

O&P ALMANAC

The Magazine for the Orthotics & Prosthetics Profession

APRIL 2015

Tips for Faster and Easier Collections

P.18

Paying the Price for a Long Appeals Process

P.22

Breaking Down the Medicare O&P Improvement Act of 2015

P.32

Beat the Clock on Medicare Deadlines

P.40

O&P Almanac
Leadership Series:
**Niche Facilities
Make a Comeback** P.34

SELF-EVALUATION

HOW DOES YOUR FACILITY COMPARE WHEN IT COMES TO PATIENT ASSESSMENTS, FABRICATION, AND MORE?

**QUIZ ME
EARN 4
BUSINESS CE
CREDITS
P.20 & 42**

WWW.AOPANET.ORG



YOUR CONNECTION TO
EVERYTHING O&P



FEATURES

COVER STORY



24 | **Self-Evaluation**

What is your strategy for assessing patients, choosing appropriate components, and performing follow-up care? Practitioners from across the country share their processes—from self-created strength and range-of-motion assessments, to the six-minute walk and timed up-and-go tests, to the Amputee Mobility Predictor® and the K-PAVET™ form, and much more.

By Christine Umbrell

22 | This Just In **The High Price of Appeals**

A new study finds that both the U.S. government and the O&P community will benefit if the lengthy backlog on administrative law judge hearings is resolved: Orthotists and prosthetists will receive their reimbursements faster, and CMS could save more than \$10 million in mounting interest rates.

32 | **A Bill That Rights the Wrongs**

The 2015 version of the Medicare Orthotics and Prosthetics Improvement Act is an all-encompassing bill with a number of provisions designed to improve conditions for O&P clinicians and patients. Among other issues, the legislation seeks to recognize orthotists'/prosthetists' notes; resolve delays in administrative law judge hearings; and clarify the definition of "minimal self adjustment."

By Don DeBolt

36 | O&P Almanac Leadership Series **Finding Your Niche**

What are the advantages and challenges associated with running a "boutique" O&P facility? In this month's Leadership Series section, the O&P Almanac speaks with three niche business owners to learn why some O&P professionals prefer to run facilities that focus on a select group of patients within the overall scope of orthotics and prosthetics.



DEPARTMENTS | COLUMNS

President's View	4
Insights from AOPA President Charles Dankmeyer, Jr., CPO	
Comments & Commentary	6
Readers share their thoughts	
AOPA Contacts	8
How to reach staff	
Numbers	10
At-a-glance statistics and data	
Happenings	12
Research, updates, and industry news	
People & Places	16
Transitions in the profession	
Reimbursement Page	18
Maximizing Your Accounts Receivable	
Tips for collecting payments and minimizing loss of reimbursement	
Compliance Corner	40
Beat the Clock	
Be watchful of the deadlines associated with the Medicare billing and appeals processes	
Tech Tutor	44
Holding C-Fabs to High Standards	
Learn how some central fabrication facilities seek accreditation	
Member Spotlight	46
<ul style="list-style-type: none"> ■ Aspen Medical Products ■ Mountain Orthotic and Prosthetic Services 	
AOPA News	50
AOPA meetings, announcements, member benefits, and more	
Welcome New Members	55
Marketplace	56
Careers	60
Professional opportunities	
Calendar	62
Upcoming meetings and events	
Ad Index	63
Ask AOPA	64
Expert answers to your questions about dispensing orders	



Self-Evaluation

How does your facility compare to O&P practices around the nation? Several practitioners share their strategies for assessing patients, fabricating devices, and providing follow-up care

By **CHRISTINE UMBRELL**



Need to Know:

- While most practitioners implement the well-known six-minute walk test and timed up-and-go test, many also make use of the Amputee Mobility Predictor® (AMP) and the K-PAVET™ form. Others also employ the Activity-Specific Balance Confidence (ABC) scale and self-created strength and range-of-motion assessments to determine patient mobility.
- When choosing a device, practitioners consider a range of factors such as evidence-based literature; patient's age, condition, and lifestyle; and payor constraints.
- Some estimates report that as much as 90 percent of O&P clinical facilities use some type of central fabrication services, but the clinicians we spoke to say a significant number of O&P professionals still rely on in-house fabrication, at least in part, to meet time constraints and to service patients in rural settings.
- Ongoing assessments are equally critical, with some practitioners using the Prosthetic Limb Users Survey of Mobility (PLUS-M™) patient-reported outcome measure to evaluate patients at follow-up appointments.

AS AN O&P PRACTITIONER, how do you decide what assessment techniques to use to evaluate the potential functional levels of new patients? How do you determine which components to use? What makes you decide to outsource fabrication? And how do you make sure that patients who receive new devices are using their components correctly and are making progress in their rehabilitation?

Making the right decisions can mean the difference between a successful practice with satisfied patients and a non-profitable facility with patients who seek alternative care. Here, several O&P professionals from a wide range of O&P companies share best practices for patient treatment decisions.

Optimal Assessment Techniques

Prosthetists and orthotists agree on the importance of thorough assessment techniques to determine functional levels and appropriate componentry for patients. Standardized tests ensure a predetermined amount of information is collected, and also promote communication between clinicians and patients.

Practitioners across the country rely on a number of tried-and-true measures to evaluate patients for initial prostheses and establish the appropriate K level as described by Medicare. While the practitioners we spoke to say they implement the well-known six-minute walk test and timed up-and-go test, many also make use of the Amputee Mobility Predictor® (AMP) and the K-PAVET™ form.

The AMP tool, developed by Robert S. Gailey, PhD, PT, is designed to measure ambulatory potential of lower-limb amputees with prostheses (AMPPRO) and without prostheses (AMPnoPRO). It takes about 15 minutes to administer. Patients are asked to perform a wide range of tasks, such as sitting, reaching, standing and balancing, picking up objects, hopping, and ascending and descending stairs. Depending on how high patients score, they can be assigned K0 to K4 functional levels. More recently, an AMP-Bilateral tool has been developed to measure the ability of bilateral amputees to perform functional tasks related to participation in advanced skill activities.



Aaron Moles, L/CP

Aaron Moles, L/CP, owner of Prosthetix Shop in Cincinnati, uses the AMP tool for every patient, in addition to range-of-motion and timed up-and-go tests. “The AMP is an excellent, thorough exam that can determine the specific functional level of a patient,” says Moles. “Without that test, sometimes you can over-predict someone’s potential functional level.”

Moles also uses the Activity-Specific Balance Confidence (ABC) scale during initial assessments. The tool asks patients to indicate their level of self-confidence in performing specific tasks without losing their balance using a percentage scoring system. By having patients fill out an ABC survey before they receive their prostheses, the tool can be used as a baseline for comparison after patients have started using their new devices.

Another evaluation tool that is gaining acceptance is the K-PAVET™ form



Aaron Moles, L/CP, works with a patient to add flexion to increase step length during a follow-up visit.

for evaluating prosthetic patients. Phil Stevens, MEd, CPO, clinic manager for Hanger Clinic in Salt Lake City, relies on the PAVET protocol, which stands for Patient Assessment Validation Evaluation Test. K-PAVET uses a ranking system of 0 to 4 to evaluate patients in each of three separate categories (activities of daily living, functional requirements, and physical capabilities) to determine the correct K level. The K-PAVET provides a numerical score related to what the patient needs to be able to accomplish (activities of daily living) and what they are capable of accomplishing (functional requirement) and quantifies the strength

of the lower-limb joints (physical capabilities).

“The K-PAVET allows us to evaluate the patients’ needs and functional capabilities and looks at their physical strength and abilities,” says Stevens.

Though the K-PAVET form is copyrighted by Hanger, it may be used by other health-care professionals: “There are no restrictions for anyone outside of Hanger to use it,” says Hanger Clinic Vice President of Clinical Operations Dale Berry, CP, RPT, LP, FAAOP. At one time the form was patent-pending, but Hanger has released the patent application “because we wanted the form to be

fully accessible to all and are promoting the adoption of this evaluation process by others. The K-PAVET is licensed by numerous national insurance companies here in the United States and a number of government agencies in other countries. We encourage and invite non-Hanger clinicians to apply the K-PAVET in day-to-day practice,” says Berry. He does note that because the form is copyright protected, it must be used

as-is, and non-Hanger facilities cannot modify or change the form.

Dave Motycka, CPO, says that in addition to muscle testing, range-of-motion testing, sit/stand evaluations, the PAVET form, and ambulation evaluations, his assessments involve communication with referring physicians and physical therapists. Motycka, a managing partner at New England Orthotic and Prosthetic Systems in Hamden, Connecticut, also says that



Dave Motycka, CPO

sitting and talking with a patient—and getting their honest feedback on their ambulatory abilities prior to amputation—“can go a long way toward establishing functional level.”

Some practitioners rely on gut instinct in addition to the formal assessment tools. Jim Young, CP, FAAOP, founder of Amputee Prosthetic Clinic in Macon, Georgia, says that he uses the AMP, the six-minute walk test, and the timed up-and-go, but also uses something he calls the “toddler sizing assessment technique”: He asks patients to try to do what a toddler can do on the floor, including getting down on the floor, rolling around, and getting up off the floor. He watches as patients perform these tasks to get an idea of their mobility.

As he assesses patients, Young analyzes five factors to determine how successful their ambulation will be: strength, balance, endurance, motivation, and confidence.

On the orthotics side of patient evaluations, assessments rely heavily on input from physicians and physical therapists, says Motycka. Often a physical therapist starts with a patient, who is referred to the orthotist for appropriate support. When working with a new orthotic patient, Motycka performs a physical exam that involves muscle and strength testing, as well as a walking test for lower-extremity patients. He also fits patients with diagnostic off-the-shelf braces, as his facility stocks different types of devices to be used as trial components. With those trial devices, “I can tell right away if a custom brace is required,” says Motycka.

At North Coast Orthotics and Prosthetics in Lorain, Ohio, Jeffrey Yakovich, CO/L, sees many lower-extremity ankle-foot orthosis patients.

What the Schools Are Doing...

O&P students at the University of Hartford focus on the fundamentals when learning evaluation techniques. Instructors “identify the global principles behind patient assessments so students learn to apply those principles to specific measures,” says Matthew Parente, MS, PT, CPO, clinical director of the university’s MSPO program. The students are trained in traditional strength and range-of-motion tests and techniques for identifying functional limitations. Instructors make sure students know how to use the Gailey Amputee Mobility

Predictor (AMP) and are aware of the K-PAVET protocol, but the focus is on a greater foundational understanding.

Parente notes that individual assessment tools may become obsolete over the years, so teaching the processes behind the currently accepted techniques prepares students to evaluate patients regardless of the tool.

At the University of California, San Francisco (UCSF), practitioners routinely employ the AMP measurement tool as a means of determining functional level at the onset of each new prosthetic treatment,



University of Hartford students take part in rehabilitation training session.

says Matthew Garibadi, CPO, director of orthotic and prosthetic centers and assistant clinical profession in the department of orthopaedic surgery at UCSF.

Once a device is provided, UCSF practitioners follow a rigorous protocol: “To determine the efficacy and functional benefit of services rendered, we administer either a six-minute walk test or the timed up-and-go test at initial evaluation for current prosthetic users and again at one month postdelivery,” says Garibaldi. “For new amputees, the six-minute walk test or timed up-and-go test are administered at one week postdelivery to establish a baseline.”

PHOTO: University of Hartford students

To evaluate these patients, Yakovich records a comprehensive patient history, conducts a basic neurologic exam, performs strength and range-of-motion exams, and considers family structures (to assess whether patients will have assistance in donning and doffing). These factors all influence his decision as to appropriate orthotic care.

Component Selection

Once a patient evaluation is complete and a functional level is determined, deciding which componentry to offer patients is the next challenge. Choosing products is “one part art

and one part science,” says Stevens. “We stay abreast of new technologies—especially if there’s literature on it—so we can provide evidence-based care. But we also look at what has been successful in the past.”

Moles says he tries not to consider a patient’s insurance plan when making his initial component decisions. “I like to keep an open mind at first, and try not to think about their insurance coverage,” he says. “I try to think of what will make them most functional. Then, I’ll look at their coverage and the local coverage determinations or policy article,” and make a final decision that will work within those parameters.

For Yakovich, “the patient’s condition determines which component we select,” he says. “If three companies make a component that fits that patient’s needs, I will look at cost, quality, and reimbursement. We try to provide the most functional component within the constraints of the payors.”

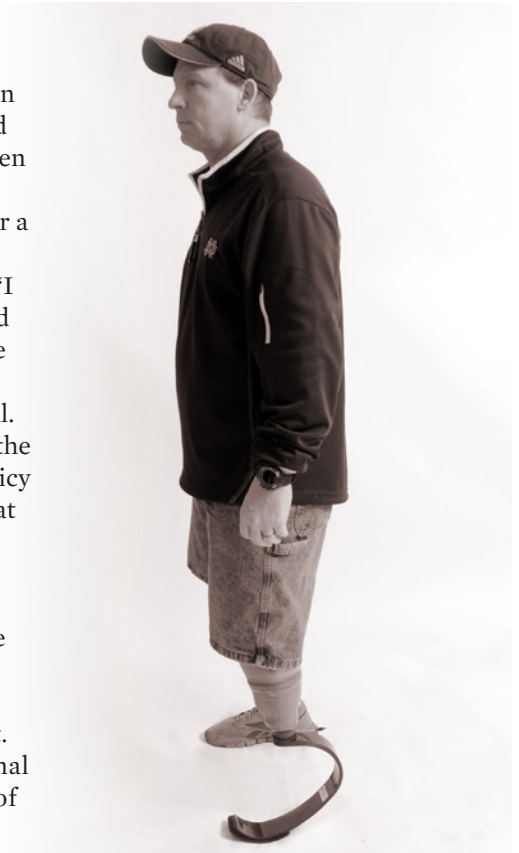
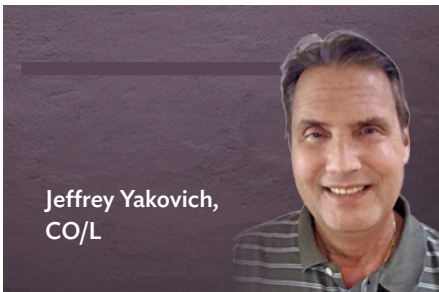


PHOTO: Courtesy Aaron Moles, U/CP



New Soft Shell Technology

- Extreme protection for extreme use
- High tear, abrasion and puncture resistance
- Exceptionally heat resistant
- One prosthesis for all activities
- No need for foam underneath
- Water compatible



Toll free: 855.955.AQUA - www.Aqualeg.com - US Distributor and Scanning Center: Matrix Imaging. Toll Free 877 394 7603

Motycka says he is willing to use any manufacturer, though he gravitates toward certain brands for specific types of residual limbs. “Some carbon or flex-feet accommodate residual limb heights differently,” he says. Patient characteristics also come into play: “For geriatric household ambulators, I lean toward lightweight components,” he says. “For little kids, I’ll choose durable devices that have warranties.”

Some practitioners admit to favoring certain products, but most are not tied to specific manufacturers. “I’m guilty, as most clinicians are, of having my ‘go-to’ component selection that I feel comfortable with,” says Young. He has found certain products to be reliable over the years. However, he is open to new products when the situation warrants. “I’m not opposed to trying new things,” he says. In fact, since Young himself is an amputee, he tries almost every knee and foot that come to market.

“If a patient comes in with a new idea and wants to try a different product, I will let them try it,” he says. Most manufacturers have 30-day trial periods, so Young works with patients to test different products to ensure they select the best component.

Young also chooses products that fit the lifestyle of his patient demographics. Many Georgians spend time outdoors on activities such as fishing or farming, so Young tends to select durable devices that can “handle dirt and grime.”



Fabrication

As much as 90 percent of O&P clinical facilities use some type of central fabrication services, according to a report on central fabrication created by Fillauer President and COO Dennis Williams, CO, BOCO. But the clinicians we spoke to say that while many facilities outsource a portion of their fabrication work, a significant number still rely on in-house fabrication for some of their work.

Young, for example, does all fabrication in-house with the assistance of a master technician, which fits with his goal of treating patients in as few visits as possible. Young has been successful primarily because he has tailored his facilities to fit the needs of the surrounding communities. With three locations in primarily rural areas of Georgia, many of his patients travel up to 100 miles for O&P care. “So we offer same-day service once everything’s approved,” he says, which limits the number of trips patients must take. “If I used central fabrication, there is no way I could deliver care the way I do now. We can go from a cast to a test socket in one or one-and-a-half hours—that would take at least three days with a central fabrication facility.”

Similarly, Yakovich does most fabrication in-house, with time constraints being the main determining factor. He services a high number of sports medicine patients, for whom time is of the essence. “We need to turn things around quickly so we don’t outsource a lot.” With three technicians on staff, “I have a tremendous technical team that has made the jobs of our practitioners much easier,” he says.

For Moles, on the other hand, outsourcing is an important part of his business strategy. As a relatively new facility, Prosthetix Shop has chosen to focus on patient care and minimize fabrication, so he relies on central fabrication to complete his work orders quickly. “We use a digital scanner to take impressions, so we can get components back in two days,” he says.

Motycka finds that a combination of in-house and outsourced fabrication best meets his needs. Having worked as a technician for several years before becoming a certified practitioner, Motycka fabricates all of his patients’ prostheses himself, but he outsources orthoses to his company’s central fabrication facility.

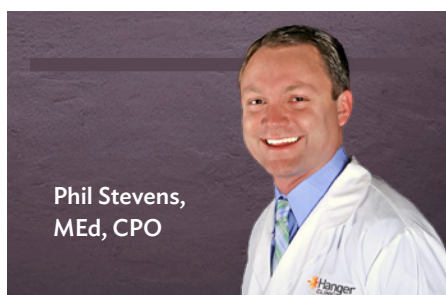
Focus on Follow-Up

Both quantity and quality of follow-up appointments contribute to successful patient outcomes, say practitioners.



In-house fabrication at AmPro Orthotics & Prosthetics Inc. in Las Vegas

Moles sees patients weekly and then monthly after they receive a new prosthesis. “For amputees to be functional, they need to be trained, and they need to understand their devices,” he says. “It takes a lot of time.” At follow-up appointments, Moles checks the components, watches patients ambulate, has patients perform two-minute walk tests, and asks patients to fill out ABC surveys once again. “By doing these assessments, patients realize how much progress they are making over time, and realize what they can now do that they couldn’t do before.”



Phil Stevens,
MEd, CPO

Stevens says his facility uses traditional 10-minute walk tests and the ABC scale when performing follow-up assessments. But more recently, he has started using the Prosthetic Limb Users Survey of Mobility (PLUS-M™) patient-reported outcome measure to evaluate patients at follow-up appointments. The survey, developed at the University of Washington Center on Outcomes Research in Rehabilitation, is a self-report instrument for measuring mobility of adults with lower-limb amputation. It measures prosthetic users’ mobility and assesses respondents’ perceived ability to carry out actions that require use of both lower limbs. The surveys provide a T-score that ranges from 17.5 to 76.6. The forms require two to three minutes to administer and one to two minutes to score. (For more information on the PLUS-M, see the article “Prosthetic Limb Users Survey of Mobility” in the July 2014 issue of the *O&P Almanac* (page 34), bit.ly/July14Almanac.)

Stevens says the benefit of using the PLUS-M during follow-up assessments is that “there is a database of results from more than 1,000 patients” that was compiled by the developers

of the survey, called the development sample. “So we see how data from our patients compares,” he says. The data also can be compared to those reported by subgroups, such as level of amputation, etiology of amputation, gender, and age, so “we can look at our patients’ data and compare it against scores from similar types of amputees.

“As we’ve started using this form, it’s been very exciting for our clinicians,” says Stevens. “When we see most of our patients functioning in the 60th or 70th percentile, that’s very gratifying.”

Motycka also believes in frequent follow-up evaluations. “We do weekly follow-ups with new patients,” he says. “I personally spend a long time doing gait training in my office so patients are prepared when they go to physical therapy.” He says this is especially critical for patients who hope to advance to a higher functional level. Once patients have passed the necessary milestones to advance, he shows evidence from O&P office visits and physical therapy appointments when referring back to the physician. “Being able to show a patient is walking well provides ammunition if we are ready to go to a higher level,” he says.

Motycka has taken his follow-up plan one step further and has put a new process in place to ensure patients communicate the necessary feedback to their physicians after they receive their new components: His facility has created a form for patients to give to their doctors to make sure those doctors ask the questions required for complete documentation. The form has been adapted from the “Dear Physician” letter and includes “questions the physician should ask to ensure documentation requirements are fulfilled.” The goal is to prod physicians to gather the feedback necessary for documentation so practitioners can be fully prepared for any audits that may come up. Both orthotic and



PHOTO: Courtesy Aaron Moles, LICP

prosthetic versions of the form are available. This is a new undertaking for Motycka, but he is hopeful that using this form will help ensure physician documentation is complete and accurate.

Finding What Works for You

There is no one-size-fits-all approach to providing optimal O&P care. Factors such as type of facility, geographical location, and patient demographics all play a part in determining the best methods for patient evaluations and device selection.

But successful practitioners do agree on one guiding principle: Patients will have optimal results when practitioners communicate closely with their patients and use tested industry tools to determine the devices that will best enhance patients’ lives. **CP**

Christine Umbrell is a staff writer and editorial/production associate for *O&P Almanac*. Reach her at cumbrell@contentcommunicators.com.