

# Industry **update**

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## OPPORTUNITY

By Bill Stelzer, Green Bay Home Medical Equipment



How are the following connected to each other: American Pioneers; Fourth of July (Independence Day); Home Modifications to Meet Medical Needs and C.E.A.C.?

Opportunity is what connects them. Let me explain. Within the last month I would venture to say that your customer service staff was asked several times by your existing customers: Do you know somebody who could install a grab bar for me, or do you know someone who could widen a doorway, or do you know someone who can help me get upstairs or downstairs, or do you know

someone who could make my bathroom more accessible? Each of these is an opportunity waiting to happen.

Back in the days when you or someone else started your company, that person was one of the pioneers in the DME business. Through the years, because of more and more regulations and more and more companies (competitors) following the opportunities that your past pioneers capitalized on, your company may feel more like it is just plugging along and you have lost that pioneering spirit (enthusiasm).

We Americans love our independence, always have, and always will and that's why the Fourth of July is so important to us. Americans have always cherished having their own home, living in their own home and even dying in their own home.

That is precisely what brings us to the opportunity that is in front of you today. You can make the changes to their home that allow them to stay there:

They get to maintain their independence. In most of the communities throughout this country, nobody is specializing in making home modifications to meet medical needs: You get to be the pioneer. The C.E.A.C. (Certified Environmental Access Consultant) education and credential administered by VGM (U.S. Rehab) can help you gain the expertise and credential to be successful, and by joining AHIA (Accessible Home Improvement of America), you can network with the other pioneers of this endeavor.

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“The C.E.A.C. credential brings another level of professionalism and diversity to your current HME/Rehab business. Your existing clientele are often in need of products and services that would greatly assist them to live more independently.

Combined with the AHIA network of trained contractors/installers, the process of helping those in need has now become a practical and plausible means to enhance your company's service offerings.”

Jerry Keiderling, President, U.S. Rehab

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We have done it and so can you. In the last quarter of 2008, during the most challenging of economic

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times that most of us have ever experienced, we did more than a quarter of a million dollars business modifying people's homes to meet medical needs. While that may not sound like a lot to some of you, it has greatly enhanced the growth of our company. It has brought excitement for the future. It has brought dignity and pride to the customers who get to stay in, and in some cases, even return to their homes. Making home modifications to meet medical needs can entail things as simple

as grab bars to as elaborate as ceiling lift systems; from ramps to stair lifts or platform lifts, from widening a doorway to completely renovating a bathroom or kitchen and from automatic door openers to complete universal design renovations.

Two ways you can learn more about doing home modifications to meet medical needs is to attend the Heartland Conference, or by contacting Jim Andreassen with AHIA.

So my challenge to you is to

make a commitment by the Fourth of July to once again become a pioneer and provide a welcome service to your community. ■

*Bill Stelzer is general manager for Green Bay Home Medical Equipment, a U.S. Rehab Member, located in Green Bay, Wis.*



Interested in writing an article for the U.S. Rehab Industry Update Newsletter? Contact Amanda Vanous with U.S. Rehab at 800-987-7342 or amanda.vanous@vgm.com

## Upcoming Events

**U.S. Rehab Tech Training Seminar**

June 9-11, 2009  
Waterloo, IA

**Southeastern HME Convention - ADMEA**

June 14-16, 2009  
Orange Beach, AL - Perdido Beach Resort

**Annual Meeting - NEMED**

June 17-19, 2009  
Hyannis, MA - Cape Codder Resort

**Billing Boot Camp<sup>sm</sup>**

July 16, 2009  
Louisville, KY

**Billing & Reimbursement Road Show with Peggy Walker**

July 23, 2009  
Sacramento, CA

**Summer Meeting - NCAMES**

July 27-29, 2009  
Wrightsville Beach, NC - Holiday Inn SunSpree

**Summer Meeting - VADMEC**

August 10-12, 2009  
Virginia Beach, VA - Hilton

**Wound Care & Bariatric Academy**

August 19-20, 2009  
Waterloo, IA

**Fall Conference - MESA**

August 26-28, 2009  
Dallas, TX

**Billing & Reimbursement Road Show with Peggy Walker**

August 27, 2009  
Omaha, NE

**U.S. Rehab Tech Training Seminar**

August 31 - September 2, 2009  
Richmond, VA

**Assistive Technology for the ATP with Elizabeth Cole**

September 15-16, 2009  
Richmond, VA

**Annual Conference - MNCHA**

September 16-17, 2009  
Columbia, MD

**Annual Convention & Trade Show - WAMES**

September 20-22, 2009  
Elkhart Lake, WI - Osthoff Resort

# Peggy Walker

# Reimbursement Update

## Repair Changes and Updates

With the new changes relating to repairs and a “repair policy” sent out by the four



DME MAC Jurisdictions, we are faced with increased cost and no real direction on how to handle the increased

documentation and decreased allowable. Let’s recap some of the recent changes:

### Repair “Policy”

The K0739 code has now replaced the labor code E1340. Under this code, 1 unit equals 15 minutes and

the allowable is \$13.41 per unit. In addition, we now have been given limits on the number of units that we can charge for certain repairs, whereas, in the past there were no “limited” amounts for the code. The new “repair policy” states that as of 2/25/09, the allowed number of units are as shown in the table below.

The policy states that “Suppliers may only bill the allowable units of service listed in the above table for each repair, regardless of the actual repair time. Claims for repairs must include narrative information itemizing each repair and the time taken for each repair. Suppliers are also reminded that Medicare does not pay for repairs to capped rental items during the rental period or items under warranty.”

The policy also states that we

cannot bill the beneficiary for a service fee if we go to the home and repair the item. Of course Medicare has never paid a service fee in the past, but we have always been allowed to bill the client for that service. It has been suggested that we can still do so if we use an ABN, however, remember that an ABN is to be used when there is a possibility of a denial based on medical necessity or for “upgrade” choices made by the patient. ABN’s are not meant to be used for a traditionally non-covered item or service. So if we are a non-participating provider, we can tell the client up front that if they bring the item to us there will be no service charge, but if we have to come to them we will not only have to bill a service charge but will have to bill the complete claim

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Type of Equipment	Part Being Repaired/Replaced	Allowed Units of Service (UOS)
Power wheelchair	Batteries (includes cleaning and testing)	2
Power wheelchair	Joystick (includes programming)	2
Power wheelchair	Charger	2
Power wheelchair	Drive wheel motors (single/pair)	2/3
Power or manual wheelchair	Wheel/tire (all types, per wheel)	1
Power or manual wheelchair	Armrest or armpad	1
Power wheelchair	Shroud/cowling	2
Manual wheelchair	Anti-tipping device	1
Hospital bed	Pendant	2
Hospital bed	Headboard/footboard	2
Seat lift	Hand control	2
Seat lift	Scissor mechanism	3
Patient lift	Hydraulic pump	2

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non-assigned. This means the client pays us for the full amount, we bill Medicare, and then Medicare pays the client the allowed amount minus their 20 percent. This may put a financial hardship on many of our clients and most suppliers hesitate to do this. However, this is not likely to change until access truly becomes an issue. According to Dr. Hughes from Jurisdiction A DME MAC, “they” are hearing that the current allowed number of units are “right on target”.... “there are probably some providers out there who take eight units of service to swap out a motor, where the average is three....If you have to eat it once in a while, well that’s just the law of averages.” However, if the average is three then why does the new policy limit the number of units to two for one motor and three for two motors? It is up to us to stop “eating it” and bill the clients up front, then let them talk to their congressmen and CMS about the cost of labor and service.

### Modifiers and Codes

As of 1/1/2009 the repair modifier RP has been deleted and two new modifiers have been added. RA is to be used when “replacing” a DME item (replacement of the base item) and should be used when an

item is being replaced because it was destroyed in a single incident (accident, natural disaster) or when an oxygen concentrator has reached the five-year useful lifetime. RB is to be used when replacing accessories on patient-owned equipment.

The next code you need to be aware of is K0462, which is the code to use when billing for a loaner item while you are repairing the patient-owned equipment. When using this code, the narrative must include the following:

- The name make and model (code) of the item being replaced
- The name, make and model (code) of the replacement equipment
- A statement as to why it takes more than one day to complete the repair

Remember that the KE modifier should be used with any manual wheelchair accessory if that accessory could also have been billed on a Round One competitive bid power wheelchair base.

The KX is required on all mobility bases and accessories if the patient meets the coverage criteria and there is appropriate documentation on file.

The overflow modifier of 99 is used if you have to use more than

four modifiers on a specific line item. For example, when replacing adjustable height armrests for a manual wheelchair base the claim line would read E0973 NURBKX99 with KERTLT in the narrative along with the statement (abbreviations) that you have replaced both armrests for a patient-owned K0003 manual wheelchair. You must indicate exactly what you provided, for example “replaced custom foot box by AES #12345MSRP\$325-ptondINV 9000SImwcpurcare1/1/2007”. Each of the DME MAC advisory committees is working to develop a comprehensive acceptable abbreviations table for the customer service staff to be familiar with, in order to make claims processing easier. The abbreviations are important but the most difficult items to get paid are those with the K0108 and E1399 miscellaneous codes or NOC (not otherwise classified) codes, since these are codes that do not have an allowable or a specific HCPCS code. ■

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### Trivia Answers:

- |           |                  |               |                       |
|-----------|------------------|---------------|-----------------------|
| 1. True   | 4. 50 miles      | 7. Typewriter | 10. 50 percent        |
| 2. True   | 5. 2 MPH, 4 MPH  | 8. True       | 11. 3 billion minutes |
| 3. 61,000 | 6. \$1.3 Million | 9. \$16,005   |                       |

# Tech Tip Corner

## NEW PRODUCT CORNER

### REMOTE TIPSY



#### The New Remote Tipsy

sensor was developed to provide greater accessibility and versatility in terms of programming lockout limits. The improved design utilizes a program box that is now separated from the sensor component of the **Remote Tipsy**. While the sensor component remains installed in a fixed position on the wheelchair, the program box may now be programmed 'in-hand', and can be mounted in any location or orientation on the chair without consequence to the existing sensor settings.

These design improvements are particularly useful to dealers during "in-field" troubleshooting, as well as in pediatric wheelchair applications where there is limited mounting space available.

## MARTY'S TECH TIP

Have you had a question ....

*"Can you check the voltage at a certain point?"*



You try your best to hold the pins of your volt meter on the connector and function the chair at the same time to check the voltage — a nearly impossible task if you ask me.

I find it easier to simply modify the leads on the volt meter which in turn makes the process easier and more accurate. So, here are the three simple steps to follow:

1. Cut the probe ends off the volt meter leads
2. Install a small Anderson connector on the end of the volt meter leads
3. Make adapters for various connections to fit your leads.



Now diagnosing is easier and more accurate, plus you can utilize old cables to make the test leads.

## High Pivot Mechanical Shear Reduction

- High Pivot Mechanical Shear Reduction module effectively reduces shear through optimal, physiological positioning of recline pivot points
- Simple, clean design boasting fewer moving parts and easy interface of after-market back supports
- Super quiet recline actuator with 168° of recline
- Pivot points are flared and padded for comfort and function



## DID YOU KNOW?

The Motion Concepts **Sigma Helix Box** allows you to change the speed of your power functions with the push of a button. Select your function by scrolling through the available functions on the LED screen; arrow key up or arrow key down. When the appropriate function is listed, select the speed by pressing the arrow key right to speed up or arrow key left to slow down while watching the LED gradient bar increase or decrease according to the desired speed level.



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# Let's Not Forget the Back Burner Issues

By Elizabeth Cole

Think back to 2005 when the new seating codes were announced. We were happy that we finally had more than a couple of codes for foam and the E0192. But then we noticed that there were now qualifying diagnoses in the coverage criteria. These codes were ICD-9 code driven with no real functional considerations for medical justification. We raised our voices and said “that’s not going to work,” “there are too many exceptions” and “there are other diagnoses that should be included!!” Well, four years has passed and what happened? What took away our attention from this issue? Was it the new NCD for MAE? The new power codes? Competitive bidding? The 9.5 percent cut? All of the above? We somehow let this slip to the back burner, but it might be time to bring it forward again. Let’s have a quick review of the issue.

To qualify for a skin protection cushion, your client must meet one of the following:

1. Current or past history of a pressure ulcer (707.03, 707.04, 707.05) on the area of contact with the seating surface; **or**
2. Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses:
  - a. SCI resulting in quadriplegia or paraplegia (344.00-344.1), other spinal cord disease (336.0-336.3),

MS (340), other demyelinating disease (341.0-341.9), CP\* (343.0-343.9), anterior horn cell diseases including ALS (335.0-335.21, 335.23-335.9), post polio paralysis (138), TBI resulting in quadriplegia (344.09), spina bifida (741.00-741.93), childhood cerebral degeneration (330.0-330.9), Alzheimer’s disease (331.0), Parkinson’s disease (332.0) or MD (359.0, 359.1).

**\*Note:** this does not include athetoid CP

OK, criteria No. 1 makes sense, but what about No. 2? According to this, if your client doesn’t actually



have a skin breakdown, has no history of one and does not have one of these diagnoses, he/she does not qualify for a skin protection cushion even though there is a high risk. What about the 78 year old person with hemiplegia post-CVA who has difficulty weight-shifting, has aging skin, poor nutrition and poor circulation. What about the person with severe cognitive impairment and cardiopulmonary issues who simply doesn’t remember to weight shift? Or how about the diabetic client who just had the second above-knee amputation, is obese and deconditioned? Or the person with cancer who is thin, in pain, has a severely decreased immune system and significantly decreased mobility? There are any number of individuals who definitely need a skin protection cushion, but do not qualify under this criteria.

Let’s look at the criteria to qualify for a positioning cushion:

1. Any significant postural asymmetries that are due to one of the diagnoses listed in criterion 2a above or to one of the following diagnoses:

- a. Monoplegia of the lower limb (344.30-344.32, 438.40-438.42) or hemiplegia (342.00-342.92, 438.20-438.22) due to stroke, TBI, or other etiology, torsion dystonias (333.4, 333.6, 333.71) or spinocerebellar disease (334.0-334.9)

So we now can provide a positioning cushion to that person with a CVA, but not a skin protection cushion. And we still have a number of clients who fall between the cracks for either type of cushion, including those with amputations, Osteogenesis Imperfecta, arthritis (rheumatoid or osteo), Arthrogryposis, dementia, mental retardation, developmental delay, Guillan Barre, dwarfism, lymphedema or just plain old aging and deconditioning.

What has been happening to these clients since the inception of these codes? Unfortunately none of the answers are ideal. Many are receiving general use cushions instead of what they truly need, and consequently are at risk for (or have developed) skin breakdown and postural deformities. Others are actually receiving what they truly need, but only because the supplier has taken the time (money) and effort to appeal, the supplier has accepted the payment for the down-code, or the client has signed an ABN and paid out of pocket. None of these options is optimal.

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So what can we do to fix this issue? For the time being, we can continue to fight for the right product for the client by appealing the denials with documented clinical justification for the skin protection and/or positioning products. Ideally, we can try and change the LCD such that qualifying criteria are based on functional and medical status rather than on specific ICD-9 codes. At the least, we can try to get more ICD-9 codes added to the list. This is a project that is currently

in its initial stages and we need your help. We need examples of your clients who truly needed a skin protection and/or positioning cushion, but did not qualify due to lack of one of the required ICD-9 codes. These can be clients who have not yet received a final product, clients who received a lesser product than recommended, or clients who received the appropriate product but only because it was funded by either the supplier or the client. We are much more likely to get a change in the LCD if we have real life examples

documenting the access problem. If you have any examples, please e-mail me at [elizabeth.cole@usrehab.com](mailto:elizabeth.cole@usrehab.com) or Peggy Walker at [peggy.walker@usrehab.com](mailto:peggy.walker@usrehab.com). Any and all help is appreciated. Let's band together and make a change!

■

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## VGM Launches Home Modification And Home Accessibility Division

By Mary Avenanti, vgm creative



VGM Group, Inc. has recently introduced its newest member service division and with veteran VGMer and former OPGA President Jim Andreassen at the helm, the fledgling ship is fast on its way to becoming a full fleet armed with the tools, vendors and manufacturers needed to provide Members with a strong partner in the blossoming home modification and home accessibility market.

“Accessible Home Improvement of America will attract two different sets of Members-- providers and contractors,” Jim says. By becoming an AHIA Member, HME/DME/O and P and rehab

providers can enter the home modification business, receive buying group discounts and partner with contractors who can install the equipment, or make the construction modifications. Contractors can become AHIA Members and receive manufacturer discounts and referrals and partnerships with our providers. It's a win-win situation for everyone involved and the best part is that we are helping people. Whether they are disabled, or want to stay in their homes as they age, we are helping them find solutions.”

Membership in AHIA requires the Certified Environmental Access Consultant credential, which is administered by U.S. Rehab.

“We administer the credential nationwide,” comments US Rehab President Jerry Keiderling. “There are approximately 124 C.E.A.C. providers right now and I think with the establishment of AHIA, we'll see that number increase pretty quickly.”

Jim is quick to point out that AHIA

was Jerry's brainchild.

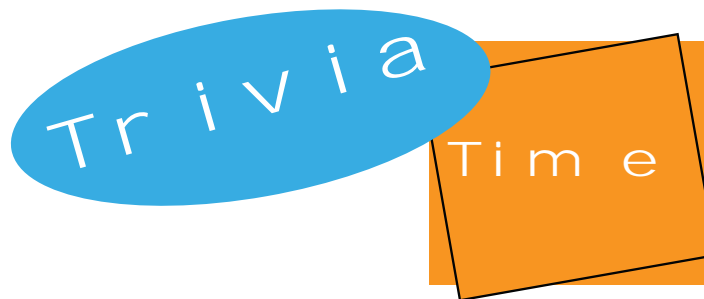
“I give so much credit to Jerry for the amazing work he has done to get AHIA off the ground,” he says. “He is the one who brought the C.E.A.C. credentialing to our Members and who really made AHIA possible. As for myself, I am nervous and excited. The expectations are high, the excitement is high and growth potential is staggering to think about. We got in on the leading edge of this industry and that makes it exciting for VGM and just as exciting for our Members.”

“This is a huge opportunity for our Members,” says VGM Associates President Ron Bendell. “Any of our Members who are looking for ways to diversify their businesses and increase profitability will find great potential in AHIA.” ■

*For more information on AHIA, please contact president Jim Andreassen at 877-404-2442.*

# Did you Know?

- ◆ U.S. Rehab is on Facebook. Find our page today!
- ◆ U.S. Rehab's toll-free phone number is 800-987-7342.
- ◆ U.S. Rehab will be releasing its updated 2009 Salary Survey during June 2009. Look for your copy in the monthly member mailing.
- ◆ The Academy of Advanced Rehab Sciences URL is: [onlineeducation.usrehab.com](http://onlineeducation.usrehab.com).
- ◆ All Legislative Updates that VGM publishes can be found at [www.vgm.com](http://www.vgm.com).
- ◆ As of January 2009, RESNA's ATP certification stands for Assistive Technology Professional. There is no longer an ATS certification.
- ◆ VGM Insurance offers an easy four-step process to obtaining a surety bond, required by Medicare.
- ◆ Van G. Miller founded VGM & Associates on September 3, 1986.



1. True or False: Every day more money is printed for Monopoly than the U.S. Treasury.
2. True or False: The highest point in Pennsylvania is lower than the lowest point in Colorado.
3. What is the average number of people airborne over the United States at any given hour?
4. Half of all Americans live within \_\_\_\_\_ miles of their birthplace.
5. In 1865, the first speed limit was introduced in Britain, \_\_\_\_\_ MPH in town and \_\_\_\_\_ in the country.
6. The most expensive cow was sold for \$\_\_\_\_\_.
7. What is the longest word that can be made using only the letters found on a single row of a keyboard?
8. True or False: The first product Sony introduced was a rice cooker.
9. Microsoft made \$\_\_\_\_\_ in its first year of operation
10. \_\_\_\_\_ percent of pizzas sold in the United States have pepperoni on them
11. On this planet more than \_\_\_\_\_ minutes are spent on Facebook - every day.

See page 4 for answers.