IPTA Working to Pass Bills Requiring Insurers to Pay Promptly

Hennessey Consulting, Inc.

While most of us must pay our bills on time, current law does not require insurance companies and HMO’s to pay providers in a timely manner. Bills introduced in both the House and Senate, if passed and signed into law, will require insurance companies to pay providers in a timely manner. Both House Bill 2713 (Coulson/Madigan R.) and Senate Bill 436 (Madigan, R./Dart) address the issue of prompt payment. While there is still disagreement on how to effectively address this issue, our work thus far has guaranteed that any final language will include physical therapists.

The original language contained in SB 436 was brought forth by the Illinois State Medical Society (ISMS) and dealt specifically with medical doctors. Now a shell bill (a shell bill is a bill with no language awaiting a substantive amendment), the original language would have required insurers and HMO’s to pay claims and capitulation payments within 30 days and 45 days respectively, with a 9% per annum penalty assessed to delinquent claims.

House Bill 2713, on the other hand, would give providers an avenue for relief by: requiring insurers and HMO’s to pay claims for health care services within 30 days after the insurer receives proof of loss; providing that if the payment is not made, the provider may file a complaint with the Illinois Department of Insurance; and, entitling the provider to receive interest for each day the reimbursement is unpaid (as of this writing, HB 2713 has been turned into a shell bill by the Senate).

The opponents to this legislation are the insurance companies who do not believe there is a problem. The insurance companies are arguing that a provision within existing law stating that payment must be made within 30 days. However, they fail to mention in their lobbying efforts that this law only applies to the insured, NOT the provider. We are working diligently to dispel that misconception.

We support physical therapists and other providers having an avenue for recourse against Insurers and HMO’s not paying claims in a timely manner. In a study conducted by Princeton University, their health care economist found that some HMOs and other carriers earn up to $400,000 PER DAY on withheld funds!

Over 30 states have enacted legislation mandating timely payment of claims by insurers for services rendered by providers. Illinois should be one of these states, which recognizes the importance that insurers are held to a reasonable payment cycle.

While many IPTA members had the opportunity to speak to legislators about this issue during their 1999 Legislative Day, it never hurts to call them again. So please contact your State Representative or State Senator and let them know that you support prompt payment to providers! If you need to know who your state legislators are, please contact Tim or Denise at Hennessey Consulting, Inc., 217/525-3474. PT

Peek at what’s inside:

PT Controlling Claim Denials
PT The Outcomes Movement: Progress in a Sea of Change
PT Getting Connected: What You Should know About ISPs and Browsers
PT Dollars & Sense
PT Questions and Answers About the National PT Examination

... and much More
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Call for Articles
Got something on your mind? Feeling creative? Trying something new or innovative? The IPTA welcomes news, comments and other contributions for publication from members! The next edition of PT Priority will be the August issue, the theme for which is the Membership issue sent to all licensed Illinois PT/PTAs. It will also highlight the Fall Conference. The deadline for articles is July 1, 1999. We are looking for job-related news, innovative programs, practice suggestions, people-oriented features and news about clinical developments. If you have any questions, please contact the Publications Committee Chair, Teri Elliott-Burke at 847/550-9079. Please see rules for submission on this page. PT
I had planned to use this space to write about what our educational programs might look like in the new millennium. I have decided to postpone that topic until August and again discuss the current employment situation. We now have a significant number of unemployed therapists in our state. At the recent state meeting, multiple examples of therapists losing their jobs were cited. Stories were told of some who found new and even better jobs but, unfortunately, others were still looking. The APTA's most recent estimate is that 3% of the physical therapists in this country are unemployed. With approximately 150,000 physical therapists in the United States that means 4500 are out of work - and 900 of those are in Illinois.

We must all accept that part of what is going on is a natural trend. When demand increased for our services, we happily increased the supply of therapists and assistants to meet the demand. Unfortunately, we now have an excess of therapists. The market is making adjustments to the supply side so that it will soon more appropriately meet the reduced demand.

How will this happen? There are several ways that come to mind. First of all, some therapists will choose to leave the profession. Reasons for this will include the inability to find a job, the inability to find the right job, or simply a decision to pursue an opportunity in another field. Another way that the supply will decrease is when we decrease the use of non-therapists in the physical therapy clinic. Because of shortages in the past, we have looked to other individuals such as athletic trainers, exercise physiologists and massage therapists to assist with the provision of care. That need no longer exists in most areas of the country. There are enough physical therapists and physical therapist assistants to fill every available job opening. The therapists and assistants provide a higher level of care and more flexibility to the employer, so why wouldn't they hire the licensed practitioner? This change will take time to occur, but it will happen.

The upcoming APTA House of Delegates session is one of many ways that our association is looking at this issue.

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**Controlling Claim Denials**

*Lynn O’Brien  
Healthcare Business Advisor*

Are you spending too much time reacting to claim denials by instituting multiple policy changes faster than you can train your staff on them? Do you spend countless staff meetings informing your clinical staff of claim denials due to "documentation"? If the answer to these questions is yes, then you are not spending enough time strategizing, analyzing and monitoring the denials or the results of your efforts. It is so important to keep your internal process simple. By taking the following steps you should be able to identify denial trends, determine a plan, and be able to monitor the results of your efforts.

**Getting Started:**

*Analyze* – Begin to track all the reasons why your claims are being denied. Have your office staff design a simple tracking tool to use over the course of several months. If you have a high volume of denials, you will soon be able to identify some trends.

**Example**

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Services</th>
<th>Reason for Denial</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jones, John</td>
<td>1/10/97-1/29/97</td>
<td>Medical Necessity</td>
<td>$1,500</td>
</tr>
<tr>
<td>Smith, Sue</td>
<td>2/18/97-2/28/97</td>
<td>Medical Necessity</td>
<td>$1,500</td>
</tr>
<tr>
<td>Thomas, Teri</td>
<td>2/2/97-2/17/97</td>
<td>Medical Necessity</td>
<td>$975</td>
</tr>
</tbody>
</table>

In this example you would need to take the following next steps:

1. Identify if the denials are a result of one therapist in particular.
2. Review the documentation to validate the denial. Was the documentation perfectly clear? Was the patient progressing? Was there a possibility that the patient should have been discharged?
3. Review the chart. Were there physician orders?

**Making Changes:**

After several weeks/months, you should be able to identify a pattern in denials. Make the organizational changes that are necessary. At this point, log in the date of the change made. This will help with future tracking as to what changes were effective. One change approach may not be enough. Note: too many changes at once will make it difficult to track change effectiveness.

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The Outcomes Movement: Progress in a Sea of Change

Ed Dobrzykowski Jr, MHS, PT, ATC

Introduction

During this decade, there has been a gradual and growing emphasis on the need for outcomes information in rehabilitation. Spearheaded by our colleagues in inpatient rehabilitation in the 1980’s, this movement is characterized today by distinct differences in the level of participation, sophistication, and application of outcomes information among rehabilitation providers and among their area of practice. Other health care constituents have a similar track record.

Historically, the need for outcomes management in health care has evolved through the documented existence of unexplainable practice variation. In a recent editorial in *Annals of Internal Medicine*, Wennberg summarized two decades of accumulated evidence and variation in physician decision making. When employers assess the delivery of healthcare, they see chaos. As an example, a prominent employer in the Midwest finds that their employees in Flint, Michigan are 70% more likely to undergo cardiac revascularization than their employees in Grand Rapids, despite similar insurance coverage. The authors label this “medical care where geography is destiny.” Do you suppose that an analogy could be drawn, whereby in a certain area or with a specific payer type, a patient is more likely to receive a prevalence of modalities, such as ultrasound and hot packs, in lieu of active approaches such as therapeutic exercise and mobilization? You bet. Distinct practice variation in physical therapy already exists. (2-4)

The Guide to Physical Therapist Practice (5), a milestone publication with which all need much more familiarity, has substantially defined physical therapy practice. The Guide has important information pertaining to outcomes. There are categories of functional limitation/disability, patient/client satisfaction, and secondary prevention. The expected range of utilization is also noted. One of the subsequent steps currently underway is the projection of practice into the next decade and anticipating what physical therapists need to know for evidence-based practice. The installation of a systematic process of outcomes management and data base development will assist in this process.

---

Payers’ View

Despite our profession’s initial foray into the definition of practice and outcomes, and long standing leadership by CARF...The Rehabilitation Accreditation Commission with program evaluation, and most recently the Joint Commission on Accreditation of Healthcare Organizations’ ORYX initiative on performance measurement, many physical therapists remain unconvinced on their need to measure outcomes. There exists a doubt for the perceived need since no payer evidently cares about outcomes or is asking for the data. This situation is abetted by the recent implementation of prospective payment in nursing homes, reimbursement caps on outpatient rehabilitation, and the ramifications of the Balanced Budget Act. Notwithstanding these very real environmental conditions, what actually is the present view of rehabilitation outcomes in the payer community which includes insurance companies, self-insured employers, and the government?

This very question was posed recently by members of the Editorial Board of the Journal of Rehabilitation Outcomes Measurement.(6) The Editorial Board represents individuals affiliated with national provider organizations, hospital systems, private practice, accreditation organizations, and outcomes researchers. There are inherent differences in response to this question that exist depending upon one’s geographic location, area of practice, the payer type considered, and the maturity of the managed care penetration in local markets.

The prevailing opinion is that the payers’ view of outcomes is evolving. A focus group of payers led by a national provider organization reported that rehabilitation providers should have an outcomes measurement program and report results regularly to payers. The reporting should include outcomes segmentation by member groups (i.e. seniors/Medicare, workers’ compensation). This requirement could be fulfilled by any “standard” outcomes measurement system, which includes “in-house” creations. It was noted that not every provider has the expertise or available administrative systems to generate outcomes that are measurable, objective and pertinent to the rehabilitation goals of the individual.(6) In the future, however, valid comparable (external) data and consistent national measurement systems will become increasingly important as payers and consumers look for ways to differentiate among providers.

Who then is actually generating and using outcomes data today? The leading participants in the measurement and application of outcomes information are national and regional providers of health care services, hospital organizations, provider networks, and contract management rehabilitation services companies. Many of these groups

continued on next page
view outcomes as a strategy for market differentiation and as a mechanism for providing value added information for their customers. Admittedly, however, the increasing performance measurement requirements of accreditation are stimulating much of the actual effort being made.

**Fundamental Components**

The fundamentals of an outcomes management process have been outlined previously (7), and include measurement of effectiveness and efficiency. Effectiveness includes an assessment and quantification of the end results of care (i.e. did the patient get better, and how much?). Examples of effectiveness include patient health related quality of life (health status), satisfaction, and clinician reported functional measures. Efficiency includes the level of resources and cost needed to achieve an outcome. Examples of efficiency include treatment units, utilization (visits), and length of stay.

Other indicators recommended for measurement are identification of modalities and procedures used in rehabilitation. Although Current Procedure Terminology (CPT) codes and descriptions for billing by physical therapists have improved recently, these codes may not provide the level of detail necessary for a description of process in outcomes management.

As physical therapists begin to use the Guide to Physical Therapist Practice and its practice patterns, I recommend documentation of the involved practice pattern(s) in each patient episode. Additionally, a mechanism for identification of physical therapists providing treatment during patient episodes will prove extremely useful in subsequent retrospective analyses of outcomes.

A plethora of measures exist to measure and quantify outcomes in rehabilitation. (8-10) There is generally little need to create new measures or to modify existing measures in populations typically seen by rehabilitation professionals. There is a consensus on several measures in use today, such as the functional independence measure in inpatient rehabilitation, the SF-36 and SF-12 (Medical Outcomes Trust, Boston MA) in ambulatory care, and the OASIS-B in home care. Research is currently underway to supplement the Minimum Data Set (MDS) with additional measures for rehabilitation and outcomes.

Although patient satisfaction is widely used and recognized, minimal agreement on constructs, measures and scaling exists. Confounding utility of those measures presently in use is the high level of satisfaction seen in most patient populations. There is little information gleaned from results. At least one organization has recognized this reality, and has attempted to improve their satisfaction results by including only the percentage of “very satisfied” responses to questions in their patient population.(11)

**Outcomes Management Development**

The cost of research and development of an internal process of outcomes management can be substantial. The design will need to define pertinent questions of interest, research and select measures and indicators; develop data collection methods and protocols; provide programming for analyses and reporting; include a risk adjustment mechanism, and consider maintenance of their data base. Significant numbers of patient episodes are necessary for statistical power and a greater representation of outcome variation.

Fortunately, there are viable cost effective alternatives to creation. There are a growing number of available vendors of performance measurement systems, which provide turn key methods, systems, and data bases for outcomes measurement and reporting in rehabilitation. (12) A recent check of the JCAHO internet site (www.jcaho.org) listed approximately 200 vendors of performance measurement systems meeting JCAHO criteria and available for selection by accredited organizations, but few exhibit utility for rehabilitation providers.

The list of applications of outcomes information is growing which has helped demonstrate value. These include continuous quality improvement, practice management, marketing, sales, and research. A few progressive organizations and practitioners have fully embraced outcomes measurement beyond a conceptual basis to a level far beyond their peers. Outcomes information is used for planning continuing education programs, identifying program areas in need of improvement, and in clinician performance appraisals. Outcomes data can be tracked by referring physician, case manager, payer, and employers. The anecdotal evidence is increasing that an organization's ability to attract and retain payer contracts is solidified through scheduled reporting of outcomes.

There are precautions which must be discussed in the design and use of any process of outcomes management. These precautions include patient selection bias, clinician attribution bias(13), application of inappropriate statistical methods to the data, misinterpretation of results, and not including a mechanism for risk adjustment. Other examples of potential problems include use of unreliable measures, inadequate demonstration of measure validity, responsiveness, and sensitivity, and making modification to existing measures without appropriate assessment of effects upon its psychometric properties. There is staff and clinician adjustment to the process, and information generated is educational and not punitive.
One of the greatest challenges in making the shift to a new practice paradigm based upon outcomes information is the management of data collection logistics, which involve the routine installation of methods for data collection, analysis, and application of outcomes data. Difficulties ensue when the administrative burden of data collection is not shared equally among all staff, and when there exists a lack of focused vision for outcomes.

Altogether practical systems and integrated information management solutions do not exist today, they are clearly technically feasible. These systems should include methods for clinical documentation, billing, and outcomes information in relational data bases. The mere existence of an integrated data collection and reporting system will not, however, guarantee success. Data must still be collected, analyzed, and managed by the organization and its providers.

Conclusion
In summary, there presently exists a broad range of provider participation in outcomes management and a perception of its value despite availability of many outcome measures, methods, and systems. Although several organizations have embraced outcomes and are advancing their knowledge of applications daily, many more organizations and providers have seen minimal value. For those of you who have not participated or have stopped this process, I pose the question: Do you know if your patients have indeed improved as a result of your intervention, and how your outcomes compare with other providers?

The bottom line: If we don't put our own house in order, we will continue to react to health care reimbursement changes and have little or no data to refute and respond to their effects upon quality. Are we our own worse enemy? Unless outcomes data and evidence is generated, analyzed, and studied and used as a strategy to counter trends of declining reimbursement, the road will certainly continue to follow this path.

References

About the Author:
Ed Dobrzykowski is Director of Development and Provider Relations at Focus On Therapeutic Outcomes, Knoxville TN; editor of Journal of Rehabilitation Outcomes Measurement, Aspen Publishers, and a member of the Publications Committee of the Administration Section.

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Getting Connected: What You Should Know About ISPs and Browsers

PeakCare onLine

Understanding the differences between Internet Service Providers (ISPs) and Browsers with help you maximize your use of the Internet. If you are relying on the Internet for e-mail and/or research you need to choose a reliable Internet Service Provider (ISP) and Browser.

What to Look for In an ISP
Typically, your computer will connect to a computer at the ISP location through a telephone line. The ISP will then have a dedicated connection to the Internet.

Who is your current ISP? America Online (AOL), Microsoft MSN, MCI WorldCom and AT&T Worldnet are examples of the larger, national ISPs. The advantage of a national ISP is that it has local phone numbers in each state that provide Internet access handy for people who travel out-of-state.

Local ISPs are available and also have advantages. They typically have a better feel for the call volume in the small area they cover, so they can respond to customer needs more quickly than a national provider. For example, if call volume increases, a local ISP will be aware almost instantly and can purchase more modems and phone lines used for connections.

Whether national or local, however, the better-established ISPs are typically more stable and the service more reliable. Be sure to find out the following information when researching ISPs:
Are there enough modems and phone lines that you won’t get a busy signal? A good customer-to-modem ratio is 10:1 or 12:1. How easy (or not) is it to reach the ISP's technical support department? Make a call or two to the departments of the ISPs you are considering and see if you get placed on hold and for how long. Ask others who use the same provider what their experience has been with the technical support.

About Browsers
A browser is a computer application that allows Web sites and their pages to be viewed. They allow you to go to a Uniform Resource Locator (URL), which is basically a web address. Common browsers include Internet Explorer, Netscape Communicator and AOL Browser.

Be aware that Internet Explorer and Netscape communicator may react differently with various Web site designs, which can result in error messages or mean that you won’t be able to view some of a site’s visual effects or content. While these browsers differences are being resolved by the industry, some Web sites are able to determine what browser is being used to view the Web site in order to direct the user to Web pages that work best with that particular browser.

Some sites include browsers that you can download to optimally view their site. The latest version of a browser is generally best, as it will address any problems identified with the previous version. The newer browsers can also handle newer versions of Web sites.

Understanding ISPs and Browsers can help you get and stay connected!

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Boulder Wellness Center- Boulder, Colo. Dec. 4th- 18th

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HCEA Deletes Correct Coding Initiative Edits on Manual Therapy

In late March, APTA learned that the Health Care Financing Administration (HCFA) would be issuing coding edits that would prohibit reimbursement for manual therapy and other therapeutic procedures provided in the same treatment session. Specifically, the following edits would be effective, beginning April 1, 1999, meaning that if the two procedures were billed as performed in the same treatment session, reimbursement for only the “comprehensive” code (97140) would be possible, since the other code (97110, 97112, 97113, or 97116) is considered a “component” of the first:

<table>
<thead>
<tr>
<th>Comprehensive / Component</th>
<th>97110</th>
<th>97112</th>
<th>97113</th>
<th>97116</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>97140</td>
<td>97140</td>
<td>97140</td>
<td>97140</td>
</tr>
</tbody>
</table>

In a March 30, 1999 letter to HCFA and AdminiStar, APTA objected to these edits, describing them as clinically inappropriate and pointing out how they would adversely affect patient care. Moreover, these edits were implemented without providing the customary “notice and comment” opportunity. APTA requested that these edits be deleted and that providers be reimbursed retroactively for any claims denied as a result of these code pair edits. In conjunction with APTA’s correspondence, Helene Fearon, PT, APTA’s representative on the AMA Health Care Professionals Advisory Committee CPT editorial panel, contacted HCFA officials urging deletion of the edits dealing with the new manual therapy code (97140).

On April 20, 1999, we were notified that HCFA and AdminiStar had agreed with our recommendations. APTA received a letter dated April 14 from AdminiStar and HCFA, which stated “Based on the review of your comments and issues you raise on behalf of the American Physical Therapy Association, HCFA has decided to delete” the manual therapy code pairs. HCFA indicated in the letter that:

These deletions will be reflected in the next regularly scheduled update to the CCI, Version 5.2, to be implemented July 1, 1999. The deletions will be retroactive to the effective date of the edits, which was April 1, 1999. The Carriers will be instructed to identify the services denied because of the application of these edits and reprocess the claims involved for proper payment.

Medicare Part B providers have the option to request an appeal on these claims if they desire after the Medicare Part B Carriers have been notified of these deletions.

These proposed edits were part of the Correct Coding Initiative (CCI) which was instituted by HCFA in 1996. The purpose of the CCI was to develop coding methodologies to curtail improper “unbundling” of services for Medicare Part B claims.

APTA members who are experiencing problems with their carriers with respect to these code edits should contact APTA’s website or Fax-on-Demand to obtain a copy of the HCFA letter. It is also advisable for providers to keep track of any manual therapy denials that are based on these code edits.

Staff revised a document concerning the April 1999 Correct Coding Initiative (CCI) edits. The revised document is on the Government Affairs web page and Fax-on-Demand.

$1,500 Limit - Update

Sponsors for the $1,500 exceptions bill have been secured in the House of Representatives. The lead sponsors in the House are Congressmen Richard Burr (R-NC), Benjamin L. Cardin (D-MD), and Frank Pallone (D-NJ). Congressman Jim McCrery, a Republican from Louisiana, also is considering the possibility of being a lead sponsor. The House bill was introduced the week of April 26.

A companion bill, the “Medicare Rehabilitation Benefit Improvement Act of 1999” has also been introduced in the Senate by Senator Charles E. Grassley (R-IA). The bill would exempt Medicare beneficiaries from the $1,500 cap if they meet certain criteria, including multiple episodes or requiring hospitalization if services are not received.

Once the House of Representatives bill is introduced, APTA will be launching a grassroots campaign urging APTA members to contact their members of Congress to sponsor the House and Senate bills. A meeting was scheduled with various consumer groups at APTA headquarters on April 27 to encourage them to become involved in the $1,500 therapy cap issue as it is imperative that the patients make their opinions known on this issue. In order for Congress to take any action on the $1,500 cap, members need to hear from patients who have or will be affected by the cap.

continued on next page
Motivating Consumers
APTA Government Affairs convened a meeting of interested consumer and patient advocacy organizations in late April to discuss the implications of the $1,500 limit on therapy services. The objective was to educate patients and consumers about the cap and the disparities that can result. The $1,500 limit is a consumer issue and members are encouraged to get patients who are affected by the cap involved in the advocacy process, motivate them to write their members of Congress and request support for the House and Senate bills that will provide for exceptions to the $1,500 limit.

APTA Opposes Non-physician Practitioners’ Therapy Services
In the final rule of the Medicare physician fee schedule, HCFA determined that nonphysician practitioners (nurse practitioners, clinical nurse specialists, and physician assistants) who are knowledgeable of therapy could refer Medicare patients for therapy services and furnish therapy services if authorized by state law. In the proposed rule, APTA strongly opposed the policy that nonphysicians could provide therapy services and continues to work with HCFA to have this policy changed.

On January 20, 1999, APTA staff, along with other rehabilitation industry representatives, met with HCFA officials to discuss this provision along with other issues of importance to physical therapy. APTA again expressed its opposition to this policy and questioned HCFA’s authority to promulgate such a policy. In follow-up questions to HCFA, APTA repeated its inquiry concerning HCFA’s authority to allow nonphysician practitioners to provide therapy services as there was no language policy in the Balanced Budget Act which directed HCFA to establish such a policy.

APTA has not received a response to these questions from HCFA. APTA will continue to work on this issue at the regulatory level. If efforts fail with HCFA to change this interpretation, a legislative resolution to the problem will be considered.

Track/Monitor Results:
As you continue to receive denials, make sure that you aren’t trying to analyze the denials for which you have already implemented changes. Stay focused. If you are not seeing positive results on dates of services that the change should have impacted, then start to re-evaluate the changes made.

This is not a “Start and Stop” solution. It is an ongoing process that needs to include all of the elements stated above – 1) Analyze 2) Make Changes 3) Track & Monitor Results. The earlier you detect any type of a trend the sooner you can strategize on the change needed. Most likely, if you are not currently tracking denial trends you have a higher amount of “write-offs” than you would like. Take the time to track so YOU can control your denials.

Brief Biography-
Lynn O’Brien has over 20 years in healthcare operations. She has expertise in the areas of reimbursement, project management and general business operations. Prior to her own business, she was the Vice President of Network Programs and Services for Marianjoy Rehabilitation Hospital & Network. Lynn can be reached at (847) 726-8097 or lynnobrien@worldnet.att.net.
Questions and Answers About the Computerized National PT Examination

Federation of State Boards of Physical Therapy

What are the steps for examination via computer?

1. Candidates will obtain application materials from the licensing authority of the state in which they are seeking licensure. These materials will include a computer-scannable application for candidates to complete. In Illinois, the licensing authority is the Department of Professional Regulation. Telephone number: (217) 782-8556. Website: www.state.il.us/dpr

2. Candidates will return completed application materials, along with payment, to the appropriate organization as identified on the instructions. If the scannable application is incomplete, it will be returned to the candidate.

3. Each state licensing authority will approve eligible candidates and mail their scannable applications to Professional Examination Service (PES).

4. PES will scan the applications and compile daily eligibility lists.

5. PES will send an “authorization-to-test” letter to each eligible candidate containing a toll-free number to call to schedule the examination.

6. Candidates will call to schedule an examination at their chosen location. Candidates must sit for the examination within 60 days of the date on the “authorization-to-test” letter provided by PES. If they do not sit for the examination within these 60 days, they will be removed from the eligibility list and will be required to begin the application process again.

7. Candidates will sit for the examination at their chosen location.

8. PES will send score reports to the state licensing authority. No information regarding pass/fail status will be available to candidates at the Sylvan Testing Center. Test results will not be given over the phone.

9. The state licensing authority will mail examination results to candidates.

10. If a retake is necessary due to failure of an examination, candidates must reapply to the licensing authority, following the steps outlined above.

Must candidates test in the jurisdiction in which they are seeking licensure?

No. Candidates may sit for the examination at any of the approximately 300 testing centers nationwide and in Canada. They are not required to sit for the examination within the jurisdiction in which they are seeking licensure. The examination is not available overseas.

When may examinations be taken?

Candidates have sixty (60) days to take the examination. Candidates are strongly encouraged to call Sylvan to make an appointment as soon as they receive the “Authorization to Test” letter from PES. Testing will be scheduled at the location and on the date and time of the candidate’s choosing, if available. If not available, alternate dates, times, and/or locations will be offered. If requested, you have a right to an appointment within thirty (30) days of your call at the location of your choosing or one within a fifty (50) mile radius of it. If you want an appointment within thirty (30) days of your call and are unable to obtain one, please notify PES and the jurisdiction to which you have applied for licensure. (You must provide the date and time of your call to Sylvan; name of the person you spoke with; and date, time and location of your requested appointment.)

Sylvan will always endeavor to accommodate your test scheduling preferences as closely as possible. However, their only obligation is to provide you a testing time within thirty (30) days of your call at any center within fifty (50) miles of your preferred center. You may find it more convenient to wait longer than thirty (30) days if, for example, you want to test only at a certain time and/or only on a certain day of the week (e.g., Saturday at 9:00 A.M. only) or only at a specific testing center.

How will you find your local Sylvan Technology Center?

If you do not know how to get to your local Sylvan Technology Center, you may access directions through Sylvan’s automated phone system when calling the “800” number, or you may ask the Sylvan Customer Service Representative for the phone number of the local Sylvan Center so that you can call the Center for directions.

How much time is given for the examinations? Candidates are allowed four (4) hours for the Physical Therapist examination and three (3) hours for the Physical Therapist Assistant examination. There are 200 items (questions)
on the Physical Therapist examination, and 150 items on the Physical Therapist Assistant examination.

What information must be provided when candidates call to schedule their examinations?
Candidates must provide:
- The name of the examination (Physical Therapist or Physical Therapist Assistant)
- Where and when the candidate would like to test (location of Sylvan Center and desired date)
- Social Security Number or ID#
- Name
- Daytime telephone number
- Type of payment: credit card or direct debit

What are the acceptable forms of payment for the test center fee?
Payment for Sylvan test center fees may be made by credit card (Visa or MasterCard) or by direct debit to a checking account. To pay by credit card, you will be asked to provide a valid credit card number and expiration date. To pay by direct debit to a checking account, you will be asked to provide bank information and a checking account number. (This information can be found on a blank check.) To facilitate this transaction, have your credit card or checkbook at hand when you call to schedule your examination. Payment must be made at the time you schedule your examination. It is not possible to pay at the testing center.

What are the requirements for admission to the testing center?
Candidates must arrive thirty (30) minutes prior to their scheduled appointment. Candidates must have a currently valid, government issued photo ID (passport, driver’s license, etc.), as well as another piece of identification which contains a signature (e.g., a credit card). All candidates will be thumb-printed and photographed at the testing center. All testing sessions will be videotaped.

What are the testing centers like?
Each testing center allows candidates to concentrate totally on their examinations, without distractions or fatigue. Private, modular testing booths provide plenty of work space, comfortable seating, proper lighting and ventilation. The computer workstations are state-of-the-art technology, with high-clarity screen displays to minimize eye strain. Please note that at your test center there may be test takers other than candidates who are registered to take the Physical Therapist and Physical Therapist Assistant examinations.

Is computer knowledge necessary?
No. Computer knowledge is definitely not required to take a computerized examination. Before the examination begins, a simple introductory lesson (tutorial) is presented that explains the process of selecting answers and moving from question to question. The time candidates spend on the practice lesson does not count against the time allotted for the examination. Most candidates take approximately five to ten minutes to complete the tutorial and may repeat it, if desired. Candidates may choose to select a letter on the keyboard and press ENTER to record answers, or they may use the mouse to click on the chosen response. Candidates are strongly encouraged to use the tutorial prior to taking the examination.

Who can I call if I have additional questions about the National Physical Therapy Examination Program?
Candidates may call Professional Examination Service’s Customer Service toll-free telephone number to obtain general information about the program, and the status of their application, authorization-to-test letter, or the score report that is mailed to their state licensing authority: 1-888-461-6905. PT

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**Comprehensive Assessment, OASIS and Home Care Therapists:**
Achieving Outcomes Through Competent Assessment, Data Collection, and Care Planning

Presented by the Community Home Health Section of the American Physical Therapy Association

Speakers: Linda Krulish, MHS, PT and Scott Swaldo, MPT

In the midst of the ever-growing demands on home care providers, the Medicare regulation mandating use of the Outcome and Assessment Information Set (OASIS) was published. In spite of delays and suspensions, the Comprehensive Assessment requirement is currently in force, with the reinstatement of the OASIS requirement pending. This course is designed to provide home care therapists (PTs, SLPs, and OTs) and rehab managers with a thorough understanding of the Comprehensive Assessment and OASIS regulation.

**Course Locations and Dates:**

<table>
<thead>
<tr>
<th>June 12-13, 1999</th>
<th>July 10-11, 1999</th>
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<tbody>
<tr>
<td>Orlando, FL</td>
<td>San Francisco, CA</td>
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<tr>
<th>July 24-25, 1999</th>
<th>August 7-8, 1999</th>
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<tbody>
<tr>
<td>Indianapolis, IN</td>
<td>Boston, MA</td>
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</table>

For a brochure with additional information, please contact Crystal Pool-Clarke at 1-800/999-2782, ext. 8588.
Foundation for Physical Therapy
Sandra E. Detwiler
Assistant Director of Development

Requests for Proposals (RFPs) are now ready for several new $40,000 research grants that will be awarded in the year 2000. The deadline for applying for these grants is August 13, 1999, and funding will begin on January 1, 2000.

Supported by APTA Sections:
1. Evaluate the effectiveness of physical therapist interventions for persons with musculoskeletal disorders, made possible by the Orthopaedic Section of APTA.
2. Evaluate the effectiveness of physical therapist interventions for older adults with musculoskeletal disorders, made possible by the Orthopaedic Section of APTA and the Section on Geriatrics of APTA.
3. Evaluate the effectiveness of physical therapist interventions for children, made possible by the Section on Pediatrics of APTA.
4. Evaluate the effectiveness of physical therapist interventions for persons with sports injuries, made possible by the Sports Physical Therapy Section of APTA.

Supported by Annual Gifts:
Evaluate the effectiveness of physical therapist practice, made possible by individuals' generous personal donations to the Foundation.

If you would like to request an RFP for one of the year 2000 grants, please call the Foundation for Physical Therapy at (800) 875-1378 or e-mail your request to foundation@apta.org Please state which grant you are interested in and include your mailing address.

IPTA Online

Do you have e-mail?
Have you been receiving IPTA Online?

If not, let us know your e-mail address so that you can be included in this new member service. IPTA Online enhances our communication with members by sending out vital information and event announcements through e-mail. This is an additional service supplementing existing publications. Send us an e-mail at eevenson@ipta.org PT

The Institute of Physical Art
presents
An Integrated Manual Therapy System

FO I: Functional Orthopedics I
Developed By Gregory S. Johnson, PT
An integrated approach to patient care, this course will emphasize the principles and skills of soft tissue evaluation and treatment, and the integration of these skills with PNF and joint mobilization. The concept of the human body as an interconnected dynamic system will be stressed. Observed changes in structure, posture and movement will be correlated to soft tissue dysfunction. Emphasis is placed on the evaluation of the soft tissue structures and the application of specific treatment techniques to normalize any identified dysfunction.
Thursday (5:00pm) through Sunday (4:00pm).
80% lab. 30 Contact Hours. Tuition: $495.
Chicago, IL ............... August 19 - 22
Institute of Physical Art, Inc.
43449 Elk Run
Steamboat Springs, CO 80487
970-870-9521 • Fax: 870-9351
International Year of Older Persons

The American Association for World Health

The United Nations has proclaimed October 1, 1998 to December 31, 1999 as the International Year of Older Persons. The year is intended to raise international awareness of the growing numbers of older people around the world and to draw attention to the major impact the shift in population age will mean to societies.

In June 1999, a federal committee comprised of agencies government-wide will convene a conference to examine the role of the federal government in planning for longevity.

One of the most striking characteristics of the world population in the 20th century has been a considerable increase in the numbers (both absolute and relative) of older people worldwide. The World Health Organization refers to this phenomenon as “population aging” and defines the elderly as individuals 60 years of age or more.

The aging of the world has been caused by changes in both mortality and fertility. That is, more people are reaching old age and relatively fewer children are born. Over the last 50 years, premature death rates in developing countries have declined dramatically and, more recently, birth rates have fallen sharply in nearly all developing countries. These factors have raised average life expectancy globally from approximately 41 years in the early 1950s to almost 62 years in 1990. By 2020, life expectancy is projected to reach 70 years. In the United States, life expectancy is 76 years today and is expected to reach 83 years by the year 2050.

In the field of international development, population aging has become an important issue. Projections for the first quarter of the next century indicate that by 2020, the number of older people worldwide will reach more than one billion, with more than 70% of them in developing countries.

Currently, there are three distinct generations of older Americans. However, in just a few years, we will encounter a fourth generation - the baby boomers. Because each of these generations has its own needs and interests, programs and services designed to serve them cannot adopt one single approach to meeting their needs.

Four Generations of Aging in the US

1. Our oldest generation was born between 1885 and 1904. Born in the pre-electric age and now living in the space age, this group has witnessed perhaps the most dramatic changes. Major life events were the first World War and the New Deal, including the introduction of Social Security.

2. Born between 1905 and 1924, this generation’s major life events include the Great Depression and World War II.

3. Born between 1925-1945, this is known as the silent, or middle, generation. The older of them experienced the Korean War while the younger were heavily influenced by World War II and the Vietnam War.

4. The baby boomers, born between 1946 and 1964, number 76 million and thus promise to change the definition of aging in America. Major life influences include the threat of nuclear war, Vietnam and the social changes of the past several decades.

In the future, the older population will continue to grow, especially between the years 2010 and 2030, when the baby boom generation reaches age 65.

Researchers have uncovered a surprising and very hopeful trend in the rates of disability among older people. Data reveals that 1.2 million fewer older Americans in 1994 were disabled than had been expected based on previous rates. Some researchers feel that this decline in disabilities is accelerating at an ever-increasing rate. Furthermore, disabilities appear to be less severe. These trends may be attributed to decreases in smoking rates and obesity, increases in exercise, and improvements in medicine, rehabilitation and public health.

America needs a new agenda for aging to ensure that it is ready for the future. Not only must this new agenda address the differing needs of the diverse generations of older Americans, but it also must address the profound impact that increasing longevity will have on every facet of our society. Some of the challenges of increased longevity include issues of financial security after retirement, new demands on health and long-term care, adaptations to transportation systems and caregiving issues.

Resources:
Eldercare Locator: 1-800-677-1116, a nationwide directory assistance service to help older adults and caregivers locate local support resources.

Maralee Lindley, Director, Department on Aging, 421 East Capitol Ave., Springfield, IL 62701, (217) 785-2870. PT
Call for Endorsements

The IPTA Nominating Committee is seeking endorsements for nomination for the following Positions:

- Treasurer (1)
- Speaker of the Assembly (1)
- Chief Delegate (1)
- Affiliate Director (1)
- Ethics Committee member (1)
- Nominating Committee member (1)
- At-Large Delegates (5)

Responsibilities, eligibility requirements, and selection criteria used by the Nominating Committee are in the IPTA bylaws printed in the 1999 Membership Directory starting on page 143. Please return this endorsement form by July 2, 1999 to:

Alice Salzman
NIU - PT Program
DeKalb, IL 60115
phone: (815) 753-6246
fax: (815) 753-0720
e-mail: asalzman@niu.edu

The slate of candidates and ballot will be mailed to each member by September 3, 1999. Please identify qualified members in your district and encourage them to consent to serve if nominated.

Election Schedule
Publish Call for endorsements ........ June, 1999
Deadline for close of nominations .... July 2, 1999
Deadline for Consent to Serve and biographical data forms .......... July 30, 1999
Deadline for final preparation of slate................................. August 6, 1999
Ballot package to Printer .............. August 20, 1999
Ballot in mail to Membership .......... September 3, 1999
Ballot Deadline, Ballots to Teller ...... October 3, 1999
Election results to be announced at the Fall Assembly .............. November 13, 1999
Publish results in December .......... December, 1999

IPTA Endorsement for Nomination Form

Instructions:
Complete this form when endorsing a person as a nominee for election. The endorsed person must have been a member of the Association for at least two (2) years prior to the election date of October 3, 1999. He/she must be qualified to execute the duties and responsibilities of the elected position(s). You may endorse a person for more than one elected position on this copy of the form. The completed form must be received by the Nominating Committee no later than July 2, 1999, by mailing or faxing to Alice Salzman, Nominating Committee Chair.

1. Name ____________________________________________
   Position Endorsed for ____________________________
   Address ________________________________________
2. Name ____________________________________________
   Position Endorsed for ____________________________
   Address ________________________________________
3. Name ____________________________________________
   Position Endorsed for ____________________________
   Address ________________________________________
4. Name ____________________________________________
   Position Endorsed for ____________________________
   Address ________________________________________

Name of Person submitting form: ______________________

____ District Endorsement:
   District Office & District __________________________

____ Individual Endorsement:
   District __________________________

____ Self Endorsement.

Return this endorsement form by July 2, 1999 to:

Alice Salzman
NIU, PT Program
DeKalb, IL 60115
phone: (815) 753-6246        fax: (815) 753-0720
e-mail: asalzman@niu.edu
When Visiting Policymakers, Mention Your Association

*American Society of Association Executives*

The number of constituents that walk in and out of a policymaker's office can be mind-boggling. Even at the local level, our elected officials are bombarded by constituent requests and member visits to the point that it can be hard to remember every name and face. That's why it's important to let them know who you're affiliated with and why.

When you indicate to your elected leaders the associations to which you belong, they can understand the big picture needs of their constituents. Most likely, they work with your association at some level on developing policy and when you, the constituent, mention the organizations you're affiliated with, the elected official will take notice of the issues you feel strongly about. They know that, as a member, you are informed about the issues affecting your industry or profession, and are serious about making the right policy decisions that impact your cause.

Our leaders understand the power of associations and recognize the importance of working with organizations like the Illinois Physical Therapy Association. They understand that you belong to an organized group and will share your experience with peers. This understanding is reinforced when you, the voter, express your affiliation with a larger constituency.

The next time you meet with your elected officials, be sure to tell them you belong to associations. You don't represent just one voice but many, and in the future, your leader will have a stronger interest in working with you as well as the Illinois Physical Therapy Association.

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Six Reasons Why Elected Officials Should Support Associations

*American Society of Association Executives*

1. Codes of ethical conduct for American workers are largely established by associations.

2. Associations invest millions of dollars and hours in retraining American's workforce to meet today's competition.

3. Associations view education in its broadest sense as their single most important contribution to society. Government, business, and consumers regard them as valued sources of research, information, and expertise.

4. Associations spend time and resources on public outreach and grassroots programs, as well as engage lawmakers and policy makers in public dialogue. Associations are responsible for setting standards for product performance and safety, as well as for certifying the competence of professionals.

5. Associations organize and provide opportunities for a host of community services, donate millions of hours in volunteer projects, underwrite pro-bono programs for the needy, and create alliances among local businesses and schools for student-work programs.

6. Associations contribute to the economy, providing more than 500,000 jobs - employing roughly the same number as the steel, computer, or airline industries.

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Many of the motions to be discussed will deal with the use of aides, athletic trainers and other extenders. Almost all of the motions propose limiting the use of such personnel, and moving back to the therapist and assistant providing the critical elements of all patient care.

Eventually the market will stabilize. Imbalances in supply and demand have occurred in medicine, in nursing and in many other professions. Now is our turn. Be assured that the APTA and the leadership of the profession are committed to strengthening the role of the physical therapist and the physical therapist assistant during this period. Our focus now, as always, should be on the core values of good patient care - and we will make it through these tough times.
In the News ...

Pennsylvania Supreme Court Rules in Favor of Physical Therapists

Pennsylvania Physical Therapists are rejoicing at the Pennsylvania Supreme Court's decision that chiropractors cannot use the term "physical therapy" for the services they provide. This issue has been ongoing for several years. More recently, a three-judge panel had ruled that the term "physical therapy" could only be used by Physical Therapists licensed in accordance with Pennsylvania law. The chiropractors appealed that decision, taking it to the Pennsylvania Supreme Court who agreed with the three-judge panel.

Reprinted from APTA's Health Policy Division's Monthly Update, POLICY MATTERS, Vol. Two, No. 4

Scholarship Awarded to Illinois Member

Christian Evans, MS, PT
Jennifer L. Hunt

The Foundation for Physical Therapy Board of Trustees has awarded $270,000 to doctorally prepared Physical Therapists in its 1999 Doctoral Opportunities for Clinicians and Scholars (DOCS) program. Foundation President Jayne L. Snyder, PT, MA, said "The Foundation Board of Trustees is pleased to award funding to nineteen Physical Therapists so that they may pursue the research goals of our profession. Our heartfelt thanks go to the many individuals and organizations who support the Foundation. Their generous gifts are making this research possible."

The DOCS program includes the New Investigator Fellowships Training Initiative (NIFTI) program and the Promotion of Doctoral Studies (PODS) program. This year three NIFTI fellowships and 16 PODS scholarships were awarded.

Christian C. Evans, MS, PT, the University of Illinois, Chicago was awarded a PODS II $15,000 scholarship to support the post-course work phase of his doctoral studies.

The Illinois Physical Therapy congratulates Mr. Evans and extends its best wishes.

University of Illinois at Chicago

The Illinois Board of Higher Education has recently approved the Doctor of Physical Therapy program at The University of Illinois at Chicago. They anticipate that their first class will commence in September, 2000. Congratulations UIC!

Dates

Put these dates for 1999 IPTA events on your calendar!

June 19 IPT-PAC Golf Classic
August 7 Board of Directors meeting
November 12-14 IPTA Fall Conference; Board of Directors meeting; Representative Assembly; Location: Eagle Ridge Resort, Galena, Illinois

IPTA Staff Changes

The IPTA staff is pleased to announce the birth of Eric Thomas, the adoptive son of Susan and Tom Jannusch on May 15, 1999. Susan has been the PT Priority Managing Editor for two years and has made many contributions to the IPTA. Susan has left the IPTA to devote her time to her new son. Although her talents will be missed, her new role as Mom will keep her busy. We wish the Jannusch's much happiness with their new family.

PT Priority - June, 1999 - 17 -
IPTA Welcomes New Members

as of April 31, 1999

Mohammed Ali, SPT
Tinley Park, IL

Rickard Baurersfeld, PT
McLean, IL

Steven Bayer, PT
Carol Stream, IL

Manuela Beals, SPTA
Mahomet, IL

Laura Bowers, PT
Chicago, IL

Julie Brannin, SPT
Springfield, IL

Brian Cunningham, PT
Park Ridge, IL

Lori Czaplewski, PTA
Quincy, IL

Brian Diaz, SPT
Libertyville, IL

Jodi Escheneyer, SPT
Wheaton, IL

Chris Gellert, SPT
Chicago, IL

Carol Gronewold, SPTA
Lima, IL

Amber Hosselton, SPT
Cisne, IL

Tracy Hufford, PT
Chicago, IL

Dean Kambros, SPT
Oak Lawn, IL

Margaret McGee, PTA
Seminole, IL

Mary McGinnis, SPT
Chicago, IL

Mila Mogilevski, PT
Chicago, IL

Deborah Muchow, SPTA
Altamont, IL

Caroline Murray, SPT
Chicago, IL

Amy Nagel, PT
East Moline, IL

Nettie Nico, PTA
Moline, IL

Margaret O'Brien, SPTA
Galesburg, IL

Christine Palmer, PT
Palos Hills, IL

Jill Rieke, SPT
Kenilworth, IL

Patricia Schomber, SPTA
Belleville, IL

Cynthia Shattuck, PTA
Poplar Grove, IL

Cynthia Simpson, PTA
Casey, IL

Leslie Snell, SPT
Wonder Lake, IL

Jee Rose Son Young, SPT
Franklin Park, IL

Jennifer Tomnitz, SPTA
Burbank, IL

Ann Twomey, SPTA
Westchester, IL

Nicole Voeller, SPTA
Rockford, IL

Destiny Woolever, SPTA
Grayville, IL

Provena Covenant Medical Center offers an outstanding flexible benefits program to both full and part-time employees.

Senior Physical Therapist: Full-time position in our CARF accredited program for experienced Physical Therapist. The department provides Outpatient and Acute Orthopedic Services, in addition to general rehabilitation services. The Senior Physical Therapist would coordinate patients' therapy schedules to ensure CARF accreditation guidelines are continuously met. Experienced Physical Therapists are encouraged to apply.

Interested candidates should contact Human Resources, Provena Covenant Medical Center at (217) 337-2224 or fax (217) 337-2619. For a further listing of opportunities at Provena Covenant Medical Center, please visit our internet site:

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Relax the Back greatly appreciates your commitment to healing.

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Dateline

Submissions to Dateline should be sent to the IPTA Chapter Office. Inclusions in the calendar are as space permits and are at the discretion of the editor with priority given to IPTA events. Cost per listing is $25 for non-IPTA events.

JUNE, 1999
10-13 McKenzie Approach, Part D: Advanced Technique Workshop
Instructor: Mark Miller, BHHK, Bsc, PT, Dip.MDT
Location: St. Francis Hospital
355 Ridge Ave.
Evanston, IL 60202
For more information please contact the McKenzie Institute at 1-800-635-8380

19 IPT-PAC Golf Classic
Glenwoodie Golf Course, Glenwood, IL

JULY
8 McKenzie Study Group Meeting
Location: TBA
Time: 7:00 pm
For more information please contact Susan Prust, PT, DipMDT (847) 316-5280

15-17 Course: Neuroanatomical Dissection: Human Brain and Spinal Cord
Instructor: William Cullinan, PhD, PT
Location: Marquette University, Milwaukee WI
For information, contact Linda Diedrich (414) 288-6057 or Linda.Diedrich@marquette.edu

17 Northern District IPTA Meeting
Time: 9:30 am Breakfast
Topic: 1999 HOD Update
Questions, please call Casey Ferguson, PT (630) 653-9995 (w) or (630) 671-9545 (h)

24 Course: Rehab Services Under PPS in Long Term Care
Location: The Dearborn Inn, Dearborn Michigan
Speaker: Susan Krall, PT
Cost: $225.00
Sponsored by National Rehabilitation Services. Contact Dianne Bowman or Tom Slominski (517) 732-3866

July 30-Aug 1 Course: Integrating NDT, SI, and Motor Learning Perspectives in Peds - Level I & II
Location: Suburban Chicago
Instructor: Leslie J. Adler, MA, OTR, FMOTA
Contact: Kids in Motion Inc., Margie Mizera or Renee Rowley (708) 371-7007

31 Medicare Documentation Requirements for Rehabilitation Services for Traditional Medicare & PPS Service Delivery
Location: Holiday Inn Columbus East
Columbus, Ohio
Instructor: Thomas Slominski
Sponsored by National Rehabilitation Services. Contact Dianne Bowman or Tom Slominski (517) 732-3866

AUGUST
7 IPTA Board of Directors Meeting

7-8 Integrating Yoga Therapy Into Rehabilitation
Location: St. Louis, MO
Instructor: Matthew Taylor, MPT, CYT
For information call toll free (877) 697-3422 or www.yogatherapy.com.

19-22 McKenzie Approach, Part A: Mechanical Diagnosis and Treatment of the Lumbar Spine
Instructor: Sheila McBride
Location: 12692 Lamplighter Square
St. Louis, MO 63128
For more information please contact the McKenzie Institute at 1-800-635-8380

SEPTEMBER
9 McKenzie Study Group Meeting
Location: TBA
Time: 7:00 pm
For more information please contact Susan Prust, PT, DipMDT (847) 316-5280

15 Northern District IPTA Meeting
Location: Elgin Community College
1700 Spartan Drive, Elgin, Illinois
(847) 697-1000
Time: 7:30 pm
Topic: Reikki - Touch Therapy
Speaker: Kathy Maras
Questions, please call Casey Ferguson, PT (630) 653-9995 (w) or (630) 671-9545 (h)

16-19 McKenzie Approach, Part A: Mechanical Diagnosis and Treatment of the Lumbar Spine
Instructor: Dana Greene, PT, Dip.MDT
Location: St. Francis Hospital
355 Ridge Ave.
Evanston, IL 60202
For more information please contact the McKenzie Institute at 1-800-635-8380
**Physical Therapists**  
**Special Education Opportunities**

80 District Special Education Agency serving physically challenged students with varied medical diagnoses, is offering excellent opportunities in several Northwest state areas. Call for details regarding:

- Job Locations
- Competitive Salary
- Medical & Dental Benefits
- Inservice Training
- Flexible School Calendar
- Variable Full or Part-Time Options

Come join our school teams, and become a part of a large progressive school system's therapy program! Please call Therapy Coordinator at (630) 208-1076, or send resume to:

Northwestern Illinois Association  
Therapy Division  
521 Hamilton Street Annex  
Geneva, Illinois 60134

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**Physical Therapists**  
**PT Assistants**

GNA, a unique therapist oriented rehabilitation service company, has opportunities in Chicago Heights and Northwest Indiana.

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**Positions Available**

- Various PT & PTA Openings  
  Northwest IN and South Chicago, IL

If interested, submit resume or call:

Steve Bartow  
GNA®  
1-800-876-1041

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Illinois Physical Therapy Association  
1010 Jorie Boulevard, Suite 134  
Oak Brook, IL 60523