

Industry **Update**

www.usrehab.com

A division of The VGM Group

The Question of Forms for Power Mobility Documentation

By Elizabeth Cole



The introduction of the new power mobility documentation policy in November 2006 brought on a barrage of “Mobility

Assistive Equipment” (MAE) forms created to help physicians adhere to the algorithmic approach when prescribing mobility devices and ensure that all required elements were included in the medical record. Although later clarifications regarding such forms were included in Q and A sessions and in the LCD itself, there still appears to be confusion as to if, how or when these forms can be used. Are they valid? Are they legal or illegal? Are they useful or helpful?

Let’s look at exactly what the LCD says. When talking about the face-to-face examination that the physician is required to have with

the patient for any power mobility device, we read “Physicians shall document the examination in a detailed narrative note in their charts in the format they use for other entries. The note must clearly indicate that a major reason for the visit was a mobility examination.”

It then goes on to describe what this examination report (i.e. chart note) should include: symptoms, related diagnoses and history, how long the condition has been present, clinical progression, interventions that have been tried and the results, past use of walker, manual wheelchair, POV, or power wheelchair and the results, physical exam results including weight, strength, range of motion, sensation, or coordination impairments, abnormal tone, deformities, neck, trunk, and pelvic posture, and sitting and standing balance, functional assessment,

See Question of Forms page 2

Guest Article

By Duwayne Kramer, Burke Inc.

IMPORTANT SAFETY AND REGULATORY INFORMATION

FEDERAL REGULATIONS REQUIRE INDEPENDENT TESTING/LISTING TO THE IEC60601-2-38 FOR ELECTRIC HOSPITAL BEDS

Attn: Directors of Bariatric Care and Patient Safety,

Many hospital administrators are unaware that all beds in their facility, including bariatric beds, should meet the IEC 60601-2-38(2-38) U.S. electric hospital bed standard. The 2-38 is the first and only standard ever developed to specifically test the safety and effectiveness of electric hospital beds. The Occupational Safety and Health Administration (OSHA) requires that any new



See Guest Article page 6

Upcoming
Events Page 2

Tech Tip Corner
Page 5

Did you know?
Page 8

Question of Forms continued from page 1

including transfer abilities and characteristics of ambulation such as distance, speed, balance and the need for assistance.

The LCD then states: “Many suppliers have created forms which have not been approved by CMS which they send to physicians and ask them to complete. Even if the physician completes this type of form and puts it in his/her chart, this supplier-generated form is not a substitute for the comprehensive medical record as noted above. Suppliers are encouraged to help educate physicians on the type of information that is needed to document a patient’s mobility needs.”

So, what does this all say? Well, it doesn’t say that forms are against regulations, or illegal. The physician can fill them out and can include them in the medical record if desired. However, he/she will basically be doing twice the amount of paperwork, because it will still be necessary to write a narrative in a chart note that

includes all of the same type of information and is in the same format that is used for any other chart note. The chart note itself must contain the information from the face-to-face exam. No form can be used as a substitute for this narrative, not even the form created by the Texas Academy of Family Physicians. CMS wants to see that the physician completed an appropriate evaluation and based their recommendation for a mobility device on their findings. They also want to see evidence the physician considered all lower cost alternatives before prescribing power and documentation as to why these lower cost alternatives were inappropriate. This should all be in the physician’s own language and style and not in canned language that is not specific to that patient.

So, if you are asking your physicians to fill out one of these “MAE” forms, you are asking them to do twice the work. And if anyone is telling the physicians that they only need to check off the appropriate boxes on a form, write a note indicating they have seen the patient face to face and refer to the

form, they are incorrect.

OK, what can you do if the physician refuses to write an appropriate chart note that includes all of the needed information because (a) “Fly-By-Nite Medical down the street doesn’t require it” or (b) “that’s not my job” or (c) he/she simply doesn’t know what is required? First, let them know that this is CMS’s policy, not yours. Then provide them with a copy of the LCD. You can also include a copy of the “Dear Colleague” letter, signed by Medical Directors Dr. Hughes and Dr. Oleck, which informs the physicians that it is indeed their responsibility to provide all the needed information in the correct format. Create an educational piece that outlines the type of information needed in the chart note as described above. Unfortunately CMS has nicely passed the buck to the supplier community to carry out their education. However, this is your assurance that you will not only be paid, but will also keep your money at the end of the day. ■

Elizabeth Cole is the Director of Clinical Rehab Services for U.S. Rehab.

Upcoming Events

Sales Training with Louis Feuer

October 27, 2008
Atlanta, GA

Medtrade

October 27-30, 2008
Atlanta, GA

Billing Boot Camp

November 5-6, 2008
Las Vegas, NV

Billing & Reimbursement Road Show with Peggy Walker

November 13, 2008
San Antonio, TX

NAMPS Member Meeting

November 19, 2008
Las Vegas, NV

Sales Training University with Louis Feuer

December 2-3, 2008
Dallas, TX

Billing Boot Camp

February 5, 2009
Birmingham, AL

Billing & Reimbursement Road Show with Peggy Walker

February 19, 2009
Sarasota, FL

Peggy Walker

Reimbursement Update

WHERE IS IT WRITTEN?



The question I receive most often when people ask me about repairs, maintenance and replacement is “Where is it

written?” or “Can you show me where I can find that in writing?”

On October 1, 2003 CMS restructured its paper-based manual system as a Web-based system which combined all the various program instructions for CMS programs and contractors. The Web site is www.cms.hhs.gov/manuals. The Medicare Policy Manual (pub. 100.2,15,110.2) is where we reference notes relating to repairs, maintenance, replacement and delivery. Let’s take a quick look at the rules:

The Rules

Payment may be made for repair, maintenance and replacement of “medically required” DME, including equipment which had been in use before the user enrolled in Part B of the program. The beneficiary must still meet the coverage criteria for that item.

Repair: *To repair* means to fix or mend and to put the equipment back in good condition after damage OR wear. Repairs to equipment which the beneficiary owns are covered when necessary

to make it serviceable. ****

A new CMN/DIF and/or physician’s order is not needed for repairs. BUT if the original item was not purchased by Medicare, you need to make sure the beneficiary meets Medicare coverage criteria for that item.

Maintenance: Routine periodic servicing, such as testing, cleaning, regulating and checking of the beneficiary’s equipment is not covered. The owner is expected to perform such routine maintenance. ***** However, Medicare will reimburse for more extensive maintenance on beneficiary-owned equipment that, according to the manufacturer, should be performed by authorized technicians.

Replacement: Replacement refers to the provision of an identical or nearly identical item. Equipment which is owned by the beneficiary “or” is a capped rental item may be replaced only in cases of irreparable damage or loss as a result of a specific accident or natural disaster (e.g. fire, flood). A physician’s order and/or new CMN [when required] is needed to reaffirm the medical necessity of the item.

If the item of equipment has been in continuous use by the patient on “EITHER” a rent or purchase basis for the equipment’s reasonable useful lifetime, the beneficiary may elect to obtain

a new piece of equipment. The reasonable useful lifetime of DME is determined through program instructions. In the absence of program instructions, carriers may determine the reasonable useful lifetime, BUT in no case can it be less than five years. Computation of the useful lifetime is based on when the equipment is “delivered” to the beneficiary, not the age of the equipment. REPLACEMENT due to WEAR is NOT COVERED during the reasonable useful lifetime of the equipment. A new order is required to demonstrate medical necessity and documented need for new equipment.

Payment for delivery of DME whether rented or purchased is generally included in the fee schedule allowance for the item.

Remember to use the VRU (automated voice response unit) to check for beneficiary history of items purchased or rented in your jurisdiction

Reimbursement

Now that we know the “rules,” how do we get paid?

The repair code for labor is E1340 and one unit equals 15 minutes. There is no fee schedule assigned to this code. The last fee schedule date 2001 showed a range from \$9.60 to \$17.66(AK) with a mean of \$11.29.

See Update page 7



RESNA is Changing Their Certification Exam

By Elizabeth Cole

For the past 13 years there have been two different certification exams offered by RESNA in Assistive Technology; one for the Assistive Technology Practitioner (ATP) and one for the Assistive Technology Supplier (ATS). The two certifications were based to some degree on the role of the person taking the exam. The ATP has been defined as a “service provider who analyzes the needs of consumers with disabilities, assists in selection of appropriate assistive technology (AT) for the consumer’s needs and provides training in the use of the selected device.” The ATS has been defined as a “service provider who is involved with the sale and service of rehabilitation equipment or commercially available AT products or devices for consumers with disabilities.” RESNA has recently announced

that beginning in January 1, 2009, there will be a single certification exam to test the core, entry-level knowledge and skills common to all involved in AT service delivery. So why the change after 13 years?

Basically, a voluntary certification should not be tied to a specific role, but instead, should be used to identify competence in core knowledge in a particular area.

When we start to link a certification to an individual’s role, there is risk that we will view the certification as giving the individual permission to perform or provide certain services or products. In actuality, this is the role of licensure, not certification. Having the ATS or ATP certification does not give that person permission to do anything that he/she was not allowed to do prior to certification. However, in the past, the industry has often viewed the ATP as someone who could perform the clinical evaluation for an AT device, while the ATS was someone who could assist with product selection and provide the prescribed equipment. This has presented several problems. First, while you

can become an ATP without any clinical degree or licensure, in most states only a licensed therapist can perform clinical evaluations. Secondly, people change roles within the industry, yet still carry the same certification. This is further “muddied” when funding sources use the ATP and/or ATS designation in their coverage policies.

So what should the purpose of the certification exam be? It should demonstrate a competency in basic knowledge regarding all areas of AT - knowledge that anyone involved in recommendation of any AT device should have, regardless of his/her area of practice. It adheres to the principle that, in addition to competency in your own area of practice, anyone involved in AT provision should have basic awareness of the other areas of AT that might impact their clients, and know when and how to refer to another AT professional. If we are looking to test for a broad knowledge base, then a single exam makes more sense, especially

See RESNA Changing page 7

Vendor Product Spotlight - Invacare



The Top End Crossfire T6A, a rigid-frame performance wheelchair, offers ample adjustability by combining a seat frame for positioning and a side frame for performance. When making a rear seat height adjustment, the performance of the chair isn’t compromised, because no “re-squaring” is needed in the front fork area and no correction is needed for rear wheel toeing errors. Packed with new accessories and customizable features, the Crossfire T6A is blazing new ground for rigid wheelchairs.

Tech Tip Corner

Introducing Invacare Virtual Service For MK6i Rehab Electronics



Invacare®
MK6i™
Laptop IVS
(Invacare
Virtual

Service) allows use of a computer to view/modify/compare/store programming settings for power wheelchairs using MK6i electronics using either an MPJ+, PSR+, PSF+ joystick, or a MK6i display with alternative driver control. New files can be created to download to a power wheelchair later. Even hard copies of a user's programming settings can be printed and/or saved to your computer.

The key to MK6i IVS is the program no longer requires the computer to be hard wired to the power wheelchair. Better yet, there is no software to install. Everything about MK6i IVS runs off of the MK6i professional SD card - including the program itself.

Leave the computer at home!
Download files from an Invacare power wheelchair to the MK6i

professional SD card in the field. Then, insert the SD card into your computer back at the office to take full advantage of all MK6i IVS features. In some cases you may be able to modify a file in your office then take the card into the field, insert the card into the chair and download the new program into the chair eliminating the need to program in the field.

New to MK6i IVS is a robust troubleshooting section. Included are answers to frequently asked questions, digital photos of power wheelchair configurations and components, repair instructions, and even troubleshooting and programming tips.

MK6i Laptop IVS is pre-loaded on all MK6i professional SD cards containing software version, 1.7.0. Additionally, MK6i IVS can be downloaded onto a current MK6i professional SD card.

Instructions for Downloading your FREE copy of MK6i IVS

1. Go to the Invacare Web site www.invacare.com
2. Login with your user name and password
3. Click on the Technical Zone tab

4. Select Software Downloads
5. Download the MK6i IVS Installer and save to your desktop.
6. Insert the MK6i professional SD card into a Microsoft based PC or laptop's SD card slot (or into a card reader via a USB port).
7. Open the MK6i installer zip folder saved on the desktop, then open the "MARK6_IVS Installer X.X.X.X.exe" file.
8. Select the drive location of the professional memory card when prompted.
9. Select "OK" and IVS will automatically be installed onto your card.

Instructions for Using MK6i Laptop IVS

MK6i IVS runs entirely off the MK6i professional SD card. Insert the MK6i professional SD card into a Microsoft based PC or laptop's SD card slot (or into a card reader via a USB port) and MK6i IVS should automatically start. Once started, the MK6i help will assist you in using IVS.

For additional information, please contact Invacare Technical Service @ 800-832-4707 ■



Guest Article continued from page 1

hospital bed used in a hospital, nursing home or any public facility be tested to meet the 2-38 standard by a nationally recognized testing laboratory (NRTL), such as UL, ETL or CSA. The NRTL 2-38 standard certification mark must be placed on the bed. For many years, the Food and Drug Administration has used the 2-38 as the recognized consensus standard for testing all electric hospital beds, defining the minimum allowable construction and performance requirements.

A bed's failure to meet the 2-38 standard raises questions of patient and staff safety as well as creating additional issues of product liability for the facility. Some bed manufacturers are currently claiming listings to invalid standards that are unacceptable to use in place of the 2-38. One current practice is placing a confusing UL label on the bed without listing the standard to which it was tested.

Any incident involving a non 2-38 NRTL tested bed puts your facility at greater liability risk. The following numbers demonstrate some of the incidents facilities are

currently encountering. The FDA's Web site reports 116 deaths by side rail entrapment, 12 bed fire incidents and 8 possible deaths by fire since 2002. In addition, there have been multiple bed recalls including one recall of over 200,000 beds for potential fires. The vast majority of these incidents involve beds that were not tested to the 2-38 standard. Protect your facility by requesting a certification letter issued by the NRTL, for any new bariatric bed rented or purchased for your facility. The letter should specifically state that the bed was tested and meets the IEC 60601-2-38 U.S. electric hospital bed standard.

For more information, visit our Web site, BurkeBariatric.com, for a listing of:

- Hospital beds that have been NRTL tested to the 2-38 standard
- Information about the IEC 60601-2-38 standard
- An explanation of the evolution of hospital bed standards including inappropriate standards usages
- An example of an appropriate NRTL 2-38 safety mark.

We believe the Burke Tri-fl ex II™ and Tri-lift™ beds are two of the relatively few bariatric beds that meet the OSHA requirement of

being independently tested to the 2-38 by a NRTL (ETL: Intertec testing lab).

Protect your patients, staff and facility by requiring a 2-38 certification letter from a Nationally Recognized Testing Laboratory (NRTL) for any bariatric bed you rent or buy.

Please Route This Letter:

- Bariatric Program and Safety Coordinator
- Medical Director
- Risk Management Administrator
- Product Evaluation Committee
- Other _____

For more information Email Us at: BariatricBedSafety@BurkeBariatric.com ■

DuWayne Kramer President of Burke, Inc. / Leisure-Lift. Burke, Inc. is an active member of RESNA providing technical knowledge for the development of safety standards designed to protect both patients and care providers.

Safety Considerations

Update continued from page 3

When billing this code you need to put a breakout narrative that states:

- Name, make, model of item repaired
- Payer source
- Date purchased
- Time required to repair

Although this information needs to be in abbreviated terms, it is important that the claims processor fully understands the name, make and model, the payor source and the date purchased.

Use the modifiers NURPKX for the items you replace. If you replace right and left items, use the NURTRPKX (1 unit) then the NULTRPKX (1 unit) to prevent having to use an overflow modifier (99). However, this

rule changes from day to day and from Jurisdiction to Jurisdiction, so if your claim denies, use the overflow modifier NURTLT99 and put RPKX in the narrative field. You always need to state “broken beyond repair”, rather than “worn” out.

If you need to supply a loaner while performing a repair use K0462. This is for up to one month rental for the loaner equipment you provide while the patient-owned equipment is being repaired. Always document why it took longer than one day to repair.

When using the E1399 or K0108 (miscellaneous codes) or any NOC (not otherwise classified code) include the name, make, model and MSRP in the narrative field, so they can establish a payment for it.

You can bill the patient for a service charge for repairs. You need to make sure you have a service fee schedule and explain this up front to the beneficiary.

CASH – the best HCPCs code there is. There is nothing wrong with asking for payment up front. After all, when does someone like Sears bill you for something after the fact? They ask for a credit card up front. That is what we need to be doing.

How you bill is up to you, but when in doubt bill non-assigned. I always suggest that if you did not provide the item it is best to bill non-assigned. It is really important to research your options in today’s changing climate. ■

Peggy Walker is Billing and Reimbursement Advisor for U.S. Rehab.

RESNA Changing continued from page 4

considering that the current ATP and ATS exams differ by only 50 of their 200 questions. In addition, a single exam does not try to define the individual’s role in service delivery. This is defined by state regulations and the practice acts of the professional licensure boards.

As with the current exams, eligibility to sit for the new exam will be based on various combinations of education (minimum GED) and work experience. The name of the new certification will be Assistive Technology Professional or ATP. All current ATP’s and ATS’s will grandfather over to the new

name, with no need to take the new test. Within the next few months, RESNA will inform all current certificants of when and how to switch over to the new name. After the change, current certificants will be able to use the Assistive Technology Professional designation, but will not be able to use the Assistive Technology Practitioner or Assistive Technology Supplier designations. However, any NRRTS™ member who has met the requirements for the CRTS™ designation may still use CRTS™. Future plans also include computer-based testing and the development of specialty certifications which will build upon the core ATP exam. The first specialty certification to be developed (targeted for summer

2009) will be for seating and mobility.

RESNA has identified current Medicare and Medicaid policies where the RESNA certification requirement exists in statutes and regulations and is working with them to ensure that the new certification is recognized once the change is effective. If you know of any other legislative policies, insurances, organizations, manuals, or employers that recognize or require the RESNA ATP or ATS certification, please e-mail or call Anjali Weber (703-524-6686 ext 311 or aweber@resna.org) to allow RESNA to follow up with these entities. ■

Elizabeth Cole is the Director of Clinical Rehab Services for U.S. Rehab.

Did you know?

◆ The C.E.A.C. (Certified Environmental Access Consultant) Credential process is now web-based.

◆ There are 206 bones in the adult human body, but 300 in children (some of the bones fuse together as a child grows).

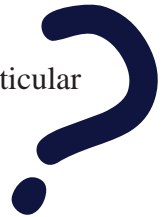
◆ U.S. Rehab has an online educational resource entitled Academy of Advanced Rehab Education. It can be found at: onlineeducation.usrehab.com.

◆ U.S. Rehab is a specialty network of VGM.

◆ Heartland 2009 will be June 8-11 so mark your calendars today.

◆ Any month that has a Friday the 13th also has a Wednesday the 25th.

◆ Complex rehab was carved out of competitive bidding, however, these particular codes are subject to the 9.5% rate cut scheduled for January 1, 2009.



Rehab Word Search

S A B I S P U G N O I T A L S I G E L A
 C E C I V R E S P G Z N K T N N F W O S
 O R P V J U X A D Y S M R A O O P Y R G
 O N G X I K T I L G R O B T I I B R T N
 T W J H O I R F G N F B A I T T Z R N J
 E A F U E B A X B V A I R O A A W E O A
 Q Z R N T I L T S P R L I N C T V C C S
 P K T V I L S K E N K I A O I N S L D E
 S C O O T E R K D H R T H G F E I A N F
 Y A D W G L U P U A J Y C Y I M U I A B
 R S A J P F N T G H B W L S T U L B H P
 P T S D R Y Z X R K V I E H R C X D G S
 A E H A G N I D N U F A E P E O F P D X
 N R I F B W S B P B R E H R C D B K O L
 E D U C A T I O N H S B W G N I D O C W

CASTER
 CERTIFICATION
 CODING
 DOCUMENTATION
 EDUCATION

FUNDING
 HAND CONTROL
 LEGISLATION
 MOBILITY
 PATIENT

RECLINE
 SERVICE
 SCOOTER
 TILT
 WHEELCHAIR