remember them yelling at me, "Spit! Spit!" And then I was out again. I also remember getting on the helicopter to get to Norfolk General Hospital, our top trauma center.

After surgery to remove the bullet from my back and repair my left lung, I was left with a T8 complete SCI and no sensory or motor function from two inches above my belly button down. My first conscious question for the physician was, "Can I have children?" His response: "I think so, with work."

The road to regaining independence was long and rough. Life was certainly different, but I was young, healthy and happy. With support of family, friends and fraternity brothers, I was treated like the same Chris Dailey and the smiles came back more and more often as I settled back onto the path of life.

I am very thankful for all my care, for the gracious blessing of surviving such a violent crime and for everything life has given me—especially my family. I've been married to Kim Dailey, a physical therapist in the home health industry, since November 2001. Our son, Jeffrey, 6, is the "best" thing we have ever accomplished. He thinks I'm cooler than any other dad, because I have a "permanent" seat for him. D

ABOUT THE AUTHOR
Chris may be reached at 757.966.7964 or chrisdailey@carolinamobility.com.

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We Fly the Plane and Move Forward, or We Fall

MELISSA KEIM
Vice President of Marketing, Education and eBusiness Development
THE ROHO GROUP

"FIRST RULE: FLY THE Plane. Second Rule: Fly the Plane. Third Rule: Fly the Plane. A plane cannot fly unless it's moving forward. That's why pilots are taught that no matter what's happening, no matter how dire the situation may look, your No. 1 responsibility as a pilot is to fly the plane." [1]

Your personal and professional lives are no different from flying a plane. Don't sit back and let it happen; move forward with action. Your competitors, associates, referral sources, clients and suppliers are all feeling the same pressures, so fly forward and encourage others to do the same. Fear can't rule our decisions. Moving forward is up to each of us.

We are feisty about our 401k plans, we are overscheduled, we see reductions in payments to support our clients, the electronic community has taken more of our personal time and energy than ever before, and we worry about the livelihood of our own families, clients, friends and businesses. Still, we must "fly the plane" and seek out opportunity. Diversify. Connect. Promote. Market. Accept that some days you will be the bug, and some days you will be the windshield.[2] But overall, "fly your plane."

This industry has taken its share of blows. Many of the industry shifts we face are ever changing and hard to keep up with, not to mention

complex and difficult to communicate to the masses. But we can still make a difference by taking action and remaining in the pilot seat.

The recent CELA/NRRTS march on Capitol Hill was an "action-packed, make-it-happen" initiative. My first year's experience with this exciting industry call to action was addictive, and it made me feel like I was making a difference. Share that enthusiasm with just one person and watch what happens.

A ROHO colleague includes the following quote in his e-mail signature: "Attitude is contagious." And in the book, "The Power of Body Language," the author describes how we mimic each other's behaviors based on body language and communication styles.[3] So it makes perfect sense the positive energy and attitude we choose to embrace each day can be part of the popular theme, "pay it forward." Do this at work. Do this at home.

For those who have been in business for an extended period of time, the cyclical nature of business—primarily marketing—is a reality. Given that we are in a down economy, here are some tips for building market share:

- Stick with the flight plan and think long term. It's not a matter of cutting back tactics to make strategies work; it is a matter of

CONTINUED ON page 16

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CONTINUED FROM PAGE 14

fine tuning those tactics to make sure they remain consistent with your pre-existing long-range plans and company vision.

- If you don't have a strategic plan and a defined set of objectives, create them, but think long term.
- While seemingly counterintuitive, the sales, education and/or marketing budgets may be considered the first to go in tough economic times. Find smarter and more cost-effective ways to execute the same initiatives. You made those marketing spending recommendations based on strategy. Stay true to them, but be smarter with your money.
- Be customer-centric, create an experience and empower your team to enhance and maintain the client relationship. In a world of electronic communication and mass marketing, we risk losing the personal touch. Each staff member must understand he or she is a marketer for your business.
- Get "back to the basics" and create an experiential sale with an existing and loyal client and/or referral base. Kim Van-Kinderman, ATS, is with RehabTECH; she recently shared a story about challenging her team to lose their smart phones and e-mail for two weeks. She claimed sales would increase or that she would host an upscale dinner for the full team on her nickel—not the company's. Tentatively, they accepted the bet and sales increased by 25 percent...and then they continued to grow.
- Invest in innovation that brings ROI.
- Investigate tools that bring more efficiency to your infrastructure.
- Negotiate with local businesses that support you (example: printing suppliers, office supplies, etc.). They, too, need your business.

Your competitors, associates, referral sources, clients and suppliers are all feeling the same pressures, so fly forward and encourage others to do the same.

I asked my 8-year-old daughter what "fly the plane" meant to her, and she responded with a simple but bold challenge for each of us. Her words were, "Steer in the right direction and look where you are going." It made me giggle that she nailed what we, as adults, sometimes forget: Fly the plane forward or take the fall. The good news, however, is the choice is ours. D

1. *"Fly the Plane," by Mike Ankelman, writer/producer in St. Louis, Mo.*
2. *Written by Mark Knopfler. Performed by Dire Straights and Mary Chapin Carpenter.*
3. *"The Power of Body Language," Tonya Reiman*

ABOUT THE AUTHOR
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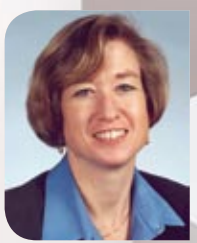

CARA C. BACHENHEIMER
Senior Vice President of Government Relations
INVACARE CORPORATION

WHAT WE KNOW AS "COMPLEX REHAB TECHNOLOGY" HAS ALWAYS BEEN PART OF THE MEDICARE DURABLE MEDICAL EQUIPMENT (DME) BENEFIT. FOR MANY YEARS, THIS DID NOT PRESENT ANY PROBLEMS IN TERMS OF CONSUMER ACCESS TO QUALITY ITEMS AND SERVICES.

TIMES HAVE CHANGED, HOWEVER. Shrinking margins combined with a clear need to ensure that Medicare recognizes and pays for the integrally related services of complex rehab technology have resulted in a need to clearly delineate it from other items of DME.

Notably, last year Congress recognized the intensive service component of complex rehab technology by excluding it from the DME competitive acquisition program as part of the Medicare Improvements for Patients and Providers Act. Further, the Centers for Medicare and Medicaid Services (CMS) has recognized complex rehab technology as a unique set of items with its unique set of quality standards with which suppliers who provide these items must comply.

Within these relatively new quality standards is a requirement that complex rehab providers have an assistive technology professional (ATP) on staff at each location who must be directly involved in the selection of the appropriate technology for each individual.

While those of us in the industry see the ATP requirement as a natural and necessary part of providing consumers with the appropriate technology and services, it was an unprecedented step for the Medicare program to require ATPs in order to have Medicare pay for the items. This is because as an "equipment only" benefit, CMS has always stated it is "not allowed" to pay for services—only equipment. Recognition of the ATP service as a necessary component is literally unprecedented under the Medicare DME benefit.

Another important distinction is complex rehab technology is primarily provided to individuals with severe disabilities who are usually younger than the Medicare senior. These individuals typically have lifelong diagnoses such as spinal cord injuries, muscular dystrophy, amyotropic lateral sclerosis (ALS), multiple sclerosis (MS), spina bifida, cerebral palsy and brain injury. These consumers qualify for the Medicare program based on their disability, not their age.

I don't want to underestimate the potential complexities of pulling out complex rehab technology from the DME benefit to creating its own benefit. Many issues must be addressed to ensure the outcome results in appropriate access to complex rehab items. There are implications for coverage, payment, coding, documentation and other issues that must be well thought out and constructed in advance. There are federal legislative as well as regulatory strategies to pursue.

While at first blush it may appear to be a relatively straightforward exercise of extracting the appropriate items from the statutory Medicare DME benefit definition—whether it is based upon beneficiary diagnosis, codes or a combination of the two—we must make sure we do all of our homework in advance to ensure a predictable and good outcome.

While we clearly understand complex rehab technology is dramatically different in many ways from standard DME, we have only just begun to gain an appreciation of that fact from federal policy makers. This is illustrated by CMS' recognition of complex rehab wheelchairs as fundamentally different from standard power wheelchairs and by Congress' recognition that complex rehab items are simply inappropriate for a "competitive" bidding system.

Our collective goal must be to craft a new and unique benefit that sufficiently encapsulates the more complex needs of consumers. We must think through and figure out the details regarding appropriate coverage (read medical necessity guidelines), payment (how do we determine the appropriate payment for the package of items and services), coding (what specific changes to the current coding systems for these items is necessary), documentation (inevitably unique documentation requirements will be necessary) and other issues to create a benefit that has really never before been created. It is indeed no small task. D

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COMPLEX REHAB:
A NEW BENEFIT CATEGORY

In case you haven't heard, efforts are developing under the auspices of NCART to obtain a new Medicare benefit category for complex rehab. Hopefully the concept is intuitive, but for those who may question the strategy, we must take a step back and look at where we are, where we have come from or, maybe more importantly, where we are going if we can't manage to quickly change the dynamics.

PEOPLE WHO ROUTINELY WORK one-on-one with individuals with physical disabilities who require wheeled mobility and seating can easily define what they do. However, the industry has struggled a bit through the years to adequately define complex rehab. To see the bright line that exists between durable medical equipment (DME) and complex rehab, we are required to assess the service delivery model, the array of available technology and the individuals who require both. These differentiators are what allow us to finally define complex rehab in a meaningful way.

Whether you are asking yourself, "what took so long" or "what are they thinking," I hope that the following information will either convince you or confirm your conviction that this is not only the right thing to do, but it may be the only way to ensure ongoing access.

Many issues have arisen since the new millennium that point to the need to distinguish complex rehab from DME. These issues provide the springboard to not only define the differences between the two, but to ultimately seek a unique benefit category separate from DME.

Complex rehab is a relatively young industry that emerged from needs left unmet by standard mobility and seating devices. Many of these new, complex devices originated in garages and homes or in rehab engineering departments and were customized for specific individuals.

Over time, manufacturers began developing products that could be built to meet the unique needs of individuals through the use of modular components, or that were constructed based on specific measurements. The ability to customize, adapt, modify, adjust and program products to meet the unique needs of each individual is now identified as complex rehab.

The complex rehab industry has been repeatedly harmed by policy and pricing changes to a point that access to choice and a broad array of product options are declining. While therapists and suppliers have a sincere desire, and in the case of clinicians, an ethical obligation to attempt to gain access to technologies that restore, maintain or improve function and independence, the reality is that in some situations, individuals can only access what funding allows.

CMS' recent acceptance of certification as an important method for identifying a basic level of knowledge and experience has led to important accreditation standards as well as conditions for coverage for some complex rehab items. The industry strongly supported these regulatory changes for a number of reasons.

One important reason is consumer protection; it is critical for the individual who is assessing complex rehab technology to have a strong understanding of the technologies, the features and options that are available, product compatibility, and most of all, an understanding of the physical and functional needs of individuals with disabilities.

In addition, within the power mobility device (PMD) local coverage determination (LCD), the supplier of complex rehab PMDs must employ at least one ATP at each location to be involved face-to-face in the selection of technology. The LCD also calls out the need for a home assessment.

Complex rehab suppliers and clinicians involved in wheeled mobility and seating have known for years how to gain this type of information; they cannot afford to provide technology assembled, adjusted and fitted to a unique individual to learn at delivery that it doesn't fit through any door in his or her home. A home assessment is now required prior to or at the time of delivery for power mobility devices, and at a minimum, a discussion around the home environment must take place for manual mobility as well. The in-home assessment creates a real cost that, to date, is not reimbursed.

The complex rehab industry has made a number of attempts to gain a stable foothold against the myriad changes and reimbursement cuts. Despite those efforts, complex rehab

suppliers are going out of business, experienced ATPs are leaving the industry, and innovation and access to choice is declining.

When we consider everything that has happened over the past decade, we realize a number of things must take place to protect access to complex rehab technologies. First, we must have adequate HCPCS codes. So far, when the industry or even state Medicaid programs have requested HCPCS codes that recognize and adequately define distinct complex rehab technologies, we have ended up with more generic code descriptors that usually include the words "any type." If "any type" would work for an individual, that might be okay. However, these are technologies that are recommended to meet the unique needs of an individual.

Second, medical policies must specifically address the small percentage of the Medicare population that is eligible based on permanent disability versus age. Because this population is small, they tend to get lost in the local coverage determination development; Medicare beneficiaries with disabilities tend to be the exception rather than the rule.

Finally, there must be a pricing methodology that takes into consideration the labor-intensive service component that is required in the service/delivery model for complex rehab. Reimbursement for equipment is already forcing suppliers to develop formularies and reduce the number of choices they make available to consumers, as the extensive service component for complex rehab has never been reimbursed.

The only real opportunity to address coding, coverage and payment in a distinct and meaningful way is to have complex rehab move into a distinct benefit category. However, we can't trick ourselves into believing this will be easy or without risk. Even if Congress approves a new benefit category, CMS would still have to draft regulation to implement it. And, revised coding, coverage and pricing would still have to be developed.

While I believe this is the right strategy, it isn't a guarantee of relief, and if relief comes, it won't be overnight. This strategy will take significant human and financial resources and will be the heaviest lift yet, but I believe it is the right answer and offers the best chance at preserving access and stabilizing the industry defined as complex rehab. D

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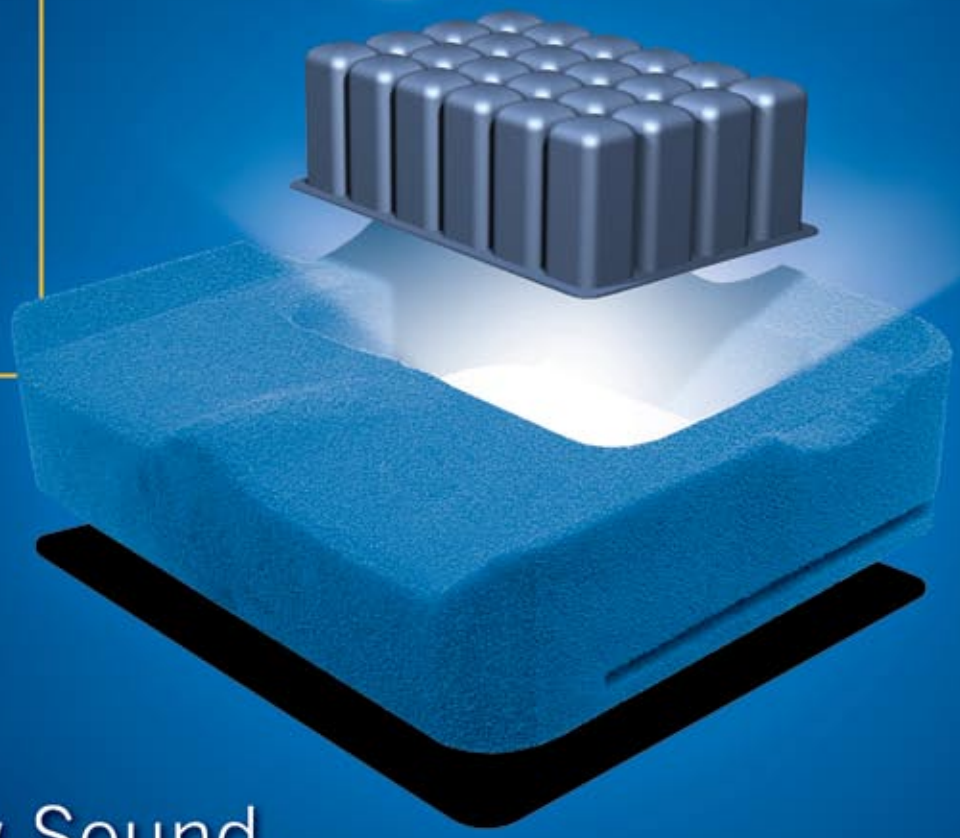

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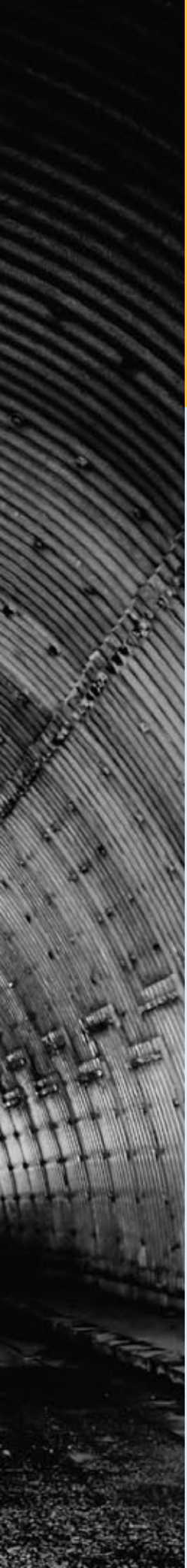
THE CHALLENGE

OF CREATING A DISTINCT BENEFIT CATEGORY FOR COMPLEX REHAB

JULIE PIRIANO, PT, ATP
Director of Rehab Industry Affairs
QUANTUM REHAB



DEVELOPING A DISTINCT BENEFIT CATEGORY FOR COMPLEX REHAB SOUNDS EASY ENOUGH IF YOU HAVE BEEN INVOLVED IN THE EQUIPMENT RECOMMENDATION PROCESS FOR A WHILE. YOU KNOW WHAT WE DO, WHY WE DO IT, AND ON WHOSE BEHALF WE DO IT FOR. YOU ALSO KNOW THERE IS A DISTINCT DIFFERENCE BETWEEN STANDARD AND COMPLEX REHAB EQUIPMENT, SO THE CONCEPT MAKES SENSE. INTUITIVELY YOU RECOGNIZE THAT IF A DISTINCT BENEFIT CATEGORY IS DEVELOPED FOR COMPLEX REHAB PRODUCTS AND SERVICES, IT WILL BENEFIT EVERYONE INVOLVED.

HOWEVER, TO ACCOMPLISH THIS, there needs to be consensus as to who the benefit is for, a clear understanding of the process, and agreement on the products and services that will be covered in the category. The roles, responsibilities and expectations of the team members involved must also be weighed. The challenge is to make sure that as the industry works toward developing a framework for a separate benefit category, the model translates into coverage and payment policies that are fair, equitable and sustainable.

As NCART has clearly articulated in their Case for a New Medicare Benefit for Complex Rehab document, "Problems arise when there is a need to address the disparity between complex rehab technologies and standard DME within the same rule or policy. A number of issues arise when technology that is highly individualized and customized and which consequently require a striking service component are governed by the same rules and policies as standard equipment."

As we move through the process of developing a distinct benefit category for complex rehab products and services we have an opportunity and an obligation to thoroughly exam the current HCPCS codes from every possible angle prior to making any recommendations for change. In doing this, we must review the coverage criteria associated with each code as well as outline the services that are necessary, required and essential for the provision of the coded products.

Establishing the skilled professional services required to provide complex rehab products is where we have the greatest opportunity to acknowledge the value of rehab professionals. It is unprecedented that the ATP certification has been recognized in current Medicare policies. It has paved the way for us to strengthen the role of the supplier in the continuum of care for complex rehab products in the future. This is something to be mindful of as we envision the future direction of assistive technology professionals who have dedicated their career to the needs of individuals with complex mobility challenges. Documenting the services you perform in the equipment recommendation process is the first step toward identifying and establishing the value of your time, knowledge and skills as we work for fair and equitable reimbursement of the products and services provided under a distinct benefit category for complex rehab.

The current medical policies also require an evaluation by a licensed or certified medical professional. These services are not reimbursed in the payment for the products and services recommended yet they are an essential component of the process. As we define complex rehab and look to better define the supplier's professional role in the continuum of medical care, we must ensure the clinical input is acknowledged, valued, required, and funded in the process.

While a distinct DMEPOS benefit category for complex rehab cannot impact, define or change the CPT codes a clinician can use to document and bill for their services, it can establish a best practices model to better define the roles and responsibilities of the team in the provision of the products. The current published standards of practice, code of ethics and roles and responsibilities for Assistive Technology Professionals (ATP), Registered Rehabilitation Technology Suppliers® (RRTS®), and Certified Rehabilitation Technology Suppliers® (CRTS®) can be used as a model to define a complex rehab supplier. More importantly, they can be written into standards and policies that are enforceable. This will go a long way in protecting the benefit, the beneficiary and the complex rehab supplier as we move forward in the development of this distinct category.

As a rehab professional, you understand the full dedication and tremendous effort needed to serve the complex rehab patient. Equipped with this unique understanding the concept of a distinct benefit category to define what sets complex rehab apart makes sense. In developing a separate category, we have a tremendous opportunity to design our own destiny but we must proceed with caution, consider all stakeholders, and get it right. D

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The Market Size is Larger than We Thought

ROBERT HAMILTON
Vice President of Strategic Networking
ATG REHAB

RECENTLY, THE CHRISTOPHER AND Dana Reeve Foundation released the study, "One Degree of Separation," which indicated that one in 50 Americans is living with paralysis. This figure translates to nearly 6 million people living with paralysis—approximately one-third more than previously estimated!

The leading causes are:

- stroke (29 percent)
- spinal cord injury (23 percent)
- multiple sclerosis (17 percent)

These new statistics show:

- Approximately 60 percent of the paralysis population earns $25,000 or less per year.
- The gender factor is 54 percent male and 46 percent female.
- The old 80/20 rule goes out the window.
- The spinal cord population is, in fact, 61 percent male and 39 percent female.

How did they arrive at these new numbers?

The information was prepared under a multiyear cooperative effort between the Christopher and Dana Reeve Foundation's Paralysis Resource Center (PRC), the University of New Mexico's School of Medicine and the Division of Disability and Health Policy at the Center for Development and Disability (CDD).

The survey process lasted more than three years, beginning in 2005 when the University of Kansas conducted a national assessment on how, historically, paralysis was defined and data was collected.

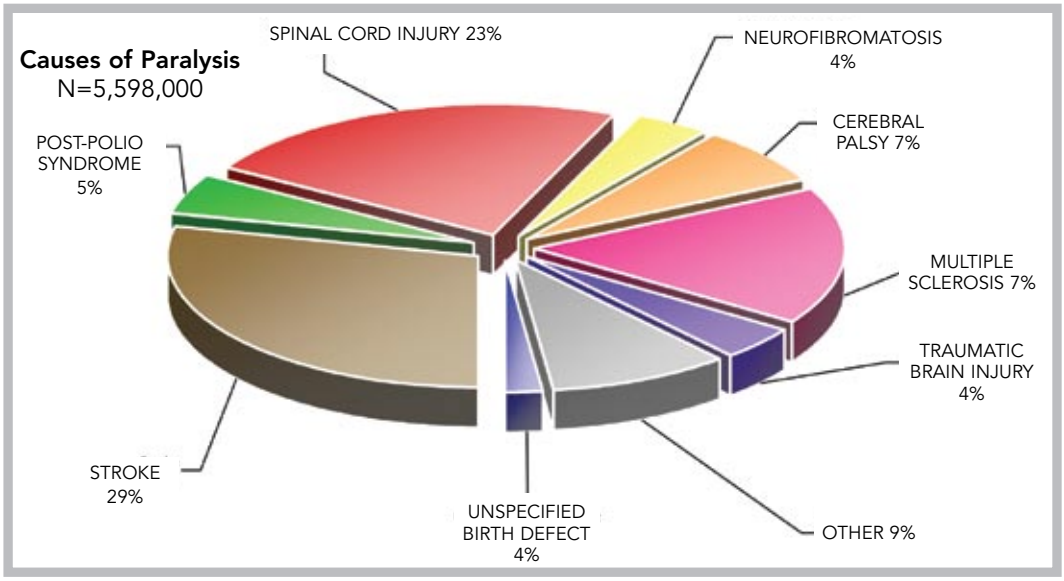
In 2006, a national consensus conference convened, led by more than 30 experts in paralysis and statistics. The group included those from the Centers for Disease Control and Prevention and 14 leading universities and medical centers. They set the parameters for the study and developed (1) a functional definition of paralysis and (2) a draft survey instrument.

The entire year of 2007 was spent refining the survey, and in late 2008, the national survey was carried out by International Communications Research (ICR).

How was paralysis defined?

For the purposes of this survey, paralysis was defined as: "A central nervous system disorder resulting in difficulty or inability to move the upper or lower extremities."

To ensure consistency, ICR used a simple screening process. For someone to be counted as "paralyzed," he or she must have answered yes to the initial screening question: "Do you or does anyone in this household have any difficulty moving their arms or legs?" If the answer was yes, the participant was then asked: "Give one of the following causes of the difficulty:"



spinal cord injury
traumatic brain injury
stroke
poisoning
multiple sclerosis
transverse myelitis
Guillain-Barre syndrome
ALS/Lou Gehrig's
complications from surgery
neurofibromatosis
epidural infection
cerebral palsy
spinal muscular atrophy
chiari malformation
post-polio syndrome
Friedrich's ataxia
syringomyelia
spina bifida

(If you are interested in reading the full report, go to *www.christoperreeve.org*, where you will find more statistics detailing age, income, ethnicity, gender, military service and number of years disabled.)

How can we estimate the size of the complex rehab market from this information?

When we consider all the different diagnoses listed in this survey, it's quite interesting because they align perfectly with the consumers we serve in the complex rehab market. We can also make some general assumptions about the percentage of consumers using mobility in each diagnosis:

Paralysis Condition	Population	% Mobility User	# Mobility Users
stroke	1,608,000	30%	482,400
spinal cord injury	1,275,000	85%	1,083,750
multiple sclerosis	939,000	50%	469,500
cerebral palsy	412,000	30%	123,600
post-polio syndrome	272,000	40%	108,800
traumatic brain injury	242,000	30%	72,600
neurofibromatosis	212,000	5%	10,600
unspecified birth defect	110,000	20%	22,000
other	526,000	40%	210,400
TOTAL	**5,596,000**	**46%**	**2,583,650**

Note that muscular dystrophy is missing from this chart because it does not meet the definition of "paralysis" according to this study. In discussions with the MDA national office, it reports there are approximately 200,000 consumers using wheeled mobility. Adding these numbers to the above chart gives us a total of 2,783,650 mobility users.

Agreeing with these assumptions, we can conclude there are approximately 2.78 million people who use complex rehab. This translates to nearly 50 percent of the total paralysis population. Conceivably, this may be our industry's best estimate for establishing the size of the complex rehab market.

How many wheelchairs are sold annually?

So we now have a market size estimate for the number of complex rehab users. Where does this lead us? Given that insurance companies generally allow consumers a new wheelchair every five years, then 20 percent of the 2.78 million consumers will acquire a new wheelchair each year. This translates to 556,730 sales to mobility users.

How can you establish your local market size?

Based on the findings that one in 50 Americans lives with paralysis, and our assumption that 50 percent of this ratio needs complex rehab, we can conclude that one in 100 Americans uses complex rehab mobility products. To establish your local market size, simply take the geographic population you serve and divide it by 100.

How can we use these new statistics to help our industry?

Currently on the legislative and regulatory front, we are lobbying for a "separate benefit category," removing complex rehab from DME. We have two compelling reasons for this request: first, CMS eliminated complex rehab from competitive bidding, and second, the precedent was set in 1997 when prosthetics and orthotics (P&O) was given a "separate benefit category" and removed from DME.

P&O's "separate benefit category" was based upon the complexity of their services, which is exactly why complex rehab was excluded from competitive bidding. By the same logic, we, too, should be excluded from DME. Additionally, since these new paralysis numbers show the complex rehab population size is as large or larger than the P&O industry, we can clearly demonstrate our justification.

Hopefully, you've followed this logic and agree. It's my belief this information provides us important data we can use to fight for positive change in the complex rehab marketplace. I welcome an open dialogue testing my assumptions so we can proactively lead our industry and build better understanding of our consumers.

Take a minute and show your appreciation to the Christopher and Dana Reeve Foundation.

"One Degree of Separation" is a powerful and important survey providing current data about people with paralysis. In summary, here are the implications from this study quoted from the Reeve Foundation website:

"Over a million more people are paralyzed than previously known; five times as many have spinal cord injury. This enormous population has tremendous implications for the public health system, health care availability and impact on entitlement spending. For example, many treatments and medical interventions that could help restore function and allow independent living are not currently covered by health insurance or Medicaid. Yet, giving people what they need to function on their own—get an education, get to work—would save society untold millions."

Check out the Reeve website and add your name as a supporter. The Christopher and Dana Reeve Foundation is working on many fronts to push for "Care and Cure" for people with paralysis. D

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From Passion to Practicality: How One Man's Journey Led Us Home

feature on

MIKE BALLARD
Chairman and CEO
NATIONAL SEATING & MOBILITY INC.

AFTER GRADUATING IN 1973 from Ripon College of Ripon, Wis., Mike Ballard, now chairman and CEO of National Seating & Mobility Inc., entered the investment banking business—when it was still, as he put it, considered an "honorable business." He remained in that industry until starting National Seating & Mobility Inc. in 1992; corporate offices are located in Franklin and Chattanooga, Tenn.

Born and raised in Green Bay, Wis., Ballard grew up just six blocks from the Packers stadium. "I am proud that I never missed a home game from 1958 to 1976, at which time I moved to Nashville, Tenn.," says Ballard. "I still have season tickets!"

When asked why he became involved in the complex rehab industry, he answers, "I honestly think it was divine intervention." In 1990, he had been helping a large home health company that was primarily engaged in the home nursing business.

"I was retooling their financial department and noticed a line item in their accounts receivable that said 'wheelchair receivables,' " explains Ballard. The company had offices in 20 states and provided a small amount of durable medical equipment that was driven by nursing referrals.

"I was naturally curious as to the severe aging of the wheelchair receivables and discovered they had only one person in Nashville, Tenn., providing pediatric wheelchairs," says Ballard. "I don't even think the term RTS was in play back then, and they merely called her the 'wheelchair lady.' "

Ballard's professional curiosity was piqued when he met with said wheelchair lady and he noticed how her face "lit up" when she talked about the kids with whom she worked. His curiosity led him on a journey, starting at the International Seating Symposium in Memphis where he learned a little about the industry. His journey then took him to a small company in Alabama, where he witnessed a 3-year-old boy with cerebral palsy getting his first mobility system.

"To see the pure joy of this child when he could move around the room independently for the first time in his life was the singular most emotional moment of my life," remembers Ballard. "My oldest boy was the same age at the time, and I made a decision right then and there that I had to figure out a way to be a part of what I perceive to be the most noble area of health care."

After deciding to get into complex rehab, Ballard spent a lot of time talking to industry people, and he absolutely fell in love with the passion he saw in professional RTSs. However, he was dismayed that many, if not most, RTSs were employed by large companies that did not share in their passion; these companies did not really understand their work.

"It seemed apparent to me it was time to create a company that could provide the stability of a larger-scale business and also provide a 'home' for the professional RTS. These professionals struggled enough just dealing with patient care and funding; they certainly didn't need to be treated like stepchildren by their employers. So, I started National Seating & Mobility in February 1992," says Ballard.

According to Ballard, proper and appropriate credentialing is the single most important issue for the long-term viability of what all want for the industry. This is one of the many reasons he has long supported RESNA and NRRTS.

"This complex rehab industry has experienced a lot of collateral damage over the past five years as a result of CMS trying to clean up the indiscretions and abuse in this fast-growing consumer-powered market," says Ballard. "While it is encouraging that we have seen progress by the regulatory folks in recognizing the need for credentialing and differentiation of the market segments, we all know passing an exam does not mean one has the necessary skills and practical experience to handle complex patients and a complex mobility system.

"The ATP exam is definitely important, but it must be joined with the CRTS® credential. Proper credentialing for any health-care professional must consist of both a strong knowledge base and a strong practical base of experience.

CONTINUED ON page 30

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CONTINUED FROM PAGE 28

From Passion to Practicality: How One Man's Journey Led Us Home

The CRTS® carries the badge of experience—necessary experience!"

Ballard has always been concerned about reconciliation of the extreme differences in skill sets that are required for the provision of equipment. On one end of the spectrum are very involved patients with disorders that require the services and expertise of skilled, knowledgeable, objective and experienced providers in order to deliver an appropriate mobility solution. On the other end are relatively less involved patients who require a simpler solution that can be provided by less experienced personnel.

"It is my opinion the ATP designation should be required of all providers, the NRRTS credential required of complex providers, and perhaps a second credential should be required for the less-involved providers," explains Ballard.

In any event, Ballard believes the long-term credibility of credentials will be dependent upon strong standards and practices that have real "teeth." For the credential to have maximum value, it must be a credential that can be revoked with cause, thereby inhibiting an individual from degrading the profession—something for which Ballard feels very strongly.

But the future of complex rehab isn't the only thing on Ballard's mind these days. "I have been married to Debbie for 26 years, and we have two sons: one 19 and the other 22. They are now both attending Samford University in Birmingham, Ala., so Debbie and I are getting to know each other once again," laughs Ballard. D

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On behalf of NRRTS Registrants, volunteer leadership and professional staff, I would like to thank Mike Ballard for his continuing and unwavering support for NRRTS and its mission over the past 17 years. We look forward to many more years of collaboration with Mike and NSM's RTSs.
—Weesie Walker, NRRTS President

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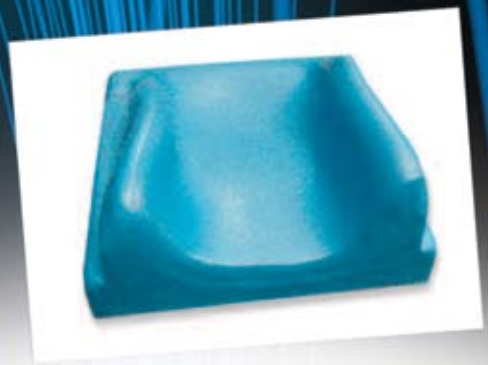

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CELA 2009 REPORT

MORE THAN 100 INDIVIDUALS attended CELA 2009, the Continuing Education and Legislative Advocacy Conference sponsored by NRRTS and held in association with NCART and the University of Pittsburgh's Department of Rehabilitation Science and Technology Continuing Education. Held in Baltimore, Md., CELA 2009 offered the opportunity to meet continuing education requirements for NRRTS and RESNA and to visit with federal legislators in their offices on Capitol Hill.

Approximately 127 appointments with legislators and their staff were scheduled for April 21 to lobby for a separate benefit category for complex rehab devices and for the restoration of the 9.5 percent reimbursement cut to Group 3 power wheelchairs and related accessories that was enacted in MIPPA last year in order to pay for the delay in competitive bidding.

Participants told their legislators that complex rehab devices were significantly different from standard DME in terms of population served, associated services rendered, complexity of equipment, specialized staff and more comprehensive quality standards. Moreover, Congress established precedents for treating customized DME differently when it exempted Group 3 complex power wheelchairs and related accessories from the national competitive bidding program and when it established a separate category for orthotic and prosthetic devices in the Balanced Budget Act of 1997.

In addition, attendees told their legislators that complex rehab providers are unable to sustain a 9.5 percent across-the-board reduction without reducing services or limiting the types of products they are able to provide. Attendees pointed out the financial impact of restoring reimbursement for Group 3 complex power wheelchairs and their related accessories would be less than $7.6 million annually.

CELA 2009 was the first attempt to lobby Congress on the separate benefit category issue. At the debriefing, participants reported the message was well received and potential sponsors of legislation were identified. A brochure developed by NRRTS—in which the proper fitting of a complex rehab device was demonstrated—was said to be especially helpful in communicating the issue to legislators.

Reports on restoring the 9.5 percent cut were mixed. Some legislative offices were unsympathetic to restoring the cut, saying it was the price complex rehab paid to be exempt from competitive bidding. Others expressed surprise that the 9.5 percent reduction was a permanent cut and would not be restored once competitive bidding was implemented again.

The next step in the journey of establishing a separate benefit category for complex rehab devices includes a regulatory assessment to determine the most appropriate model for creating this category and developing legislative language to take back to Capitol Hill to solicit sponsors.

Sharon Hildebrandt
Executive Director, NCART

MY FIRST CELA

Attending CELA was an amazing and intoxicating experience. Although I used to live outside the Washington area and am familiar with all the touristy spots, I had never met with any of my elected representatives.

I was lucky to be teamed with Michele Gunn, who had attended the first CELA and had a good idea of how to approach our issues. From the minute we arrived on the bus and walked through the Capitol grounds, I was awestruck. We walked within a hundred yards of the Capitol, Supreme Court and Library of Congress. We walked up the worn marble steps of the historic office buildings, and I couldn't help but wonder who had used these same steps and made policy decisions that have upheld our democracy through time.

Our first appointment was with Sen. Mel Martinez's research assistant for the Special Committee on Aging. Sen. Martinez is the ranking member of that committee and is dedicating his remaining year in Congress to pursuing health issues. His assistant was rather indifferent about the 9.5 percent cut and suggested they were going to wait out the Health Care Reform Initiative to see how things worked out. He was much more positive about creating a separate benefits category and RESNA's initiative to create an advanced credential for seating and mobility that could go hand in hand with the separate benefits category.

Our next appointment was with Congressman Alan Grayson's deputy chief of staff. His office is new to Congress, and they are definitely looking to find a meaningful way to make a difference. The deputy chief listened to our concerns regarding the 9.5 percent cut, but was fairly impassive. However, she jumped all over the separate benefits category and was looking for draft language for a bill. This was absolutely our best meeting of the day. We left very charged up and ready to go on to our third meeting.

We were only able to cold-call Sen. Bill Nelson's office. We do have his health liaison's name and will follow up on the materials we left him. I was a little disappointed, because Sen. Nelson's office has intervened for two of my patients and assisted us in overturning their ADMC denials. I had hoped to thank them for their help and urge them to continue helping us with our present issues.

We also made a cold call to Congresswoman Suzanne Kosmos' office. She, too, is in her first term and working to establish herself in Washington. Her health liaison was very receptive. I don't think he has been in his position long enough to understand all the nuances of everything that is going on yet, but he was very open and eager to learn.

Finally, we went to visit Congressman John Mica's office to meet with his health liaison. It was a little awkward because we were filling in for someone else, we were not the congressman's constituents and we had been double booked with another group representing some oxygen issues. This health liaison was knowledgeable of the issues, but made a point that they were not from the ruling party; they had no qualms telling us they were not interested in helping with the issues surrounding the 9.5 percent cut. He was somewhat more receptive about the separate benefits category, but thought it should be put through with health-care reform. He was courteous, but we left his office feeling there would be no help there.

As we all reconvened and shared our information, we agreed this year the people we spoke with had a much better grasp of who we are and why our clients are different from the "lady at the Grand Canyon." We also noted those who took an end user along with them had the most productive experiences. I am already looking forward to next year. Michele and I have each thought of a client to take. Why don't you mark your calendar to join us? You won't be sorry.

Thana France, ATP, CRTS®
Browning's Pharmacy & Health Care
Orlando, Fla.

A CONSUMER'S EXPERIENCE AT CELA 2009

At 17, I had high hopes of becoming a nurse, but everything changed in an instant on July 18, 1993. I had a car accident on my way to soccer camp with three of my friends; the end result was that I would never play soccer again because I sustained a spinal cord injury.

My senior year was not what I expected it to be, and while I still maintained my position of co-captain of my soccer team, I had to sit on the sidelines in my wheelchair, knowing I would never walk or kick a soccer ball again. I had to accept that I would be using a wheelchair for mobility for the rest of my life. After seeing a few different types of wheelchairs while I was still in the rehabilitation hospital, I knew I had some choices, but I didn't know what was best for me.

By working with a seating specialist when I was in rehab, I got my first wheelchair. But over time my body changed; I lost weight and was having back pain from not having good postural support. As the years have gone by, one thing I have learned is that every person who uses a wheelchair has different issues related to seating and positioning.

If users don't have the right type of wheelchair custom fit for them, it can truly affect their quality of life. I feel as though it has taken a long time for me to get a wheelchair that is truly custom fit for me; I know I will have to adapt and make changes to every wheelchair that I get for the rest of my life as I age.

Without the proper funding for people with disabilities to get the equipment we need, how are we are as individuals supposed to be proactive in our communities? How are we supposed to live a quality life when the only wheelchairs and equipment insurance companies will pay for is what is allowed? This is wrong and it needs to be changed because I do not feel that anyone should have the right to tell me what I should be using for a wheelchair; it's my life.

This year I knew I wanted to attend CELA as a consumer and go to Capitol Hill to do whatever I could on behalf of people with disabilities. Since I have both a personal and professional background in the medical industry, I wanted my voice to be heard. Luckily, I have TiLite wheelchairs to thank for sponsoring me to attend the conference. Although I was nervous at first, knowing I would be meeting with senators from the state of Washington, I felt as though it was a success.

I am so thankful I had the opportunity to participate and attend CELA this year, and I know that if more senators are educated about what is going on, we will get the support that is desperately needed to address the issue of creating an entirely new benefit category for complex rehab technology. It was great to see the entire medical industry come together as one, because these issues will directly affect people with disabilities, like me. So, from one consumer's perspective, I want to thank everyone for rallying together to make CELA 2009 happen, and I am proud to have been involved.

Tammy Wilber, Seattle, Wash.
Consumer and advocate for 16 years









Bobcat


ROUND TWO

For me, CELA 2009 was round two in the heavyweight championship fight to win respect for our industry. I was fortunate enough to go to CELA last year and meet others in our industry who share the same concerns and have a strong passion about the well-being of our clients and industry.

Going to Baltimore gave me time to get out of the day-to-day rat race that we are all accustomed to, and reflect on what my goals would be this year and on what the message was that I wanted to bring to Capitol Hill as a representative for my patients. Even though CELA 2009 was held in a different venue with a different approach as a part of the HME Expo, I saw many of the same faces from last year and the approach was in many ways still the same. The question now is, how will our presence and voice be perceived by Capitol Hill with a new president in place and new challenges coming forth with the push for reduced budgets and socialized medicine?

When I step back and look at the planning that an event like CELA requires, as well as the dedication to our industry standards it represents, I have to first say thank you to NRRTS, NCART and the sponsors for their support and perseverance. As many of the attendees probably noticed, there were a lot of special interest groups on Capitol Hill making some of the same visits we made. I didn't even know for what some groups stood!

I will say that the highlight of the conference was visiting Capitol Hill and sharing the stories on the day after of how our messages were received. This year was a little different from last because we were going into our meetings without support of a particular piece of legislature. Instead, we went as a single voice for patient advocacy and stood up for complex rehab and for what our jobs truly entail.

We asked for support in establishing a new benefit category for complex rehab—much like orthotics and prosthetics—as well as sought support to rescind the 9.5 percent cuts due to the competitive bidding delay. Out of three meetings that I attended with the health advisors of my representatives, I found that two were new to their position and did not have a lot of knowledge of the industry or an in-depth understanding of competitive bidding in the DME industry.

Being new, they were receptive and concerned about access to equipment for end users, and they wanted us to send them more information about our industry. I was able to set up a conference call with one health advisor for a more detailed talk once I was back in the office as well.

It is refreshing to know that the health advisor I met with last year for Sen. Lindsey Graham was still there and remembered our meeting last year; he agreed with the need for a new benefit category. The overall message from representatives stayed the same throughout the day: we have a good cause and there is the establishment for a need, but without a bill to support it, they will not discuss any health reform until June, as the president has requested.

All conference participants should hold their heads high, as they are leaders of our industry and have made valuable contacts on behalf of the patients we serve. It is evident that this will be a difficult and trying year for HME as well as for complex rehab, but if we maintain the open communication and share our stories with referrals and patients, we can see progress.

Yes, we will stumble, and yes, we will lose members, but there are some representatives who are new and want to blaze a trail in Washington, and there are still some that will take up the good fight for our cause. If there is one message that I can truly pass on to my referrals and fellow ATPs, it is to keep the patient involved. Help them to know who their representatives are and how to contact them.

We are in the process of developing a simple follow-up tool that allows our patients to give a brief story of who they are, what they do and what their equipment means to them. We will collect these and forward them to our representatives, because without a face on our cause, some see us as just people who want to make another dollar and not for what we truly do—and that is make a difference.

Michael Causey, ATP, CRTS®
Carolina Homecare Medical Equipment Center Inc.
Greenville, S.C.

FIVE REASONS TO BRING CONSUMERS TO CELA 2010

I would like to thank NRRTS and NCART for their extraordinary hard work in making the CELA Capitol Hill event such a success. This event was rewarding to the industry, as well as to me personally.

During the CELA conference, I was honored to accompany a family to our Capitol Hill visits. Carol Bell and Michael Halper, and their children Ben and Sandra, live in Maryland, about an hour's drive from the Capitol. Both Ben and Sandra have significant cognitive and mobility disabilities. Their therapist, Ginny Paleg, recommended them for the CELA conference, as they were willing to tell their stories to the legislators on Capitol Hill.

They readily shared their story and made a powerful impact. Having been involved with this positive experience and seeing the impact it made, I encourage others to bring a consumer to CELA for the following reasons:

IT EMPOWERS CONSUMERS TO ADVOCATE FOR THEMSELVES.

I can only imagine the effort it took for the Bell-Halper family to get ready for the day—gathering medical supplies, securing the wheelchairs in their van, driving in traffic and riding the metro to morning meetings. But in spite of the great effort it took, they were pleased to participate in such a meaningful event.

Michael said that he had called his representatives in the past, but never imagined actually visiting them in their Capitol Hill offices. After attending CELA, he thought the visit so effective, that he is considering doing it again. In the future, he will likely contact his legislators in their home offices. Both he and Carol said that the CELA visit empowered them to speak up for their children's rights regarding unfair decisions made by insurance payers.

LEGISLATORS ARE MORE LIKELY TO LISTEN TO CONSTITUENTS WHOSE LIVES ARE DIRECTLY IMPACTED BY LEGISLATIVE DECISIONS.

The health aide to whom we spoke was mesmerized as Carol and Michael described the problems they had encountered in getting complex rehab equipment and services within the current funding environment and as they explained that the issues will become much worse when products are reimbursed based upon competitive bidding rates. They explained that even though their health care is provided for under a combination of Medicaid and private insurance coverage, Medicare fee schedules will impact the quality of care they receive unless reimbursement is adequate to cover the cost of specialized equipment and service delivery.

WORKING TOGETHER PRESENTS A STRONG MESSAGE.

NCART gave us a clear goal and message to bring to Capitol Hill: to ask for rescission of the 9.5 percent fee cut, and to support a separate benefit category for complex rehab equipment and services. Manufacturers, suppliers and clinicians worked shoulder to shoulder, putting aside competition to deliver this common message. We realize that competitive bidding and reimbursement policies affect us all either indirectly or directly, so we must speak as a unified industry. And in doing so, we must also say "no" when we cannot provide equipment or service because reimbursement policies are unreasonable. And then we must let our legislators know that their constituents are being negatively impacted by these policies.

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WHEN WORKING TOGETHER, WE WILL BE HEARD AND OUR EFFORTS WILL BE SUCCESSFUL.

Together we will be heard! Take for example when legislation for a complex rehab carve-out from competitive bidding was initiated and passed. That was a direct result of previous Capitol Hill visits and of NCART and its members sponsoring lobbying activities as well as sending letters and initiating calling campaigns to representative offices. The passing of this bill demonstrates that by working together we are capable of so much more, so let us be heard and let us show our support by attending CELA 2010!

It is my hope that we, as an industry, bring one consumer from each state to CELA 2010. I truly believe that if we all work together, my hope will become reality. Imagine the attention we will receive when the "halls on the Hill" are filled with people in wheelchairs sharing their life stories!

Sue Johnson
Columbia Medical
Santa Fe Springs, Calif.

What do you do when the government is on the edge of one of the largest financial decisions durable medical and rehab equipment has seen in decades? You go see your state senators, of course. As we have begun to feel the effects of the recent competitive bidding crisis that is sweeping across the country, it became inevitable that Frontier Access would have to take the plunge into politics. So, after weeks of preparation, we held our breath and boarded a plane for Washington, D.C.

Our first appointment was with Congresswoman Lummis' aide, Landon Stropko. He seemed to enjoy our presentation and assured us that he would speak with Congresswoman Lummis about our concerns. Mr. Stropko's main question to us was, "What do the voters think the challenges of the 9.5 percent reductions to complex rehab users would mean to them?" I left the meeting feeling the issues were understood, but realizing that I had to empower my clients and get them contacting our representatives. It was their voices that needed to be heard there.

We walked across the grounds and to my amazement we saw a car show on Capitol Hill. All industries go to the Hill to educate on the importance of the products they provide. I couldn't help but wonder what an impact we would have if we had a large group of wheelchair users on Capitol Hill!

Next, we joined a luncheon and enjoyed the opportunity to get to know a few rehab providers from across the United States. We all shared the same passion for the services we provide and the customers we serve. It was encouraging to meet others in this field who are facing the same struggles as my little company out in Wyoming.

We headed back out to meet up with Sen. Enzi and Sen. Barasso. We met with Sen. Enzi's health aides, and they were quite interested in carving out the rehab equipment and services; they understood the need for a separate benefit category. At our next appointment we had the privilege to meet with Sen. Barasso himself.

We first met with his aide, and I was quite impressed with Bryn Stewart; he spent time researching the reason we came to Washington, D.C. The door opened and Sen. Barrasso came in to speak with us. I was very honored that as busy as the senator was, he took the time to meet and listen to us. I feel the senator understood the need to carve out the complex rehab industry from the DME Medicare benefit. He also understood what business components are required to have a successful outcome for clients of complex rehab and the issues of rural America and health care.

He agreed that TV and Internet sales hurt our industry, and they were difficult to control. In the end, we were even lucky enough to have our picture taken with Sen. Barasso.

What a great way to end our trip to Capitol Hill.

Michelle McMahon, ATP, CRTS®
Frontier Access & Mobility
Cheyenne, Wyo.

THANKS TO THE FOLLOWING SPONSORS OF CELA 2009!

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How Do I Compete with Suppliers Who Don't Play by the Rules?

JIM STEPHENSON
Rehab Reimbursement Specialist
INVACARE CORPORATION

WHEN IT COMES TO gathering power mobility device (PMD) documentation, how many times do you hear from a physician, "Well, so-and-so was in here yesterday and all I had to do for them was sign a form; why are you asking me for so much more information?"

The guidelines for PMD documentation are extremely overwhelming to a physician, especially when he or she gets conflicting information from different suppliers. In the perfect world everyone would play by the same rules and help alleviate the mass amount of confusion that is inflicted upon the physician community.

The guidelines for PMD documentation are extremely overwhelming to a physician, especially when he or she gets conflicting information from different suppliers.

Medicare has left the burden of educating physicians about face-to-face examinations, seven-element orders and detailed product descriptions up to our industry. Finding an opportunity when we are afforded enough time to make sure a physician understands the complex nature of documenting for a PMD can be difficult.

Physicians are busy and have a huge amount of responsibility to their patients, so being able to save time by simply signing a form is particularly appealing to them. It's human nature; we all want to take the easy route as often as we can. Unfortunately, taking the easy route with PMD documentation can become quite expensive for a supplier when Medicare comes looking for medical records to conduct a post-payment audit.

What many physicians don't realize is there are several statutory requirements they must meet in order for their patients to receive Medicare reimbursement for a PMD. Physicians must conduct a face–to-face examination and record the results from the exam in the patient's medical record. They cannot write the prescription until a face-to-face exam has occurred, and they must provide this information to the supplier within 45 days. By simply signing off on a supplier-generated form or document, they are not in compliance with these statutes.

The next issue that many of us encounter is the use of forms to document the face-to-face examination. Some suppliers provide forms for the physician to complete, giving the false impression that these documents are a sufficient record of the in-person visit and medical evaluation. Even if the physician completes this type of form and includes it in the patient's medical record, it does not provide sufficient documentation of a comprehensive assessment of the patient's mobility needs.

It is essential the physician be aware of this, because if he or she completes a form it is still expected there will be notes about the visit in the patient's medical records to substantiate the information on the form. So to be compliant with policy, those suppliers who use forms are actually asking the physician to document face-to-face exams twice: once on the form and once in the medical record. Talk about extra work!

We all know double documentation does not happen, but that is the only way a form can be used within Medicare guidelines. To keep documentation simple and consistent, physicians should document the results of face-to-face exams in the same format they use for other entries in their patient medical records.

It can be tempting to cut corners when there is the potential for loss of a referral on the line, but in the long run, standing your ground and obtaining the necessary information will help you keep your money. Use of forms, incomplete documentation and missing key information are among

CONTINUED ON page 42

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CONTINUED FROM PAGE 40

How Do I Compete with Suppliers Who Don't Play by the Rules?

the top reasons Medicare denies PMD claims. With the recent reimbursement cuts for power mobility devices we cannot afford overpayments or the time required to defend ourselves in an audit. It is always better to do it right the first time.

So, how do you respond to physicians who have been led to believe incorrect information? First, let them know that you realize their time is valuable and that you are only requesting information that is absolutely necessary to qualify their patients. Remind them Medicare created the documentation guidelines and that you understand the rules are very labor intensive, but you are simply trying to follow the policy.

Ultimately, there is no black-and-white answer to this question, but there are a few tools you can keep handy to ensure the physician will recognize that you're only asking for what you need to do your job. Keep a complete copy of the PMD local coverage determination (LCD) on hand with the documentation requirements highlighted. There is also a letter written by the medical directors from each of the Medicare Administrative Contractors (MAC) outlining the requirements for documenting and prescribing PMD, which you can leave behind as a reference. This letter is available on each of the DME MAC Web sites.

The most important thing to keep in mind is there are no short cuts to this process; the policy is what it is. With a little luck, Medicare will start clamping down on those who are misleading the physician community and creating headaches for those of us who are doing things right. D

ABOUT THE AUTHOR
Jim can be reached at 440.329.6350 or jstephenson@invacare.com.

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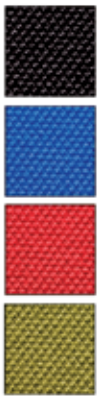

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Focus on Pediatrics: Functional Mobility vs. Exercise

AMY MEYER, PT, ATP
Pediatric and Standing Specialist
PERMOBIL

WHAT IS MOBILITY? IS there a difference between functional mobility and physical activity or exercise? What is different when prescribing mobility devices for pediatric clients versus adults? How do we, as providers, account for these differences? Or ... do we?

Exercise vs. Mobility

People with physical disabilities, including children, need to be able to get around effortlessly in a reasonable amount of time throughout their day, accessing the same environments as others without becoming fatigued. Sometimes moving a manual wheelchair or walking requires too much energy or risks shoulder damage, making a person non-functional.[1] For example, if a child requires excessive energy to get to a classroom, he or she may not learn as effectively after getting there.[2] Powered mobility is an option that provides efficient functional mobility when walking or using a manual wheelchair proves to be non-functional.[3]

Anyone who is involved with pediatrics will attest to the fact that kids are not simply tiny adults.

Consider Emily, a 7-year-old girl with spina bifida. She was using an ultra-lightweight manual wheelchair, which, on the surface, appeared to be meeting her functional needs. However, her mom reported that Emily would come home from school, eat dinner and then be so tired she went directly to bed. This is not typical behavior for a child. Emily was so exhausted from pushing her wheelchair that she couldn't "be a kid" when she got home. Emily's therapy team decided she needed a power wheelchair to be independent and efficient with her mobility, and now she enjoys a full day of playing with her peers!

Emily

How do we assess the most appropriate functional mobility device for our clients? Often, we are forced to take a "clinic snapshot" of the patient, which is not always the most accurate method. Therefore, it is essential that we conduct a thorough subjective evaluation, asking the questions that will help us gain a better perspective on a person's individual situation and mobility needs. Additionally, a trial in the equipment is crucial. If considering a manual wheelchair, the patient should use the chair both in the clinic and outside if possible—navigating ramps, various terrains, etc. Document his or her efficiency using that equipment in a variety of environments.

Pediatric Differences

Anyone who is involved with pediatrics will attest to the fact that kids are not simply tiny adults. Children have distinct needs and require equipment that specifically meets those needs. Whether you're a part of the medical therapy model, the school therapy model, a teacher, a parent or just enjoy the company of young people—we all want kids to be kids!

Allowing differently abled children to have the opportunity to interact at the same level and in the same types of activities as their peers is essential for their overall development, for improving their self-image and confidence, and for helping them feel less isolated or

CONTINUED ON page 46

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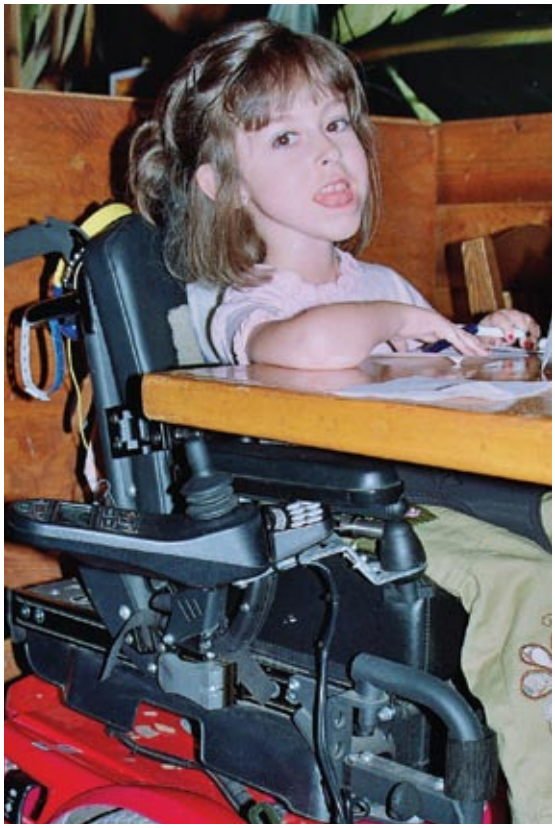
different. Whether a child is in need of crutches, a manual wheelchair or a powered wheelchair, we need to be aware of that child's specific needs when prescribing his or her mobility equipment and seat functions.[4]

How do we decide what type of equipment is the most appropriate to meet the needs of our pediatric clients? The Medicare algorithm is a good framework to help decide on the general class of equipment. However, with children, we need to consider not only their home environments, but also all other areas of their lives: the classroom, the playground, the backyard, the ball field, the garden and wherever else children need to be.[5]



Kendle

We must remember that a child's job is to play and explore the world every day in order to develop the same skills as children without mobility restrictions. We shouldn't restrict a child to the home environment when his or her peers are out and about seeking experiences in the world! Our goal as a therapy team should be to integrate the child as much as possible into his or her world, allowing the child to function with peers independently.

We also need to keep children safe in the process—prevent the acceleration of disease progression and reduce the risk of developing secondary complications such as contractures, scoliosis, etc.—but only to the extent that they may also remain functional. There is a fine balance between position and function, and the challenge is to find the most appropriate device that can effectively manage both.

As I heard a representative from The Roho Group® say, "There comes a point in seating where skin wins." Likewise, there's also a point when function prevails over positioning. Let's face it: if someone is not comfortable or functional in his or her mobility device, he or she won't use it. Or, even worse, he or she will use it inappropriately, which increases risk for further injury or worsening secondary complications.

Negative Perceptions of Power Mobility

When considering power mobility, parents often wonder if their child will lose strength due to using a power wheelchair, or worry that a power wheelchair will keep the child from walking.[6] Exercising is important for everyone; however, mobility and exercise are not one in the same.

Think of your routine: you drive to the gym to get on the treadmill. You drive to the park to ride your bicycle. We even drive around just to find the nearest parking spot at the mall. There are many ways for children with disabilities to develop strength and endurance. Studies have found that children typically do not lose gross motor function due to power wheelchair use. On the contrary, it has been shown that after receiving independence through power mobility, gross motor skills actually improve as children are more motivated to move and do things for themselves![7]

Caregiver Assistance vs. Independence

We hear it all the time from funding sources: "Children have 24-hour caregiver assistance." Sometimes funding sources see this as justification to deny power seat functions for young children, or possibly even deny power mobility or ultra-lightweight manual wheelchairs altogether! Studies have shown that without independent mobility, people develop dependency on others—"learned helplessness."[8] Mobility opens doors for opportunity as well as responsibility—prerequisites for independence, confidence and a positive self-image and attitude.

Let's specifically discuss power seat functions for children. Often, we might be tempted to save some money by providing manual seat functions on a power wheelchair base, but at what cost to the patient? Sometimes manual seat functions are appropriate, but this is typically the exception rather than the rule. Just like learned helplessness develops with dependent mobility, the same applies to children who cannot effectively reposition themselves or reach objects without the assistance of someone else.

If a child has the ability to operate his or her own seat functions, an opportunity for independence is revealed. By giving children the ability to reposition themselves independently, they no longer need to ask for help (learning helplessness) but are empowered to fidget in their chair just like their peers do. Whether it's for postural stability, pressure relief or simply for sensory stimulation, kids should have the right to move.

Take, for example, Kendle, a 6-year-old with congenital muscular dystrophy. She has normal sensation

CONTINUED ON page 48

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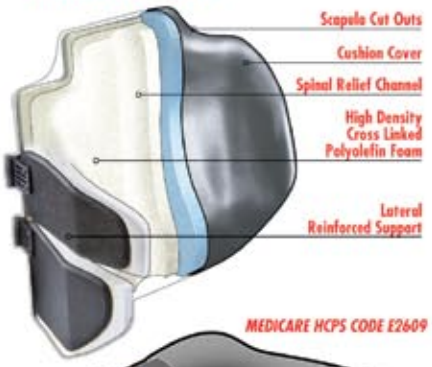

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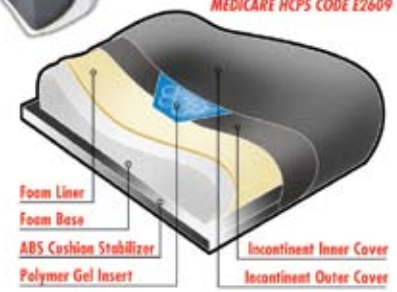

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and is extremely weak (especially proximally). When recently talking to Kendle about her power seat functions (seat elevator and tilt), she had much to say! We had dinner together, and throughout the meal she used both seat functions multiple times—independently!

I asked Kendle why she needs her power tilt feature. She responded, "When my butt gets sore, I tilt. Or, when I am going down the ramp at our house, I tilt so that my head leans back." Even a 6-year-old can figure out that when gravity assists her posture, she doesn't have to work as hard and therefore has more energy to participate in her daily activities.

Kendle loves to draw and hopes to one day become a professional artist. There was a problem ... her shoulder weakness requires her upper extremities to be supported in order to effectively complete her drawings. Thankfully, that's no longer a problem for Kendle; she uses her power seat elevator to access various table heights to give her arms proper support. Actually, during dinner, she needed to elevate her seat to access the table so she could feed herself (after completing her drawing, of course, which will go on my desk as a reminder of her beautiful spirit). Thanks, Kendle, for teaching me about how important independence is and how effective power seat functions can be—even in young children.

We need to keep pushing the envelope, advocating for our patients and fighting funding sources to approve the mobility equipment that our patients need and deserve in order to be fully INDEPENDENT. We will get through this crisis and there is light at the end of the tunnel. But, we need to make sure our voice is heard. We must continue to raise the bar for quality products in our industry! D

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ABOUT THE AUTHOR
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Congratulations to the Newest NRRTS Registrants!

(April 1, 2009 through May 18, 2009)

Paul Angeli, RRTS®
Homecare Medical
5665 S Westridge
New Berlin, WI 53151
Telephone: 262-786-9870 x.292
Toll Free: 800-369-6939 x.292
Fax: 262-957-5566
Registration Date: 5/7/2009

Linda Donaldson, RRTS®
Gateway Medical Equipment
302 Shelley
Suite 8
Springfield, OR 97427
Telephone: 541-747-5430
Fax: 541-744-7122
Registration Date: 4/16/2009

Jason LaTray, RRTS®
St. Vincent Healthcare/Home Oxygen & Medical Equipment
1124 16th St, Suite 6
Billings, MT 59102
Telephone: 406-237-8927
Fax: 406-237-8905
Registration Date: 4/9/2009

Jason Sharpe, RRTS®
Amerimed Pharmacy & Equipment
3782 Old US Hwy 41N
Valdosta, GA 31602
Telephone: 229-253-0067 x.204
Fax: 229-253-9010
Registration Date: 5/7/2009

Marco A. Sudduth, RRTS®
Care Medical
1090 Baxter St
Athens, GA 30606
Telephone: 706-369-6615
Toll Free: 800-287-2618
Fax: 706-369-6894
Registration Date: 5/7/2009

Kate Thieschafer, RRTS®
Rice Home Medical
115 18th Ave W
Alexandria, MN 56308
Telephone: 320-762-6036 x.18
Toll Free: 800-450-6036 x.18
Fax: 320-762-6089
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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 April 1, 2009, through May 18, 2009.

Larry M. Bowen, ATP, CRTS®
St. John's Medical Supply
Springfield, MO

Michael A. Gartner, ATP, CRTS®
Whitley Home Medical Equipment
Hendersonville, NC

Cary Marsh, ATP, CRTS®
Motion, Mobility & Design Inc.
North Canton, OH

James R. Pearson, II, ATP, CRTS®
Total Respiratory & Rehab
Omaha, NE

Joseph F. Perrault, ATP, CRTS®
Hudson Home Health Care, Inc.
Chicopee, MA

Lynn Springfield, ATP, CRTS®
United Rehab Specialists, Inc.
Woodway, TX

FORMER NRRTS REGISTRANTS

The NRRTS Board determined RRTS®and CRTS® should know who has maintained his/her registration in NRRTS, and who has not. Names included are from April 1, 2009, through May 18, 2009. For an up-to-date verification on Registrants, visit www.nrrts.org, updated daily.

Piotr Czapla, MS, ATP — Wetumpka, AL
Paul R. Eklund — Huntersville, NC
James W. Rogers — Eastman, GA
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Call for Nominations

Calling all NRRTS Registrants!
Do you want to be a shaker, a mover and a decision maker?

The success of NRRTS as an organization in supporting RTSs and the clients they serve, depends upon volunteers who realize the value of serving their profession. They believe in NRRTS and are willing to volunteer their time, resources and passion.

If you are ready to step up and serve our industry and profession as a NRRTS volunteer leader or know of someone else who would make a great candidate, please e-mail your nomination(s) to Amy Odom at aodom@nrrts.org no later than ***Friday, June 26, 2009***. Include your name and contact information or if nominating another NRRTS Registrant, please discuss the nomination with your nominee to determine that, if elected, he or she will serve.

Candidates must:

- be NRRTS Registrants in good standing.
- commit to participate in two face-to-face meetings and 10 teleconferences annually.
- hold office for a term of two years or until a successor has been elected and qualified.

NRRTS is seeking nominees from NRRTS Registrants to serve as:

VICE-PRESIDENT: In the absence of the President or President-Elect, the Vice President shall perform the duties of the President or President-Elect and when so acting shall have all the powers of and be subject to all the restrictions upon the President and the President-Elect. The Vice President shall be responsible for supervising the activities of the Regional Review Chairpersons. Nominees for Vice-president must have served at least one term as a NRRTS Review Board Chair or NRRTS Board Member At-large.

SECRETARY: The Secretary shall keep the minutes of the meetings of the Registrants and of the Board of Directors; see that all notices are duly given in accordance with the provisions of these Bylaws or as required by law; be custodian of the corporate records and of the seal of the Corporation. In addition the Secretary shall perform all duties incident to the office of Secretary and such other duties as may be assigned to the Secretary by the President or the Board of Directors. The Secretary may delegate any or all of these duties to the chief staff officer or other designee. Nominees for Secretary must have served at least one term as a NRRTS Review Board Chair or NRRTS Board Member At-large.

DIRECTORS (2): The affairs of the Corporation shall be managed by its Board of Directors. Among other things the Board of Directors shall be responsible for establishing and overseeing the application review process to ensure uniformity and fairness. The Board of Directors shall actively and vigorously protect the interests of the Corporation including protection of the trademarks registered to the Corporation.

REVIEW DMAC B (RESIDES DMAC A): The Regional Chairperson will review all applications and renewals. The Regional Chairperson will forward applications and renewals in question to the Board of Directors for review and action. The activities of the Regional Chairpersons shall be subject to the direction and supervision of the Vice-President.

REVIEW DMAC C (RESIDES DMAC D): The Regional Chairperson will review all applications and renewals. The Regional Chairperson will forward applications and renewals in question to the Board of Directors for review and action. The activities of the Regional Chairpersons shall be subject to the direction and supervision of the Vice-President.

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EASTERN TIME ZONE

Thursday, July 16, 2009 • 5:00pm to 7:00pm Eastern

HOW TO GET HIGH TECH COMPLEX REHAB FUNDED

Kevin Phillips, ATP, CRTS®

You can't get that funded! Have you heard that lately? An entire generation of participants in the health-care system…clinicians, suppliers, and clients have been hoodwinked into believing that complex assistive technology just can't get paid for. Clinicians and suppliers may feel that funding needs to dictate the evaluation process. As a result, there is a trend to recommend suboptimal and inadequate solutions because they're easier to get funded. Well, it's just not true. In fact, good funding for high end, functional, and creative AT solutions is alive and well. This course will review some of the keys to a successful equipment request and review several examples of successful interventions. We will also discuss alternative funding when insurance won't pay and guidelines for a successful sales process. Kevin has been an equipment provider for almost 15 years. He started providing consumer power to people with age-related disorders in 1995 and began serving the needs of people with more complex disabilities in 2002

Tuesday, August 18, 2009 • 5:00pm to 7:00pm Eastern

AVOIDING LEGAL PITFALLS: TYPES OF RELATIONSHIPS YOU CAN AND CANNOT HAVE WITH PHYSICIANS AND OTHER REFERRAL SOURCES

Denise Fletcher, Attorney

The rehab industry today is a totally different animal from yesterday. The industry has matured, technology has progressed, and demand is increasing. The flip side is that the industry has been hit with breathtaking legislative and regulatory changes. Now, more than ever, in order to succeed the rehab provider must have an innovative marketing program and enter into strategic relationships. This program will discuss the legal parameters that the rehab provider must follow when implementing marketing programs and entering into contractual arrangements with physicians, hospitals, clinics and other providers. More importantly, the program will discuss innovative and successful marketing techniques and contractual arrangements that comply with legal requirements. Denise is an attorney with Brown & Fortunato Law Firm.

Thursday, September 10, 2009 • 5:00pm to 7:00pm Eastern

USING ADVANCED TECHNOLOGY TO REDUCE SEATING ACQUIRED PRESSURE ULCERS

Darren Hammond, MPT, CWS

Pressure ulcers occurring from a seated position has always been challenging for the health-care team to manage. Various wheelchair cushions made from different materials have been introduced recently to give clinicians options when choosing the most appropriate wheelchair cushion. These health-care team members choosing these options are very knowledgeable and experienced in products used; however, small variations in posture and incorrect utilization of the cushions still contribute to pressure ulcers. Darren is Director of The ROHO Institute for Continuing Education and Research.

Thursday, October 29, 2009 • 5:00pm to 7:00pm Eastern

PEDIATRIC POWER MOBILITY & FUNDING

Amy Meyer, PT, ATP

Understanding and articulating clients' skills and abilities, prior to prescribing a power wheelchair, improves the likelihood of appropriate funding. It is important to justify the power wheelchair using developmental and neurological evidence–based practice along with orthopedic justification. The session will acquaint the audience to the visual and perceptual predictors for driving powered mobility along with the developmental training steps to allow more clients to be successful and enhance learning skills with powered mobility. This session will address specific elements and techniques to write a letter of medical necessity for mobility equipment. It offers the clinician the tools and knowledge to be more successful in obtaining funding for appropriate equipment to meet the functional mobility needs of clients. Current funding trends and federal regulations will be discussed. Examples of successful letters of medical necessity will also be presented. Amy is Pediatric and Standing Specialist for Permobil.

Thursday, November 19, 2009 • 5:00pm to 7:00pm Eastern

SAYING NO – A SURVIVAL SKILL FOR COMPLEX REHAB PROVIDERS

Gerry Dickerson, ATP, CRTS®

It is an understatement that the world of Complex Rehab has changed over the last 24-36 months. The survival of individual Complex Rehab suppliers and possibly the survival of the entire industry and profession are dependent on individuals making appropriate clinical decisions tempered by sound business practices. Therapists and other referral partners need to understand and accept their clients can only receive equipment covered by Medicare, Medicaid and their insurance carriers' allowable amounts. This presentation will stress the imperative for both the supplier and referral source to say no - and give the client the knowledge to discuss with their carriers about the level of funding that is keeping them from getting equipment. Gerry is a 30 plus year veteran of the DME/Complex Rehabilitation industry.

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The University of Pittsburgh is certifying the educational contact hours of this program and by doing so is in no way endorsing any specific content, company or product. The information presented in this program may represent only a sample of appropriate interventions. Each person should claim only those hours of credit that he or she actually spent in the educational activity.

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

PACIFIC TIME ZONE

Thursday, July 23, 2009 • 5:00pm to 7:00pm Pacific

STANDING: ADVANCED PRINCIPLES, PRACTICES AND CLINICAL APPLICATIONS

Ginny Paleg, PT

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

Thursday, August 13, 2009 • 5:00pm to 7:00pm Pacific

PRESSURE MAPPING

Sharon Pratt, PT

This session will provide a review of what clinical best practices are in place around the world to date. Their pitfalls and strengths will be discussed and demonstrated. A suggested baseline protocol for effective clinical use of pressure mapping will be reviewed. When selecting a seat cushion, what does immersion, envelopment and magnitude mean and how can pressure mapping be used as a tool to assist with measuring these outcomes? Sharon is Director of Education, Seating for Sunrise Medical.

Thursday, September 24, 2009 • 5:00pm to 7:00pm Pacific

STAND & DELIVER - 10 WAYS TO BUILD A STRONGER COMPLEX REHAB BUSINESS FOR TOMORROW

Cody Verrett, ATP

This session will deliver 10 important ways to strengthen your business. From hiring staff to clinical development, this course will cover 10 important areas essential to running a premiere complex rehab company in today's marketplace. There are many challenges that face the complex rehab provider today, and this course will cover 10 important topics to consider in elevating your business to the next level. Cody is the National Sales Director for Quantum Rehab and has a diverse background that includes consumer, provider and manufacturer experience.

Thursday, October 22, 2009 • 5:00pm to 7:00pm Pacific

MANUAL WHEELCHAIR CONFIGURATION AND TRAINING: AN UPDATE ON THE EVIDENCE

Tina Roesler, PT, MS, ABDA

During this session, clinically relevant studies that have been published since the printing of the clinical guidelines will be provided. Relevant clinical examples of how to apply this knowledge to clinical practice and equipment justification will also be shared. Information on how to easily access current research materials and discuss time saving ways to review for relevance to your practice will also be shown. The motto of the era is "We don't have time!" but if we don't learn to make the time to practice based on evidence funding for equipment and therapy intervention will continue to decline. Tina is Director of Sales and Education for TiLite.

Tuesday, November 17, 2009 • 5:00pm to 7:00pm Pacific

MEDICARE – DO YOU REALLY KNOW HOW IT WORKS?

Elizabeth Cole, MSPT

As a clinician, you treat and prescribe equipment for your patients who have Medicare, but do you really know how the system works? As a RTS or ATP, do you truly understand how Medicare reimburses and the processes involved? Do you know what it means for a product to be under capped rental vs inexpensively or routinely purchased and which products are in these categories? Do you know what a first month purchase option is? Are you aware of exactly what is submitted with a claim? Do you know how and why an ABN or an ADMC would be used and the pros and cons? Do you know what documentation is required and who should provide it? Attend this session to gain valuable information to assist you in understanding the Medicare reimbursement process as a clinician and as a supplier. Liz is Director of Clinical Rehab Services for U.S. Rehab and has been in the industry for over 24 years.

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