



The Polio Post

Ohio Polio Network Newsletter

Summer 2013 Issue

Medicare Coverage Settlement

Jimmo v. Sebelius Settlement Agreement

Fact Sheet

Overview:

On January 24, 2013, the U. S. District Court for the District of Vermont approved a settlement agreement in the case of Jimmo v. Sebelius, in which the plaintiffs alleged that Medicare contractors were inappropriately applying an “Improvement Standard” in making claims determinations for Medicare coverage involving skilled care (e.g., the skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) benefits). The settlement agreement sets forth a series of specific steps for the Centers for Medicare & Medicaid Services (CMS) to undertake, including issuing clarifications to existing program guidance and new educational material on this subject. The goal of this settlement agreement is to ensure that claims are correctly adjudicated in accordance with existing Medicare policy, so that Medicare beneficiaries receive the full coverage to which they are entitled.

Background:

In the case of Jimmo v. Sebelius, the Center for Medicare Advocacy (CMA) alleged that Medicare claims involving skilled care were being inappropriately denied by contractors based on a rule-of-thumb “Improvement Standard”—under which a claim would be summarily denied due to a beneficiary’s lack of restoration potential, even though the beneficiary did in fact require a covered level of skilled care in order to prevent or slow further deterioration in his or her clinical condition. In the Jimmo lawsuit, CMS denied establishing an improper rule-of-thumb “Improvement Standard.” The Court never ruled on the validity of the Jimmo plaintiffs’ allegations.

(Continued on Page 2)

Editor: Alice Sporar

Inside this Issue

Medicare Coverage Settlement <i>(cont)</i>	2,3
Ralph Braun	3
Pumping Gas	3
Accessible Housing	4
Transportation Security Administration	4
Anesthesia & PPS	5
Exercise & PPS	5
Orthopedic Surgery & PPS	7
Delayed Fatigue	8
Post-Polio Contact Information	9

POST-POLIO EMERGENCY INFORMATION

Because paramedics, physicians, and other health care specialists do not have knowledge of post-polio issues, it's important to carry this information with you.

I have two packets in my wheelchair backpack, plus four family members each have a packet. If you don't use a wheelchair, carry the information in your car or the car you are traveling in and have one at home in an easy place to find. You can have a wallet card that tells where they're located.

My packet contains information on respiratory treatment, anesthesia use, general PPS information, and a list of my medications. If polio affects your breathing, Post-Polio Health International has a form for you and your doctor to fill out, which should be included in the packet.

A little planning ahead may just save your life.

Contact me at [440-942-1557](tel:440-942-1557) or amsporar@worldnetoh.com if you want more information.

(Continued from Page 1)

While an expectation of improvement would be a reasonable criterion to consider when evaluating, for example, a claim in which the goal of treatment is restoring a prior capability, Medicare policy has long recognized that there may also be specific instances where no improvement is expected but skilled care is, nevertheless, required in order to prevent or slow deterioration and maintain a beneficiary at the maximum practicable level of function. For example, in the regulations at 42 CFR 409.32(c), the level of care criteria for SNF coverage specify that the “. . . restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities.”

The Medicare statute and regulations have never supported the imposition of an “Improvement Standard” rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient’s condition. A beneficiary’s lack of restoration potential cannot, in itself, serve as the basis for denying coverage, without regard to an individualized assessment of the beneficiary’s medical condition and the reasonableness and necessity of the treatment, care, or services in question. Conversely, coverage in this context would not be available in a situation where the beneficiary’s care needs can be addressed safely and effectively through the use of non-skilled personnel.

Thus, such coverage depends not on the beneficiary’s restoration potential, but on whether skilled care is required, along with the underlying reasonableness and necessity of the services themselves. Any Medicare coverage or appeals decisions concerning skilled care coverage must reflect this basic principle. In this context, it is also essential and has always been required that claims for skilled care coverage include sufficient documentation to substantiate clearly that skilled care is required, that it is in fact provided, and that the services themselves are reasonable and necessary, thereby facilitating accurate and appropriate claims adjudication.

The Settlement Agreement - No Expansion of Medicare Coverage: The Jimmo v. Sebelius settlement agreement itself includes language specifying that “Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility for receiving Medicare coverage.”

The settlement agreement is intended to clarify that when skilled services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration. As such, any actions undertaken in connection with this settlement do not represent an expansion of coverage, but rather, serve to clarify existing policy so that Medicare claims will be adjudicated consistently and appropriately.

Forthcoming Activities: CMS plans to conduct the following activities under the terms of the settlement agreement:

Clarifying Policy – Updating Program Manuals

The first action CMS will undertake as specified in the settlement agreement will be revising the relevant program manuals used by Medicare contractors. The Medicare program manuals will be reworded for clarity, so as to reinforce the intent of the policy. Specifically, in accordance with the settlement agreement, manual revisions will clarify that coverage of therapy “. . . does not turn on the presence or absence of a beneficiary’s potential for improvement from the therapy, but rather on the beneficiary’s need for skilled care

(Continued on Page 3)

(Continued From Page 2)

Educational Campaign – Informing Stakeholders The next step CMS will take will be an educational campaign for contractors, adjudicators, and providers and suppliers. CMS will disseminate to these recipients a variety of written materials, including:

- Program Transmittal;
- Medicare Learning Network (MLN) Matters article;
- Updated 1-800 MEDICARE scripts.

CMS will also conduct national conference calls with providers and suppliers as well as Medicare contractors, Administrative Law Judges, medical reviewers, and agency staff, to communicate the policy clarifications described herein and answer questions.

Claims Review

In addition, to ensure beneficiaries receive the care to which they are entitled, CMS will engage in accountability measures, including review of a random sample of SNF, HH, and OPT coverage decisions to determine overall trends and identify any problems, as well as a review of claims determinations that may not have been made in accordance with the principles set forth in the settlement agreement.

According to the terms of the settlement agreement, CMS will complete the manual revisions and educational campaign by January 23, 2014, which is within one year of the approval date of the settlement agreement.



RALPH BRAUN - December 18, 1940-February 8, 2013

Many of you own or have owned a van with a Braun wheelchair lift. Ralph Braun invented the lift and installed it on an old mail truck, which he purchased in order to go to work.

Ralph passed away in February from cancer. As a child, he was diagnosed with spinal muscular atrophy, which is a form of muscular dystrophy.

Ralph's first invention was the Tri-Wheeler electric scooter, which he invented in order to get to his first job at a factory in his home town of Winamac, Indiana. The company then moved to a new location farther away from his home. This spurred him on to purchase an old used mail truck and invent a lift in order to get into it. Word of mouth spread all over the country, and Ralph had more orders than he could handle in his garage, while working full time at the factory. Thus, he went off on his own and started the Braun Corporation, which today is a multi-million dollar company, with headquarters still in Winamac, Indiana.

Ralph's legacy will be passed on to future generations of people with disabilities as they look to solve their transportation issues.

Ralph recently formed the Ralph Braun Foundation to help individuals with disabilities who need financial assistance in purchasing vehicles and other mobility equipment.

Ralph is survived by his wife of eight years, Melody, five children, eight grandchildren, four step children, seven step grandchildren, and one sister.

GAS STATIONS

Fuelcall.net lists 500 gas stations that will pump gas for people with disabilities. With support from users, more stations can be added, according to Patrick Hughes, Jr., founder and CEO.

MAXIMUM ACCESSIBLE HOUSING OF OHIO (MAHO)

Our History

Founding and Early Years

Maximum Accessible Housing of Ohio (MAHO) was formed in 1981 to address the need for accessible, affordable housing for people with physical mobility disabilities. Until 2007, our organization was known as Maximum Independent Living (MIL); the name was changed to better reflect our focus on accessibility and housing.

From 1981 to 1998, MAHO concentrated its efforts on developing the Vistas Apartment Communities in Northeast Ohio specifically designed to give people with mobility disabilities the opportunity to live on their own. This resulted in five fully accessible apartment communities in Cuyahoga, Lake, and Lorain Counties. At the Vistas, more than 150 people with mobility disabilities to live life to the fullest. MAHO continues to own and operate these [communities](#).

Advocacy

In 1998, MAHO shifted focus to a leadership role in advocacy and education around accessible housing. This initiative, called the Accessible Housing Resource Center (AHRC), has had multiple successes. We have provided training on accessible housing to hundreds of people and organizations; a number of them have started to regularly use accessibility features. Collaboratively, MAHO was instrumental in starting the successful on-line searchable affordable housing database known as housingcleveland.org. MAHO serves on numerous advisory committees on local, state, and federal levels.

Although MAHO works successfully with many other agencies, both in the disability and housing fields, MAHO is the only agency that focuses on accessible housing. This enables MAHO to get the disability agencies to think about housing and the housing agencies to think about people with disabilities. Twenty-seven years of focusing on accessible housing have made MAHO the leader in this area in the state of Ohio.

TRANSPORTATION SECURITY ADMINISTRATION

TSA has begun the Passenger Support Specialist program with 3000 employees to help resolve security conflicts involving passengers with disabilities. Passengers or security personnel can request a specialist while at the airport. If you have any disability concerns before you head to the airport, you can call the TSA helpline at [855-787-2227](tel:855-787-2227).

MAKING PUSHING A WHEELCHAIR EASIER

There are several types of attachments that can assist a person in a manual wheelchair with pushing, and thus take the strain off of his/ her arms. Check them out at newmobility.com and while you're there, subscribe to the magazine which is full of helpful articles each month.

ANESTHESIA ISSUES FOR THOSE WITH POST POLIO SYNDROME

by Selma Harrison Calmes, MD, Clinical Professor of Anesthesiology

(Retired)

University of California at Los Angeles School of Medicine, Los Angeles, CA

Current recommendations are based on anatomic changes from the original disease of polio, except in the area of muscle relaxant dose.

Modern anesthesia is quite safe, and with a good preoperative evaluation and a cooperative team for post op care, every polio survivor can have needed surgery safely.

Every post-polio patient is different and needs to be evaluated before surgery. This should start with a pulmonary evaluation.

(Continued on Page 5)

(Continued from Page 4)

Although not documented in the medical literature, postop pulmonary failure appears to be the greatest hazard from surgery and those who needed iron lungs in their original disease appear to be at greatest risk. Sleep apnea patients and those with scoliosis are other high-risk groups for post op respiratory failure. Pulmonary function test, and perhaps, arterial blood gas are needed. Laryngeal and oropharynx dysfunction is common and should be evaluated if suspected, because of the risk of aspiration. Other medical diseases need to be evaluated and controlled.

An anesthesiologist should see the patient well before surgery. The anesthesia plan should be complete and should include a plan for aggressive post op pain management, usually with local anesthesia.

There should be a plan for post op ventilation needs. The anesthetic requirements for the operation, especially the position needed, should be discussed ahead of time with the surgeon. Position is an important issue; not every polio patient can be placed in the more difficult surgical positions.

If muscle relaxants are used, neuromuscular transmission should be monitored with a nerve stimulator experienced intensive care unit.

Half the usual dose is recommended. Complete reversal of the relaxants must be documented at the end of case, before attempting extubation.

If the patient has sleep apnea, uses positive airway pressure (CPAP or BiPAP) at home and can be extubated, they should be extubated to CPAP or BiPAP. Anesthesia causes worsening of sleep apnea abnormalities.

Regional anesthesia is suitable for post-polio patients and has been widely used, without documented worsening of existing neurologic damage. Portable ultrasound and other imaging techniques are helpful in placing blocks in patients with anatomic distortions from polio.

Because post op pain is often a problem, regional techniques can be extended into the post op period to provide pain relief.

Patients should be closely observed for post op respiratory failure, especially those at greatest risk. Post op respiratory failure can be difficult to manage and should be done in an experienced intensive care unit.

Source: ABSTRACTS, Post-Polio Syndrome - a Challenge of Today - European Conference, August 31 - September 2, 2011, Copenhagen, Denmark.

Reprinted from August 2012 Publication of Post-Polio Alliance of South Florida, Inc.

Editor's note: It's a good idea to save this page, in case you need surgery. Copies can be given to the surgeon, anesthesiologist and anyone else on the team.

WHAT IS THE ROLE OF EXERCISE IN THE TREATMENT OF PPS?

From US National Institute of Health Website - Post Polio Fact Sheet at http://www.ninds.nih.gov/disorders/post_polio/detail_post_polio.htm#17896317%202

The symptoms of pain, weakness, and fatigue can result from the overuse of muscles and joints. These same symptoms can also result from disuse of muscles and joints. This fact has caused a misunderstanding about whether to encourage or discourage exercise for polio survivors or individuals who already have PPS.

Exercise is safe and effective when carefully prescribed and monitored by experienced health professionals. Exercise is more likely to benefit those muscle groups that were least affected by polio. Cardiopulmonary endurance training is usually more effective than strengthening exercises, especially when coupled with the pacing of activities to allow for frequent breaks and strategies to conserve energy. Heavy or intense resistive exercise and weight-lifting using polio-affected muscles may be counterproductive because they can further weaken rather than strengthen these muscles.

(Continued on Page 6)

(Continued from Page 5)

Exercise prescriptions should include:

- The specific muscle groups to be excluded
- The type of exercise, together with frequency and duration

Exercise should be reduced or discontinued if it is associated with additional weakness, excessive fatigue, or unduly prolonged recovery time that is noted by either the individual with PPS or the professional monitoring the exercise. As a general safe rule, no muscle should be exercised to the point of causing ache, fatigue, or weakness.

Source: National Institute of Health-National Institute of Neurological Disorders and Stroke

http://www.ninds.nih.gov/disorders/post_polio/detail_post_polio.htm

Reprinted from Post Polio Alliance of South Florida, Inc. August, 2012.

What is Post-Polio Syndrome?

Post-polio syndrome (PPS) is a condition that affects polio survivors many years after recovery from an initial attack of the poliomyelitis virus. PPS is characterized by a further weakening of muscles that were previously affected by the polio infection. The most common symptoms include slowly progressive muscle weakness, fatigue (both general and muscular), and a decrease in muscle size (muscular atrophy). Pain from joint deterioration and increasing skeletal deformities such as scoliosis are common. Some individuals experience only minor symptoms, while others develop more visible muscle weakness and atrophy. PPS is rarely life-threatening but the symptoms can interfere significantly with the individual's capacity to function independently. While polio is contagious, PPS is not transmissible. Only a polio survivor can develop PPS.

Is there any treatment?

Presently, no prevention has been found that can stop deterioration or reverse the deficits caused by the syndrome. A number of controlled studies have demonstrated that non-fatiguing exercises may improve muscle strength and reduce tiredness. Doctors recommend that polio survivors follow standard healthy lifestyle practices: consuming a well-balanced diet, exercising judiciously (preferably under the supervision of an experienced health professional), and visiting a doctor regularly. There has been much debated about whether to encourage or discourage exercise for polio survivors or individuals who already have PPS. A commonsense approach, in which people use individual tolerance as their limit, is currently recommended. Preliminary studies indicate that intravenous immunoglobulin therapy may reduce pain, increase quality of life, and improve strength modestly.

What is the prognosis?

PPS is a very slowly progressing condition marked by long periods of stability. The severity of PPS depends on the degree of the residual weakness and disability an individual has after the original polio attack. People who had only minimal symptoms from the original attack and subsequently develop PPS will most likely experience only mild PPS symptoms. People originally hit hard by the polio virus, who were left with severe residual weakness, may develop a more severe case of PPS with a greater loss of muscle function, difficulty in swallowing, and more periods of fatigue.

What research is being done?

The National Institute of Neurological Disorders and Stroke (NINDS) and other institutes of the National Institutes of Health (NIH) conduct research related to PPS in laboratories at the NIH, and also support additional PPS research through grants to major medical institutions across the country.

(Source: http://www.ninds.nih.gov/disorders/post_polio/detail_post_polio.htm)

ORTHOPEDIC SURGERY IN POST POLIO SURVIVORS

Anders Stenstrom, MD, PhD, Professor of Orthopedics, Department of Rehabilitation Medicine, Skane University Hospital, Lund, Sweden

The problem of operating on people with post-polio (now often between 50 and 80 years of age) has to do with weak muscles, paralysis, muscle atrophy, and imbalance between extensor and flexor muscles, and it puts high demands on postoperative rehabilitation and orthotic treatment.

Hip disease is a relatively common problem in people with post-polio due to overload, muscular stiffness, trochanteritis, and arthrosis. Local cortisone injections may cure some of these diseases. There have been hesitations about operating hip arthrosis with total hip replacement due to the risk of luxation of the endoprosthesis, because of the weak muscles, but in our experience careful preoperative planning often including CT or MRI and postoperative rehabilitation shows successful outcome of total hip replacement in people with post-polio.

Regarding the knee, there are no contraindications to perform arthroscopic surgery for the meniscal and chondral lesions. In knee arthrosis, total knee replacement using a stabilized knee endoprosthesis can sometimes be successfully performed. Performing high tibial osteotomy hyperextension secondary to polio should preferably be treated with orthosis.

In the ankle joint athrodesis might be considered in severe medio-lateral instability. Most ankle and foot deformity as well as drop foot can successfully be treated with orthosis, insoles, shoes or boots.

Performing tendon transfers is as a rule contraindicated in people with post-polio. Fractures, like for instance hip fractures, supracondylar femoral fractures, tibial condylar and tibial fractures, ankle and foot fractures and luxations as well as fractures in the upper extremity, are treated surgically in the same way as in non-post-polio people. Physiotherapy and plaster orthosis are mandatory in the postoperative treatment.

In summary, orthopedic operations can successfully be performed on people with post-polio, but on very strict indications and with special postoperative rehabilitation. Special orthosis can in many situations be a valuable solution as an alternative to operation.

Source: ABSTRACTS, Post-Polio Syndrome - a Challenge of Today - European Conference, August 31-September 2, 2011, Copenhagen Denmark

Reprinted from August 2012 Publication of Post-Polio Alliance of South Florida, Inc.

**HAVE A
GREAT!!!
SUMMER**

DELAYED FATIGUE: GRACE YOUNG'S ADVICE

I think most of us can relate to "DELAYED FATIGUE." We over-do on good days and then are sidelined for several more. It helps, if you can identify when fatigue starts, and stop for a rest "before you reach the point of no return." (Easier said than done.)

Here are a few ideas:

- 1) Stop when you feel a little tired. This may sound simplistic, but most of us were taught to ignore pain and fatigue so we don't notice until the fatigue overwhelms us. Listen to your body!
- 2) Stop if there is decreased quality of movement. If motions that are usually done smoothly, develop a tremor or become shaky, it is usually time to stop.
- 3) Stop if there is decreased quality of movement. If your range of motion declines while you are working, it is time to stop.
- 4) Stop if you start using compensatory motions. For instance, you start having to "hunch" your shoulders in order to raise your arm, or your legs start swinging out to the side instead of flexing at the hip when you walk.

If you stop in time, you can usually resume activity after you rest for a while. (You may need more than one rest.) This is much more productive than being out of commission for several days afterward.

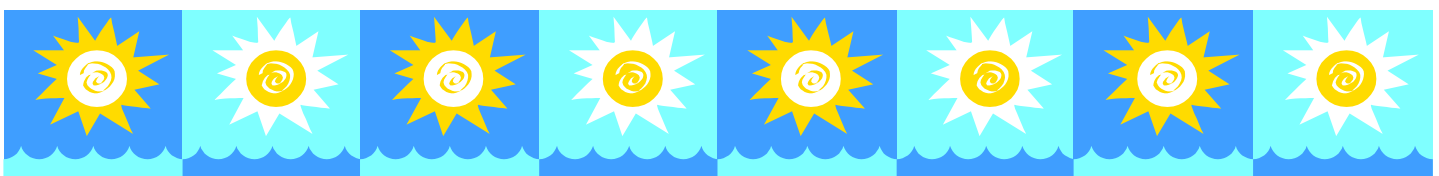
Editors Note: Listen to your pain - Jeff Anthony, DO of San Diego says, "Stress fractures, hairline cracks in the bone, are unheard of in most animals, but they are prevalent in humans, racehorses, and greyhounds. Why? Other animals stop when they start to feel pain."

"When you feel a twinge, you may have strained the tissues around the bond. Stop and rest."

So, listen to your body!

Source: San Fernando Valley Post-Polio Group POLIO REPORTER, June 2000

Reprinted from Polio Post News, North Central Post-Polio Support Group, Jan./Feb. 2013.



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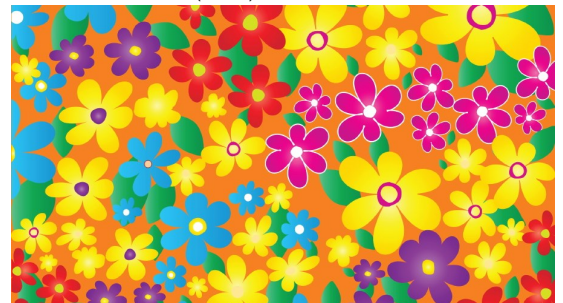
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