Ever since CMS stepped up its program integrity efforts and sent a growing avalanche of pre- and post-payment audits in the direction of DMEPOS providers, HME businesses have been fighting to keep up with auditor requests and appealing recoupments. Furthermore, they were succeeding to a certain degree. Providers created various documentation policies and procedures to ensure clean claims and to quickly reply to requests. And, depending on the type of audit, providers saw substantial overturn rates when they appealed audits. The situation wasn’t ideal, but like the survivors they have demonstrated themselves to be, HME businesses were adapting to a difficult situation. That is until CMS’s Office of Medicare Hearings and Appeals recently announced it was suffering from a tremendous backlog of appeals and was going to delay assigning administrative law judges to appeal by two years. This means providers have to suffer through recoupments and sobering penalties and fees for two years. It’s enough to kill a business. That is why the industry has quickly moved to craft a response to this unreasonable situation. Read this month’s cover story to learn what the industry needs to accomplish, and what it will take to get there.
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Audits: Breaking Through

CMS’s audit onslaught has been a trial and tribulation for the HME industry, but matters took a turn for the terrifying when the agency announced that it would delay assigning Administrative Law Judges to audit appeals by two years. Now the industry has redoubled its efforts to bring an out-of-control situation back under control.

Smart Inventory Strategies

Inventory typically represents the top overhead item for providers. In a cost-conscious reimbursement environment, HME providers have needed to develop smart inventory management and purchasing strategies to cope. HMEB looks at some of the techniques and tools they are using to contend with a constantly changing environment.

AAHomecare outlines audit reform objectives, prepares legislation; Competitive bidding to go national by 2016; Sleepsafe, Trucking Association launch sleep education; National expansion of bidding a ‘disaster; Obama expands bidding in 2015 budget; ResMed unveils new branding; Compliance Team celebrates 20th anniversary; AAHomecare to launch social media campaign.
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Editor’s Note

Hopping Out of CMS’s Pot

What one amphibian’s dinnertime dilemma can demonstrate to the HME industry.

Ever hear of the frog and the cooking pot? Indulge me, because the story is an apt metaphor for where the home medical equipment industry finds itself with the Medicare program.

The story basically goes like this: a frog is put into a cooking pot full of water. The cook turns on the gas very low. At first the hot water is too uncomfortable for the frog, but eventually the frog gets used to it. After a while, the cook turns up the heat a little more. The new level of heat is initially unpleasant for the frog, but eventually it gets used to it. Again, after a little bit, the cook turns up the heat again, and after initial suffering, the frog grows accustomed to the new heat. This process repeats itself multiple times until the frog eventually is boiled alive.

The moral of the story is that you can only stand so much heat before you’re cooked.

Which Brings Us to Medicare

And in the case of Medicare, providers are the frog and CMS is the cook. I know that’s a grim scenario to describe, but in many respects it is true. Just look at how competitive bidding has unfolded: first Round One was announced and bid; then the industry secured a delay; Round One was re-bid again; then Round One was implemented; then Round Two was set into motion; it was bid out; and it reached implementation. And now what’s happening? The President is suggesting that bid rates be applied to the Medicaid program, and CMS just recently asked for comments on a plan to expand competitive bidding pricing nationwide by 2016 (see, News, Trends & Analysis on page 8 to read more about these two developments).

Or, we could look at the pressure cooker that is audits. Here, the industry has worked to adapt to very hot waters indeed, but just when it looks like providers might be treading water, CMS announces that will delay assigning Administrative Law Judges to audit appeals by two years. If you read this month’s cover story on audits, found on page 18, you’ll see that arrangement poses a very clear present danger to HME providers businesses. It’s not simply an issue of having recouped fees hanging in limbo for two years, because, as the experts show, when you factor in the various fees and penalties, providers will pay massive sums.

These examples are why HME Business has been steadily starting for several years that providers must develop new business models. To that end, we have provided in-depth coverage of cash sales, home access, orthotics & prosthetics, senior care, wound care and other business models into which providers can expand in order to diversify their revenues. (We even present another new business model in this issue, which is featured in this month’s “People in HME” section, on page 14.)

Many times, when I talk about the need to pursue new business models, people make it a point to tell me that they wholeheartedly agree with that message. They say they get it and are pursuing new sources of revenue beyond the Medicare benefit.

Other times, people tell me that for an industry that has been built around Medicare’s DMEPOS benefit, such a suggestion isn’t realistic. I completely understand that point of view, and can’t argue against it. Medicare is a key service to a multiplicity of beneficiaries who depend on the services HME providers deliver. Moreover, I agree without equivocation that the industry must continue to fight to protect the DMEPOS benefit and the patients that depend on it. ( Heck, that seems to be my regular mantra in many of these Editor’s Note columns.)

But at the same time, competitive bidding, CMS’s audits, face-to-face, capped rental and a multiplicity of Medicare challenges demonstrate very clearly that CMS is turning up the heat, little by little, and eventually there are going to be many providers that find the waters simply too hot. That’s why we need to remember what our amphibian friend forgot. We can hop out of CMS’s pot.

David Kopf
Editor
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AAHomecare Outlines Audit Reform Objectives, Prepares Legislation

The American Association for Homecare and other healthcare associations are working to draft legislation to reform the Centers for Medicare and Medicaid's current audit program, and representatives of the association met with the Senate Finance Committee to discuss audits today.

Kim Brummett, vice president of regulatory affairs for the American Association for Homecare met with and discussed various recommendations with the Senate Finance Committee at a special roundtable meeting today, after the association outlined a broad set of objectives for reforming CMS's current audit program earlier this week Medtrade Spring this week.

At the meeting, AAHomecare presenting the following recommendations based on input from its members to the committee:
1. Stop new audits until the backlog is cleared up.
2. Stop interest penalties until an audit is through all levels of appeals.
3. Stop the recoupment/repayment process until an audit is through all levels of appeals.

The objectives represent a blend of goals the industry has in terms implementing improvements in the audit system while working in conjunction with the MACs, which have a good deal of discretion in the process, while other objectives would be put into some form of legislations, according to Brummett.

Earlier in the week, during AAHomecare's March 11 Washington Update at the Medtrade Spring event held at the Mandalay Bay in Las Vegas, Brummett presented a set of much broad and far-reaching audit reform recommendations to providers attending the event:
- Conduct independent reviews of contractors to hold them accountable.
- Issue guidance to DME MACs to require reopening after a re-determination on a technical denial.
- Issue guidance to DME MACs to require reopening after a re-determination on a technical denial.
- Issue guidance to DME MACs to require reopening after a re-determination on a technical denial.
- Assign greater weight to clinical inference: let the medical record speak to the need of the patient and pay for services based on those facts.
- “Today’s roundtable was an excellent opportunity to explain those recommendations to the Committee as they prepare a legislative solution to the audit problem,” Brummett said.

Law Judge.
- Reinstate "clinical inference" policy.
- Require that electronic health records include DME medical necessity documentation.
- Mandate use of a template such as in the power mobility device prior authorization demonstration.

The objectives represent a blend of goals the industry has in terms implementing improvements in the audit system while working in conjunction with the MACs, which have a good deal of discretion in the process, while other objectives would be put into some form of legislations, according to Brummett.

“They’re very close to being finalized,” Witter said at this week’s Washington Update. “We’re very sensitive because of competitive bidding efforts on the Hill; we don’t want to ask for too many things. But we are close. We have

See Audit Reform Objectives continued on page 10
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centers for Medicare & Medicaid Services (CMS) announced it was moving forward nationwide implementation of its competitive bidding program last month, and sought public comment on the initiative.

With the Round One re-compete contracts hitting implementation on Jan. 1, and Round Two going into effect July 1, 2013, the program now spans 100 competitive bidding areas, covering much of the nation. It also covers nationwide mail order for diabetes testing supplies.

However, by 2016, Medicare must extend the bidding program or competitive bidding pricing for included items to areas that are current not part of the program, thus bringing the program nationwide.

So, CMS is soliciting public comment on the methodology it would use to comply with the statute when using competitive bidding pricing information to adjust payment amounts in non-competitive bidding areas. CMS also is requesting comments regarding the potential for simplifying the payment rules and enhancing beneficiary access to items and services under the competitive bidding programs for certain durable medical equipment (DME) and enteral nutrition.

Bearing in mind Round Two’s 45 percent average cut in reimbursement for bid DMEPOS categories, and the 72 percent cut to diabetic testing supplies, the announcement regarding nationwide bidding by 2016 has put HME/DME providers on red alert.

CMS is also considering whether different payment rules for DME and enteral nutrients, supplies, and equipment or for certain DME?

The monthly payments would continue as long as medical necessity for the covered items continued and the supplier would be responsible for furnishing all items and services needed each month.

(CMS) implemented this provision of the law and adjusted prices of DMEPOS items in non-bidding areas.

(bid DMEPOS categories, and the 72 percent cut to diabetic testing supplies, the announcement regarding nationwide bidding by 2016 has put HME/DME providers on red alert.)

The survey asked six questions that reflected the questions asked by CMS about expanding the competitive bidding program. The questions provided examples and were simplified to better reflect a provider’s day-to-day business experience.

“We need a sounding board for our issues and know that that squeaky wheel is what gets heard,” Gallagher noted. “We’re working to make it easier for the voice of providers to be heard.”

CMS gearing up to expand program or pricing to non-bid areas; seeks public comment.

The Competitive Bidding to Go National by 2016

The Centers for Medicare & Medicaid Services (CMS) announced it was moving forward nationwide implementation of its competitive bidding program last month, and sought public comment on the initiative.

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CMS is also considering whether different payment rules for DME and enteral nutrients, supplies, and equipment or for certain DME?

The monthly payments would continue as long as medical necessity for the covered items continued and the supplier would be responsible for furnishing all items and services needed each month.

In this regard, CMS is seeking input on various points, including:

- Are lump sum purchases and capped rental payment rules for DME and enteral nutrition equipment still needed?
- Are there reasons why beneficiaries need to own expensive DME or enteral nutrition equipment?
- Would there be any negative impacts associated with continuous bundled monthly payments for enteral nutrients, supplies, and equipment or for certain DME?

CMS set the deadline for submission comments on CMS-1460-ANPRM for March 28, and to help providers respond to CMS’s request for public comments on nationwide expansion, the VGM Group created an online survey that facilitated the process.

The survey asked six questions that reflected the questions asked by CMS about expanding the competitive bidding program. The questions provided examples and were simplified to better reflect a provider’s day-to-day business experience.

“Our staff reviewed the CMS instructions and online tools to see if the public comment process was simple to understand and complete quickly,” said John Gallagher, vice president—government relations. “What they found was far from ideal for busy business owners. So we developed a straightforward solution that can be completed in a short amount of time.”

Submitted surveys were then processed and sent to CMS by courier before the March 28 deadline. Also, VGM staff members followed up with participants via email to provide a step-by-step process to quickly message Congress with the information provided in the survey.

“We need a sounding board for our issues and know that that squeaky wheel is what gets heard,” Gallagher noted. “We’re working to make it easier for the voice of providers to be heard.”

CEDI Calling on ICD-10 Volunteers

Participants for each DME MAC will help prepare for Oct. 1 transition to new classification codes.

The test will involve 32 volunteers for each DME MAC. To volunteer, providers must complete a volunteer form by March 24. The form can be found by selecting the “ICD-10 Testing Information” menu item found at www.ngscedi.com. The resulting page provides a link to the form via large, blue button. Minimum requirements for eligibility:

- Testers must be able to provide the National Provider Identifiers (NPIs), Provider Transaction Account Numbers (PTANs), and beneficiary Health Insurance Claim Numbers (HICNs) they will use for test claims when requested by CEDI. This information will be needed several months prior to the start of testing for set-up purposes.
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**National Expansion of Bidding a ‘Disaster’**

Recent Senate win on ‘doc fix’ step forward, more co-sponsors needed for H.R. 1717.

**After** building a successful provider business 27 years ago that is now “on life support” thanks to competitive bidding, American Association for Homecare President Tom Ryan told attendees of Medtrade Spring’s Washington Update that he has been personally impacted by competitive bidding, but called on them to support industry efforts to stop CMS’s bid program.

“When you talk about ‘battle fatigue,’” he said, “But the people who are going to win this battle are the ones who get up every single day, get in the ring and fight.”

And while some providers might have thought the program would not necessarily impact them, because of CMS’s recently announced intent to expand competitive bidding rates nationwide by 2016, they were “now in the soup,” Ryan noted. He added that a nationwide expansion of competitive bidding actually poses bigger problems for smaller, rural providers, as well.

“The problem is, when competitive bidding came for most of us, we anticipated increased market share,” he explained. “But if you’re in a rural area, you’re not getting any more market share; you’re just going to get egregious prices.”

Ryan joked that he was literally on his third set of shoes from walking around Washington, D.C., but explained that stopping the bid program would require “tireless” work by the associations and providers alike. To that end, he said the two best opportunities the industry has for reversing competitive bidding were H.R. 1717, the bill that would replace bidding with the Market Pricing Program, and attaching the bill’s provisions as an amendment to sustainable growth rate (aka the “doc fix”) legislation.

To that end, the association is working with House and Senate committees to include MPP elements in current SGR legislation, according to Jay Witter, vice president of Government Affairs for AAHomecare. Witter, who referred to the 2016 expansion as “a disaster,” noted that already the association enjoyed a rare in the Senate by attaching an amendment to require out of state providers to prove they are licensed at the time of bid submission.

For the first time, the association is working with House and Senate committees to include MPP elements in current SGR legislation, according to Jay Witter, vice president of Government Affairs for AAHomecare. Witter, who referred to the 2016 expansion as “a disaster,” noted that already the association enjoyed a rare in the Senate by attaching an amendment to require out of state providers to prove they are licensed at the time of bid submission.

The power mobility portion of the industry has been working through the prior authorization demonstration project since September 2012. While the project has been relatively straightforward, the language in the President’s budget was less so.

“AAHomecare is working with CMS to make necessary changes [to the demonstration project], and continues to advocate for improvements,” a public statement from AAHomecare read. “However, the budget proposal is very vague, so it’s unclear how it would be implemented.”

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**Obama Expands Bidding in 2015 Budget**

President’s package would apply NCB rates to Medicaid program.

At the same time CMS began soliciting comments on expanding competitive bidding nationwide by 2016, President Obama’s 2015 budget, released last month, included a number of DME-related proposals, including applying competitive bidding payments to Medicare reimbursements.

The President’s 2015 budget aims to enhance efforts to cut “waste, fraud, and abuse” in Medicare and Medicaid in order to save nearly $1.1 billion over the next 10 years. As part of that agenda, the budget proposes having Medicare reimbursement mirror Medicaid reimbursement rates.

“States have experienced challenges in preventing overpayments for durable medical equipment (DME),” the budget reads. “Starting in 2015, the Budget would limit Federal reimbursement for a State’s Medicaid spending on certain DME services to what Medicare would have paid in the same State for the same services.”

In addition to applying Medicare rates to Medicaid reimbursement, the President’s 2015 also proposes to:

- Implement new initiatives to reduce improper payments in Medicare.
- Require prior authorization for power mobility devices and advanced imaging.
- Possibly expand that prior authorization to “other items and services at high risk of fraud and abuse.”

The power mobility portion of the industry has been working through the prior authorization demonstration project since September 2012. While the project has been relatively straightforward, the language in the President’s budget was less so.

“AAHomecare is working with CMS to make necessary changes [to the demonstration project], and continues to advocate for improvements,” a public statement from AAHomecare read. “However, the budget proposal is very vague, so it’s unclear how it would be implemented.”

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**ResMed Unveils New Branding**

Slogan ‘Changing lives with every breath’ accompanies new logo; strategy starts in U.S., to go global.

Ventilation and sleep equipment maker ResMed has debuted new branding including, “Changing lives with every breath,” a new tagline accompanying a refreshed logo that shifts in color from bright blue to red to symbolize the transition that deoxygenated blood makes to oxygenated blood with every breath, and every beat of the heart.

“Our purpose is to improve the lives of patients who use our solutions to treat sleep-disordered breathing, COPD, and other chronic diseases,” said ResMed CEO Mick Farrell. “… Worldwide shifts in healthcare dynamics have opened up important opportunities to further impact the well-being of millions of undiagnosed patients.”

“Our new brand will be front and center as we continue making a difference to patients, to physicians, and to healthcare systems,” he added. “It’s exciting and it’s just the first step in what will be a landmark year for ResMed, with launches of game-changing products and solutions.”

The new brand transition starts with ResMed’s U.S. operations, and will roll out globally throughout the year. A key element will be a refreshed and user-friendly company website at ResMed.com that helps people more easily find information to help them on their journey to better breathing.

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**Compliance Team Celebrates 20th Anniversary**

Medicare accrediting organization launched by founder Canally, RN with eye on easing process for providers.

Medicare accrediting organization The Compliance Team Inc. (TCT), the nation’s only woman-owned healthcare accreditation organization to bold Medicare “deeming authority” to accredit DMEPOS providers, is celebrating its 20th anniversary.

The firm was founded in 1994 by president, Sandra Canally, RN, who is the principal author and architect of TCT’s Exemplary Provider programs, and its respective Safety-Honesty-Caring quality standards. Canally incorporated the firm as a self-funded independent healthcare evaluation enterprise.

“From the outset, I focused on accreditation simplification,” the former Nurse Oncologist explained. “My intent was to make it easier for everyone within an organization to buy into compliance.”
AAHomecare to Launch Social Media Campaign

Effort designed to drive consumer awareness of negative impacts of Medicare reforms.

The American Association for Homecare will launch a new digital communications campaign this month that is aimed at driving consumer awareness about the problems associated with Medicare reform mistakes that are restricting consumers’ access to homecare medical equipment, services and supplies.

“This campaign will help consumers better understand why flawed policies affect their health and how they can make their voices heard,” said AAHomecare president and CEO Tom Ryan. “Consumers will be able to stand up and defend their access to the equipment, services and supplies they need to receive healthcare at home.”

“This campaign will help reach, educate and unite consumers around our shared mission of strengthening access to care for the millions of Americans who require medical care in their homes,” said Robert Stedley, president of Barnes Healthcare Services and chairman of the AAHomcare Board of Directors.

Starting early this month, the campaign will be managed by AAHomecare, along with Lisa Wells, president of Get Social Consulting Inc., and supported by Anna McDevitt, president of Laboratory Marketing.

“The heart of the whole campaign will revolve around humanizing the policy issues that are hurting the patients we serve as care providers,” Wells said. “As care advocates and small business owners, we will be sharing individual, personal stories in a format that is visual, viral and digital.”

“Digital media is a powerful tool for unifying providers and consumers to make our voices heard in Washington,” McDevitt added. “Our mission is to help consumers understand the power they have to speak up for their quality of care – and give them the proper tools to do so. We are thrilled to be part of this advocacy initiative.”

“AAHomecare is excited to be working with Get Social and Laboratory Marketing. This campaign will be a rallying cry for consumers and share AAHomecare’s messages on a national level,” said Ryan.

Campaign resources and specifics will be shared with providers as the kick-off date approaches, according to the association. Industry supporters and HME businesses should contact Beth Ludwick at bethl@aaahomecare.org for more information and to learn how they can get involved.
HME Home Medical’s Eric Hagen explains the origin of the GO HME distributor model.

Exploring new businesses models has been a top priority for many providers trying to expand beyond Medicare reimbursement. To that end, many HME businesses have tapped into retail sales, home access and orthotics & prosthetics, just to name a few. But one Northeastern Wisconsin provider has hit on yet another option: business-to-business supply.

On March 1, Green Bay-based HME Home Medical launched GO HME (www.gohme.com), a new business-to-business-to-business supply. That kind of creative thinking will keep HME businesses such as HME Home Medical and GO HME providing a full line of incontinence products that includes briefs, pull-ups, underpads, gloves, wipes and skin-care products.

And there’s a longer play at work, as well. If a patient at a skilled nursing facility gets better and goes home, know HME Home Medical can step in and help, because of the relationship that was established by GO HME.

“When they discharge from that facility, they might need a hospital bed and a wheelchair,” Hagen says. “We’re able to do that, too. So being a DME company, as well as a distributor, we’re able to help patients 360 degrees.”

That kind of creative thinking will keep HME businesses such as HME Home Medical and GO HME providing product and value throughout the healthcare continuum.
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Problem Solvers

Safe Bariatric Living Spaces

Two experienced home access experts discuss how providers can create safe bathing environments for bariatric patients.

By Joseph Duffy

Bathrooms get a lot of attention when it comes to keeping bariatric patients safe in their homes. But challenges also abound in patients’ living spaces, which include bedrooms, living rooms and common areas. When Blair Ferguson, President, Beyond Barriers Minneapolis, goes into a home to assess a client, he first notices the personal hygiene of the person. It will also be obvious if the individual is spending the entire day in the same bed or chair without being transferred. Both of these are commonly a direct result of their living environment not being able to accommodate their specific needs, he says.

“A tactfully ask if the client is able to utilize all the facilities of the home and move about it or at least be transferred by their care providers to minimize bed sores and a better quality of life,” Ferguson says.

Living space safety concerns

“One of the main safety concerns commonly encountered is being able to safely lift and transfer a bariatric client,” says Ferguson. “This includes safety for the client but as importantly the safety of the care provider performing the transfer. Floor lifts may accommodate the needs if the floor surface is smooth, transition-free, and hard enough to allow the maneuvering of the lift, and if you have enough care providers to assist along with having adequate space. A much more efficient and safer means to transfer is with an overhead ceiling lift and if properly installed can lift up to 1000 pounds although reinforcement of the structure may be necessary.”

Another main safety concern in living spaces is egress — in this case, the client’s ability to get out of the home in case of an emergency. Ferguson says that HME providers must make sure the doors and paths of travel are negotiable by the client with or without a mobility device and that the client can get to a safe place outside of the home.

“A second consideration is that many of these individuals have chronic medical conditions or are not mobile and we need to consider making the home EMS friendly.”

— Blair Ferguson,
Beyond Barriers Minneapolis

to-ceiling pole that you place next to the bed. A ceiling-mount trapeze might also work. Carricato says it is also important to carry a wide range of furniture products in order to meet the weight and construction challenges of bariatric patients.

Home modifications

Besides the sale of appropriate HME/DME equipment, including mobility devices and lifting and transferring devices, the provider may be able to consult or provide the home modifications necessary to use the equipment they provide. This may mean doing the home modifications themselves if they are set up and licensed to do so or having the necessary business relationships with companies that are qualified and experienced to do the work.

“Dealing with the environment for a bariatric need differs slightly because of additional loads placed on the structure, such as overhead lifts and point loads on tile floors, along with being able to accommodate installing larger-than-normal doors, which also involves structural modifications,” says Ferguson. “Providing or being a resource for these services may provide an additional revenue resource even if you subcontract the work to a qualified company.”

Typical home modifications include widening doors, both interior and exterior, commonly using a 42-inch door instead of the usual 36-inch door, says Ferguson. This may involve moving walls and placing doors in new locations.

“New flooring is frequently installed, as carpet does not withstand anything rolling over it with significant weight involved,” Ferguson explains. “Special consideration needs to be applied when dealing with tile floor because the additional load placed applied can cause the tile to ‘pop’ if not done correctly, resulting in costly call backs.”

Get educated

“There is a significant lack of knowledge regarding environmental modifications for bariatric clients,” says Ferguson. “Along with that is a lack of experience with companies able to perform appropriate modifications and have the skill sets to accommodate the additional structural reinforcements that would be appropriate.”

Carricato suggests that an HME provider who wants to get serious about home access and how to help specialized clients, such as bariatric patients, should look into becoming a Certified Environmental Access Consultant, a designation offered by the Accessible Home Improvement of America (AHIA).”

Joseph Duffy is a freelance writer and marketing consultant, and a regular contributor to HME Business magazine and Respiratory & Sleep Management. He can be reached via e-mail at jduffy@hmemediagroup.com, or joe@prooferati.com.
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Those are just some of the words that have been used to describe the Centers for Medicare and Medicaid’s pre- and post-payment audit programs for Medicare. Perhaps another appropriate descriptor would be “wall.”

Steadily, brick by brick, CMS has been building an audit system that, whether intentionally or not, is effectively shutting providers out of the Medicare business. From the outset CMS’s ramped up audits were a concern to Medicare providers, including DMEPOS providers, because the Recovery Audit Contractors (RAC), Comprehensive Error Rate Testing (CERT) and Zone Program Integrity Contractors (ZPIC) audits were being conducted largely by auditing contractors that were set up by large technology firms that were using very vague interpretations of Medicare guidelines, which threw many recoupments into question.

As CMS began doubling its program integrity budgets and adding new programs, it began crowing about the amount of claims it was recovering through the contractors (the latest announcement, from last month, was that the federal government recovered $4.3 billion in 2013 as part of its Medicare anti-fraud efforts), and warned of increasing waste, fraud and abuse. Clearly, CMS sees the program as essential and successful, which means it is here to stay.

So providers worked with their referral partners to implement solid documentation procedures, and began appealing claims that auditors recouped. That’s when providers discovered high rates of overturn at the appeal level,

The two-year ALJ delay could shut many providers down. Can the industry get CMS to see sense on audits?

By David Kopf
and realized that they could find a way to get their money back despite audit contractors’ broad interpretations. It wasn’t a perfect system, but at least providers were seeing some daylight.

That is until the start of 2014, when a letter from Nancy Griswold, the chief judge of CMS’ Office of Medicare Hearings and Appeals (OMHA) stated OMHA was going to delay assigning an Administrative Law Judge to any new audit appeals for two years. The reason cited was a backlog of 357,000 claims appeals stacked up in the system that were pushing the current turnaround time for an appeal to 16 months.

But that backlog was a fact accomplished that many in the industry and in other healthcare fields impacted by the audits claim CMS should have known about. Over the past three years, the agency’s radically revamped audits have resulted in appeals growing by 184 percent. Meanwhile, “the resources to adjudicate the appeals remained relatively constant” at 65 administrative law judges, Griswold wrote in her memo. While OMHA received 1,250 appeals a week in January 2012, it received more than 15,000 appeals a week by November 2013. How could CMS not realize OMHA would need additional ALJs, especially with the high rate of overturn?

“The huge increase in the volume of appeals is a direct result of the significant increase in the number of audits being conducted,” says Wayne van Halem, CFE, AHFI, president of The van Halem Group LLC, which helps providers contend with Medicare claims audits. “CMS keeps awarding lucrative contracts to private audit entities to find ‘t’s that aren’t crossed and ‘i’s that aren’t dotted, yet the beneficiaries clearly needed the services that were provided.”

“Getting before an ALJ is generally the first time where reason enters the equation and we still see a large number of claims overturned, so providers should and will continue to fight,” he continues. “Rather than spend hundreds of millions of dollars to increase the volume of audits which subsequently increases the volume of appeals, why not spend some money on increasing staff and lessening the burden on the judges in the Office of Medicare Hearings and Appeals?”

“Something is going to have to change with the current audit program,” says attorney Edward Vishnevetsky, who is an Associate in the Business Litigation section of the Dallas office of industry law firm Munsch Hardt Kopf & Harr. “If you’re going to delay appeals for at least two years, at least don’t take the money back during that time frame.

“So there needs to be a reprieve,” he continues. “Either we get the 90 days in order to have a hearing that statute requires, or you can’t take our money back. Otherwise it’ll just be the end of providers. And obviously this is more than just DME providers … Something needs to change.”

Quantifying the ALJ Delay’s Impact
The problem with the ALJ delay is that the impact goes far beyond a simple delay. On the face of things, one might conclude that a recouped reimbursement might be sitting in limbo for a while, and that’s it, but the impact goes much, much further than that.

In last month’s issue of HME Business, Vishnevetsky wrote an “Observation Deck” column (March 2014, page 34) about the overall impact of the ALJ delay on providers, and the impact is staggering. Vishnevetsky used a hypothetical scenario in which CMS notifies a provider that 40 percent of its claims were incorrect and resulted in an overpayment of $150,000. Extrapolating the denial percentage to all of the provider’s claims for those HCPCS or CPT codes within the past five years, CMS says the provider must repay $4.5 million in overpayments.

Now, factoring in the Extended Repayment Schedule (ERS), which Medicare will approve if the total amount of all outstanding overpayments is 10 percent or greater than the total Medicare payments made for the previous calendar year, Vishnevetsky’s example yields two sobering results.

“Getting before an ALJ is generally the first time where reason enters the equation and we still see a large number of claims overturned, so providers should and will continue to fight.”

— Wayne van Halem, CFE, AHFI, The van Halem Group LLC

the provider must pay $97,560.61 in principal and interest each month, and based on the delay, the provider will pay $3,512,181.96 before an ALJ adjudicates the claim.

If the provider decides to not go the ERS route, and brings their audit to the Re-determination and Reconsideration levels of appeal, the provider must still pay interest on all unpaid overpayments within 30 days of the provider’s receipt of the Initial Demand Letter until the overpayment is repaid in full. Vishnevetsky points out. The rate on that interest is 10.125 percent. Based on his hypothetical example, if the provider wins 40 percent of the claims at the Re-determination and Reconsideration levels, then CMS will begin recouping approximately $2,768,345.75 after the Reconsideration decision is issued.

And beyond that, once the provider needs to make payments, there is a stringent program for ensuring the provider adheres to payments. If the provider doesn’t make payment arrangements with CMS, or CMS cannot recoup the overpayment debt in 180 days, then the debt becomes delinquent. Delinquency ushers in a whole new set of problems because CMS will refer the case to the Department of Treasury, which will begin collecting under the Treasury Offset Program (TOP), which can begin collecting funds via various sources of debtor income.

Not a pretty picture. So what’s the bottom line for many HME provider businesses under such a scenario?

“It’s gone,” Vishnevetsky states. “If you have any extrapolations, your business is gone. Unless you have significant financial capital.”

The Audit Contractor Gravy Train
Compounding the vexation felt over the two-year ALJ delay is that it’s not just a problem for providers, but a temptation for audit contractors. Despite a history of faulty audits that have been regularly overturned at appeals, now these contractors can engage in this behavior unconcerned about future overturns, because providers might not survive to see their day before an ALJ.

“My biggest concern is that if you are a RAC auditor, this just sounds like gravy,” Vishnevetsky says. “If we take two to three years to get to a hearing, and I [as an auditor] get paid on a percentage of what I collect, I’m going to put everyone on extrapolated pre-payment or post-payment audit, and I know that they’re not going to be able to fight anymore, not because they don’t have the time, but because they can’t sustain their business. If you can’t maintain your business, then you can’t maintain your license, and if you can’t maintain your license, then you can’t even appeal.”

So to be able to fight an appeal two or three years down the road, a provider needs to keep its license, which means it needs to maintain its accreditation and storefront. That’s a lot of investing to even be allowed to
appeal when a huge chunk of its claims could be have been recouped, and the provider could be paying all those attached fees.

“You still have to be putting out money just to fight to get the money that might have been taken inappropriately by Medicare,” Vishnevetsky says. And that’s if the provider were able to exist. There’s a strong change it could have folded due to those fees and financial pressures by the time two or three years rolls around.

“And Medicare will use that information to make its numbers to look attractive and more appealing, depending on how much fraud and abuse is being controlled,” Vishnevetsky explains. “They’re going to say ‘Well, we just got another $25 billion in overpayments due to fraud and abuse,’ not indicating how much of that figure is related to overpayments that took two years to go through the process and so the company had to fold.”

That’s a gloomy scenario. If there is one bit of respite in the current audit situation facing providers, it is that their personal liability is somewhat mitigated (unless there were actual fraud and abuse). Except for their surety bond, that is.

“A lot of providers don’t realize that their surety bonds are personally guaranteed,” Vishnevetsky explains. “So you could be responsible for that additional $25,000 of your surety bond — let alone that your company folded.”

Fighting Back
This scenario means that the industry really has only one option: overturn the entire audit process by fighting back. To that end, the American Association for Homecare, working with other healthcare interests, has assembled a broad audit agenda that is a combination of legislative objectives to reform the program, as well as initiatives to work with CMS and OMHA to change the system in the meantime, so as to at least give providers some sort of respite while the two-year delay is in effect.

To that end, during the American Association for Homecare’s March 11 Washington Update at Medtrade Spring, Kim Brummett, vice president of regulatory affairs for AAHomecare, presented a broad set of far-reaching audit reform recommendations the industry would pursue. They included:

- Conduct independent reviews of contractors to hold them accountable.
- Interest penalties for MACs when claims are overturned.
- Remove ability for MACs to issue “clarifications.”
- Enhance review of DME providers who do not respond to audit requests.
- Limit the number of audits a DME provider can receive during a given period.
- Reinstate “clinical inference” policy.
- Require that electronic health records include DME medical necessity documentation.
- Mandate use of a template such as in the power mobility device prior authorization demonstration.

And there is some collaboration happening. In a recent forum with Judge Griswold, AAHomecare president and CEO Tom Ryan explained the dire situation facing providers. That resulted in setting up a meeting with key CMS staff. The association president...
AAHomecare has created an audit tracking tool that is available to all providers. This will help providers quantify the audit impact so that the industry can discuss those numbers with lawmakers. That is available as an Excel spreadsheet at www.aahomecare.org/issues/audits.

In addition to pursuing those reforms in a collaborative fashion with the various agencies involved, the association is also working on drafting audit reform legislation, Brummett said. That legislation, according to Jay Witter, vice president of Government Affairs for the association, has been in the works for a couple of years with various parties, and, at press time, was set for a release sometime in April.

“It’s very close to being finalized,” Witter said at the Washington Update. “We’re very sensitive because of competitive bidding efforts on the Hill; we don’t want to ask for too many things. But we are close. We have built the foundation and we will be making an announcement very soon about a huge audit effort.”

In pursuit of those legislative aims, Brummett met with the Senate Finance Committee at a special roundtable meeting last month to discuss various audit reform recommendations. The agenda she pursued included:

- Stop new audits until the backlog is cleared up.
- Stop interest penalties until an audit is through all levels of appeals.
- Stop the recoupment/repayment process until an audit is through all levels of appeals.
- Issue guidance to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) to allow for timely filing override on continuous rental or supply claims.
- Issue guidance to DME MACs to require reopening after a re-determination on a technical denial.
- Evaluate the Qualified Independent Contractor (QIC) to determine if this step is effective or merely a stop-gap on the way to the Administrative Law Judge.
- Assign greater weight to clinical inference: let the medical record speak to the need of the patient and pay for services based on those facts.

Also, the association is already gearing up the advocacy efforts that would back lobbying efforts on behalf of such legislation. Witter noted that the advocacy challenge for the industry and provider advocates will be to simplify audits, which are a very complex issue. To help simplify the issue in a way that will resonate with lawmakers and staff and help “sell” the issue, the association is also collecting provider stories about their audit frustrations and the negative impact the program is having on their businesses and patients. (To submit stories, providers should email auditproblems@aahomecare.org.)

“I get calls all the time, and at first they’re anecdotal and very sad stories,” Brummett says. “But we’d like to gather those stories, because they help give impetus to [the legislation]. … It really helps to paint the picture.”

Also, to help providers keep track of their audits so that they can begin to get a clear picture of the source and extent of the audits they are facing,
“This is a taking without due process. And that issue is still very relevant and part and parcel of what’s occurring. ... I think this has serious grounds for a due process violation.”
— Edward Vishnevetsky, Munsch Hardt Kopf & Harr

“What we find is that when providers call and we ask, ‘Where did you get your audit from?’ or ‘How many audits have you gotten?,’ many are not really sure,” Brummett says. “This really forces each of us to know those things. We want to aggregate numbers, so that we can demonstrate to CMS and Congress the number of audits we are getting. If nothing else, start tracking what’s happening to your company.”

The Legal Route
In addition to the legislative approach, there is a legal aspect of CMS’s approach to audits, as well, Vishnevetsky says. CMS, via the audit contractors, is recouping provider money when it doesn’t necessarily know if it can truly do so, and is then holding it for at least two years due to the ALJ delay. That’s especially disconcerting due to the high level of overturn once providers elevate their appeals through the process, but it also might be out of legal bounds.

“This is a taking without due process,” he explains. “And that issue is still very relevant and part and parcel of what’s occurring. ... I think this has serious grounds for a due process violation.”

Besides recouping claims for two years without giving providers a chance to fight back, the entire notion of a delay could fall outside federal law, Vishnevetsky argues.

“There are rules and statutes that govern how long it takes an ALJ to provide an opinion and go to a hearing, which is 90 days,” he explains. “By taking two years, that is essentially re-writing the law, and they’re not following notice and comment rulemaking, which is what’s required. So my argument would be that if it says 90 days and you’re taking two years, you’ve effectively changed the law, and you haven’t done that in the appropriate manner, so it is arbitrary and capricious under the Administrative Procedures Act.

“As a provider, if I’m required to respond within 30 days, and I don’t, I lose my appeal,” Vishnevetsky continues. “If [CMS] doesn’t respond according to its statutory period of 90 days, what happens? Nothing. So the law needs to change. And the only way to really make the law change, in my opinion, is by legislative means, or you file a lawsuit that will have legislative implications.”

All that needs to happen for these arguments to be made in court is for someone in the industry to take up the issue.

“Hopefully someone in the Medicare Part B community will file a constitutional lawsuit on this issue,” Vishnevetsky says. “Because I don’t see a reprieve coming very quickly.”

To that end, Vishnevetsky says his firm has been in discussions with some larger providers and other entities within the industry to see if such a suit could be feasible.

“The difficulty is that it is an expensive endeavor,” he explains. “But I think the chances of success are reasonable.”

Documentation: Dealing With Audits

Of course, in the meantime, providers must contend with the audits in the here and now. That means having a plan and systems in place for working with referral partners; responding to auditor requests; and having the right assets in place when appealing claims — even if there is a two-year ALJ delay (read the main story, starting on page 18, for more information on the delay). Much of this comes down to having the right documentation procedures in place. Here are some key considerations:

Have the right staff expertise. Make sure that all team members involved in the claims workflow understand all documentation requirements needed to ensure that claims will not raise flags with audit contractors. Staff should also know what is required to respond to auditor documentation requests. Work with internal and third-party experts as needed to train everyone on the team who needs help, and require all claims staff to regularly refer to key reference documents such as jurisdiction supplier manuals to monitor any possible policies changes or new requirements.

Set documentation requirements in stone. Provider management must set guidelines that require complete and correct medical documentation for all claims. Workflows must conform to documentation requirements, and no claims should be able go past any step in the workflow without having the necessary documentation. More to the point, those requirements must apply to both staff and all referral partners — and the latter group could prove problematic, at least initially. This means providers must work to educate physician staff via in-services and similar opportunities so that those partners understand any changes in documentation policies. More than likely, physician partners and other referral sources will be more than understanding, because they are experiencing the same audit pressures from Medicare, as well.

Leverage information technology. One of the key tools to help providers make the audit process as smooth and rapid as possible is software. The billing, claims and management systems they have in place often can help providers implement the workflow procedures that will ensure they are collecting all the necessary documentation up front, and that it is formatted the correct way. Also, because billing software houses all documentation electronically, it inherently makes responding to auditor documentation requests much easier. Auditors will stipulate which documentation is needed, and the provider can quickly retrieve it to prove the claim’s validity.

Perform self-audits. Routinely check claims to determine if they are exposing the business to audits through a faulty or missing workflow step. Claims should be reviewed for missing or incorrectly formatted documentation elements, and if any are found, the provider should be looking for repeat problems to isolate a trend. Here, too, software can help. The overwhelming majority of audits result from data analysis (no small wonder, given that the audit contractors are typically owned by technology companies). So, the reporting tools in software systems can help warn HME providers to analyze their claims to judge their level of exposure to audits.

Continue pursuing appeals. While CMS brags to Congress about the amounts of claims it is recouping, it downplays the fact that HME providers were seeing as high as 60 percent of their audits being overturned when brought to appeal. That means providers need to have documentation in place to overturn any recoupments. Sure there might be a two-year delay that could entail massive charges, but the industry is working hard to bring that situation under control. So, in addition to supporting the industry’s efforts, providers must put into place the assets that will help them appeal once the process is restarted.
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Smart solutions to an increasingly complex problem: that is inventory management for the home medical equipment industry in a nutshell. In the quest to drive costs from the HME business model, the inventory management technologies available to HME providers have continued to evolve — perhaps at a faster pace than many of them realize.

Successful HME businesses are often driving by one overriding capability: efficiency. As reimbursement levels and profit margins have become razor thin, providers have had to become equally sharp when it comes to driving cost out of their business strategies and processes. And perhaps no area of their business requires more efficiency than their inventory.

“With reduced reimbursement rates, providers are more sensitive to the value of their inventory,” says Richard Mehan, president of HME software company Noble House. “They’re certainly not going to maintain inventory that goes above and beyond their monthly, or quarterly needs. So it’s tightened up the ship, if you will.”

“Where we used to count nickels, we now have to count pennies,” says Ryan McDevitt, Technical Account Manager for HME software service company Brightree LLC. “A successful DME inventory management operation is now run electronically.”

And that electronic management translates to money. For many HME providers, inventory represents their biggest element of overhead. And unlike many aspects of their businesses, such as salaries, benefits, deliveries or workflow processes, inventory offers a substantial arena for finding gains. While a provider might not be able to make HR cuts, inventory can be slimmed down.

And that’s important, because money that isn’t collecting dust as products in the warehouse or as stock languishing on retail shelves can be put directly toward the bottom line. The key is for providers to ensure that they balance their need for having the right stock on-hand without having too much of it on-hand. Moreover, they need to be able to quickly replenish their supplies.

Also, providers can reduce cost by cutting the number of “touches” that happen in the warehouse, McDevitt explains. For instance, now when an order is processed, a UPS label will get generated, along with ticket with all the items. But it goes deeper than that, because multiple requests for the item can be ganged together so that warehouse staff can pick the total number and then distribute them among the outgoing orders. This means fewer trips to the same bin and, multiplied across a day, week, month or year, can save substantial amounts in terms of wasted time.

McDevitt uses the example of Handi Medical Supply in St. Paul, Minn., which installed a pick carousel in its warehouse. Sort of akin to a giant DME carousel, it allowed staff to pick a total number of an item and then distribute among the outgoing orders.

“With reduced reimbursement rates, providers are more sensitive to the value of their inventory. ... So it’s tightened up the ship, if you will.”

— Richard Mehan, Noble House
vending machine, orders are assigned to boxes, which travel to rotating carousels that drop the correct type and quantity of DME into the order box. At the end of the process, staff ensure the order is correct and send it on its way. This way human interaction and product knowledge is saved for where it counts: working with patients and partners.

Moreover, more automated inventory management offers additional benefits for the HME business. For instance, whenever providers need to take static accounting of their inventory, such as at tax time, they now can simply run a report. That’s a process that previously would have consumed several days and involved overtime costs (an obligatory pizza run) for staff having to stay in the warehouse putting neon stickers all over everything.

The Basics
To that end, providers have been leveraging technology to strike that balance. Using HME software systems, providers have been able to leverage various inventory tools that help them bring order to the chaos from which they might suffer. Some basic approaches have been develop a coding system; begin bar-coding the warehouse; and then leverage automated repurchasing. To review:

Coding The first step in organizing inventory is determining a system for coding products. This can actually take some time, as various types of medical equipment involve different tracking requirements and other considerations. For example, how a provider decides to organize and code its oxygen supplies or rental equipment, will differ greatly from how it codes the more standalone types of DME, such as walkers or beds. Also, many providers often will want to incorporate vendor serial or product numbers into their coding. Many providers start with broad categories and narrow them down to more specific products to make the inventory management system easier to navigate and maintain.

Barcoding Barcoding has become an incredible asset in the HME industry, because it lets everyone who touches a piece of DME (and that can be several people) quickly update the inventory system. Once a coding system is created, it can be turned into barcodes that maximize efficiency and prevents errors. Barcoding also lets management monitor inventory in real-time, or nearly real time, thanks to wireless hand-held scanners. DME is logged in as it is received and updated and tracked as it moves through the system, which is often critical to accreditation requirements.

Automated purchasing Having just the right amount of a frequently ordered item is critical. Retain too much of the item, and a provider is wasting money, too little and a patient might go elsewhere. So, many inventory control systems can monitor user-defined thresholds for various supplies and automatically reorder them when they become too low. Also, the costs associated with making the order, such as shipping or lag time can cost nearly as much as the DME itself, so some systems will log recent purchases so the provider can review those purchases to find the best shipping price, or the least amount of lead time or shipping time needed.

Reporting Combining inventory management with other intelligence within the organization lets providers run reports that show them what products are real revenue generators for the companies. It’s not uncommon for businesses to confuse gross revenue from a product or volume for a product with value, but with the right tools, providers can actually see what is the actual value from an inventory item.

New Challenges, New Tools
Those basic inventory technology advances have been indispensable in the

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HME industry, but providers don’t operate in a static environment. Over the past several years, as HME businesses have increasingly integrated technology advances into their operations and strategic plans, their inventory challenges have changed, as well.

For instance, one approach that once would have drawn sidelong glances from competitors and peers alike, is remote warehousing and drop shipping. Many providers today have sought to keep so little inventory on-hand that many of them are insisting on their manufacturer vendors and distributors to house the inventory, and then to drop ship the DME for the provider.

“From a financial perspective, those that are utilizing a distributor, their overheard or inventory asset is minimal, because they don’t have to maintain stock in-house.” Noble House’s Mehan explains. “We have some very large providers that do have a warehouse with their own inventory, but a lot of our base is of the model that makes them perfect candidates for a distributor.”

So the challenge becomes working with that distributor’s inventory, as if it was the providers’ inventory so that they can tell patients what providers are available, but not treating the inventory as though it were a cost. Call it “virtual inventory” Mehan says.

“They [the provider] populates their inventory management software with the appropriate part numbers and they basically ignore quantity on-hand,” he explains. “Depending upon the distributor, we have an interface where the request will go to the distributor electronically. So the distributor receives the electronic request that contains all the demographic information for the patient, and the items that are to be received. So the system automates that process.”

A key to success in the distributor/drop-ship model is having good information, according to Brightree’s McDevitt.

“The tricks are in the ‘look back,’” he says. “Let’s say I’m going to do a traditional drop-ship model, and I’m going to all of my new set-ups out of my warehouse, and all of my re-supply via drop-ship. I think that the only true way to find out whether that wins for your company is to automate that process; when your customer service rep sends that order that nobody else has to touch it.”

Once the process is automated, the provider needs to go back and check its work, because drop-shipping isn’t a guarantee of success. It all comes down to the cost model of the warehouse. That is why reporting is crucial.

“You have to look back at a quarterly or annual comparison of what that really means for your company,” McDevitt continues. “Because some organizations do better by employing more people, because they exist in a community where local wages or cost of real estate allow them to do that.”

Like DME, inventory management is a work in progress. As the industry’s challenges grow, so will the approaches and innovations to meet them. This means that efficiency-oriented providers will continue to monitor trends in this important aspect of their business so that they can continue to turn what was once a primary cost center into a cornerstone of their survival and success.

“Where we used to count nickels, we now have to count pennies. A successful DME inventory management operation is now run electronically.”

— Ryan McDevitt, Brightree
The Brains of the Operation

Inventory Management Tools

Various HME software makers integrate inventory and re-purchasing tools in their offerings. Here is a roundup of some of the features offered by various HME management systems available on the market:

**AR-Express**
- **Company name:** DIABCO – Healthcare Software Solutions, Inc.
- **Web Address:** www.AR-Express.net
- **Toll-free phone number:** 800-864-6210
- **Type of system:** A stand-alone system installed on-site
- **Programming languages and database environments:** Microsoft Windows 7, Server 2008, MSQL 2008, net, VB, VFP

**Inventory management:** The purchasing and receiving process updates inventory on-order, on-hand, and last costs for all products by manufacturer, and can produce bar coded price tags. Using the EPO feature will send purchase orders electronically to vendors. As patient orders are entered, inventory is depleted and stock status reporting gives providers a reorder tool.

**Brighttree**
- **Company name:** Brightree, LLC.
- **Web Address:** www.brightree.com
- **Toll-free phone number:** 888-598-7797
- **Type of system:** A hosted, web-based/SaaS system
- **Programming languages and database environments:** Brightree’s billing and business management solutions are built using Microsoft’s .NET framework and uses MS SQL Server for its database environment.

**Inventory management:** Brightree’s integrated ordering and inventory tracking maximizes inventory turnover, tracks repair and maintenance plus flags obsolete items as well as superseded products. Brightree supports handheld scanning devices to quickly and accurately count inventory items. Our Integrated ePurchasing with major suppliers, like McKesson, ResMed and Assuramed, enables seamless and accurate ordering from within the Brightree system. When integrated ePurchasing is combined with drop shipping, providers can reduce delivery charges and inventory carrying costs. Brightree works in real-time, so when shipments are received they are immediately reflected in inventory.
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**CPR+, Fastrack, Caretinuum, MestaMed**

**Company name:** Mediware Information Systems  
**Web Address:** http://www.mediware.com/hme  
**Toll-free phone number:** 866-277-4876  
**Type of System:** A stand-alone system installed on-site; A hosted system, but uses special client software  
**Programming languages and database environments:** Visual FoxPro and .NET Framework front-end with a Microsoft SQL backend. Microsoft .NET, Microsoft SQL DB, and C#

**Inventory management:** Mediware offers full inventory control with barcoding of inventory for field scanning, ordering and replenishing of purchase orders, 850 purchase orders, full interface with MSD for patient home delivery (drop-ship) and bulk ordering. Other inventory features include purchasing and receiving, physical inventory and asset maintenance for serialized equipment.

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**Inscrybe Referral Management**

**Company name:** Authentidate  
**Web Address:** www.authentidate.com/  
**Toll-free phone number:** 877-467-2792  
**Type of system:** A hosted, web-based/SAAS system  
**Programming languages and database environments:** .NET

**Inventory management:** Faxes are barcoded to link files to related case electronically. Interfaces available to practice management and billing systems where inventory records are kept and managed.

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**MedAct Software**

**Company name:** MedAct Software  
**Web Address:** www.medactsoftware.com  
**Toll-free phone number:** 800-326-0314  
**Type of system:** A stand-alone system installed on-site; A hosted, web-based/SAAS system  
**Programming languages and database environments:** MedAct Software Client/Server Edition is a Windows based system utilizing a SQL based RDB.

**Inventory management:** Inventory Management Module provides the inventory management tools needed to manage your capital investment. The module maintains inventory items and details, transactions and audit trails, multiple warehouses, vendors, parts, lots, serialized items and availability status. Bar code scanning technology allows you to replace the tedious task of manually performing physical counts with an automated solution for maintaining your inventory with
Inventory Management Tools

The accuracy you need. The Purchase Order Module works in conjunction with the inventory management module to order the items you need for order fulfillment. Inventory management for retail sales includes gross margin pricing tools to allow HME providers to set retail pricing for a single unit, or family of products based on target gross margins.

**Medeq Manager**

Company name: Bonafide Management Systems
Web Address: www.bonafide.com
Toll-free phone number: 805-908-2333
Type of System: Hosted, web-based only.
Programming languages and database environments: Java for application on redundant unix based web servers. Database is in SQL 2012 active/passive cluster for high availability.

Inventory management: Unlimited locations using barcodes and just in time ordering protocols. Sell today, have replenishment delivered tomorrow with automatic EDI ordering. Receivables offset payables with proper payment terms from vendor.

**MedFORCE Scan, MedFORCE D&R, MedFORCE WorkFLOW, UPS, USPS and FedEx Shipment Tracker, ZipMit.**

Company name: MedFORCE Technologies, Inc.
Web Address: www.medforcetech.com
Toll-free phone number: 866-237-1190
Type of system: A stand-alone system installed on-site; A hosted, web-based/SAAS system
Programming languages and database environments: Programming languages used are Asp.net, Delphi and C Sharp and uses a SQL database to securely store data.

Inventory management: MedFORCE Scan has the ability to scan in documents with barcode information and allow that information to be saved into demographic fields which reports can be generated from.

**Noble*Direct for Windows**

Company name: Noble House
Web Address: www.nobledirect.com
Toll-free phone number: (800) 749-6700
Years company has been in business: 24
Type of system: A stand-alone system installed on-site
Programming languages and database environments: Noble*Direct is a true Windows application utilizing Pervasive SQL

Inventory management: Noble*Direct has integrated inventory and also provides drop ship capabilities to various medical equipment distributors.

**SystemOne**

Company name: QS/1
Web Address: www.qs1.com
Toll-free phone number: 800-231-7776
Type of System: A stand-alone system installed on-site; a hosted system, but uses special client software
Programming languages and database environments: Assembler/Visual Basic

Inventory management: Our Purchase Order module enhances SystemOne’s inventory management. Gives you the ability to have a primary and secondary vendor/sku number entry, automatically create purchase orders, receive purchase orders, and view real time on-hand quantities.

**TIMS Software**

Company name: Computers Unlimited
Web Address: www.cu.net
Toll-free phone number: 406-255-9500
Type of system: A stand-alone system installed on-site; A hosted, web-based/SAAS system
Programming languages and database environments: Microsoft .Net and SQL server

Inventory management: Supports single and multiple warehouses and bin locations and includes bar code tracking for supplies, medical gases and rental equipment, including serial number and lot number tracking with easy access for recalls. Handles rental equipment tracking and repairs. Offers wireless warehouse management for cycle counting, picking and receiving and annual physical inventory counting.

**U-Sleep**

Company name: Umbian
Web Address: http://u-sleep.com
Toll-free phone number: 1-877-242-1703
Type of system: A hosted, web-based/SAAS system
Programming languages and database environments: .Net

Inventory management: U-Sleep supports the entry (either keyed or barcode scanned) of CPAP device serial numbers for supported makes and models. This value can be updated at any time, to ensure that the user always has visibility into the particular device which is associated with a given patient.
Cash Sales

Retail sales offers an excellent way for providers to increase their cash flow, because they are straightforward cash transactions that don’t involve Medicare, private payor insurance carriers or anyone else — only the provider and the patient doing business in a simple, retail transaction.

Cash sales items such as bath safety items, home access products and aids to daily living are often actively sought, but also make great add-on items to patients that are already coming into the store for other items. But funded items, such as sleep, mobility and oxygen equipment are also appealing to covered patients that aren’t satisfied with what Medicare covers, or the delays Medicare entails.

Considerations such as merchandising, planning floor space, and proper signage are critical to cash sales success, but there’s more. As retail is constantly evolving, it opens up an endless amount of possibilities for an enterprising provider to take advantage. One example is moving sales outside of the showroom. Online sales are becoming increasingly critical and providers willing to ship all over the country or world will find continued success in retail sales.

Product Solutions

By Cindy Horbrook

**Portable CPAP**

Transcend

- Weighs less than 1 lb. pound and fits in the palm of the hand
- Includes multiple power accessories, such as small and portable battery options, a solar battery charger and mobile power adaptor, which give patients the ability to customize their therapy to their active lifestyles.
- Features free marketing materials and customer support designed to help homecare providers achieve success with Transcend cash sales.

Somnetics International Inc.
(877) 621-9626
www.mytranscend.com

**Machine Washable**

Bedding in a Box

- Suitable for use with most standard manual, semi-electric and full electric beds.
- Includes a fitted bottom sheet (36” x 80” x 5”-6”), a top sheet and a pillowcase—all constructed from a cotton/polyester blend—along with a 100% cotton thermal blanket.
- All components are comfortable and machine washable.

Drive Medical
(877) 224-0946
www.drivemedical.com

**Independence and Accessibility**

**Luggie**

- Lightweight, compact and easy folding mobility scooter.
- Suitable for all forms of travel including planes, trains and automobiles.
- Offers a compact size and light weight that makes it manageable and maneuverable, whether on a crowded street, at the grocery store, or in the hallways at home.

FreeRider USA
(888) 957-1888
www.freeriderusa.com

**New Compression Categories**

**Dr. Comfort Full-Line of Retail Products**

- Shape-to-Fit compression wear adds new categories including, anti-embolism, medical/surgical and mastectomy compression.
- The padded, seamless, moisture wicking socks are designed especially for diabetics, but provide all day comfort for everyone.
- Diabetic slippers are extra-depth to accommodate prescription inserts. The sandals feature an integrated post and shank, and comfort cushioned foot-bed that offers true support.

Dr. Comfort
(877) 352-7833
www.drcomfort.com

**Breathable and Comfortable**

SIGVARIS Sea Island Cotton Socks

- Breathable and comfortable socks are made from rare cotton.
- Features graduated compression of 15-20mmHg.
- Suitable for travel and daily wear. Available for both men and women in black, brown and navy.

SIGVARIS Inc.
(800) 322-7744
www.sigvarisusa.com

**Diabetes Testing**

GLUCOCARD Expression

- Downloadable talking meter features large tactile buttons and picture display.
- HME/DMEs are now seeing the value of the cash-pay model for their diabetes testing supplies.
- The cost-effective product line can target the needs of a new market segment left behind by expensive brands and large co-pays.

ARKRAY USA
(800) 848-0614
www.glucocardusa.com/hmebusiness

Management Solutions | Technology | Products
Big Benefit, Small Size

CHART’s new SeQual eQuinox POC combines a small, portable form factor with ease of use.

By David Kopf

Good DME can take time to develop. One example of that is CAIRE’s eQuinox portable oxygen concentrator. The tiny POC highlights ease of use and transportability, along with a slew of new features that have been under development for sometime.

The POC started as a project at SeQual, before the San Diego oxygen equipment maker was purchased by Chart Industries — CAIRE’s parent company — a little more than three years ago, says Brett Townsend, sales and marketing director at Chart Industries. The goal was to add a range of new user features while cutting down the size. Not an easy feat, but one that continued after the acquisition.

“We continued to capture user, provider and patient feedback on things that they wanted to see from the Eclipse, and we encapsulated it into the eQuinox,” Townsend explains, adding that, all told, the POC has been a project four years in the making.

The 14-pound eQuinox continues to deliver the clinical benefits providers have come to expect from the SeQual Eclipse POCs, but now includes some unique user enhancements.

One of those enhancements is the Multi-Language Voice Interface offers a new layer of ease to users by providing verbal confirmation of changed flow rate settings, as well as announcing battery times and any alarms. The language can even be changed to offer feedback in the end user’s most comfortable language. To that end, the eQuinox speaks eight languages in total.

This is a key development for older patients who might need some “ease of use” assistance, and especially visually impaired users.

“It’s the first smart POC,” Townsend says. “If I take out the battery, it will audibly tell you that it has lost power and it needs the user to plug in a battery or external power.

“If you change the setting, it will give you audible confirmation that it has changed the setting,” he continues. “It will tell you any alarms. If you have a kinked cannula, it will tell you that. So it gives direction on how to fix the alarm codes.”

And for moments when silence is golden, the device can be muted, if need be as well. Also, speaking of sound, Townsend notes that the eQuinox is the most quiet portable oxygen concentrator, as well.

Portable Performance

Weighing in at only 14 pounds, the newly designed, easy-to-maneuver frame makes the SeQual eQuinox the lightest weight POC able to offer 3.0 LPM continuous flow. In that respect, users and providers could consider this a smaller version of the SeQual Eclipse 5.

“We duplicated the performance, it has the largest bolus output of any portable concentrator available,” Townsend says. “So the performance is exactly the same as from the Eclipse 5, this is just put in a 35 percent smaller, lighter weight package.”

Providing continuous flow options from 0.5 LPM to 3.0 LPM and 9 pulse flow settings from 16 mL to 192 mL, the SeQual eQuinox can meet a patient’s 24-7 needs. The comprehensive dosing selection allows a patient to be treated at rest, during sleep, at exercise, and at altitude.

In terms of power the small package is still powerful enough to give patients the freedom to enjoy life without worrying about battery life. A 12-cell pack comes standard, while an optional, longer lasting 24-cell battery pack, the eQuinox can achieve 2.75 hours of operation at 2.0 LPM. (The standard battery lasts about half that time.)

As the device runs, a display shows how much battery life is left at the current flow setting. If the flow is adjusted, the battery life will adjust and recalculate accordingly.

Also, now the battery is accessible from the front. This means that if the patient is traveling and has the device under a seat or in a tough to reach space, swapping out the battery is that much easier. The larger battery also mounts in the same way, and in terms of looks, the 24-cell pack sticks out from the device a little more, but that’s about it.

The eQuinox is also fully functional on AC Power, DC Power, and battery power. Wherever a patient goes, the eQuinox goes with them and keeps up with the various activities of daily living.

For traveling patients, the device is FAA approved and sports a large airplane logo on the front to ensure airport and airline staff know that fact. The eQuinox is now on the market and already shipping. Providers interested in finding out more should contact:

SeQual eQuinox
CAIRE Medical
(800) 874-0202
Thermoplastic splints/casts treat many different types of injuries
Orfit Industries America
Orficast is a moldable thermoplastic for simple finger splints, thumb splints and supportive bandage wraps. The stretchable, self-adhesive textile is knitted from thermoplastic fibers and is available in both blue and black colors in two widths. The product is first softened in a matter of seconds in hot water and then can be molded directly onto the patient while the knitted structure allows skin ventilation. The material can also be cut to length and shape with regular scissors and applied directly on the skin without the need for protective gloves or lotion.
Orfit Industries America
(516) 935-8500
www.orfit.com

No tools needed for grab bar
Drive Medical’s Suction-Cup Grab Bar installs and removes without tools or professional installation. It can be installed at any angle and will not damage property. Large suction cups provide an extremely strong hold. Release levers make installing and removing the suction-cup grab bars quick and easy.
Drive Medical
(877) 224-0946
www.drivemedical.com

Urinal is designed to prevent spills
Drive Medical’s Male Urinal is essential for anyone who has trouble getting out of bed. Designed to prevent spills, the product features a sturdy grip for easy handling and can be used in several positions by the patient. It is lightweight, durable and easy to clean, and includes graduation marks to measure output. It can hold 32 oz. and the cap helps confine odors.
Drive Medical
(877) 224-0946
www.drivemedical.com

Power wheelchair designed to meet performance needs of active users
Quantum Rehab’s Q6 Edge features four-pole motors, Mid-Wheel 6 drive design, ATX suspension, a 300 lb. weight capacity and transit securement points. The wheelchair accepts a complete range of seating and electronics options, including TRU-Balance 3 power positioning with power tilt, recline, elevation and foot platform variations, and Q-Logic 2 electronics that provide advanced drive controls. Seat sizes range from 12x12 inches to 22x22 inches.
Quantum Rehab
(866) 800-2002
www.quantumrehab.com

Scooter offers advanced travel mobility features
Pride Mobility’s Go-Go LX with CTS Suspension (Comfort-Trac Suspension) brings a new level of performance features and value to travel mobility. The scooter features CTS independent front and rear suspension, a sleek style, feather-touch disassembly, charger port in tiller and standard lighting, the Go-Go LX.
Pride Mobility Products Corp.
(800) 800-8586
www.pridemobility.com

Lift chair provides cooling comfort
The Serta Perfect Lift Chair, available in Pride Mobility’s two most popular configurations, has unique features including premium Cool Action Gel Memory Foam for cooling comfort and support; a premium DACRON top layer; Pirelli webbing for personalized comfort; individually wrapped coil springs; and a no-sag spring base.
Pride Mobility Products Corp.
(800) 800-8586
www.pridemobility.com

Get the latest HME inventory news and reviews in HME Business, the industry’s most trusted source for business management solutions, technology and products. Compiled by Cindy Horbrook.
Blood pressure cuffs work with automated BP monitors in clinical areas
SunTech Medical's Vinyl Blood Pressure Cuffs deliver accurate blood pressure (BP) readings while providing an economical alternative to traditional durable blood pressure cuffs. Designed for short-term use, the easily-cleaned cuffs work with automated BP monitors in clinical areas such as hospital emergency rooms and EMS transport where disinfection is critical. The cuffs feature a tapered end for easier application and patient comfort, as well as color coding to simplify size selection. Size indicators on both the interior and exterior of the cuff ensure the user selects the accurate size.

SunTech Medical
(800) 421-8626
www.suntechmed.com

Patient handling system now available in bariatric size
ErgoNurse's B1K Adjustable Bariatric system is designed for use in the safe patient handling of bariatric patients. The ErgoNurse is a patented system that allows a single caregiver to quickly and safely perform all on-bed patient repositioning and eliminate all manual lifting. The B1K has a 1,000-lb. patient rating and is designed to be adjustable from 35 to 51 inches to accommodate a wide range of bariatric beds. It also comes standard with 60-inch sheet clamps and new non-porous belts to assist with infection control.

ErgoNurse Inc.
(888) 512-6765
www.ergonurse.com

Web-based software helps providers develop efficient routes
Roadnet Technologies’ Roadnet Anywhere is a Web-based software solution designed to make it easy for small to mid-sized organizations to develop efficient routes and track them throughout the day. The software can be deployed in days without any hardware and with very low upfront costs. It uses powerful algorithms that create the most efficient pick-up and delivery routes possible. Businesses can customize and adjust routes in real-time and changes are pushed to, and reflected automatically in the driver’s mobile app.

Roadnet Technologies
(800) 762-3638
www.roadnet.com

Vertical home lifts eliminate the burden of pushing someone up a ramp
Mac’s Lift Gate model PL-50 is reliable, affordable and made in the USA. All lifts come standard with a 750 lbs. weight capacity, emergency manual hand crank, are outdoor ready and operate on 110 volts AC. The lift allows users to save space and time, and it eliminates the burden of pushing someone up a ramp.

Mac’s Lift Gate Inc.
(800) 795-6227
www.macsliftgate.com
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### Upcoming Industry Events

**April 2014**

- Apr 3 - 6  
  The American Occupational Therapy Association (AOTA) Annual Conference
  [www.aota.org](http://www.aota.org)

- Apr 14 - 15  
  Tennessee Association for Home Care (TAHC) Spring Conference  
  [www.tahc-net.org](http://www.tahc-net.org)

- Apr 17 - 28  
  Oregon Association for Home Care (OAHC) Annual Conference  
  [www.oahc.org](http://www.oahc.org)

- Apr 29 - May 1  
  National CRT Leadership & Advocacy Conference  
  [www.nrrts.org](http://www.nrrts.org)

**May 2014**

- May 1 - 2  
  Pennsylvania Association of Medical Suppliers (PAMS) Annual Conference  
  [www.pamsonline.org](http://www.pamsonline.org)

- May 2  
  Georgia Association of Medical Equipment Suppliers (GAMES) 2014 Spring Meeting  
  [www.gameshme.org](http://www.gameshme.org)

- May 6 - 8  
  American Association for Homecare Washington Legislative Conference  
  [www.aahomecare.org](http://www.aahomecare.org)

- May 31 - June 4  
  Associated Professional Sleep Societies (APSS) Meeting — SLEEP 2014  
  [www.sleepmeeting.org](http://www.sleepmeeting.org)

**June 2014**

- June 9 - 12  
  VGM Group Inc. Heartland Conference  
  [www.vgmheartland.com](http://www.vgmheartland.com)

- June 11 - 14  
  American Physical Therapy Association (APTA) 2014 Conference  
  [www.apta.org](http://www.apta.org)

- June 25 - 27  
  North Carolina Association of Medical Equipment Suppliers (NCAMES) Summer Meeting  
  [www.ncames.org](http://www.ncames.org)

**October 2014**

- Oct 20 - 23  
  Medtrade 2014  
  [www.medtrade.com](http://www.medtrade.com)
Those of us in the business of providing home healthcare DME and supplies are committed to helping people live better lives. But every supplier is in business to drive a profit. We provide services and products within a continuum of care. We are not social service agencies, we are not non-profit agencies.

Our profit margins determine how extensively we can provide comprehensive services and give us the ability to obtain and retain educated staff to competently service our customers. And, in no division is this dynamic more evident than in the DME repair arena.

For example, the lifetime of power mobility devices (PMDs) is five years, so repairs are inevitable. PMD users often rely on their equipment up to 18 hours per day, and they need to know that they can obtain the required skillful services they need quickly. Suppliers need to be able to provide those services efficiently and profitably.

For several years our industry has struggled with the capped labor limits allowed when providing repair services. This particular issue is in the hands of the four DMEMAC medical directors. They decided the limits, not CMS. They can increase those limits if we can provide data showing the labor unit caps on specific repairs is too low. To date, the supplier community and even this writer have been unable to convincingly do so, indicating we must gather more evidence to a comprehensive estimate. Meanwhile, the beneficiary is waiting.

Let's take the labor payment out of the equation and discuss the allowable set for repair replacement parts. Seriously skewed by inclusion of certain codes in the competitive bid categories, in competitive bid areas where any supplier may do repairs for the single price allowed, we've seen a diminishing number of suppliers willing to do the work. And we've all heard from beneficiaries who can't get their products fixed anymore.

Compounding the situation is the demise of a large national PMD supplier whose customers now must turn elsewhere for service, but providing that service cannot come into your service facility; you need to send a technician out to their residence to a comprehensive estimate. Meanwhile, the beneficiary is waiting.

Medicare doesn't pay for travel unless you do the work non-assigned, having the beneficiary sign an Advance Beneficiary Notice (ABN) explaining all the inconsistencies that prevents you from simply doing the work and filing the claim directly with Medicare for payment. Wisely, you begin a discussion to collect the total fee up front so payment is retained in event of audit. CMS says it doesn't plan to audit repairs, but does that statement offer any real comfort?

If the beneficiary can't pay, do you take the risk of filing assigned? Do you refuse to do the repair? Do you tell the beneficiary to call 1 (800) MEDICARE and see what CMS suggests? Meanwhile, the beneficiary is waiting.

**A Growing Problem**

The repair conundrum has been mushrooming since the onset of Round One. The original nine competitive bidding areas (CBAs) recognized the problem early on. Contract awardees were required to do only warranty repairs. Companies that did not win contracts found themselves inundated with general repair calls because many contract holders chose not to provide those services, saying they weren't profitable. When the situation was exacerbated by Round Two's expansion of an additional 91 CBAs, individual voices became a choir. Our industry, beneficiaries and advocacy groups are outraged.

CMS recently requested comments from stakeholders regarding nationwide expansion of competitive bidding pricing by 2016. CMS suggests that possibly it is time to modify the payment structure for certain DME and enteral nutrition by requesting a single bid for all related items and services needed on a monthly basis, including repairs. While on the surface this “bundling” might seem to CMS a logical fix for CPAP and enteral nutrition under the bid program, it would further challenge suppliers to place sustainable bids.

Bottom line, as the number of beneficiaries requiring DME increases, the need for repair services will increase. How will CMS insure beneficiaries have prompt access to repair services? How can suppliers afford to do the work if payment is below cost coupled with the continual fear of audits?

Since 2011, Competitive bidding has seriously interrupted the continuum of care across America dismembering the supplier network and upending solid patient-supplier relationships. Its tentacles are about to spread further by 2016.

Well, forget the low-balled pricing issues, forget the non-binding bids, and forget the delivery delays patients are incurring for new equipment. The repair dilemma alone underscores one of the bid program's serious structural flaws. It's time we connect the dots for our congressmen. Outcome data is what they need to help change policy. Let's make sure beneficiaries who are having a difficult time finding a supplier to do their repairs reach out to their representative and explain their difficulty and how it is affecting their health. In working to stop competitive bidding, let's all work hard to make sure the repair issue adds fuel to the fire for passage of H.R. 1717.

**Illustrating the Point**

It is in our genes to want to help. Here's a likely scenario: The beneficiary explains they can't find anyone to fix their power wheelchair. Often, they don't have a back up chair to use. We recognize their need.

A complete intake process ensues, making certain coverage exists, determining the accurate primary and secondary insurance to bill. To qualify for repair and replacement parts under the Medicare guideline, the beneficiary must qualify for the specific PMD when it was obtained from the original supplier. But the original documentation is not in the hands of the beneficiary and the prescribing doctor is unable to find the packet he or she sent the original supplier, or is reluctant to take time to search through records. If by chance the prescribing physician does try to find “something,” the data you receive is not comprehensive. Meanwhile, the beneficiary is waiting.

The company who provided the PMD is now out of business or no longer provides repair services. If still in business and they have the information you seek, they are not mandated to provide it to you.

Regardless of how the client described the problem on the phone, you must evaluate what needs done and the parts that are needed. The patient cannot come into your service facility; you need to send a technician out to their residence to a comprehensive estimate. Meanwhile, the beneficiary is waiting.

Georgie Blackburn is vice president of Government Relations and Legislative Affairs for Pennsylvania-based provider BLACKBURN’S. She can be reached at georgie.blackburn@blackburnsmed.com.
WASHINGTON LEGISLATIVE CONFERENCE

Join the American Association for Homecare in your nation’s capital this May to fight for your business. Learn how to lobby from experts on the Association’s government affairs staff and attend briefings for all of the issues facing the homecare sector. Then, meet with your members of Congress and let them know what they can do to best represent you.

www.aahomecare.org/conference
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