The financing happens mainly by payment by act (consultations and technical acts).

Our nomenclature and our fees are discussed. The diagnostic acts are mainly electrophysiological acts (EMG–nerve conduction studies–evoked potentials). Some complementary acts are available e.g. measurement of pressure for an acute compartment syndrome and kinesiologic evaluation (only for a child suffering of a cerebral motor infirmity). We have also access to muscular echography. For isokinetic analysis there is no nomenclature available.

The therapeutic acts include vertebral manipulations, the mono-disciplinary acts (as general rehabilitation–maximum 48 sessions, pelvic re-education and lymphedema treatment–max 60 sessions) as well as the pluridisciplinary acts: back school program (36 sessions of 2 hours) and neurological and locomotor system rehabilitation programs of 60, 90 or 120 minutes (with a maximum of 60 to 120 sessions) according to a list of pathology. These programs are complicated by extremely severe rules.

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The reimbursement system of mobility aids in Belgium
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Keywords: Mobility aid; Wheelchair; Reimbursement; Health insurance
In Belgium, the National Institute for Health and Disability Insurance (NIHDI) organizes, manages, and supervises the application of the compulsory health insurance. The reimbursement of mobility aids is regulated by article 28§8 of the Belgian “nomenclature of health care services”. A renewed version was published as a royal decree in January 2005. This nomenclature has been developed by the ‘Technical board for the wheelchairs’ (TBW), composed in 2003 of a president, experts, the health insurance funds, the physicians, the wheelchair providers, the industry, the four regional funds and persons with disability. The TBW is not only responsible for the nomenclature but also composes the list of reimbursed equipment, taking into account the different criteria as defined in art. 28§8 and advises the NIHDI on custom-made mobility aids for patients with specific needs.

A part from (manual or electronic) wheelchairs, the nomenclature covers walking aids, orthopaedical tricycles, standing systems, anti-decubitus cushions and modular back systems.

In order to obtain reimbursement, the person should have a permanently impaired mobility of any origin and the mobility aid must be delivered by a certified wheelchair provider. The criteria for reimbursement are based on the qualifiers of a number of ICF items, independent of a medical diagnosis. A medical prescription is always required, describing the ICF based functional status of the patient. There are three types of procedures for acquisition: basic, extended and special. The special procedure is necessary for more costly and complex mobility aids, such as electronic wheelchairs and require a multidisciplinary report.

Art. 28 § 8 is composed of four parts, which will be discussed more in detail during the lecture. For children till the age of 18, the criteria and reimbursement of the equipment are determined separately. In elderly facilities, a renting system is being applied. The reimbursement price for each item (aid or adaptation) is set in a ‘convention’ commission between the NIHDI, the health insurance funds and the professional union of the wheelchair providers.

The total expenses in 2011 were approximately 65 million Euros of which 15 million for the renting system.

Further Reading
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CO61-004-e
The Belgian reimbursement system for prostheses for lower limb amputation in 2013
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Keywords: Lower limb amputation; Prosthesis; Reimbursement; Health insurance; Belgium
In Belgium, social security reimburses to a large extent the equipment provided by a certified prosthetist or orthotist (CPO). The reimbursement is controlled within one budgetary envelope.

The utilization of this envelope and the modalities of reimbursement are discussed and decided by a commission consisting of members of the NIHDI (National Institute for Health and Disability Insurance), representatives of the health insurance funds and delegates of the professional union of CPO’s.

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Very rarely, the professional organisation of the involved physicians are invited to share their opinion on a specific item.

The criteria and modalities of reimbursement of lower limb prostheses has been revised in 2004. First, an ‘evaluation’ prosthesis is provided followed six months later by a permanent prosthesis, taking into account the classification of the patient in one of five defined functional categories. This functional classification determines the technical components that will be reimbursed for the confection of the prosthesis as well as the delay for renewal (between 3 and 10 years). An annual technical revision is also foreseen, thus, preventing technical defects of the prosthesis. When the volume or the morphology of the stump shows a significant modification, a new socket can be reimbursed.

A physician specialised in PRM, surgery, rheumatology, neurology or paediatrics is required to fill in a document describing the clinical status of the patient and informing the prosthetist of specific clinical aspects that have to be taken into account.

The physician also has to ratify the functional category as proposed by the prosthetist when it concerns the categories 4 or 5, indicating the highest functional levels. However, this document is not a medical prescription sensu stricto.

The advantages and problems of this reimbursement system will be discussed more in detail during the lecture.

Pour en savoir plus
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Organization and funding of physical and rehabilitation medicine in France
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Keywords: Physical and rehabilitation medicine; Care pathways; Funding; Organisation; France; Europe; SYFMER; SOFMER; COFEMER
There are 1850 PRM specialists in France. Three quarters of them are employees, 350 have an exclusive private practice and 150 share their activities between institutional and private practice.

French PRM is represented by a scientific society (SOFMER), a professional union (SYFMER) and a board of academic professors (COFEMER). Altogether, they make up the National Board of PRM, set up by law for supervising Continuing Professional Development and for advising the Government about health issues.

PRM private practices are often part of multidisciplinary and multiprofessional settings, either in the community or alongside a private hospital. Their activity is mainly focused on musculoskeletal impairments (93%), but 6% deal with pelvic floor issues and 1% with cognitive, sensory or cardiovascular/respiratory impairments. Patients pay for each consultation or technical act. Then, the National Health Insurance pays them back for the expenses.

Technical activity is listed in the “Common Classification of Medical Acts–CCAM”, shared by all specialties. In NHU database, 467,000 acts have been coded by PRM doctors in 2011–2012, using 443 different codes. Activity focused on musculoskeletal issues represents 92% of the total number of acts and is shared between vertebral therapy (28%), orthopaedic and traumatologic treatments (3%), hand orthoses (3%), punctures and injections (31%), X-ray and ultrasound imaging (15%), and ENMG (15%). Posture and movement assessment, together with sensory assessment, only account for 1.5%. Despite the reimbursement of isokinetic dynamometry since mid 2011, only 1230 related codes (0.3%) appear in this survey. However, SYFMER still asks for the refund of more functional assessment techniques, especially for Surface Topography in spinal deformities. Pelvic floor functional assessment in France accounts for only 6%. It is currently hindered by the high cost of sterile consumables, which SYFMER claims to be specially refunded. Cardiotoracic and respiratory assessment and rehabilitation remain marginal.

Further Reading
SYFMER: http://www.sfymer.org/
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