

# Industry **update**

*www.usrehab.com*

*A division of The VGM Group*

## The Clinical Justification Corner

By Elizabeth Cole

**P**rescribing and providing the optimal seating and mobility equipment for our clients involves matching the client's needs to appropriate product parameters. A crucial part of obtaining appropriate reimbursement for this equipment is to document clinical justification - why does this particular client need this specific type of product? This section of the newsletter will provide potential clinical justifications for different bases, options and accessories to help you and your clinicians in your documentation.

### High-Strength Lightweight Wheelchairs

Whenever you choose a product for your client, it is important to rule out any lower cost alternatives. So what differentiates a high-strength lightweight wheelchair from a lightweight wheelchair or a standard wheelchair and why would your client require these

features? The most obvious answer is weight - a high-strength lightweight is several pounds lighter than a lightweight and many pounds lighter than a standard. Although the elimination of four or five pounds truly can affect the ability to functionally propel the chair, with some funding sources it might be difficult to justify these chairs based on weight alone. You would need to document that the client truly could not propel the weight of a lightweight chair. This is especially hard for our Medicare clients since Medicare will only pay for what is needed for mobility within the home. Fortunately, some high-strength lightweight models have other features which can help with justification:

- Additional sizing – some models offer more seat widths and depths and/or back heights compared to the standard sizes offered by lower

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## Guest Article

By Darren Jernigan, Permobil

To Our Partners at U.S. Rehab:

**W**hen I entered this industry in the summer of 2002 all talk at that time was centered on or around competitive bidding. I knew about the concept of competitive bidding from when astronaut Alan Sheppard made famous his quip about the Mercury capsule, "All of this was built by the lowest bidder". Sheppard was joking but surely he was thinking about the quality of product that was about to shoot him into space and return him safely to Earth. I simply knew competitive bidding was not a good thing when applied to certain products, i.e., wheelchairs and rocket ships.

I was then further encouraged when I found out Congress was on the case. The Medicare Modernization Act was passed in 2003 and competitive bidding

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# Your U.S. ★ REHAB<sup>®</sup> Team

*Peggy Walker, Billing and Reimbursement Advisor*



Peggy assists members with pre-pay review of rehab claims, post-pay audits, denials, reviews, hearings and other reimbursement issues. She can be reached at 800-401-3643.

*Elizabeth Cole, MSPT, Director of Clinical Rehab Services*



Elizabeth develops educational products, programs and services for members and participating vendors. She can be reached at 888-324-4731.

*Amanda Vanous, Marketing Coordinator*



Amanda works to promote products and services to members. She also handles education registrations and monthly member mailings.

## *From the President*

### **The Rehab Rollercoaster**

Dear U.S. Rehab Members:

I'm sure many of you will agree it seems like we've been on the longest rollercoaster ride in history! Within the past couple of years, the Rehab industry has been filled with ups, downs, loops and twists. All of which, combined or on their own, could make you a little lightheaded and queasy about the stability and profitability of your company and its future.



And guess what...we've not reached the exit gate yet.

We still have a ways to go, with more changes just around the bend. The new manual wheelchair coding, policy and allowables will soon be upon us.

Our battles with CMS have been many -- and our victories few -- but those "wins" were vastly important.

H.R.6331 (The Medicare Improvements for Patients and Providers Act) or MIPPA was enacted on July 15, 2008 as Public Law 110-275. The provisions of MIPPA brought important relief to the rehab community by providing:

- \*An exemption of complex rehab from the NCB bidding projects
- \*Preserves the first month purchase option for all power mobility
- \*Omitted the implementation of a 9.5% decrease on bidded codes for seating and accessory items utilized on manual wheelchairs or non-bidded power products

It's now more important than ever to stay informed on the issues and get involved on the action items that are critical to your success! The intent of this newsletter is to do just that...to keep you informed. Along with our Web site, e-mails and fax updates, this new format is intended to be a summary of events, changes and proposed changes that will affect your future as a Rehab provider.

Take a moment to read and review, then pass it along to your fellow associates. I believe you will find the content of this newsletter to be informative and useful. We look forward to bringing you helpful information on a timely basis.

As Always,



JK



*Carrie Etten, Administrative Assistant*

Carrie greets members on the phone. She is also responsible for processing new members and coordinating the tech training sessions.

## **New coding clarification relating to electronics**

SADMERC has issued the following clarifications relating to coding for power wheelchair electronics:

- There is no separate billing for a standard proportional remote joystick when it is provided at the time of initial issue of a power wheelchair.
- If an expandable controller is provided at the time of initial issue, code E2377 (expandable controller) and E2313 (harness for upgrade to expandable controller) are separately billable and payable.
- If a power seating system is provided and if the system is controlled through the drive control interface, code E2310 or E2311 is used.
- There is no additional separate billing using code E2399 or K0108 for any components of a non-expandable or an expandable controller.

## **SADMERC Contract**

PalmettoGBA has lost the SADMERC contract. As of 08/08/2008 the new contractor will be Noridian Administrative Services (NAS). The new Web site will be [www.dmepdac.com](http://www.dmepdac.com). NAS will assume the following responsibilities:

- 1) Provide data analysis support to the DME safeguard contractors (PSCs)
- 2) Guide the provider community in proper use of HCPCS through product reviews, the DMECS

system and HCPCS helpline

- 3) Conduct national pricing functions for DMEPOS services
- 4) Assist CMS with the DMEPOS fee schedules

## **Power Wheelchair**

### **Documentation: a brief summary of the Rehab team responsibilities**

#### **Physician/ordering practitioner:**

1. Conduct a face-to-face evaluation of the patient's functional needs for a scooter or power wheelchair
  - a. Must include basic information relating to ability to perform MRADLs within the home.
  - b. Basically establish need by ruling out use of a cane, walker, manual wheelchair and, when going to a power wheelchair, why a scooter/POV will not meet needs.
  - c. Both cognitive and functional abilities need to be addressed.
  - d. \*\*\*MUST\*\*\* state the reason for visit was for a mobility evaluation.
  - e. Write the order which includes patient's name, date of the face-to-face, length of need, diagnosis relating to impaired mobility, the item being ordered (this can simply state power mobility device, power wheelchair or scooter/POV), signature and NPI #, date of signature.
2. If a PT/OT evaluation is completed, review and sign the evaluation to indicate concurrence.
3. Make sure the supplier receives the progress notes from the date

of the face-to-face and the order within 45 days of the completion of the face-to-face process.

4. Review and sign off on supplier's "Detailed Product Description."

\*\*\* The key is that the face to face needs to be specifically for an evaluation for power mobility\*\*\* There is no need to complete "forms or CMNs". The information needs to be written in a narrative description using the same format that is used to write any other progress note.

#### **Physical Therapist – Occupational Therapist:**

1. Complete a mobility assessment which addresses the patient's functional needs within the home.
  - a. It is OK to mention what they complete outside the home also. The key is to justify what they need within the home in order to complete basic ADLs they could not without the use of a power mobility device.
  - b. This needs to be a step-by-step approach ruling out less costly alternatives from cane to walker to manual wheelchair (all types) to scooter to power wheelchair.
  - c. Make sure this is detailed and legible. Keep it basic and simple.
  - d. Provide details of each accessory and why it is medically necessary (ie: adjustable height armrests are needed because patient is 6'3" and requires higher armrests for upper extremity support; or

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# Clinical Justification

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cost wheelchairs.

Certain clients require specific seat and back dimensions for optimal support at the trunk, pelvis and lower extremities, as well as for appropriate weight distribution along the lower extremities and for maximum access to the rear wheels. For these clients, standard sizing will not meet their postural and functional needs.

■ **Minimally adjustable axle plate:** A minimally adjustable axle plate has two or more vertical positions for the axle and rear wheel. This allows the chair to be configured in several different seat-to-floor heights (STFH). A specific STFH might be needed by the client for safe transfers, foot propulsion or access to certain surfaces or objects in the environment. The specific STFH needed might not be achievable on the lower cost alternatives.

The vertical positions on the minimally adjustable axle plate, along with an adjustable caster housing, also provide the ability to create a fixed tilt in the frame. For many clients, adding a fixed tilt makes it easier to maintain an upright posture against gravity, thus reducing the tendency to slide into poor positioning due to compromised trunk muscles, fatigue and/or impaired balance.

Some minimally adjustable axle plates also offer an offset axle position which places the wheel slightly in front of the rear frame. This brings the wheel closer to the client, providing better access to the wheel and a more efficient propulsion stroke. This results in less energy expenditure and less stress to the upper extremities.

■ **Adjustable seat to back angle:** This provides a minimal fixed recline (or “open” seat to back angle). Like a fixed tilt, it can “reduce” the effects of gravity, helping the client to maintain optimal upright posture. It can also accommodate the client who

is unable to sit in a standard 90-degree seat-to-back angle due to fixed deformities, such as hip extension contractures or a fixed posterior pelvic tilt. This describes many of our older clients!

■ **Ultra-hemi frames -** some manufacturers offer frame options that provide STFHs as low as 13”-14”. This allows even clients of very short stature to functionally and efficiently propel with one or both lower extremities while maintaining good upright posture.

In all cases, it is critical to assess each individual client regarding their physical, functional, cognitive and medical needs to determine if, in fact, they require one or more of the above features. It is also important to be familiar with the various options available on the different high-strength lightweight models since not all products offer all of these features. ■

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

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## Great Teacher, Great Students

**I**t pays to study. And those who took the ATS review course with Elizabeth Cole, MSPT, Director of Clinical Rehab Services for U.S. Rehab, discovered just that!

The course was offered during the 2008 Heartland Conference and was one of the few events that was not canceled when Waterloo experienced record flooding. Thirty-five of the 53 students passed the RESNA exam according to Anjali Weber, ATP, RESNA Director of Certification. “It looks like your training raised their chances!” she told U.S. Rehab.

# Tech Tip Corner

## **WANT BETTER BATTERY PERFORMANCE? AVOID CHRONIC UNDERCHARGING!**

By Dennis Sharpe

For years, technicians have worried about overcharging batteries used in mobility equipment. Not too long ago, large amperage chargers, designed and set for wet batteries, often caused sealed batteries to fail and wet batteries to dry out quickly. Today, the biggest threat to the sealed batteries we use is chronic undercharge. Why does this happen? Think of your customer. They frequently charge their mobility device at night and begin using it first thing each morning. They sometimes do not wait for the completion of the charging process. This problem is more significant with active users who may need more time to fully charge their batteries.

When a battery is discharged, lead sulfate is deposited on the plates.

When the battery is recharged, the lead sulfate is converted back to lead and sulfuric acid. If the battery is not fully charged, some lead sulfate will remain on the plates. If undercharging takes place repeatedly, this lead sulfate will begin to crystallize which will eventually damage battery performance and impact longevity.

Why has undercharging developed into a problem? Chargers have become smaller in output and batteries are discharged more deeply with active users.

How can you identify undercharged batteries? The most common symptom is poor running time. Check voltage on each of the batteries in a pair. If the voltage readings are very close, even when run down, there is strong possibility they have been undercharged. Full charging for a number of cycles may improve their performance.

What should you tell your customer



to do? Always allow the mobility device charger to complete the charging process. The customer who fully charges their batteries each time will have better performance and longer battery life. We work hard at MK Battery to provide a quality power source for mobility applications. Proper charging will help to maximize the life and performance of the batteries and thus keep your service issues to a minimum while improving your customer satisfaction record. ■

*Dennis Sharpe is involved with National Medical Sales for MK Battery.*

## Vendor Spotlight



MK BATTERY

TEL (800) 372-9253 \* TEL (714) 937-1033 \*

FAX (714) 937-0818

1631 S. Sinclair Street \* Anaheim, CA 92806

There's a simple reason why MK Battery is the number one brand of mobility battery among all major wheelchair manufacturers and leading rehab equipment suppliers. These industry leaders cannot afford to have their reputations riding on anything but the best power source available. That's why the MK name is your assurance of getting the best battery available for your wheelchair, scooter or other mobility device.

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was going to solely balance our nation's budget and eliminate the debt with the savings that would occur. But the DME industry responded with a tenacious attitude never giving in and refusing to sit on the sidelines as CMS was planning to implement competitive bidding. We understood that if we didn't help educate the government with making the correct decision then the government would end up making the wrong one for us.

So we lobbied, had fly-ins to Washington DC, had national call-in days, and were encouraged to personally visit our members of Congress. It was great to see checks and balances at its best when the Medicare Improvements for Patients and Providers Act was passed by Congress, vetoed by the President, and passed again on July 15th by Congress with an override. Yes we now have a delay, but at what cost? I'll tell you – a 9.5% cut in reimbursement to providers. As an end user I can't really tell a difference between competitive bidding and a 9.5% cut as providers are now back to limiting product. I'm still, as Alan Sheppard would

believe, using a product nobody cares about or will even be able to service without a "reasonable" margin. Did anything really good come out of the bill? I say, "Oh yeah it did."

Believe it or not the rehab industry just got a little clearer with the passage of this Act. Complex rehabilitation is now a legitimate category and has become recognized separately from its very big brother "HME". As an end user I finally got something to focus on. The complex rehab carve-out is here to stay, not even the National Guard mandating we all get out of Waterloo can get rid of this. Why? Because it would take an act of Congress and that never happens twice!

Now I'm not sure if having our own complex rehab category means another organization with another acronym will emerge, but what I do know is that money, influence, expertise, and political agendas can now focus on a specific message in a specific area. The same way oxygen and prosthetics have separated themselves and now complex rehab can do the same.

I believe the message to be tackled is the 9.5% cut. If anyone

has a shot at getting this cut removed, it is complex rehab. The diagnoses that are associated with our category are some of the most recognized and devastating ailments on the planet, complete with their own very powerful national associations. We must merge profit and non-profit organizations to form one message that holds the interest of the wheelchair user, keep their issues on the forefront, and continue to work for the betterment of the severely disabled. Take care of the end user and they will take care of you.

Time is getting short with this Congress, however. There is a chance we may see the 9.5% cut carved out from our newly created complex rehab category. We need to hit Congress now while it still has a vague idea of what we are talking to. Let's keep up the pressure for a few more months and see if we can file a technical amendment and break totally clear from our HME counterpart. We should fight as if our lives depended on it because a lot of our customers' lives do! ■

*Darren Jernigan is Director of Government Affairs for Permobil, Inc.*



# Current Legislation

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lateral trunk supports are needed to maintain upright trunk position).

e. The patient's cognitive awareness needs to be addressed as well.

### Supplier:

1. Home environmental evaluation must be completed on-site at the patient's home and can be completed by a clinician or supplier employee.

2. Education of patient/caregiver in the safe use and care of the equipment.

3. Attestation statement (if a PT or OT is involved) stating the evaluating PT or OT has no financial ties to the supplier.

4. Higher-end power wheelchair orders require an evaluation by an ATS with documentation of personal involvement.

5. Complete the Detailed Product Description which must include: HCPCS codes for the base to be provided and all separately billed options; manufacturer name and model (or general description) for each of those codes; supplier's charges; Medicare fee schedules ("not applicable" if no fee schedule). Send to the physician/ordering practitioner for review,

signature and date of signature.  
6. Date stamp all documentation when it comes in.

7. Complete all follow-up and processing of paperwork flow.

8. Make sure ABN and purchase option letter are also completed accurately. ■

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

## Upcoming Events

### **Billing Boot Camp with Jane Bunch**

August 20-21, 2008  
Doubletree Hotel Rochester  
1111 Jefferson Road  
Rochester, NY

### **MESA Fall Conference 2008**

September 3-5, 2008  
Crowne Plaza Hotel  
14315 Midway Road  
Addison, TX

### **Sales Training University with Louis Feuer**

September 9-10, 2008  
VGM Training Theater  
1101 W San Marnan Drive  
Waterloo, IA

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

September 11, 2008  
VGM Training Theater  
1101 W San Marnan Drive  
Waterloo, IA

### **MNCHA Annual Meeting**

September 17-18, 2008

### **Wound Care & Bariatric Academy**

September 17-18, 2008  
Chicago, IL

### **Wound Care & Bariatric Academy**

September 24-25, 2008  
Philadelphia, PA

### **U.S. Rehab Tech Training**

September 22-24, 2008  
Crowne Plaza Chicago O'Hare  
5440 North River Road  
Rosemont, IL 60018

### **Billing Boot Camp with Jane Bunch**

October 1-2, 2008  
Doubletree Hotel Columbus-Worthington  
175 Hutchinson Avenue  
Columbus, OH

### **ATS Review Program**

October 8-9, 2008  
Crowne Plaza Dallas - Market Place  
7050 Stemmons Freeway  
Dallas, TX

### **Sales Training with Louis Feuer**

October 27, 2008  
Atlanta, GA

### **Medtrade**

October 27-30, 2008  
Georgia World Congress Center  
Atlanta, GA

# Did you know?

◆ U.S. Rehab offers a credential in home modifications, known as the Certified Environmental Access Consultant (C.E.A.C.) credential.

◆ More than 2,500 left-handed people are killed each year from using products that are made for right-handed people.

◆ To find upcoming ATS credentialing exam dates, visit RESNA's Web site at: [www.resna.org](http://www.resna.org) and click on certification.

◆ The members-only section of U.S. Rehab contains a wealth of information. If you aren't registered yet, do so today at [www.usrehab.com](http://www.usrehab.com)

◆ Heartland 2009 will be June 8-11 so mark your calendars today to attend!

◆ One of Hewlett Packard's first ideas was an automatic urinal flusher.

◆ To see the most current specials participating vendors are offering, go to the Current Promotions page on U.S. Rehab's Website (under 'members only').

◆ U.S. Rehab has developed an Assistive Technology Training Program (ATTP). It provides 30 CEC's. Check it out today by clicking on "Online Education" at our main Web page.



## Alphabet Soup

**X**

1. PMD: (1) \_\_\_\_\_

2. EADL: \_\_\_\_\_ (2)

3. ATP: \_\_\_\_\_ (3)

**H**

4. CEAC: \_\_\_\_\_ (4) \_\_\_\_\_ (5)

5. ADA 1990: \_\_\_\_\_ (6) \_\_\_\_\_ (7) \_\_\_\_\_ (8)  
1990

6. CNS: \_\_\_\_\_ (9)

**P**

7. AAC: \_\_\_\_\_ (10) \_\_\_\_\_ (11)

8. PPT: \_\_\_\_\_ (12) \_\_\_\_\_ (13)

9. MAE: \_\_\_\_\_ (14)

**T**

10. LCD: \_\_\_\_\_ (15)

\_\_\_\_\_

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15