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 limitative list of pathology. These programs are complicated by extremely severe rules.

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CO61-002-e

Session francobelge–convention systems in rehabilitation

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Keywords: Conventions nomenclature Ninety percent of the hospitals dispose of a rehabilitation service with at least one part-time or full-time PRM specialist. He or she coordinates the rehabilitation programs of the inpatients and most of the times there is also an outpatient service. A hospital can also have Sp-beds, which are generally led by a PRM specialist and serve as the rehabilitation unit. The National Institute for Health and Disability Insurance (NHIDI), that organises and controls the mandatory health insurance and where the conditions and height of reimbursements are decided, pays a fee for each hospitalisation day to cover nursing and other non-medical expenses. This price differs between hospitals. The medical and paramedical care themselves are financed by either nomenclature or a convention. The nomenclature will be discussed in a following presentation.

There are many types of conventions, e.g. for cardiac and pulmonary rehabilitation, for sensory disorders (vision, speech)...even in the domain of locomotor and neurological rehabilitation where PRM speciality is strongly involved. Depending on the type of convention there is only a fee for each rehabilitation session or there is a supplementary lump sum provided for the organisation of the service.

There isn’t a great difference in the fee for each rehabilitation session between nomenclature and convention and most indications for rehabilitation are covered in the two systems. The differences concern mainly indications for rehabilitation in the orthopedic domain, the required infrastructure and staffing, the length of reimbursement for rehabilitation and the reimbursement of transportation for some outpatients.

In general, the convention centers are the longest existing ones and are more involved in the rehabilitation of the neurological patient with more complex deficits but this varies strongly, depending on the region and the internal arrangements in the hospitals.

The remuneration of the PRM specialists can take all forms (employee or independent contractor) and depends on their individually negotiated contracts.

Concerning rehabilitation outside the hospitals, there is only a reimbursement for physiotherapists and speech therapists.

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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 (NHIDI) 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, orthopaedic 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 qualifications 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 NHIDI, 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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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 NHIDI (National Institute for Health and Disability Insurance), representatives of the health insurance funds and delegates of the professional union of CPO’s.
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 foresee, 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 as well as cardiovascular/respiratory impairments. Patients pay for each consultation or technical act. Then, the National Health Insurance pays them back for the expenses. Care facilities are divided into: (i) acute care settings (MCO) and (ii) post-acute and rehabilitation care settings (SSR). PRM takes place mainly within SSR. Those are sorted out in “versatile facilities” and “specialized facilities”. Departments headed by a PRM specialist are usually classified as “specialised” in musculoskeletal and/or neurologic issues. In the past, every care facility used to be funded on a daily cost basis. An activity based funding has been established in 2007 for MCO. But the Government has found more difficult to reach a relevant funding system for SSR, despite having collected plenty of management data for years. The provisional funding model is based on four items: activity funding index, expensive drugs, specialised technical platforms and missions of public interest. SYFMER and SOFMER are claiming for an increased valuation of dependence criteria, of personal conditions, such as co-morbidity, cognitive impairments, behavioural troubles and precarious situations, as well as environmental factors with respect to ICF. All those conditions can reasonably explain an increase of care costs and longer stays in PRM departments than in versatile post-acute settings.

In this perspective, SOFMER is negotiating with public authorities for a pilot study on PRM care pathways for stroke patients

Further Reading
SYFMER: http://www.syfmer.org/
SOFMER: http://www.sofmer.com/
COFEMER: http://www.cofemer.fr/
http://dx.doi.org/10.1016/j.rehab.2013.07.662

CO61-006-e
The CIF international classification: A model to fund SSR activities in France?
Unknown abstract.
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CO61-007-e
Funding of PRM activity in France
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Keywords: Physical and rehabilitation medicine; Funding; Clinical activity; Technical activity; Public health; Insurance; SYFMER; Union; France
In PRM private practice, patients pay for each medical act and are refunded by the National Health Insurance (NSI). The price scale has been frozen for about ten years, but negotiations between Medical Unions and NSI seem to be starting again. Clinical consultations (54% of the total number of acts) are divided into “Specialised Consultations” (CS = €23) and “Experts Opinions” (C2 = €46), which are evidenced by a letter to the patient’s General Practitioner. Recently, the time period between two C2 consultations has been reduced from 6 to 4 months and a “Synthesis consultation” may be coded CS shortly after. French Union of Medical Specialists (UMESPE) is advocating for a better paid “Complex Clinical Consultation” (C3). French Union of PRM (SYFMER) has proposed a series eligible situations, such as “back pain persisting more than 3 months”, “stroke patients after hospitalization” and “persisting pelvic floor impairments despite two previous primary treatments”. SYFMER is also wishing for a “Clinical Functional Assessments”, for the close supervision of multiprofessional programmes of care. Technical activity is listed in the “Common Classification of Medical Acts–CCAM”, shared by all specialties. In NSI 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. Cardiopulmonary and vascular assessment and rehabilitation remain marginal.

Further Reading
SYFMER: http://www.syfmer.org/
http://dx.doi.org/10.1016/j.rehab.2013.07.664

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