PEL: Joint Effort Results in Top-notch Customer Service . . . page 4

Research Recap from Breg . . page 6

RAC Audits: Calm Before the Storm . . . page 8

Making a Mess of Prefabricated Orthoses . . . page 14
"You Teach People How to Treat You"

Early in my prosthetic and orthotic career, I was working with clinicians and technicians that had many years of experience, as you might expect they looked at me as “a new guy in their world,” not yet ready to make suggestions or decisions on how to make prostheses or orthoses.

Because I respected these men, I immersed myself in improving my technical skills, but still there were differences of opinion. I would see the patient and determine a course of treatment and would be met with resistance. “We don’t do it that way, and this is the way we have always done it.”

Please understand, I was the only academically trained and credentialed orthotist in our practice but still had to wrangle with the old guard to move the orthotic practice into the plastics world from the metal and leather world.

Finally I went to my father, the owner and namesake of the practice, for some advice and this is what he told me. “You teach people how to treat you.” It was a short statement but I have never forgotten it. In the context of my situation with moving the level of care we were providing forward, I worked hard to share with my associates the results and clinical advantages of thermoplastics. In time the environment changed and the resistance subsided. Patients and our practice were better served.

How does this apply to our situation today?

• We must unite behind a description of our role as clinical professionals.

“We manage prosthetic, orthotic and pedorthic care for the patients we serve; with goals of improving their function and their health.”

Please note there is no mention of making or fabricating in this role description, if you are routinely involved in fabrication that is fine, but fabricating/making cannot be the defining terminology in our professional description.

• It is critical that we measure our results in a consistent, verifiable, reliable and repeatable way.

We are managing care, managing at its core demands measuring. To put it another way, “If you are not measuring it, you are not managing it.”

These two steps will help teach people how to treat us. We have helped other health care professionals and payers profile us since 1917. It is time to change the perception. Here is the catch: You must become what you want the change to be before it can happen.

Dennis E. Clark, CPO, President, OPGA
Your Independent Partner in the Fight of Our Professional Lives
<table>
<thead>
<tr>
<th>Section</th>
<th>Page(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letter from OPGA President Dennis Clark</td>
<td>2</td>
</tr>
<tr>
<td>O&amp;P</td>
<td>2</td>
</tr>
<tr>
<td>A Joint Effort Between Practitioners and Suppliers Results in Top-notch Customer Service</td>
<td>4</td>
</tr>
<tr>
<td>PEL</td>
<td>5</td>
</tr>
<tr>
<td>Research Recap</td>
<td>6</td>
</tr>
<tr>
<td>By Breg®</td>
<td>7</td>
</tr>
<tr>
<td>Breg®</td>
<td></td>
</tr>
<tr>
<td>RAC Audits: Calm Before the Storm</td>
<td>8, 32</td>
</tr>
<tr>
<td>By Kelly Grahnac, The van Halem Group</td>
<td>9</td>
</tr>
<tr>
<td>The van Halem Group</td>
<td></td>
</tr>
<tr>
<td>Making a Mess of Prefabricated Prostheses</td>
<td>10, 14</td>
</tr>
<tr>
<td>By David McGill, Össur Americas</td>
<td>11</td>
</tr>
<tr>
<td>Össur®</td>
<td></td>
</tr>
<tr>
<td>The Fence is Gone</td>
<td>12, 14</td>
</tr>
<tr>
<td>By Scott Williamson, Quality Outcomes</td>
<td>13</td>
</tr>
<tr>
<td>Quality Outcomes</td>
<td></td>
</tr>
<tr>
<td>Evidence</td>
<td>15, 34-35</td>
</tr>
<tr>
<td>By Ray Fikes, Fikes Brace and Limb</td>
<td></td>
</tr>
<tr>
<td>Breg®</td>
<td>15</td>
</tr>
<tr>
<td>CMS Begins Rollout of Fingerprint Analysis</td>
<td>16</td>
</tr>
<tr>
<td>By Ryan Ball, OPGA Government Relations</td>
<td>17</td>
</tr>
<tr>
<td>Unite O&amp;P</td>
<td></td>
</tr>
<tr>
<td>Prosthetic Shrinkers</td>
<td>18</td>
</tr>
<tr>
<td>By Knit-Rite</td>
<td>19</td>
</tr>
<tr>
<td>Knit-Rite®</td>
<td></td>
</tr>
<tr>
<td>OA Rehabilitator™ Knee Brace</td>
<td>20</td>
</tr>
<tr>
<td>By John Kenney, OCSI</td>
<td></td>
</tr>
<tr>
<td>Guardian</td>
<td>21</td>
</tr>
<tr>
<td>DavMar Shoes: A Proud OPGA Partner</td>
<td>22</td>
</tr>
<tr>
<td>By DavMar Shoes</td>
<td>23</td>
</tr>
<tr>
<td>DavMar Shoes</td>
<td></td>
</tr>
<tr>
<td>O&amp;P Solutions</td>
<td>24</td>
</tr>
<tr>
<td>O&amp;P Education for PTs and OTs: The Proof is in the Numbers</td>
<td>25</td>
</tr>
<tr>
<td>By Scott Schall, O&amp;P Solutions</td>
<td></td>
</tr>
<tr>
<td>Responsive Design: Why You MUST Know What it Is</td>
<td>26</td>
</tr>
<tr>
<td>By VGM Forbin</td>
<td>27</td>
</tr>
<tr>
<td>VGM Forbin</td>
<td></td>
</tr>
<tr>
<td>biodesigns, inc.</td>
<td>28</td>
</tr>
<tr>
<td>Bioness®</td>
<td>29</td>
</tr>
<tr>
<td>Trulife</td>
<td>30-31</td>
</tr>
<tr>
<td>Coyote Designs</td>
<td>33</td>
</tr>
<tr>
<td>VGM Corporate Specialties</td>
<td>35</td>
</tr>
<tr>
<td>Streifeneder from Euro International</td>
<td>36</td>
</tr>
<tr>
<td>Small Business Administration Focuses on Audit Policies</td>
<td>37</td>
</tr>
<tr>
<td>By Ryan Ball, OPGA Government Relations</td>
<td>38</td>
</tr>
<tr>
<td>Strategic Imaging</td>
<td></td>
</tr>
<tr>
<td>Liberating Technologies, Inc.</td>
<td>40</td>
</tr>
<tr>
<td>Flo-Tech</td>
<td>41</td>
</tr>
<tr>
<td>VGM Insurance</td>
<td>42</td>
</tr>
<tr>
<td>SRS Designs</td>
<td>43</td>
</tr>
</tbody>
</table>
A Joint Effort Between Practitioners And Suppliers Results In Top-Notch Service Customers Deserve.

PEL, the exclusive distributor for OPGA, is exploring ways to provide a more productive relationship between practitioners and suppliers that is transparent, valuable and innovative.

An era of open information in healthcare is underway. We have experienced years of progress as organizations move toward data transparency by digitizing medical records and making stored data usable, searchable and actionable within the healthcare industry. These technology advancements allow healthcare stakeholders to have access to insightful pieces of information. A recent study conducted by the Center for US Health System Reform Business Technology Office notes that this collection and transparency of information is referred to as “big data” due to its volume, complexity, diversity and timeliness. Researchers can now mine the data to see what treatments and/or products are most effective for particular conditions, identify patterns related to the patient and gain other insightful information that can improve the overall patient experience and reduce costs.

Many innovative companies that play a role in providing quality healthcare are following suit by using this data to create effective strategies to help patients, physicians, manufacturers and other healthcare influencers identify value. PEL believes the combination of its product knowledge and exceptional service can help practitioners better meet the needs of its patients. By focusing on the patient and the tools the practitioner needs to deliver proper care, PEL improves efficiency, reduces waste and creates greater patient and practitioner satisfaction because better care is delivered.

“There is no team in this industry more committed to the independent practitioner. Our values are focused on quality, not just the lowest price,” said PEL CEO Mike Sotak. “When you call PEL, we answer the phone in a very personal and energetic way. You will find that our team is sincerely interested in helping our customers and will offer insightful advice and recommendations on the first call.”

Since its beginning, PEL has focused on helping practitioners provide the greatest possible care for their patients. They’ve stayed accessible, always there to discuss the best potential products and solutions that can be delivered in a timely manner.

PEL’s newly designed website offers practitioners an advanced search functionality to quickly access product information based on the patient’s needs versus searching by manufacturer. Practitioners can easily view like products at the same time to simplify the product search for each patient.

“With our new website, practitioners can check inventory, pricing and place orders with a more user-friendly platform,” adds Sotak.

Through its service-focused mission, PEL has created high-quality and personal relationships with healthcare practitioners, ultimately resulting in enjoyable patient experiences.

PEL is a leading distributor of orthotic and prosthetic components to the O&P industry. PEL, LLC is headquartered in Cleveland, Ohio.
Let's complete someone's life today.

You have a life to put back together. We have the products and the knowledge to help you do it. Learn more at pelsupply.com

The Service You Deserve
Research Recap:
The efficacy of unloader bracing in reducing the pain and symptoms of knee osteoarthritis

At the 23rd annual meeting of the American Society of Sports Medicine in New Orleans, researchers from the Andrews Orthopedic & Sports Medicine Center, Gulf Breeze, Fla., presented the findings of a clinical investigation evaluating the efficacy of unloader bracing in reducing the pain and symptoms of knee osteoarthritis.

The researchers at the orthopedic center completed a prospective, randomized controlled, single-blinded study evaluating patients with symptomatic, unicompartmental osteoarthritis involving the medial compartment of the knee. Fifty randomly assigned braced patients were compared to a control group of patients who did not receive a knee brace but were treated with standard modality care, including oral analgesic, non-steroidal anti-inflammatory agents (NSAIDS), weight loss, physical therapy and others.

All patients were restricted from receiving any type of injection therapy or utilizing narcotic pain medications. Patient outcomes were evaluated using the Knee Injury and Osteoarthritis Outcomes Score (KOOS) and Visual Analog Scales (VAS) for pain and other symptoms, which were administered upon inclusion into investigation and again at four follow-up periods; at 4, 8, 16 and 24 weeks.

The data from the study demonstrates favorable results within the braced group when compared to the non-braced. The KOOS data demonstrate fewer arthritis symptoms, significantly less pain and better ability to perform daily living activities. The VAS data show significantly less pain throughout the day and improved activity level. There was no difference shown between groups in ability to sleep, NSAID use, perform sports and recreation or quality of life.

This prospective, randomized, controlled trial has shown that off-loader braces are increasingly recommended as a conservative treatment modality for knee osteoarthritis with beneficial outcomes.

Breg’s OA brace family has been specifically designed with patient needs in mind. The braces are comfortable with easy-to-use features for patients with varying stages of OA. The products are indicated for support and alignment for medial or lateral compartment OA. Additional benefits of Breg OA bracing include:

- Cool and comfortable padding with Airtech® for enhanced breathability and suspension.
- Low profile, offloading thumb wheel dial provides a repeatable offload setting with an easy-to-read view window. Additionally, offloading adjustments can be made without the use of a tool.
- ProForm® technology engineered for a precise and comfortable fit to promote compliance without compromising mobility.

For more information on this data visit: www.breg.com/unloaderbracing

For additional information about the Breg family of OA bracing or other Breg products visit www.breg.com, contact your local sales rep or call 800-321-0607.

Affiliation: Andrews Orthopedic & Sports Medicine, Gulf Breeze, FL
Disclosures: The institute of the authors have received research funding by Breg, Inc.
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Introducing the Fusion® OA Plus family of knee braces

In order to meet the varied needs of your osteoarthritis (OA) patients, Fusion OA Plus braces are designed for mild, moderate and severe OA. All Fusion OA Plus braces include AirTech® padding for enhanced breathability and suspension. Redesigned strap tabs provide a customized fit for every leg shape.

The low profile design helps your patient go from one activity to another with comfort and confidence. The slim thumbwheel hinge makes offloading adjustments easy, without the need for a tool.

Learn about all Fusion OA Plus knee braces. Go to Breg.com/FusionOAPlus or call 800-321-0607
Have you noticed a reduction in the number of ADRs you have received from the RAC as of late? If so, you’re not alone.

On Feb. 18, 2014, CMS announced that they were in the procurement process for the next round of Recovery Audit Program contracts and that, as a result, RAC activity would slow to allow the current Recovery Auditors to complete all outstanding claim reviews and other processes by the end date of the current contracts. While you may see this as a welcome relief, a better perspective may be one of the “calm before the storm. Do not get complacent during this period of inactivity.

The new Recovery Audit contracts will align the RAC jurisdictions with those of the A/B Medicare Administrative Contractors (MACs), and create a national RAC dedicated to Home Health and Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). To put that into perspective, the current RACs are responsible for auditing Medicare Parts A and B services, Home Health and DMEPOS, which means they are dividing their resources four ways. The creation of a national Home Health and DMEPOS RAC means that these types of claims will be their only focus. It would be reasonable to assume that the audits will then increase in number, since the national RAC has a more narrow focus that includes orthotics and prosthetics.

A good strategy to implement during this audit respite is to be proactive and get prepared for later this year when the national RAC ramps up its audit activities. At The van Halem Group, we work with numerous O& P clients, which means we are more than familiar with the vulnerabilities O & P providers face when met with a RAC audit. At the top of the list are issues with documentation, both on the physician side and the documentation created by the orthotist/prosthetist. Specific to documentation from the physician, there are five commonalities we see frequently in our practice. These are:

1. The documentation does not include an actual assessment of the area of the body affected.
2. There is no mention of the need for the orthotic/prosthetic, including why it needs to be customized (if applicable).
3. There is no mention of why a replacement is required (if applicable).
4. There is no mention of the patient’s actual functional abilities.
5. The documents were created by the orthotist/prosthetist and signed by the practitioner and kept in the medical records. This type of documentation cannot take the place of actual documentation.

If you are being proactive in obtaining documentation from the physician - by which I mean making sure that what you receive is sufficient before billing the item to Medicare - then you can simply go back to the physician and request the missing information be added to your patient’s records. While this process can be easier if you have a good relationship with the patient’s physician, it is not impossible even when you do not. One suggestion is to simply contact the physician and explain that in order for the item to be covered by Medicare, “X, Y and Z” need to be included in his notes.

If the physician agrees that the beneficiary needs the item, then he should have no trouble adding this information. If you are trying to obtain the documentation post-billing, request the physician write an addendum to his notes that will include the necessary information. Remember that the addendum should be dated currently and not backdated. The addendum may not be considered during review, but can be in an appeal. Of course, the time in which this addendum is obtained makes all the difference. Days or weeks certainly show the reviewer the patient’s condition was still very fresh in the physician’s mind. Years after the fact, the addendum can still have weight, but probably not as much. But don’t let his discourage you in attempting to get the documentation you need to get paid.

Another approach often taken is utilizing a physical therapist. While PTs have always done a good job documenting the functional abilities and limitations of patients, in recent years Medicare has added many more layers to the way in which a PT documents the beneficiary’s abilities. For you, this means excellent documentation that you can include in the patient’s file to indicate the need for the orthosis/prosthesis.

If the physician has not already referred the beneficiary to the PT, consider making the suggestion. Not only does this get the physician off the hook in terms of documentation, but it also allows the PT to bill for the patient encounter, which in turn gives you the documentation you need. In this scenario, the physician, the therapist and YOU win. If you aren’t already using this approach, we recommend you consider it in your processes moving forward.
The van Halem Group offers OPGA members a 15 percent discount off hourly services, including audit assistance, appeal preparation, medical review and consultative services. In addition, the following services are available:

**ON-SITE COMPLIANCE ASSESSMENT/REPORT:** Visit from regulatory compliance expert generally takes one day and includes interviews with senior management and key personnel. The van Halem Group (vHG) drafts a report that outlines vulnerabilities, risk areas and best practices, along with recommendations. $2,000 + travel expenses.

**CONTINUOUS COMPLIANCE PROGRAM SUPPORT PACKAGES:** All packages include toll-free anonymous reporting hotline and Web-based reporting mechanism for staff. Hotline is monitored, screened and administered by vHG, and communicated to client’s compliance officer. Compliance program literature for each location is also included in each package.

- **Bronze Package:** $300 per month for 12 months:
  - A compliance education program designed to be conducted by your compliance officer or dedicated staff; updated annually.
  - Identification of random sample and audit of 30 claims by former Medicare auditors and clinicians to be broken down semi-annually or annually. Includes summary report with corrective actions and follow-up.
  - Additional consulting services are billed at a normal hourly rate minus 5 percent discount.

- **Silver Package:** $400 per month for 12 months:
  - Compliance education program.
  - Identification and audit of 45 claims, plus report.
  - Additional consulting services are billed at a normal hourly rate minus 10 percent discount.

- **Gold Package:** $500 per month for 12 months:
  - On-site compliance education and training conducted annually by vHG experts (travel expenses not included).
  - Identification and audit of 80 claims; includes summary report and follow-up teleconference to review results.
  - Additional consulting services are billed at a normal hourly rate minus 15 percent discount.

- **Platinum Package:** $600 per month for 12 months:
  - On-site compliance education and training conducted annually by vHG experts (travel expenses not included).
  - Identification and audit of 120 claims; includes summary report and follow-up teleconference or on-site visit to review results with management (travel expenses not included).
  - Additional consulting services are billed at a normal hourly rate minus 20 percent discount.
Making a Mess of Prefabricated Orthoses

When launching something new — anything at all — a good rule of thumb is to make the new thing easy to understand. Applying this simple measuring stick, one can only conclude that Medicare's contractors either (1) don't subscribe to this principle, or (2) can't follow it. The Medicare Administrative Contractors' efforts to provide purportedly clarifying guidance about prefabricated orthoses provide a shining example of how to confuse everyone, throwing a monkey wrench into how suppliers of orthotics operate.

Why the MACs Needed to Issue Guidance in the First Place

The MACs wouldn't have had to do anything if Medicare hadn't made critical changes to numerous orthotic codes when it released the 2014 code set last November. But Medicare split the general category of prefabricated orthoses into two smaller subgroups: (1) off-the-shelf and (2) custom fit.

The primary reason for creating an orthotic class system? Two words: competitive bidding. Medicare can place only OTS orthoses into its competitive bidding program. However, before 2014, orthotic L codes didn't clearly differentiate between OTS and more custom orthoses. By changing the language of more than 20 codes to include the words “off-the-shelf” in the description, Medicare created the pathway for competitively bidding these products in the future.

The (Painful) Rollout

Nearly 60 days after these codes became active, the MACs published a joint announcement explaining what the new language meant. But before anyone could fully digest it, the MACs retracted their publication without explanation. Another 30 days went by before the MACs re-released their guidance.

That brings us to “current state” — what we know today.

The Codes Explained

As a DMEPOS supplier, you are tasked with responsibility for coding orthotic devices correctly. But the OTS/custom fit distinction greatly complicates your ability to do so, as the determination of which of two possible codes applies now rests on a two-step analysis that you have to perform for affected orthoses.

The first step requires you to analyze what happened to the device before you delivered it to the patient. If it required only “minimal self-adjustment for fitting at the time of delivery,” you must use the code. Minimal self-adjustment means something the beneficiary, her caretaker, or the supplier can do that doesn't require the services of an ABC/BOC-certified orthotist or an individual with “specialized training.” The MACs state that “adjustment of straps and closures, bending or trimming for final fit or comfort” are examples of minimal self-adjustment.

On the other hand, if the orthosis requires “substantial modification for fitting at the time of delivery in order to provide an individualized fit,” then it's possible the custom-fit code might apply. Examples of substantial modification include trimming, bending, molding (with or without heat), or “otherwise modifying,” resulting in alterations beyond minimal self-adjustment.

However, before billing the custom-fit code you must proceed to step two of the analysis: who fit the device? Under the MACs' guidance, only an ABC/BOC-certified orthotist or individual with “specialized training” — a physician, PT, OT “treating practitioner” — can deliver a “custom-fit” device. If you cannot document that an orthotist or person with specialized training substantially modified the orthosis at the time of delivery to provide an individualized fit, then you cannot satisfy the requirements necessary to bill the custom-fit code.

What Happens Next?

We expect that orthoses will eventually become part of Medicare’s competitive bidding program. Once that process is complete, the codes will receive new fee schedule amounts. (Today, the and custom-fit allowables are identical.) Based on other products placed into the competitive bidding program, it's likely those fee schedule amounts will be 20-40 percent lower than the current fees.

In addition, Medicare and its contractors will likely engage in extensive auditing/prepayment claim reviews of custom-fit devices. If you can't show that substantial modification by a qualified individual occurred, Medicare will try to recoup/prevent payment for those claims.

Össur continued on page 14
RHEO KNEE® 3
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The Fence is Gone

During the past 18 months or so, we have been reviewing a new way of thinking for O&P providers. We have explored PROMs and PROs. We have talked about becoming more focused on the whole patient and the role you can take in helping to coordinate their care. The health care paradigm has shifted and the change is happening now.

The good news is that if you have been paying attention to all of the chatter, not just from us but from many people, you should be in a good position to leverage your knowledge and step up to the plate. If you still think that we will go back to the old ways of doing business, then key elements of these messages have not permeated your gray matter. There is a choice to be made here - step into the world of the health care professional or recede into the world of a parts assembler. The fence on which we have been sitting is being removed for us whether we like it or not.

Change is uncomfortable, especially when you are not the one promoting the change. But by embracing this new opportunity to demonstrate the relevance and value of appropriate O&P intervention, you have the ability to prove to the other health care professional the degree of clinical knowledge you have. It’s not just the O&P world that is being rocked by change. The entire health care landscape is being impacted by the nationwide shifts underway.

Our challenge, however, is that the clinical value O&P brings is not well understood by the other health care professionals. It is up to you to demonstrate that value. No one can do it for you, and without you, the patients that need you the most will suffer. By shifting your thought processes, you can represent the work you do in terms of the functional change in the way your patients engage their environment and the difference in your patients’ lives.

**Patient-centeredness**

“Patient-centeredness” is an approach to improving health care quality that has been promoted extensively in recent years. Early conceptual models of patient-centeredness focused on how health care providers and patients might interact at the interpersonal level but later conceptual models were expanded to consider how patients might be treated by the health care system as a whole. This latter approach holds promise for improving the quality of health care for individual patients, communities and patient populations.

You cannot simply wave a wand and declare yourself “patient-centered.” It requires a culture change all the way down to the core values and attitudes of the company and its employees. It is not simply the implementation of new programs. This shift is about engaging the hearts and minds of those with whom you work and those for whom you provide care. It is about reconnecting your practice’s staff with their passion for serving others.

It is about examining all aspects of the patient experience and considering them from the perspective of patients versus the convenience of providers. Ultimately, it is about a collective commitment to a set of beliefs about the way patients will be cared for, how family will be treated, how leadership will support staff, and how staff will nurture each other and themselves.

Patient-centeredness is not a check-list, a dashboard or an action plan. It is a cultural transformation. As such, it requires buy-in and engagement from all levels of the organization, it requires a long-term commitment, and a willingness to routinely challenge the “that’s the way we’ve always done it” mentality. What’s more, patient-centeredness is not a goal to be achieved in order to move on to the next initiative.

The true test of a culture of patient-centered care is its sustainability and its ability to endure even in the face of busy days, staffing shortages, demanding patients and staff turnover. True to any profound organizational culture change, the gradual shift to patient-centeredness comes with a natural ebb and flow of momentum. Rather than a reason to abandon efforts to become more patient-centered, these ebbs represent opportunities for revitalization, celebration of past accomplishments and setting new goals. The flows are opportunities to push through barriers to further advance the culture.

At Quality Outcomes, our goal is to help you navigate through this critical transformation. Our team has strategically aligned with experts to help with all aspects of the transition to a relevant health care professional in the new paradigm. This means your documentation needs to be stellar, your communication with referral sources needs to be on point and relevant to their priorities. You need to be a resource to other allied health care providers and the resident expert on the patient populations you manage (yes, manage).
OPGA and Quality Outcomes want to make sure you are prepared. All companies renewing in 2014 will be surveyed against the new standards.

We can help!

Our Guidebook

• Fully customized to your company
• Addresses all new and revised standards in a logical flow and outlines the path to compliance
• Includes sample forms, sample letters and disaster plan templates
• Gives you all the tools you need to put the standards to work for you

OPGA Member pricing is $1,500. This reflects a $750 discount!

Get your company’s guide today by emailing info@opga.com, or call 800-214-6742
With the tools we are assembling, you can provide education to your local PT or OT and be recognized as a continuing education provider. You can administer functional outcomes measures and have access to score sheets and explanations that help you understand what those measures are telling you. You can share that information with your physicians and use the data to help your PT develop a treatment plan. You will be the default “manager” of your patient populations, and your health care community will begin to understand that you are a valuable team member, not just the “go to” person for legs and braces.

We are pleased to introduce a new system for helping your business achieve its highest level of performance. “APEX100” is Optimus Prosthetics and O&P Solutions’ proprietary professional management system that can be licensed to other O&P practices. Quality Outcomes is now working with OPS to include APEX100 in the mix of solutions to help you run your practice. This unique business leadership tool integrates well with the Policies and Procedures Guidelines that QO has offered for some time, but this system also helps you work through the change management processes necessary to become a patient-centered professional O&P practice.

Please remember why you got into this business anyway. It’s the young child who doesn’t even know she is “disabled” after you worked with her for years. It’s the veteran who was injured fighting for our freedom who you helped and now has the ability to be independent. It’s the parent that you served who can confidently hold their child. This is not about the leg you built, the arm you made, or any other “device” you have at your disposal. It’s all about the difference you make in each patient’s life and the freedom you give them to feel whole again. You know how good it makes you feel to be able to give that freedom back to your patients. If you want to keep doing the good work you do, you will need to be able to prove to the health care system that you really do make a difference.

In order to win the good fight, our entire profession has to be able to show the broader health care world that the unique interventions provided by QUALIFIED PRACTITIONERS are the reasons that persons with amputations are able to perform the activities that matter most to them. Don’t brag about the device you fabricated, but instead demonstrate the change that YOU made as a medical professional in that person’s well-being. At the end of the day, a simple shift in focus from “widget maker” to “change agent” will lead you right into outcomes-based patient care management.

Once you see the “before and after” numbers that come back from these PROMs, you will have a newfound belief that outcomes are not just for those academic types.

- We are putting real measures into the hands of the everyday practitioner.
- We will provide the tools you need to understand what these measures are telling you (and what they are not).
- We will provide the tools to help you be a valuable resource to your referral sources by helping you monitor your patients’ progress in objective ways (or lack thereof)
- We will be able to identify patients who are not performing as well as we might expect, or who are outperforming their peers.
- We will help you show whether your patient is better off as a result of the intervention.
- You will truly be recognized as a partner in the patient’s well-being, not the leg vendor.

You can be a leader or a follower. Don’t be a roadblock. Get started now!

Finally, the guidance from the MACs is hardly a model of clarity. The MACs have signaled that they intend to provide further guidance in the near future in an effort to answer the myriad questions that still remain.

(Two examples: (1) how is a doctor supposed to know whether to prescribe an OTS or custom-fit device before the supplier ever evaluates the patient; (2) who is a “treating practitioner?”)
Evidence

Jokingly, I tell people now that I don’t treat patients, I collect evidence. I had no idea how much reality there was to this levity. Truly, I’m spending more time on paperwork and tasks related to evidence than I am treating patients.

I thought it would be a great spoof to make a video of an AFO casting, where I first start off by outlining the foot on the floor with chalk. Then I would go to the mirror and read the Miranda rights to myself. Then I would stretch the crime tape at the door of my cast room. This would be followed by obtaining the records from the doctor who is under a spotlight in a dark room with a line of questioning like, where were you on the night of...

Maybe you think that this is a little corny but it truly is our reality. We live in a world of evidence, or lack of it in too many cases. We need it for our survival. Medicare needs it because they have paid someone without it and they need their money back. The RACs need it but only just enough to initiate their commissions process. The ALJs world not only revolves around it but is made up entirely of it. We need it to protect ourselves from these entities but as you will see later in this article, this evidence can be used to protect us from other influences also.

The commonality with all parties is that evidence is what we are all looking for. The crazy part is that no one can agree on exactly what evidence is. Even more maddening is the fact that there’s a timing issue that adds more variables to the equation. For example, I may have a gigantic body of evidence on one case but only the evidence at the time of billing can be considered.

But what of the evidence after the date of service? What is this time period and why should it be so sacred to us and so trivial to the RACs? Every good caregiver in any medical discipline will tell you that success comes from good follow-up. The term itself is used to define this period after the date of service. It shows the willingness and dedication of the caregiver to make sure that their procedure is successful for their patient. This is the magic time. This is where evidence can actually alter previous evidence. It’s called progression, in many cases it’s called success. The fact that money can be taken away from us without the consideration of this evidence is ludicrous and unconstitutional. It’s crazy because if someone took money from me wrongfully, I would have to go to a judge to get this money back. But with Medicare, they don’t wait for the judge as they should, they take the money back and then go to the judge. Whaaaat? With these Draconian tactics, you would think Medicare was hurting for money or something.

Evidence in Alien Formats

There is still a matter of what I call evidence of alien format. I was in a committee meeting on a Medicare project where we were flowcharting a website. I was incensed that there was no mechanism in place for the RACs to even look at our substantiating data in its simplest form. They can’t see our data but they can take our money at this point.

It seems that the most alien of all evidentiary formats is video. In just about any court in the land, video will be considered second to maybe only DNA evidence. In my first RAC audits, I was very confident because these cases were a success by all measures. I confidently sent in my records with ample video to show just how well these patients did. I was horrified as I was recouped in full. And then it happened again and then again. Of course, the video does nothing to address the physician documentation that these recruitments were based on, but my video addressed the functional level issues that the physician documentation left out on one case and the medical necessity issues on another. I won both of these RAC audits because the ALJs considered this evidence and the RAC auditor lost his commission. The third case is still pending, but I feel even more confident now because I have even more video substantiation.

One of the cases left me with physician documentation in its entirety said, “patient needs prosthesis” in his records. This particular audit was a four-year-old case and now the patient was deceased. In the video for this patient that was considered by the ALJs, I had videotaped the AMPPRO test so the judge could see the patient doing each and every task.

I had the occasion to speak with someone from the audit world and share this case with them. When I mentioned what the ALJs considered in this case, they stopped me short and said that the ALJs are apples and we are oranges. I replied by asking him, “If the ALJs are apples and they could take my commissions away by a preponderance of all the evidence, then I think that I would try to see the same evidence that they are basing their decisions on.”

No wonder there was a 75 percent overturn rate initially with RAC audits. With one investigator observing the crime scene from his squad car while the judge looks at all of the evidence in the case.

By Ray Fikes BOCPO, Fikes Brace and Limb

Fikes continued on page 34
CMS Begins Rollout of Fingerprint Analysis for NEW DMEPOS Providers

CMS recently released guidance on the rollout of their new fingerprint background check requirement for certain DMEPOS providers. It has been more than three years since CMS released their final rule on developing a fingerprint background check process for new DMEPOS and home health suppliers that was created as part of the Affordable Care Act.

The final rule created three groups of DMEPOS and home health suppliers and their potential risk level for fraud and abusive billing. The group classifications are “limited risk,” “moderate risk” and “high risk.” At this point, this initiative is limited to those suppliers designated as “high risk,” who will be subject to the fingerprint background check.

According to the final rule, currently enrolled DMEPOS suppliers (which includes orthotists and prosthetists) who are subject to revalidation prior to 2015 will be classified as “moderate risk” and will not be subject to the fingerprint background check. However, newly enrolling DMEPOS suppliers will be classified as “high risk,” meaning they will be subject to the fingerprint analysis and background check.

Additionally, as you will see below, there are other ways a supplier can be moved into the “high risk” category, including CMS payment suspensions going back 10 years and several other similar distinctions that would require an existing O&P practitioner to be subject to the new fingerprint rules.

The “moderate” and “high” risk classification screening requirements and actions are listed below. The following is taken directly from the CMS release on the new effort.

Moderate screening level (currently enrolled O&P providers)
When CMS designates a provider or supplier as a “moderate” categorical level of risk, the Medicare contractor does all of the following:

(i) Performs the “limited” screening requirements described in paragraph (a)(2) of this section.

(ii) Conducts an on-site visit.

High screening level (newly enrolling O&P provider)
When CMS designates a provider or supplier as a “high” categorical level of risk, the Medicare contractor does all of the following:

(i) Performs the “limited” and “moderate” screening requirements described above.

(ii) Requires the submission of a set of fingerprints for a national background check from all individuals who maintain a 5 percent or greater direct or indirect ownership interest in the provider or supplier; and

(iii) Conducts a fingerprint-based criminal history record check of the Federal Bureau of Investigation’s Integrated Automated Fingerprint Identification System on all individuals who maintain a 5 percent or greater direct or indirect ownership interest in the provider or supplier.

Adjustment in the categorical risk
CMS adjusts the screening level from “limited” or “moderate” to “high” if any of the following occur:

(i) CMS imposes a payment suspension on a provider or supplier at any time in the last 10 years.

(ii) The provider or supplier—

(A) Has been excluded from Medicare by the OIG; or

(B) Had billing privileges revoked by a Medicare contractor within the previous 10 years and is attempting to establish additional Medicare billing privileges by—

(1) Enrolling as a new provider or supplier; or

(2) Billing privileges for a new practice location;

(C) Has been terminated or is otherwise precluded from billing Medicaid;

(D) Has been excluded from any Federal health care program; or

(E) Has been subject to any final adverse action, as defined at § 424.502, within the previous 10 years.

(iii) CMS lifts a temporary moratorium for a particular provider or supplier type and a provider or supplier that was prevented from enrolling based on the moratorium, applies for enrollment as a Medicare provider or supplier at any time within 6 months from the date the moratorium was lifted.

More information on CMS policies pertaining to the fingerprint analysis or background checks can be found on the Government Effects blog@www.opga.com

By Ryan Ball, OPGA Government Relations
I am a firm believer in the people. If given the truth, they can be depended upon to meet any national crisis. The great point is to bring them the real facts...

~Abraham Lincoln

Join your colleagues uniting to preserve the O&P profession.

UniteOandP.com/preserve
Prosthetic Shrinkers for Expanding Patients and an Expanded Bottom

As a company which has been led by O&P practitioners for four generations, Knit-Rite® prides itself on developing new textile solutions for the challenges prosthetists and orthotists face on a daily basis.

Enter two new innovations in 2014: The Extra Large AK Compressogrip Prosthetic Shrinker®, and the new 4-Way™ Prosthetic Shrinker line.

More than three decades ago, Knit-Rite developed the original Compressogrip tubular prosthetic shrinker with its sliding ring/two-layer concept. "The ease of fitting, and relatively low cost, of the Compressogrip shrinker design has made it much easier to stock and to deliver shrinkers to inpatients during the same visit," said Mark Smith, CEO of the company. "Same-day delivery allows the prosthetic facility to provide outstanding service for referring hospitals and thereby capture more new prosthetic patient referrals. An additional benefit of the design has been the way the shrinker is donned, by applying the compression in two individual layers, because the higher single layer compression levels often tends to cause discomfort during donning," he said.

Some years later, consulting prosthetists worked with the company as they developed an AK version of the Compressogrip design. The femoral version was awarded a U.S. patent.

But with the growth in body size of Americans, it has remained a challenge to find an off-the-shelf shrinker product that will fit very large individuals. The new extra-large AK Compressogrip Shrinker will accommodate massive thighs, up to 40 inches/100 cm in circumference, providing a very significant solution, according to Knit-Rite. Additionally the company has introduced a unique 4-inch wide waist belt that helps prevent rolling for situations where a pendulous abdomen or abdominal fold can create a tendency to cause narrower waist belts to roll up.

Smith also reports that Knit-Rite has been working on a more traditional closed-toe shrinker design that will also help address donning and comfort issues, while at the same time affording an improved bottom line to the prosthetic practice.

Smith said that in the 1970s, Knit-Rite’s R&D team helped revolutionize the textile art of making prosthetic and orthotic socks, with the introduction to the knitting process of a new type of yarn which allows extreme stretch in the end garment. "These 'corespun' yarns offer significantly better fit qualities and comfort for the wearer wherever we use them," he said.

Eventually the corespun yarns have come to dominate virtually every category of O&P textile sock interface that the company manufactures, for patient requirements from head to toe.

"Applying the use of corespun yarns to the prosthetic shrinker category only made sense, but we also wanted to offer an exceptionally lower cost point along with a higher quality product," said Smith. "So we tried using these yarns on faster knitting equipment, which allows us to lower manufacturing costs, and still provide a product that offers exceptional attributes for the wearer and a better bottom line for the practice."

The exceptional stretch and softness of the new 4-Way Prosthetic Shrinker helps patients put them on relatively easily. And they are softer than many other shrinkers on the market, according to Smith.

Smith said Knit-Rite has always been focused on serving the O&P field by listening and helping practitioners find effective clinical solutions for patients, while also being aware of providing excellent service and delivery.

"2014 marks our 91st year of supporting the textile needs of the profession," he said.

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SOLUTIONS THAT FIT™

4-WAY SHRINKER®
WITH ROUNDED TOE

The new 4-Way Stretch Shriner features stretchy polyester/Lycra core-spun yarns providing multidirectional stretch for a shriner that is softer, more comfortable to wear, and easier to don. Available in Medium (20-30 mmHg) and Heavy (30-40 mmHg) compression, Transtibial and Transmoral sizes.

- Multidirectional stretch
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- Familiar Sizing
- Quality with improved profitability

New X-Large Size!

The Compressogrip A/K for transmoral applications is clinically effective and easy to use and apply.

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- Easy and affordable to keep on hand for same day delivery.

For more information please contact Knit-Rite at 800-821-3094 or email customerservice@knitrite.com.
At the December 2013 Current Concepts in Joint Replacement orthopedic surgery conference in Orlando, Fla., researchers from Sinai Hospital in Baltimore released the findings of a Class I clinical investigation evaluating the rehabilitation benefits of the OA Rehabilitator™ Knee Brace in delaying the progression of knee OA.

The Rubin Institute of Advanced Orthopedics in Baltimore completed a prospective randomized controlled, single-blinded study evaluating the effectiveness of the OA Rehabilitator™ Knee Brace on Kellgren Lawrence Grade III and IV OA patients who were referred to the center for possible total knee arthroplasty. Randomly assigned braced patients were compared to a control group of patients who did not receive a knee brace but received standard of care.

Patients wearing the knee brace were asked to use the brace a minimum of three hours a day. A unique aspect of this study was the comparison of knee pain, gait, and functional abilities UNBRACED at the initial visit and after a 90-day period. Unbraced improvements were the focus of the study to determine if the OA Rehabilitator Knee brace rehabilitated the affected leg and the patients’ gait with routine use and if patients retained that effect.

The OA Rehabilitator Knee Brace utilizes an innovative design that uses pneumatic air bladders to unload the affected knee compartment, along with a gait correcting dynamic extension SWING ASSIST™ mechanism to correct OA gait as a means to increase quadriceps muscle activation. OA patients have decreased excitation of the quadriceps muscles during gait. This disruption in quadriceps firing is believed to lead to affected leg muscle weakness, reduced dynamic support of the affected knee joint, and increased complaints of pain and discomfort.

The brace corrects gait to improve the loading at the ankle / foot to activate underutilized quadriceps muscles while walking in the brace. Over time, muscles increase strength, provide better support of the knee joint, and result in reduced UNBRACED knee pain and improved functional abilities.

A broad spectrum of functional tests were performed in the study including a Timed Up and Go test, stair climb test and Lower Extremity Functional Score analysis. The braced group improved in both functional tests and subjective scores. This represents a significant improvement in function abilities unbraced after 90 days of brace use. The study also found improved loading during gait at the ankle / foot unbraced, which demonstrated improved quadriceps activation at weight bearing compared to baseline. The brace group was found to have neuromuscular gait retraining benefits that carried over after 90 days of brace use. The control group had no retained gait improvements.

The braced group increased their gait speed. Knee extension in gait was improved, and the loading response at knee flexion was improved. The foot placement unbraced by the brace group improved by 1.7 cms toward the midline of the foot. This improvement in foot placement results in improved quadriceps activation during gait. There was no improvement in the control group in foot placement after 90 days.

A key finding of the study found that use of the OA Rehabilitator Knee Brace for 90 days was significantly more effective than exercise alone in delaying the progression of knee OA. The brace group with various deformities had a reduction in the knee adduction moment of 48 percent after 90 days of brace use. Patients who completed 90 days of self-directed exercise therapy alone were reported to have a reduction in the knee adduction moment of 14 percent after 90 days. The use of the OA Rehabilitator Knee brace was found to be more effective than exercise alone in the conservative management of knee OA to reduce pain, improve thigh muscle strength and gait.

For more information on the OA Rehabilitator Knee Brace, contact OCSI at 800 375-0207.
Guardian

OA Rehabilitator™

The Future Standard of Care in the World of Knee Bracing

Improve Patient Outcomes!

- Increases quadriceps and hamstring strength
- Reduces pain and inflammation
- Increases leg extension
- Improves gait
- Improves functional capabilities
- Improvements retained unbraced!

800-375-0207

<table>
<thead>
<tr>
<th>Brace Selection</th>
<th>Indication</th>
<th>Unloads</th>
<th>Stability</th>
<th>Pain Relief</th>
<th>Unbraced Pain Relief After 90 Days</th>
<th>Improve Quad / Hamstring Strength</th>
<th>Improves Knee Extension</th>
<th>Improves Foot Placement</th>
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<tr>
<td>OA Rehabilitator™</td>
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U.S. Patents: 7,608,051 / 7,963,933 / 8,057,414 / 8,308,669 / 8,376,947
DavMar Comfort Shoes is a proud partner with OPGA and its members. Quality, comfort, fit and value have always been our main priorities in manufacturing and distributing some of the finest shoes available. Our Nature’s Stride shoes have been designed with special attention for the O & P profession. We have raised the bar by designing shoes that are extra-depth and are style setters for the diabetic and comfort shoe industry.

With several decades of foot and shoe experience, we at DavMar have put our extensive knowledge to work for you. Our Nature’s Stride shoes are manufactured in North America, using fine American leathers. We have solved the issues that are important. Nature Stride shoes are a combination last, with the heel being two widths narrower than the forefoot. This helps prevent heel slippage. We have also designed the lateral counter to be lower under the fibular malleolus so that the ankle cannot be irritated. Nature’s Stride shoes are orthotic friendly and easy to modify when necessary. The shoes are available in four distinct widths – N, M W, and XW, utilizing a gradient width outsole.

Nature’s Stride shoes look like regular conventional footwear, rather than the old orthopedic looking products. We have countersunk the insole to allow for extra depth in a manner that disguises that additional depth, allowing the shoe to look like regular footwear.

The skid resistant outsole is made of closed cell polyurethane. The thickness of the outsole allows you to easily make shoe modifications. A fiberglass shank has been incorporated into the outsole to provide additional stability and support for your patient. The shoes are designed to flex at the MT-P joint on a 26° angle. This permits the foot and the shoe to flex at the same point.

All shoes offered by DavMar are PDAC approved, coded A-5500. This includes Nature’s Stride, Hush Puppies, Wolverine boot (steel toe and soft toe), Brooks, as well as the Sebago deck shoe for men.

DavMar also offers heat moldable inserts (A-5512) with a top cover of plastizote rather than p-cell or poron material. The bottom layer of the inserts has built-in support under the medial longitudinal arch area, which helps to maintain contact with the foot during gait. We also provide custom inserts (A-5513) for those conditions needing to have specific areas off-loaded, or modifications made to the insert. We offer what is considered to be one of the finest L-5000 prosthesis available. It is washable, has a suede bottom cover, and a carbon plate to give the foot needed propulsion that is absent once the hallux is amputated, or if the patient had a TMA. For the L-5000 we require a neutral cast and a weight-bearing tracing of the foot.

We at DavMar have enjoyed working with the OPGA and have arranged special pricing for its members.

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All shoes are A5500 Medicare coded. We offer A5512, A5513 inserts and L5000 toe fillers.

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O&P Education for PTS and OTs: The Proof is in the Numbers

“I find the content to be relevant and helpful in my field.” – 98 percent agreed or strongly agreed.

“I feel more confident working with amputee patients.” – 81 percent agreed or strongly agreed.

“I feel that participating has resulted in better outcomes for my amputee patients.” – 70 percent agreed or strongly agreed.

“I would recommend participating to other professionals in my field.” – 95 percent agreed or strongly agreed.

Those are some big numbers! They are the results of a survey one prosthetic practice conducted of local therapists participating in the “Prosthetics for PTS and OTs” program from O&P Solutions.

Of course, it is good to know that the education you are providing is beneficial to those participating. But it’s equally important to know that your efforts position you as the “prosthetic expert” in your area, which can lead to making a difference in your own practice.

How can educating make a difference in your practice? Here is another big number: 30 percent. That’s the percentage of total patient referrals received by that prosthetic practice from therapists AFTER introducing this program. Prior to the program, less than 2 percent of their referrals came from therapists.

More Than Just a Sales Pitch

O&P Solutions provides you with a 10-course series of one-hour presentations, specific to prosthetics. Each is approved for one credit-hour with the physical and occupational therapy associations of your state (where applicable). More than just a sales pitch, you are offering needed continuing education credits and valuable training, while establishing a strong relationship with the entire therapy team. You present at THEIR location, work around THEIR schedule, and offer the program free of charge. You demonstrate your commitment to the entire continuum of care and solidify your reputation as an expert in your field. This is one of the easiest marketing tools you will ever have available to you, as there is no down side to the therapist.

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You will receive one new course as frequently as you wish. We recommend promoting a new course quarterly. Research for the content has already been performed, organized fully referenced. It is customized to your practice with your logo, contact information and presenter information. Some presentations are even customized based on your practicing methods. We also provide participant handouts, quizzes and evaluation forms, as well as a step-by-step guide for promoting, presenting and maintaining the program. We take care of the approval process with your state-specific associations. We create the Certificates of Completion, and maintain all necessary records for audit purposes.

First to Market = Strong Advantage For Your Practice

By offering free CEUs to local rehab facilities and skilled nursing facilities, you are providing them with valuable information and education credits vital to their career. By being the first in your market area to do so, you are establishing your practice as the premier prosthetic educator in your region. Because each course is part of a series, once the first course is scheduled and the value of the program is established, you are locked in with that therapy group for consistent, on-going education for years to come!

Minimal Risk

All of our products and services are a la carte, so if you want to test the waters to see if this educational initiative is right for your practice, the only investment needed to get started is the cost of one presentation, CEU authorization eCertificate creation which, for OPGA members, is $1250*. *Cost includes up to 100 eCertificates and does not include presentation equipment or state application fees.

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Responsive Design: Why You MUST Know What It Is

Think about how many different devices you use to access the Internet during the day. There’s your desktop or laptop for work, a smartphone for quick searches during the day, and maybe even a tablet for entertainment when you’re relaxing in the evening on your couch. There’s no denying we live in an “era of mobile,” as ownership and use of multiple mobile devices has increased dramatically over the past few years. If you use multiple devices during the day, you are just one of millions who do so.

In the United States, 94 percent of consumers age 16 and older own a mobile phone, and 42 percent of adults 18 and older own a tablet. Even more importantly, 90 percent of adult consumers are moving “sequentially” between multiple screens every day, e.g., smartphone → PC → tablet.

So, what does this mean for your company’s website? In simplest terms, your website needs to provide users with the best experience possible on a variety of screen sizes. In the past, this has meant creating a completely separate mobile website. However, this is no longer necessary thanks to responsive design.

About Responsive Design

Responsive design technology allows for a website to reshape itself to fit any screen size while giving users the best experience possible. This reshaping process ensures that the navigation, images, content and other essentials of your website are displayed in a way that benefits customers visiting your site on a PC, laptop, smart phone or tablet of any size.

Put another way, the elements of the page — the navigation, images, etc. — have not shrunk, but rather repositioned to fit the new size of the screen. Visually speaking, this is what happened:

The page elements (the colored blocks) resize and shift around based on the screen size in responsive design.

In a quest to make the most user-friendly websites, VGM Forbin is continually researching and testing new technologies such as responsive design. It is essential in this age of mobile use to have a website with responsive design to reach users clearly and effectively, and Forbin is one of the first agencies in our area to make this technology a standard in the websites we build.

To learn more about responsive design and how it can benefit you, contact VGM Forbin today.

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Forbin delivers custom content to your target audience by promoting your business’ unique brand on Facebook, Wordpress, Twitter and more.

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All custom social content and graphic posts are delivered to you for review before scheduling. Help us, help you!

Forbin Schedules Your Social Media Posts
Forbin’s tool, socialhub™, turns a lengthy posting process into an efficient way of scheduling social content.

Forbin Manages Your Social Media Pages Daily
Forbin addresses questions and comments posted to your social platforms in a timely fashion.

To get your social media pages going today, visit VGM Forbin at www.forbin.com or call 877-814-7485!
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Custom Carbon AFOs

50% thinner • 10% lighter • 10% more reimbursement

Sure Step Pro Custom

- Custom articulating AFO with custom footplate, posting and custom upright
- Posterior stabilizer connects with custom uprights to provide greater stability control
- Removable and washable interface pads
- Articulating, temporary fixed or permanent fixed joint options
- Available in pediatric sizing or with shin guard

Indications: Posterior tibial tendon dysfunction (PTTD), pes planus, pes cavus, lateral ankle instability, peroneal nerve palsy, Achilles tendonitis, sinus tarsi syndrome

SPECIFICATIONS

<table>
<thead>
<tr>
<th>Model No.</th>
<th>Material</th>
<th>Cast Type</th>
<th>Standard Features</th>
<th>Warranty</th>
<th>PDAC Code</th>
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</thead>
<tbody>
<tr>
<td>SURE-02C</td>
<td>Carbon Composite</td>
<td>Above Calf</td>
<td>Top Cover: EVA, Top Cover Length: Sulcus Joint: Variable Articulating</td>
<td>90 days</td>
<td>L1970, L2820, L2750 (x2)</td>
</tr>
</tbody>
</table>

Sure Step Dynamic Assist

- Custom, dynamic assist AFO with custom footplate, posting and custom upright(s)
- Tamarack joint provides spring for those with drop foot
- Removable and washable interface pads

Indications: Peroneal nerve palsy, drop foot

SPECIFICATIONS

<table>
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<th>Cast Type</th>
<th>Standard Features</th>
<th>Warranty</th>
<th>PDAC Code</th>
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<td>SURE-02C</td>
<td>Carbon Composite</td>
<td>Above Calf</td>
<td>Top Cover: EVA, Top Cover Length: Sulcus Joint: Pre-flexed Dorsal Assist</td>
<td>90 days</td>
<td>L1970, L2820, L2750 (x2)</td>
</tr>
</tbody>
</table>

*percentages are approximate for custom braces
### Sure Step Variable R.O.M.

- Custom range of motion AFO with custom footplate and upright
- Variable R.O.M. from free moving to permanently fixed
- Posterior bar links the custom uprights to provide greater stability and control
- Removable and washable interface pads

**Indications:** Posterior tibial tendon dysfunction (PTTD), post-fracture/surgical, tarsal coalition, peroneal nerve palsy, Achilles tendinitis, severe ulcers, drop foot

**SPECIFICATIONS**

<table>
<thead>
<tr>
<th>Model No.</th>
<th>Material</th>
<th>Cast Type</th>
<th>Standard Features</th>
<th>PF/DF Stop: 0° - Free Motion</th>
<th>Heel Cup: 35 mm</th>
<th>Foot Plate Length: Mid-tarsal</th>
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<td>Above Calf</td>
<td>Top Cover: EVA</td>
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<td>Top Cover Length: Salicu</td>
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<td>Joint: Variable R.O.M.</td>
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<td>L27755 (x2)</td>
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### Rainier Boot Standard with Solid Ankle

**Indications:** Posterior tibial tendon dysfunction (PTTD), tarsal coalition, achilles tendinitis, charcot deformity, post ankle fusion/triple arthrodesis

**SPECIFICATIONS**

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<th>Material</th>
<th>Liner</th>
<th>Closure Options</th>
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<td>Mid-calf</td>
<td>Full Grain Leather/Carbon Composite</td>
<td>Soft Leather</td>
<td>Combo (Velcro and Laces) Only Velcro Only Laces and Boot Hooks</td>
<td>Solid Ankle</td>
<td>Rear metatarsal heads</td>
<td>90 days</td>
<td>L1960</td>
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<td>Soft Interface</td>
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Now let’s take a look at the documentation that is in your control. While Medicare requires the physician order the orthosis/prosthesis and document the need, it’s the orthotist/prosthetist that spends the majority of time with the patient. Don’t get so caught up in the patient encounter that you miss key pieces of information in your own notes. Below are some examples.

6. A complete initial assessment to support the need for the orthotic/prosthetic including gait is not documented (if applicable).

7. Notes do not mention the location/side of site being assessed.

8. There is no documentation to justify the orthotic/prosthetic chosen, including justification for major components.

9. When providing a custom orthosis, there is nothing in the documentation to indicate why a prefabricated orthosis would not meet the patient’s needs. This applies even if it is of permanent or long duration; either way it should be stated.

10. Your documentation does not indicate how images were obtained for the customized orthosis.

11. At the time of delivery, no actual assessment of gait (if applicable) and gait correction with orthotic/prosthetic is documented.

12. The beneficiary’s name and the date are not on each page of notes, which should be legible and include a (legible) signature.

13. The delivery ticket does not include the manufacturer, product name or model number to determine if the item provided was coded correctly, or a list of all the components was not provided.

Above all, it is important to remember that each page of your notes should be able to stand on its own, meaning all of the following are listed on the page:

- Patient identification and date
- Side and location of body part
- The author of the note and their signature

Keep in mind those issues listed above are within your control. Take this opportunity to get prepared. While you can’t make the RAC program go away, you can make it go away for your practice. If the RAC comes in and audits your files and finds no major issues, they’re not going to come back and request more documentation because they will want to focus on where they find errors so they can get paid.

The van Halem Group is a Medicare audit and compliance consulting firm. Among the services we provide to O & P clients are a pre-screen service, audit response solution and appeal preparation. Some of our clients using our pre-screen service have undergone RAC audits that have resulted in no recoupments. For more information and to take advantage of OPGA discounts, please call us at (404) 343-1815 to schedule a free consultation.
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We still have a 53 percent overturn rate now, but the tragedy here is that the RACs are not looking any deeper into the evidence, rather the ALJs were made to conform to the evidence that the RACs would look at and be more harsh and strict in their decisions. Apples-to-apples logic is the goal for all intelligent people, but he brought up the analogy, not me.

**Apples to Apples**

So how do we get an apples-to-apples comparison when the RACs will only look at evidence in some formats and not beyond a certain date, when the ALJs will look at all of this evidence? I think it’s going to be more simple than we think. Bear with me on another analogy. How aggavated are you when someone sends you something in a digital format that you really need to see, but it’s in a format that’s alien to you and you can’t open it. Then you find out that you have to download a program after you have searched the subject on Google. Then you try to download the software and it won’t load. The person I was talking to from the audit world was alluding to this very phenomena. He said, “What are we going to do with video? We want things in a PDF.”

Could it be that simple? I guarantee you that it is. I am developing an app right now for functional level assessments. It allows the patient to be videoed as the specific task is shown on the screen. After the patient is videoed, a score is given before it will cycle to the next task. This produces a file of video for each task quickly and without any video editing. This file is then compiled into a PDF form. When the RAC auditor opens the PDF form, he will see an AMPPRO, or other test, that he or she is used to seeing, except that there will be a video tab. When they click on this video tab within this PDF, the video of that specific patient doing that specific task will be shown.

This is a very powerful tool. It is virtually fraud-proof and I think that it will do something that has not been done to this point and that is to personalize that patient to the RAC auditor. RAC auditors are not dumb. They want to keep their commissions. When they are provided with more and more irrefutable evidence, they will move on to cases without such.

Many of you are aware of the situation that I’ve had now for two years with physical therapists. When I realized that my notes were not accepted as part of the record, I started thinking about how I should get my data to the physician and into his records. I have the physician write a referral to the physical therapist for a functional level assessment, and the therapist then reports to the physician in answer to his prescriptive request. This makes an entry in the official record that can be outside of the physician’s formatted notes. This has worked very well, and Medicare has let me know both in the Physicians Template Forum meetings, and in another committee that this is their preference. Problem solved right? Whoops?

All of a sudden I started getting very strange scores on patients that I was absolutely confident were solid K3 ambulators. I practice in Phoenix, Ariz., and with the snowbird population I invariably get patients coming in two weeks before they are going home for the summer with a prescription for a new prosthesis. To be able to get these patients fit in a timely manner and still have some measure of follow-up before they leave, I have to order the componentry immediately. I found myself in situations where the patient has been fit and a functional level assessment done, but the K level came back as a K2! As if we do not have enough hurdles in our pathway now, I have just found another one.

As I went back and checked the functional level assessments on these patients, I noticed areas of the AMPPRO test where the patient scored zeros. The patient was then promptly scheduled in and asked to do these tests in these areas and they scored perfectly. I then had to prepare a rebuttal to the physician and show him the video of these tasks the patient was scored 0 on and asked him to make an entry in his notes of the erroneous AMPPRO scores and please categorize the patient as a K3. When this information was given to the positions in question, it was a no-brainer for them. Why? Evidence!

It seems that in the physical therapy world, there is much more money to make on a prosthetic patient who needs strength and balance training before they get their prosthesis. The PT services are much harder to get justified if the patient is a K3 versus a K2. Indeed, in the PT’s report to the doctor just above the K level determination of K2 was the last statement and advice from the therapist:

“This patient may benefit from skilled therapy to address balance deficits, strength and ROM.”

And there you have it.

Truly, how reliable can a written document be? It can be the most objective test that has been validated on all criteria and administered in the most objective way but the subjectivity lies in the question, did it ever really happen. What proof does the physician have that the physical therapist did the test or was even honest with the test. Even if it’s digitally signed off on by the therapist who created it and the physician who is reviewing it, is there any evidence that it actually happened? And even if it did happen, did the therapist score the task correctly? I now have evidence that can be scrutinized task for task. I now have evidence that can be scored by another person including the physician himself. And if you are not skilled in collecting your evidence, how are you going to combat a bad functional level score from a therapist? At right are graphics of the evidence that I’m proposing and in a format that is not alien to the RAC auditors.

When the auditor clicks on the video tab beside the “single leg stance” task he will see this video pop-up and see the actual patient doing the actual task.
Let this be a cautionary tale to all of you. It truly makes us think of our situation with Medicare distrusting our financial interest when we see another medical discipline that is abusing their financial interest. All of my functional level assessments now are videotaped.

As I am finishing this article, I just received a report from the Federation of State Medical Boards and their recent new telehealth policy. They have passed measures to allow initial first-time visits with their physician to be virtual. There are already two commercial models in place, one named “American Well” and “Doctor on Demand.” In this report there is one issue that people see as a negative but I see as an absolute positive. Audio meetings, no matter how well documented, will not be considered for reimbursement. The FSMB contention is that video is absolutely necessary for reimbursement. Video is solid evidence. It is evidence for Medicare. It is evidence for the RACs and ALJs. And it is evidence for you and I.
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Small Business Administration Focuses on Medicare Audit Policies

The Small Business Administration’s Office of the National Ombudsman recently announced a national Regulatory Fairness Hearing to discuss issues that small businesses are dealing with because of onerous federal regulations and policies.

To provide some background, OPGA has met with National Ombudsman Brian Castro, as well as Deputy Yolanda Swift several times during the past 18 months to discuss the impact of Medicare audit policies on independent providers. In addition to providing testimony and coordinating the testimony of several independent O&P facilities in 2013, OPGA has also taken an active role in advocating on behalf of independent O&P facilities with the SBA.

Because of our active engagement with the SBA, they’ve since met with CMS personnel multiple times to bring our concerns directly to the federal agency where we have been directing our complaints. Additionally, we have been in contact with the Ombudsman’s office during the past 18 months to answer any questions that may come up and make recommendations on what potential policy solutions would most help independent O&Ps remain in business and continue seeing Medicare patients.

OPGA President Dennis Clark, Vice President Todd Eagen, Director of Government Relations Ryan Ball and OPGA Member John Tyo of Syracuse Prosthetics, met with the Ombudsman’s office in April to update the office on the plight of independent orthotic and prosthetic providers. In our meeting, we discussed several potential policy solutions that could help lessen the burden of Medicare audits until proposed changes are to take effect in 2015. Below is a sampling of our short-term solutions:

OPGA has devoted extensive time, resources and effort toward identifying the roots of our challenges and developing the means to effectively protect the O&P profession, with goals of:

• Bring more accountability and transparency to current Medicare audit programs by ensuring auditors have financial penalties for claims that are audited and overturned on appeal.
• Ensure claim recoupments cannot be made until after full adjudication of appeals process.
• Engaging amputees, family members, physicians, physical therapists and others to join independent O&P practitioners in educating elected officials about the negative impact audits are having on patient care for amputees.

Financial penalty for auditors on claims overturned on appeal

When a prosthetic claim for a Medicare beneficiary is created and subsequently appealed, providers are forced to pay for attorneys, audit consultants, additional billing staff – and worst of all, they are forced to reduce time treating patients to focus on paperwork. The Medicare program also incurs costs associated with the appeals process. Why aren’t auditors penalized financially for identifying claims that are eventually overturned on appeal?

OIG recently released a report that stated CMS lacks the ability to evaluate auditors on this key metric. With overturned appeals accounting for more than 50 percent of all appealed prosthetic audits, a monetary penalty would force auditors to better scrutinize their evaluations prior to initiating an audit.

Recoupment not made until after full adjudication of appeal process

In what court of law in the United States of America are you guilty until proven innocent? The audit appeals process governing orthotic and prosthetic claims specifically states that recoupment of reimbursement associated with an appealed audited claim that is appealed past reconsideration phase to an Administrative Law Judge can begin 30 days after the provider requests the hearing. However, with the dramatic increase in the frequency of audits, and of appeals in orthotics and prosthetics, there is currently a 28-month backlog before one receives an appeal date. CMS should not be allowed to recoup tens of thousands of dollars in reimbursement of a claim identified by audit contractors, while that provider still protests the recoupment and has an appeal pending.

We also spoke to the Ombudsman’s office about how we can better educate the public, federal agencies and Congress about the unique nature of Medicare’s audit programs have on independent medical providers. In response to our, and many other independent O&P’s efforts and questions, the SBA recently announced they will be holding a national Regulatory Fairness Hearing in Washington D.C., June 26. Additionally, there will be a specific block of time designated to discuss the impact of Medicare policies on independent medical providers.

OPGA plans to testify at this hearing and is asking OPGA members to consider submitting comments as well. Amputees would also have the ability to testify about the impact of audit policies on their provider, or their care. Testimony can be given in written form or in person. For those that can travel to Washington and testify in person, OPGA is planning a series of visits to congressional representatives to update them on our efforts to save and preserve the provision of orthotics and prosthetics to Medicare beneficiaries. Contact OPGA for more details on the hearing or for guidance in developing testimony. We will send more details as they become available, but mark your calendars for this important event.

More from Ryan Ball

Ryan Ball is the director of government relations for Orthotic and Prosthetic Group of America. If you want more updates on pressing government and regulatory policies affecting independent O&P facilities, sign up to receive the Government Effects blog updates at www.opga.com
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Dennis Clark, CPO

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<table>
<thead>
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