

# DIRECTIONS

Formerly NRRTS News

## *Consumer Involvement* **THE KEY TO SAVING "REHAB?"**



[NRRTS]

**SERVICE OR  
DISSERVICE?**

*page 24*



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# DIRECTIONS

VOL 2 » SPRING 2008

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PRINTER Parks Printing

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# NRRTS Update



SIMON MARGOLIS  
Executive Director  
NRRTS

### Legislative/Regulatory

NRRTS continues working to assure the interests of NRRTS Registrants and other members of the complex rehab industry and profession are voiced on Capitol Hill and in the individual statehouses. Whenever issues arise, NRRTS responds. Please visit [www.nrrts.org](http://www.nrrts.org) for additional information.

### Continuing Education

NRRTS has been working diligently to help our Registrants and ATS and ATP colleagues meet the continuing education requirement in a quality cost-effective manner.

*Register for  
CELA 2008 &  
The Teleseminar  
Series Today!  
Info on  
pages 46-48*

Two different and unique programs have been developed.

The first, a distance-learning program, is the NRRTS 2008 TeleSeminar Series. It's comprised of five two-hour conference-call seminars. More than 100 people have signed up for this series to date. In response to the overwhelming demand, NRRTS has modified the original program design to include a rolling schedule; after each TeleSeminar, an additional, new TeleSeminar will be added to the end of the schedule. This will

assure there is always a five-seminar TeleSeminar series available to meet continuing-education requirements.

The second is CELA '08 – Continuing Education and Legislative Advocacy, a conference presented by NRRTS and cosponsored by NCART and the University of Pittsburgh. This unique hybrid event, held in the Washington, D.C., area, brings together a high-quality, cost-effective continuing-education program and an opportunity to meet with members of Congress to discuss the critical issues facing the complex rehab and assistive technology

industry and profession. (Foremost is HR 2231, a bill already introduced in Congress that would exempt complex rehab products from national competitive bidding)

Information about these programs can be found on pages 46 - 48 in this issue of DIRECTIONS. **D**

#### ABOUT THE AUTHOR:

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# Freedom Designs, Inc.

## 2008 Educational Program



### **"Seating: Bottom to Top"**

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If you have not yet attended our seminar **"Seating: Bottom to Top"**, we hope you can join us this year! This course is well suited for (but not limited to) physical and occupational therapists, as well as equipment suppliers who service the neurologically and/or orthopedically involved client. There is a focus on pediatrics.

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This is Missy's 14th year as Seating Clinic Consultant/Educational Specialist for Freedom Designs. Her vast experience and expertise is recognized throughout the industry.

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Brad Moore, ATS,CRTS

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*"As an ATP and physical therapist practicing in the field of seating and mobility for 17 years, courses in this subject can be repetitive and dry. The material presented by Missy Ball, in cooperation with Freedom Designs, was diverse, thought provoking, and challenging. I could glean new information and insights even if it wasn't the first time hearing the information."*

Shirl Erb, LPT,ATP

Good Shepherd Rehabilitation Network, Allentown, PA

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May 14 & 15	Edison, NJ
Jun 4 & 5	Sioux Falls, SD
Jun 18 & 19	Portland, OR
Jul 9 & 10	Raleigh, NC
Aug 6 & 7	Orlando, FL
Sep 3 & 4	St Louis, MO
Sep 17 & 18	Columbus, OH
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Nov 19 & 20	Los Angeles, CA
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# Don't Abandon the Emotion!



**TOM ROLICK**  
Vice President of Business Development  
PERMOBIL

EVERY NOW AND THEN we all need a reminder of why we are in this business. My reminder came at a recent ALS Association conference. It was a powerful message of emotions. I had never been surrounded by so many people who thought of nothing else but how to help those stricken with one of life's most horrific diseases: ALS. It wasn't about coding and reimbursement; it was all about

emotions—shattered emotions and committed emotions. These folks were determined to do anything and everything they could to help anyone and everyone affected by ALS.

It was truly unconditional support. It felt good. It was empowering. It stirred my emotions and I hope to stir yours.

It is time to get the emotion back into the definition of our complex rehab world. We failed to define the rehab world as we once knew it, and like everything that needs to be done, but doesn't get done, someone else did it for us. Let's not let that happen with taking care of the individuals in need of complex rehab products and services.

The spotlight is on complex rehab, and quite frankly, some in our industry can't stand the heat. Let's face it, the burden to advocate for the consumer is the reason we exist. I don't resent that; I embrace that, and I believe you do, too. The whole world is watching, so stop whining and start shining. Put on a show. Get creative and make magic out of four wheels and a joystick. Give life back to someone who just had it ripped away in an instant as a result of an accident, or to someone who was just diagnosed with a debilitating disease. Nobody plans for our services, but they turn to us. This is a little dramatic, but they literally put their shattered lives in our hands. They need advice, comfort and hope. What are we to do?

How about a nice little ditty that is the clinical equivalent, least-costly alternative, number-one best pick and available in red or blue? Oh yeah, and it is only available from a provider located 100 miles away.

Hopefully that hurt a little bit. Share a little emotion.

We've got to come through. To say we can't afford to fight for the consumer anymore is a copout. We need to lead the fight for consumer access to and payment for the best available rehab products and services. We need to show this is what the people want and deserve. If we continue to accept a third-party's definition of what the need is, we are

headed down a slippery slope. The most basic need is to breathe, and beyond that is a luxury some say.

I hear and appreciate all the talk in terms of doing things a certain way to stay in business. It is a tough business environment—always has been. Living with a disability is no picnic, either. Empower the consumer through education; together, choose services and the appropriate equipment, and get it paid.

If our industry is not going push for more, then who is? You know what happens when things that need to be done don't get done. I don't want to see the day when complex rehab equipment and services are not provided by local RTSs.

So, fire up the emotion. Are you doing everything you can for the complex rehab industry and for your customers who are depending on you? Don't do more with less. Just do more. Let your emotions run wild; you'll be amazed at how successful you will be. **D**

*ABOUT THE AUTHOR:*  
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*The burden to advocate for the consumer is the reason we exist.*



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# Medicare's Program



CARA C. BACHENHEIMER  
Senior Vice President Government Relations  
INVACARE CORPORATION

THIS IS THE YEAR that the Medicare program's competitive-acquisition program goes live and we witness its impact on consumers with needs for high-end rehab items and services. Since 2003, when Congress passed the Medicare Modernization Act, the Centers for Medicare and Medicaid Services (CMS) has been implementing the program.

Meanwhile, we have been working to get CMS or Congress to recognize the individualized needs of consumers with high-end rehab needs and exempt these items from the bidding program.

With CMS' imminent release of its list of winning bidders and bid

prices in the first ten metropolitan areas, and its scheduled July 1 start date for the bidding process in the next 70 metropolitan areas, we will have meaningful data about the real effects of this program. As we continue our legislative efforts to

get Congress to pass H.R. 2231 (the bill in the House of Representatives that would exempt high-end rehab items from the bidding program), we will have the benefit of real life experience starting July 1, 2008. Not only will we experience it first hand, but we must also record and relay to members of Congress how consumers' lives and their ability to obtain the appropriate items and services is impacted by this program.

CMS made the decision to include high-end rehabilitative items, accessories and services in the bidding program. Our only opportunity to get these items excluded is through Congress and change to the original law. The best way to accomplish that goal is to engage clinicians and consumers—more so than industry—in our efforts to educate members of Congress on this critical issue.

It is difficult for those of us in this business to imagine how consumers will fare when rock-bottom bid prices are set for complex items, largely driven by a minority of bidders submitting low-ball bids as a desperate move to survive. The problem is the bid prices in the first ten areas will dictate the quality of products and services that consumers will receive.

There is a real need to exempt complex rehab products due to the potential negative impacts on individuals with disabilities who rely

upon the sophisticated technology to be mobile and improve the quality of their lives. The truth is quality will suffer and may cause reverse discrimination. Many suppliers are fearful of losing Medicare business for three years, which could mean shutting down their businesses entirely. Therefore, they will seek out lower-cost items to establish a formulary for purposes of submitting a bid. The selection of lower-cost items to be provided to all clients, not just Medicare beneficiaries, will result in a lack of access to products with many of the features that improve the functional capabilities of individuals with disabilities.

If you are in the business of providing consumers complex rehab and assistive technology, you readily understand that people with disabilities need explicit protection from the impact competitive bidding would have on their ability to receive appropriate items of high-tech rehab and assistive technology—to receive appropriate evaluation, fitting, follow up and service. Our collective challenge is to educate members of Congress who are unfamiliar with not just the items and services provided, but more importantly, with the consumers and their series of individualized needs that require extreme

CONTINUED ON page 10

*There is a real need to exempt complex rehab products due to the potential negative impacts on individuals with disabilities.*

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Medicare's Program

customization. Undoubtedly, the best way to educate Congress is through consumers themselves. Words become less relevant when

a member of Congress sits down with a consumer with complex needs who describes the process he or she has gone through to obtain the most appropriate system. A conversation

with a consumer is typically all it takes for policymakers to understand why these items are inappropriate for the bid process, and to enlist their support of H.R. 2231.

*Undoubtedly, the best way to educate Congress is through consumers.*

So, what is our best strategy for obtaining the legislative remedy we need? Across the country we all need to participate in basic grassroots lobbying and engage our consumers (and clinicians) in our efforts. Set up a local meeting with your members of Congress—they are home frequently (especially during the weeks of March 17 and May 26)—and bring along a consumer who can relay in plain English what the bidding program will mean to him or her. If we are to succeed, we must all rise to the challenge—today. You can also take a consumer and a clinician to visit your senators and representatives. If we each don't do our share of educating members of Congress, senators and representatives, we all will suffer. **D**

ABOUT THE AUTHOR:

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# Fast Lane



SELENE FAER DALTON-KUMINS  
Disability Rights Advocate  
METROACCESS WASHINGTON METROPOLITAN  
AREA TRANSIT AUTHORITY

“THERE ARE CERTAIN QUESTIONS people always ask about me, so ... I’ll just tell you the answers right from the start! The disease I have, Spinal Muscular Atrophy (SMA), a progressive neuromuscular disease, was diagnosed before I was age 2. Never having walked independently, I received my first power wheelchair when I was 8.”

*I learned how to be my own advocate to receive the services, accommodations and equipment I needed.*

So began a speech I wrote and delivered at age 11, almost two decades ago, in which I sought to familiarize the audience with some of the daily consequences of disability. Shortly after being diagnosed, I was taught that one who has talents and capabilities and who has been given life and sufficient breath is obligated to speak out for those who cannot. In the thousands of speeches I gave to civic, business, advocacy, and educational organizations, I talked about laws regarding disability, the exceptionally high costs of equipment and

medical care, and the ongoing and enormous obstacles encountered. I described the loss of life and unrealized potential that resulted at times from disease or injury, and at other times from ignorance and the inattentiveness of society. My presentations were based on the fundamental principle that each individual has the right to equal opportunity. I have asserted that right during my life, standing on the shoulders of giants in the disability rights’ movement who had blazed paths toward inclusion and equality.

I learned how to be my own advocate in order to receive the services, accommodations and equipment I needed. My mother and I developed and implemented medical and educational delivery systems for me during middle and high school. Later, I helped to develop the same systems for three students who were significantly physically disabled. Perhaps portentously, during the 1988 presidential campaign, I presented a four-minute speech about the need to pass the Americans With Disabilities Act (ADA). At a podium shared with the nominee, I became the first person ever to speak on behalf of a presidential candidate about disability issues. The ADA, passed in 1990, has underpinned many of my pursuits.

As a junior at Duke University in 1996, I filed an ADA complaint to the Department of Justice (DOJ) alleging that the university failed to make the campus accessible to persons with disabilities. I provided extensive documentation and evidence of the university’s failure to comply with transportation and housing practices, refusal to grant longstanding academic accommodations and failure to remove physical barriers. According to Duke, I was its first wheelchair-using undergraduate student. The Duke settlement, the first agreement DOJ reached regarding widespread accessibility of a college or university, eliminated numerous egregious physical obstructions and noncompliant practices. It remains federal legal precedent.

Three years after that, while a legal intern in 1999, I conducted research on the integration mandate of the ADA and comparative costs of institutionalization versus community care for argument of a landmark U.S. Supreme Court case (Olmstead). Now the director of a paratransit service mandated and defined by the ADA, it is the ADA that provides guidance when I make policy and operational decisions.

CONTINUED ON page 14

# “I Shoulda Used MK”



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*Fast Lane* Disability rights activists debate which issue should be emphasized—education, employment, transportation, housing, healthcare, personal care assistance—to eliminate

discrimination and systemic barriers to equal opportunity for people with disabilities (PWDs). I think each of these areas is important. Far more important than any of these individual issues, however, is the larger challenge:

changing public perception. The effort to change public perception is at the core of everything I do, whether it is in my career, in my community work or in my artistic endeavors. Until public perception changes, progress can be achieved only through the coercive arm of regulation. Only when we are viewed as equals by society will we obtain substantive, far-reaching advancement.

My love of acting, singing and directing has influenced others' impressions of me. I noticed early on that I was perceived to be more accessible and approachable through performance. My ability to entertain made me less disabled to others. Stage roles that rejected the stereotypical depictions of PWDs as inspirations, victims

or villains influenced other people's perceptions of me, while opening their minds to the notion that PWDs do not conform to stereotypes anymore than do those without disabilities. Performance is my passion. To me, it is both art and politics, expression and advocacy.

At the same time, I value expediency and practicality. I am programmed to think about many things because I have had this disability all my life. Will the building be accessible? If it doesn't have an electric door, will someone notice me sitting outside? Will the wheelchair lift or elevator function? Will I be able to reach the elevator buttons? Will my wheelchair fit through the airplane cargo door and arrive at my destination

*My disability is an integral part of my life, my existence, my socialization and my perspective. It does not dictate my life.*

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in working condition? For how long will I sit in soaking clothes on a saturated cushion if caught in a rainstorm? Will curb cuts be impassable after a snowstorm? Unable to stand, dress myself, bathe or wash and brush my hair, I need physical assistance. I cannot get into or out of bed, or on and off the toilet independently. Even things that I can do by myself take longer than they do the average person because my muscles are extremely weak—with the exception of walking, because I drive a lot faster than people walk. Additionally, I have an associated cost with each human need. Finances—dollars and cents needed to pay personal care assistants and to purchase assistive technology—are the

frighteningly fragile bulwark between life in the world and life in a nursing home.

As a society, we value hard-charging, committed, tough, highly trained and disciplined leaders who bravely run to the sounds of an emergency rather than from them. That is how I try to live my life, working and fighting for equal opportunity and rights for others and myself. I am a person with a disability. My disability is an *integral* part of my life, my existence, my socialization and my perspective. It does not *dictate* my life. **D**

*ABOUT THE AUTHOR:*

*Selene Faer Dalton-Kumins is director of the Washington Metropolitan Area Transit Authority Office of MetroAccess Service, the first PWD to be appointed to that position. She is a commissioner on the Arlington County Disability Advisory Commission, Arlington, Virginia.*

*Selene has lobbied on Capitol Hill with NCART to ensure patient access to high-end rehab and assistive technology products and services. She has an A.B. in Drama from Duke University and a J.D. from Emory University School of Law. Selene may be reached at [selenefaer@gmail.com](mailto:selenefaer@gmail.com).*

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Selene Faer Dalton-Kumins is a keynote speaker for **CELA 2008** in Washington, D.C. See page 46 & 47 for more details.

# Higher Manufacturer Standards Protect Client Needs and Industry Interests



**SETH JOHNSON**  
Vice President of Government Affairs  
QUANTUM REHAB

EVERYONE IN THE REHAB community shares a common goal: using the best possible rehab solutions available to provide patients with superior outcomes. However, changes in Medicare documentation requirements as well as significantly reduced reimbursement rates have certainly made it more challenging to achieve that goal. That's why it's crucial for rehab equipment

manufacturers to adhere to higher business standards and protect both the short-term and long-term interests of patients, rehab professionals and the industry.

Following are several key principles that can help manufacturers make a significant difference and positively impact the overall welfare of the people

who require their products and protect the interests of the rehab community at large.

## **Require Providers to Adhere to Higher Standards**

Manufacturers need to implement, publish and enforce a list of standards that detail what is required of providers to supply their products. These standards should be developed to ensure that patients are aided by only qualified professionals.

Examples of higher standards that will protect patients and the integrity of the rehab community include the prohibition of Internet sales and direct-drop shipments of complex rehab equipment, and the requirement of every provider to employ an RESNA-certified assistive technology supplier (ATS) or an RESNA-certified assistive technology practitioner (ATP), directly involving them in the selection of complex rehab products for clients.

Manufacturers that allow complex rehab equipment sales over the Internet and drop-ship to patients' homes are compromising what's in the patients' best interests. Ordering and fitting complex rehab equipment is not a trial and error process and cannot be learned at the expense of proper patient care. Only the personal attention of a skilled rehab professional working with a client to address unique requirements can deliver the best solution to meet patient needs.

The standards we impose on ourselves as an industry and on those who provide our products

demonstrate to stakeholders that our patients' interests are paramount and that we are clearly focused on this above all else.

## **Join the Fight to Ensure Product Access**

Manufacturers should utilize their resources to support the fight in Washington over your right to ensure access to the most appropriate products for your patients' needs. Companies should actively seek to partner with respected rehab organizations, such as NRRTS, NCART and AAHomecare, and support their lobbying efforts, including those to build support of important legislation like Allen-Lewis, HR 2231, which exempts complex rehab equipment from competitive bidding.

Competitive bidding and programs like it present a very real threat to patients' access to quality care and products. Programs like this tend to drive quality of care down unless standards are strictly laid out and enforced.

Efforts should also be made to encourage everyone who has a stake in the rehab community, including providers, rehab professionals and patients, to take an active role in lobbying to protect their rights in Washington. We are stronger, have a much louder voice in Washington and end up

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*The standards we impose on ourselves as an industry and on those who provide our products demonstrate to stakeholders that our patients' interests are paramount.*

# INTRODUCING THE **R-4000**

## FEATURES

- INNOVATIVE COMPACT DESIGN
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*Higher Manufacturer Standards Protect Client Needs and Industry Interests*

with better outcomes in our lobbying efforts when we work together. Deliver Products that Make Sense in the New Code Environment

From the earliest stages of development, manufacturers should be focusing their efforts on designing innovative, high-quality products that meet patients' needs while also fitting into the relatively new coding guidelines. The goal is to help streamline the process, reduce

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When manufacturers employ therapists and clinicians as part of a rehab-specific support team, great patient outcomes become easier to achieve. Manufacturers should strive to incorporate rehab professionals into their operations at all levels and should require their complex rehab providers to employ certified therapists and clinicians as well.

**Adhere to These Practices**

Providers and rehab professionals should require the manufacturers

they work with to adhere to these practices. The approach of a clinician is the one that places the patient's well being first and foremost. Manufacturers who take these steps display a superior commitment to patient care and the rehab community as a whole.

When everyone works together to ensure that patients are receiving the best possible products to meet their unique needs, a higher standard of care results for all clients. In today's changing and ever-challenging environment, it is more important than ever to take the steps necessary to ensure the industry never loses sight of this important goal. **D**

*ABOUT THE AUTHOR:*

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*Manufacturers should be focusing their efforts on designing innovative, high-quality products that meet patients' needs.*



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# Ti

L I T E



**LOGAN OLSON**  
Founder and President  
of Logan Magazine

**Chair of Choice**  
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(I can't pick just one)

## Introducing the new TiLite **Aero X**

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## My Story



MIKE OSBORN, CRTS®  
Secretary of NRRTS  
ALLIANCE REHAB & MEDICAL EQUIPMENT

I GRADUATED IN 1991 with a Bachelors of Science in Business with a degree in Marketing Management. I always knew I wanted to get into sales of some sort, and upon graduation was hired for a position in the advertising and sales department of a large newspaper chain in southeastern Missouri.

During my time there, I called on a local DME who was just starting to get into assistive technology and had been in complex rehab for a short

time. The owner of his company approached me about a position working with environmental control units and other small areas of assistive technology. I took the job and started working for that company in March of 1994.

I began attending seminars, training classes and as many manufacturer classes as possible. Many of the seminars were regarding seating and positioning and wheelchairs, which I found to be incredibly interesting. I learned then what many of us know now: positioning in the wheelchair can and does affect every aspect of our clients' daily lives.

I spent as much time as possible working with and listening to the RTS, Greg Clark, who was with the

company at the time. I was very fortunate to be with a small company that was growing. They allowed me to attend rehab classes, and I began to work more and more in the rehab realm. I researched new diagnoses that I wasn't familiar with and tried to relate them to the different types of equipment we were using. Greg invested a lot of time and spent many long hours helping me with my start in rehab. Strangely enough, today that RTS who trained me and helped mold my feelings and ideals about our industry all those years ago is one of my business partners in Alliance Rehab and Medical Equipment.

He and I, along with two other gentlemen, formed Alliance Rehab and Medical Equipment in October of 2006. Trying to start a complex rehab business in today's environment has been difficult, but it is also very exciting. Like many of you, I see the ups and downs of our industry. It can make you question what we do at times. BUT, like many of you I have those individual situations that help remind me why we do what we do.

I remember a particular pediatric client who we started working with when he was only 5 years old. He was a spastic CP client and we were trying to help him become more independent through power mobility. During the evaluation, we observed that every time he grabbed the joystick, his tone would trigger and he would pull it inward to his chest, which caused him

to go in circles. We (the assessment team) set up a power wheelchair with proximity switches under a clear tray.

Once his positioning was corrected, he could activate one switch: *forward*. I spent most of the afternoon teaching him to operate the wheelchair controls. It was the first time in his life of five years that he was independently mobile. Teachers were crying, his peers were cheering him on and his grandmother was speechless.

It took time, but eventually he was able to activate the switches and drive the chair left, right *and* forward. His therapy team has spent many more hours with him, and today he uses a joystick to independently operate his chair and seat functions. He even races in his chair yearly in the Special Olympics. I realize not all of our stories are like this one, but every time someone asks me why I remain a CRTS®, I think of that moment when he drove his chair for the first time. I realized he (and many others like him,) has affected me as much, if not more at times, than I affected him. That is why I couldn't do anything else.

I joined NRRTS and became a CRTS® for the very simple reason that the previous company I worked for demanded it of all RTSs. My previous owner and the head of rehab believed fully in the purpose of NRRTS. They believed, as I do now, that the CRTS® credential is the highest level of certification in our industry. It is the one organization

*Every effort we  
as Registrants  
put into NRRTS  
will come back  
to impact  
us and our  
businesses.*

that all RTs have available to them where they can unite as one voice.

I ended up on the NRRTS board as a result of a conversation I had with Mike Seidel in St. Louis during a NRRTS conference. We were discussing the CRTS® credential and its importance to our industry as well as what it means to be a CRTS®. I wanted to know how to bring CRTS® into the light; it's about more than being the "wheelchair guy." I guess I was a bit pushy with my thoughts and feelings regarding our industry and the certification of CRTS®, because by the end of our discussion, Mike had asked me if I would be interested in running for an NRRTS board position. I was concerned I didn't have the time or the knowledge to accept the opportunity at the time, but I did it anyway. I still don't know if I have the knowledge even today, but I have made the time to be on the board, and it has been a great experience for me.

The CRTS® is at a pivotal point right now. I think the CRTS® is not really recognized at this time in the complex rehab process; we seem to be the one everybody needs to pull complex rehab together, but we are still just the "wheelchair people." In the therapy circle, I think they see us as a valuable part of complex rehab, but the funding sources don't seem to realize our worth. However, I also think CRTS®s are headed in the right direction. The changes in our industry, while frustrating and difficult to understand, will bring the CRTS®s and their skills to the forefront. We, after all, are the individuals who spend the most time with our clients. We are the individuals who relate most with our clients, and we are the individuals who take care of our clients on an ongoing basis. If we can adhere to

quality services and stand our ground on ethical matters, realizing we make a difference not only in our industry but also to our clients, we will be successful. NRRTS is working to see to that, but only with your help.

We just haven't done that enough yet. NRRTS has always worked hard for its Registrants, and is working harder today than ever before. I am very fortunate to be on the board and witness the behind-the-scenes effort put forth by the NRRTS staff and fellow board members. We are at a time in our industry's life when we must stand together. Whether we are competitors or not, we must stand up and have a single voice. NRRTS gives us that voice. NRRTS has not only made great strides in working with RESNA, NCART and the University of Pittsburgh, but it has also taken steps to assist Registrants with education and legislative issues that are of the utmost importance today.

One of our major obstacles of the NRRTS Board is growth. It is difficult to have the time to do all the things we need to do for our organization to grow. For me, finding the time to run a new business, see clients and referrals and maintain a family life isn't easy. However, every member of your NRRTS Board works hard to do just that—find time. It is a voluntary position these individuals take very seriously, and they work extra hours on top of their already busy schedules. Any one who feels like they can make a difference in our industry or who has a desire to make a difference should step up and accept a nomination to run for a board position. We need help to grow and become stronger. It is as simple as the old saying goes: "You get out what you put in." Every effort we as

Registrants put into NRRTS will come back to impact us and our businesses.

On a personal note, I have been lucky enough in life to be blessed with a beautiful wife and two children. My wife, Julie, works at our office three days a week and is the high school dance coach where we live. My daughter, Ginna, is 14 years old, and my son, Peyton, is 10 years old.

We are a very athletic family—Ginna is a cheerleader for school and is on a competitive cheer squad as well. Peyton keeps us running with basketball and baseball. My wife and I, on top of running from practice to practice, are co-directors of our local Upward Basketball program. My days consist of going to the gym at 5:00 a.m. and then to the office by 7:00 a.m. to check e-mail and return phone calls from the previous day. I usually try to spend an hour or so with Alliance Rehab business and paperwork in the mornings and then I'm off to assess clients, wheelchair clinics or delivery of the equipment that is in and ready to be fit to clients. I like to end the day by organizing my schedule for the following day and by preparing for whatever we have scheduled. Then, it's from the office to whatever practice or sporting event my family may have that night. I love what I do as a CRTS® and I can't imagine doing anything else, but the most important thing in my life is my family. Though I spend so much time on my work, I try to let my family know they still hold the number one place in my life. **D**

*ABOUT THE AUTHOR:*

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# Navigating Turbulent Seas: The Rehab Industry in 2008 and Beyond



DOUG MCDANIEL  
Vice President for Strategic Operations  
NATIONAL SEATING & MOBILITY

COMPETITIVE BIDDING. BUDGET CUTS. Reimbursement reductions. Mass marketers trying their hands in rehab. Powered mobility renting for more than 13 months instead of purchasing. Commercial payers following suit with Medicare on competitive bidding. Negative publicity about our industry and our services arising from poorly researched and downright erroneous information.

What seems like five years' worth of potential problems has just happened within the past six weeks!

How did we get here? Why, you ask, are we constantly under fire? Why can't we just focus on doing our jobs? Why can't we just use our

expertise to serve our clients in their time of need? Well, there are a lot of different answers: a lagging economy results in tax coffers that aren't as full as the states need, yielding the need to find places to save money; the proliferation of consumer marketing, which has created a dangerous level of growth in the provision of powered mobility—utilization that is not part of the

standard, clinical medical model; heightened awareness in the public eye (and that of our legislators, too) of the powered mobility market arising from well-publicized fraud committed by unscrupulous, illegitimate providers; and TV commercials and ads in USA Today offering “free” power wheelchairs. Who foots the bill?

**What can we do about it? Differentiate. Educate. Persevere.**

**Differentiate.** If you're even reading this article, you're already part of the solution. You've subscribed to the principles of NRRTS and have dedicated yourself to the ethical advancement of the cause of the rehab technology supplier. You're committed to continuing your education in the field of rehab technology to ensure that your recommendations reflect the most clinically appropriate, fiscally responsible equipment solutions. Many of you have chosen to further differentiate yourselves through RESNA certification, and that effort should be absolutely applauded. Continue to uphold the tenets of NRRTS. Continue to strive to advance yourself and your profession through certification. Continue to widen the sea of separation between serving the clinical needs of the disabled community (there are children impacted here, folks!) and the mass marketers who prey

upon the vulnerable elderly (and our tax dollars).

**Educate.** Decision makers within payers (Medicare, Medicaid and commercial) and our legislators don't yet fully appreciate the difference between what you do and the provision of basic DME. Ours is not a one-size-fits-all commodity! We need to educate the payers on the hours upon hours of labor involved in your treatment of a client's needs. They need to understand the hours that go into a professional assessment (which we're most frequently not reimbursed for), system design (from multiple manufacturer sources), system assembly to spec, delivery of the equipment, training of the client on the safe and appropriate use of the equipment and then the ongoing modifications and adjustments needed to maintain proper fit and function. Our clients don't order our services from watching a commercial and just pick red or blue! Call your legislators—or, better yet, meet them in person when they're in your district. Every interaction with these decision makers must be used to help educate them on the complexity of our cases.

**Persevere.** Don't give up! Understand that the seas we're in are going to be choppy for a while. External pressures are taking a toll on us as an industry. Declining

*Your chosen occupation is a worthy one, and the need for your skills is only going to continue to grow.*



# Service or *Disservice*?



**THIS IS NOT A work of fiction or a blown-up half-truth. This is a parable—a true account of just what can happen when the late-night advertisers promise power chairs within 48 hours.**



CONTRIBUTED BY  
JOHN ZONA CRTS®  
NRRTS At-Large Board Member

Let me start at the beginning. Not long ago, a therapist called to inquire if I would do her a favor. She asked if I would go with her to a new patient's apartment to evaluate the patient and her power chair (which I did not provide) for a vent tray and some seating needs. She reported the patient was a woman in her late 50s with a diagnosis of ALS (Amyotrophic Lateral Sclerosis). The therapist also reported the patient had been using the chair for less than a year, so I asked her if she'd called the company that provided it. She said she had, and that they told her, "we don't do vent trays."

When we got to the apartment and saw the chair, the therapist and I looked at each other; we both knew the answers to our evaluation questions already. What we saw was a very basic mid-wheel-drive consumer power chair with basic electronics and a van-type seat.

I asked the patient how she got the chair and she said her ALS had progressed rapidly to the point where she couldn't walk; she was falling and she felt unsafe. She first

deliver it later in the week. This "nice" man knew the woman had ALS. He knew that she was already using a ventilator nocturnally. He *should* have known this was not the proper power chair for her. But did he know this? Did he care? I can only hope he was ignorant of her diagnosis and did not knowingly provide an inappropriate piece of equipment.

Of course, on a very basic consumer power chair, you cannot add a vent tray to the frame or make seating changes to a van-type seat. This type of chair is not designed or engineered for that.

The therapist and patient were saddened by my news. The therapist brought up the fact that I had provided custom vent trays for her in the past. "Why not on this chair?" I felt she knew the answer, but didn't like it. She asked if I would call the manufacturer's custom department and inquire if anything could be done.

I wrote the serial number down and called them, but as I predicted, they said nothing could be done. They also said if anything like a vent

rehab-type seat and seating system, advanced electronics, ability to add posterior and anterior tilt, and the ability to add a third battery for a vent and more. She received none of this expertise from the company of "experts" that provided her chair.

Following is a brief outline of a basic delivery model we can follow to help ensure a successful outcome when a patient is trying to obtain a piece of complex rehab equipment. Keep in mind that patients with progressive disorders should go through a far different model than the one used in this case for complex rehab equipment needs.

Usually, patients—either through a referral from a health-care professional (physician, therapist, nurse, etc.) or a support group—should first be evaluated by a wheelchair-clinic team. This team must consist of a qualified supplier, and usually a physical therapist and occupational therapist all of whom have extensive experience in custom seating and mobility. These team members have advanced credentials (ATP, ATS or CRTS®), which are only

## This poor woman called an 800 number of a company that professed to employ experts in powered mobility. They were far from it.

went on the Internet to familiarize herself with power mobility, but she grew very confused about which piece of equipment she needed and delivery methods. She later saw an advertisement on late-night TV for power chairs, so she called the 800 number. That same week, a "very nice man" came out and brought a chair with him. She could drive around her apartment and she felt safe. The man took a lot of information from her, including her diagnosis, and said he had the perfect chair for her and could

tray was added, it would void all warranties and I would be liable for anything that happened.

This poor woman called an 800 number of a company that professed to employ experts in power mobility. They were far from it. They were the worst of the worst. This woman, because of her diagnosis, should have been evaluated by a team of experts (a wheelchair clinic) who specializes in complex rehab issues. She should have been provided with a chair that would change as she changed. She should have had a

obtained through demonstrating an appropriate knowledge base, continuing education and extensive experience. The patient should have family members, caregivers, home therapists, etc., present at this clinic setting—any and all individuals who can provide valuable pieces to the equipment-prescription puzzle.

Once thoroughly evaluated (PT, OT and mat assessments performed, measurements taken, equipment needs discussed patient goals outlined), a clinical trial of the

CONTINUED ON page 26

equipment must be completed. The piece of equipment tested should be as close to what the team thinks is appropriate, and if possible, trialed in the home as well. At the least, a home visit must take place to check the environment (i.e., door widths, ramps, hallways, etc.). The clinical team should discuss the changing status of the patient to plan for future needs that may arise.

Once the correct equipment is chosen, write the medical necessity letters, get an MD's approval and submit a prescription and the letters to the insurance company or other payer sources.

After approved by the payer(s), the equipment will be ordered. If the approval has taken more than one month, the supplier (seating specialist) should contact the patient to make

should make sure the seat cushion, back cushion, foot rests, arm rests, laterals, headrests, drive controls, etc., are all adjusted to the patient.

The patient is now ready for initial driving. During this time, programming is fine-tuned for optimum patient function and performance. If everything goes well, the chair is ready to go home with the patient. Once the patient is familiar with the equipment (usually one to two weeks) at home, the chair will usually be programmed again.

This basic delivery model for obtaining complex rehab equipment for patients with progressive disorders takes a lot of time, experience and expertise.

One who is not ignorant of the time, experience and expertise that goes into providing the proper piece

This—the loss of a person's mobility and quality of life due to the unsupervised sale of power chairs—should be a crime. It is why we need strict guidelines on who should provide advanced, complex power mobility for those patients with progressive disorders or diagnoses. It is why there should be a complex rehab “carve-out.” It is precisely why the late-night 800 power mobility “experts” should not be allowed to sell any type of power mobility to these types of patients. I feel if an experienced seating and wheeled mobility supplier (ATS, ATP or CRTS®) and a clinical team had evaluated this woman and given her the proper power chair, she would not be bedridden; she would be driving her chair and enjoying her mobility and independence.

**I feel if an experienced seating and wheeled mobility supplier and a clinical team had evaluated this woman and given her the proper chair, she would not be bedridden; she would be driving her chair and enjoying her mobility and independence.**

sure there have been no changes since the evaluation. The equipment will usually come from different manufacturers (i.e., base from one, tilt from another) or may be shipped to different manufacturers for completion. When the equipment is received, the chair assembly is then completed by the supplier's rehab seating techs. The seating specialist (ATS or CRTS®) then inspects the chair, making sure everything needed is present and functioning correctly and that the chair has been properly adjusted to the basic initial measurements provided by the clinic. The seating specialist or tech then programs the chair within basic parameters for different drive levels and functions.

The chair is now ready for initial delivery. The best delivery model is to have everyone who was involved in the initial evaluation come back to the clinic to check for any further adjustments that should be made. The clinical team

of equipment to patients can see that using Internet pricing as a basis for payment is absurd. When equipment is ordered through the Internet, the chair is shipped to the patient's door. Who adjusts this equipment? Who programs this equipment? Who repairs it in the future? One can also see the late-night TV delivery model is also absurd for this type of patient. Unfortunately, the woman patient I encountered did not have knowledge of this process. The “nice” man should have, however.

The last time I saw the therapist who'd called me, she said she hadn't seen the woman patient since our visit but had been told by nursing staff that she was bedridden and now on a vent 24 hours a day. She could not use her chair for many reasons, but the main cause was the lack of a ventilator. The chair now sits in her apartment unused.

It makes me angry that one of these late-night 800 companies saw it fit to draft and circulate a letter to some politicians letting them know that their “experts” don't feel a need for a rehab carve-out from competitive bidding—that it would not be good for Medicare or Medicare recipients. They went on to say the carve-out would only help a small group of companies that primarily serves complex rehab patients. This perfectly illustrates the ignorance and greed of these companies. **D**

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*The opinions expressed in this article are those of the individual author and do not necessarily represent the opinion of the National Registry of Rehabilitation Technology Suppliers, its staff, board members or officers.*

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# DME ON THE INTERNET:

## *Busting the Myth*



**The Internet**  
The mere word elicits a strong emotional response in this industry. Yes, we've all purchased a book through Amazon, but a wheelchair? How can that be done on the Web?  
And given the recent concerns regarding drop-shipment of complex rehab PMDs by Internet retailers, NRRTS invited me to explain the reality of DME retailing on the Internet.



CONTRIBUTED BY  
LISA STEIN  
CEO/Founder  
SPINLIFE.COM



Quality Internet retailers are not tiny operators selling a few things out of the spare bedroom or basement. Rather, they are full-fledged and fully staffed DME providers who have dedicated customer service, follow-up service and possibly even courtesy insurance and Medicare billing.

**4. The top Internet retailers do a great job.** Of course, we think SpinLife does the best job! Still, we must admit there are several very good online retailers who keep us on our toes. The volume of business for any quality Internet retailer allows for the staffing of a range of product experts in one location, insuring the customer has access to solid advice. Plus, talking to hundreds of thousands of customers over the phone and through online chat has taught

these experts to ask the right questions. They can tell when customers need more support than can be offered online and they steer them to use a local supplier. I can't speak for all Internet retailers, but our experts will even help those customers find a dealer near them.

**5. For every anecdotal story you hear about an incompetent Internet experience, the Internet retailers hear one regarding an incompetent traditional dealer.** The reality is that sometimes mistakes are made and sometimes customers are difficult to make happy, no matter how hard we try. Customers must be careful about who they buy from online just like they must be careful about who they buy from offline.

**6. The reputable Internet retailers think that all**

**providers drop-shipping complex rehab PMDs should be run on the web.**

The occasional unethical and incompetent retailer is a fact of life in our industry—traditional or internet-based—and quality and caring dealers should work together with our vendor partners to weed out and expose subpar performers.

#### **The Challenge**

As the leading Internet DME retailer, we are proud to support NRRTS' efforts to ensure consumers receive high-quality products, expert advice and excellent support after the sale. We hope NRRTS Registrants and Friends of NRRTS recognize the issue is not one of traditional versus Internet-based providers, but rather competent versus incompetent ones. Slingshotting arrows at online retailers and the vendors who support them is not only unfair, but it is also unproductive and distracts everyone from our common goal: encouraging and supporting a quality experience for customers and their caregivers. **D**

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*The opinions expressed in this article are those of the individual author and do not necessarily represent the opinion of the National Registry of Rehabilitation Technology Suppliers, its staff, board members or officers.*

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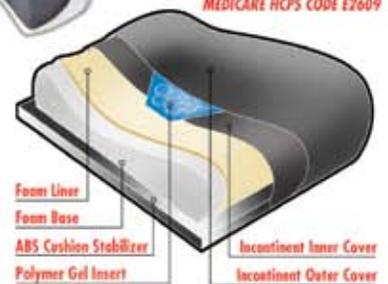
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## Persistence is the Key



DENISE M. FLETCHER  
Attorney  
BROWN & FORTUNATO PC

PROVIDING POWER MOBILITY DEVICES for Medicare beneficiaries has been a challenge since Operation Wheeler Dealer, and the hurdles are about to be raised again. The local coverage determination (LCD) for power mobility devices was issued in 2006, which planned to require a specialty evaluation for patients receiving a Group 2 single-power option or multiple-power option PWC, any Group 3 or Group 4 PWC

or a push-rim activated power-assist device for a manual wheelchair be performed by a RESNA-certified assistive technology practitioner (ATP) specializing in wheelchairs or by a physician board certified in physical medicine and rehabilitation, effective April 1, 2008.

**This provision also required occupational and physical therapists to obtain additional certifications to perform the specialty evaluation required for many beneficiaries to obtain a power mobility device. The American Occupational Therapy**

**Association (AOTA) has spent two years attempting to eliminate this requirement, and it appears that AOTA's persistence and hard work has finally paid off.**

In a December 2007 announcement from the DME PSC medical directors, the PSCs revealed their decision to remove the requirement of a specialty evaluation by a RESNA-certified ATP from the LCD for power mobility devices. The LCD will retain the provision currently in place, which requires that a specialty evaluation be performed by a licensed/certified medical professional such as an occupational therapist or a physical therapist, or by a physician who has specific training and experience in rehabilitation wheelchair evaluations.

AOTA sent a formal request for reconsideration of the power mobility device LCD to Dr. Adrian Oleck in August. One of the three reasons advanced by AOTA for the reconsideration was that the requirement would create an access barrier for Medicare beneficiaries due to the limited number of ATPs. AOTA pointed out that there are fewer than 1,300 RESNA ATPs in the United States, leaving some areas of the country severely underserved. For example, at the time the request was submitted, there were only two RESNA-certified ATPs in Nevada. These two individuals would have a very difficult time meeting the needs of the entire state.

Additionally, AOTA was concerned that the requirements improperly infringed on the practice of occupational therapy by its members. AOTA believes that occupational therapists working in the area of seating and mobility have gained the relevant experience through education, mentoring relationships and clinical settings to properly evaluate individuals for power mobility devices.

AOTA also correctly pointed out that the RESNA ATP certification does not address program integrity issues, as the ATP credentialing test covers a very wide set of topics and it would be possible to pass the test with only a cursory knowledge of some areas. They argued that because many types of clinicians are allowed to sit for the examination—for example, a speech language pathologist could sit for it and obtain certification—someone could potentially meet the LCD requirements to perform an evaluation without having any special knowledge related to the provision of power mobility devices. To resolve this issue, AOTA urged the medical directors to specifically identify the skills they believe an individual should have in order to provide specialty evaluations.

It should be noted the LCD also requires a supplier to employ a RESNA-certified assistive technology supplier or an ATP who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair

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### Persistence is the Key

selection for the patient. This provision will remain in place. This means effective April 1, 2008, suppliers must have an employee on staff who meets one of these requirements.

In addition, the specialty evaluation cannot be performed by anyone who has a financial relationship with the supplier. (It is pretty clear why a supplier cannot pay someone for an evaluation.) However, suppliers often want to push the envelope when it comes to what is and is not a financial relationship. This is particularly true when a supplier is in a rural area and certain types of health-care professionals are in limited supply. Pushing the envelope in this case will only result in trouble. The purpose behind this policy is to avoid conflicts of interest. Furthermore, if a supplier has a financial relationship with another entity, it is Medicare's opinion that the entity will go out of

its way to benefit the supplier. If a supplier has a family member who is an occupational or physical therapist, it is considered to be a financial relationship; someone other than the family member should perform the evaluation. And unlike the oxygen policy, which allows an exception to the oxygen testing for a supplier by the hospital for hospital-owned DMEs, there is no similar exception in this case. Therefore, the performance of an evaluation by an entity with common ownership should also be avoided. If you are uncertain about whether a conflict of interest exists, it is most likely because there is a conflict. Such situations should be avoided.

AOTA has shown us that persistence can result in positive changes. Suppliers should continue to be advocates for their patients in the power mobility device arena. The only way to make change happen is

to continue to educate Medicare and its agencies regarding the provision of these items. **D**

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# Mobility Decision Tree



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FOR A CANE, A patient must have instability of gait, or for a walker, there must be documentation for its provision of greater stability than what can be obtained with a cane.

If a cane or walker is not meeting the patient needs, then the next step is trying a manual chair, and you need to know exactly what the patient does during the day before you can figure out which chair he or she needs. You need to make

sure you have the justification of need for a manual wheelchair over a cane, walker, walker with wheels, etc.

Standard manual wheelchairs require a need for mobility and an inability to ambulate

within the home (the patient can be independent in propulsion or dependent). The level of chair needed depends on the patient's functional needs within the home. The two manual wheelchairs that require a patient to be completely independent in the base being provided are the K0003 (light weight) and the K0005 (ultra light weight). Weight issues are addressed in the K0006 base, which requires

the patient to weigh more than 250 pounds (or to have acute spasticity), and in the K0007 base, which requires the patient to weigh more than 300 pounds.

To obtain a manual tilt in space, whether for an adult or for a pediatric, you must document the reasons why a tilt in space is needed instead of a standard manual wheelchair with a reclining back. The K0009 (other wheelchair base) is used at this time primarily for bariatric bases, although there are some ultra lightweight bases in this code as well.

Once you have established the patient cannot use a manual wheelchair and requires some type of power mobility device, you can jump into the need for a complete documented face-to-face evaluation. The seven-element order that is required must state the date of the face-to-face, length of the product need, item being ordered and diagnosis related to mobility impairment. The face-to-face must address the algorithm and be documented in a physician's normal chart-note format—not on any type of supplier-generated form. The ordering practitioner must state the main reason for the visit was for an evaluation of mobility and not a "follow up for multiple medical problems."

The practitioner must first establish a need and then refer

the patient to a PT/OT for a more detailed evaluation. Then, the practitioner must review the notes from the PT/OT and concur; he or she does not have to write a new seven-element order per the LCD (Local Coverage Decision) policy.

However, the 45-day deadline for getting the documentation to the supplier starts on the date the practitioner reviewed the evaluation. The patient does not have to go back for another face-to-face. There are several areas of concern here, but the LCD policy does state the physician should perform the face-to-face, write the seven-element order, review and sign off on the PT/OT notes and then review and sign off on the detailed product description prepared by the supplier.

The supplier completes the evaluation with the PT/OT, then writes the detailed product description and completes the home environmental evaluation (either at time of or prior to delivery). The supplier must have the detailed product description signed and dated prior to delivery of the chair, and if any section of the description changes, a new order would be required.

The supplier is also responsible for completing and signing an attestation statement, which basically states that he or she has no financial relationship with the

*The level of chair needed depends on the patient's functional needs in the home.*



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**Mobility Decision Tree** PT/OT who is completing the evaluation on the specific patient on the specific date. The hospital-owned DME is exempt of this requirement if the PT/OT is an employee of the hospital.

*The best thing to remember is this: fit the patient to the chair and not the chair to the patient.*

There is no requirement in the policy for the physician to write two separate seven-element orders. The LCD policy states the 45-day timeframe for submitting the order begins on the date the physician reviewed the evaluation, but it does not state he or she must write a new seven-element order.

Also note that the group 3s will not down code to a group 2 if the diagnosis is appropriate. The group 2 single-power options and multi-power options and all of group 3 and 4 power chairs require a PT or OT evaluation. There is no longer going to be a requirement for the clinician to be an ATP after April 1, 2008. However, the requirement for a supplier to hire an ATS or ATP who is directly involved in the evaluation of the client remains in place.

When determining least-costly equipment, Medicare will take into account the patient's weight, seating needs and requirements for specialty features such as tilt, recline, alternative drive controls, ventilators, etc.

When down coding to least-costly alternatives, the first level of down coding will occur during an

automated system edit. But manual reviews or fraud investigations could also cause further adjustment in payment or even a denial based on all applicable criteria.

The best thing to remember is this: fit the patient to the chair and not the chair to the patient. **D**

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# From Assessment to Prescription: Are We the Best We Can Be?



SHARON PRATT, PT  
 Director of Education  
 SEATING FOR SUNRISE MEDICAL

FOR YEARS NOW, I have been assessing clients for seating and mobility as well as helping clinicians and RTSs enhance their skills in this specialty area. Every day, I learn something new, and most days I share my mistakes with those new to this area of clinical practice in the hope that the repetition of these mistakes will be reduced! Our industry is going through some big changes,

but the issues I wish to address stay relevant regardless of industry change.

One of the issues I see repeatedly is our inability to stick with the facts and identify causes of patient discomfort

rather than get bogged down in the symptoms reported by our clients. Sometimes we fail to see the limitations of technology and recognize when “enough is enough” and perhaps that the solution lies outside of the parameters of the seating equipment.

Have you ever thought about seating as a footprint? When assessing our clients for seating, would it help to think about the potential seating footprint? What would an optimal footprint look

like—or does one even exist? Have you ever wondered if we more often reach for bandages than for real solutions? Do we even see the difference? Do we recognize symptoms and are we able to clearly identify the cause or the source behind the symptom?

When writing justification letters, have we provided clarity on the facts and reduced the story?

Have we left the reader with a clear picture of the consequences to the client in the absence of having the recommended equipment? Have we specified that the recommended equipment is in fact the minimal equipment essential to this client, that policy has been adhered to and that what we are recommending is in fact the least costly alternative? Have we demonstrated how we have ruled out anything lesser? You can break this process down into three steps:

- Diagnose the cause before developing a treatment plan, going AGAINST our initial response to just react to the symptoms that present themselves. To diagnose, use the appropriate tools with which our professionals should be very familiar (i.e., a mat evaluation, etc.).
- For supporting documentation, clearly ARTICULATE AND

CONNECT the diagnoses and presenting posture, function and skin analysis to the treatment plan put forward. Use the correct clinical terms and descriptors, pointing out how the plan fits with policy.

- DETAIL which equipment is essential to meet the need and state that anything else would have a high likelihood of failing. Include an explanation of potential consequences of failure.

Questions, questions and more questions. I don’t for one second claim to have all the answers, but I certainly enjoy challenging each of us to think outside of the box and ask ourselves, “Are we the best we can be, and have we represented the clients in the best possible way” when it comes to the selection of the equipment that they rely on to live a quality life?” Let’s take a closer look at that three-step process.

**First:** Diagnose the cause before developing a treatment plan, going AGAINST our initial response to just react to the symptoms that present themselves.

This is contributing to the sliding out of the chair”? My guess is that the more typical is the first example. Let’s break this down. “The client is sliding.” Now, if we just thought about that, we might find ourselves reaching for

*The issues I wish to address stay relevant regardless of industry change.*

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*From Assessment to Prescription: Are We the Best We Can Be?*

items such as straps, trays (upper extremity supports), pommels (medial thigh supports), wedge cushions, knee blocks, etc. How successful would we be with these items? In all likelihood, we would not be truly successful. Yes, maybe, just maybe, the client would not slide out of the seat anymore due to the fact he/she has reached theommel combined with the tray and strap, but at what cost? What have we done to comfort (sitting tolerance), skin integrity and quality of life? Is it a long-term solution? By providing this now, what have we done

slide with all the consequences. By opening up the seat-to-back angle, we are respecting the limitations of the body. Once we open this angle, let's say we open the back as opposed to dropping the front of the seat. This is step one.

We have now aligned the angles of the technology with the body. The body mass is now behind the center of gravity, so we will have to add five to 15 degrees of tilt (less is best) to overcome the negative impact of gravity on the body when the seat-to-back angle is opened.

Now we need to match the body shapes. This is where the idea of footprint comes to play. Some great questions to ask ourselves: Where are all our loading surfaces when sitting? Can the femurs take load? Has the contact area been maximized? Is the shape of the cushion optimal? Is the surface tension of the cushion materials allowing optimal immersion and envelopment? Have peak pressures been reduced? How about the feet? Are they loaded to the best of our ability? (Loaded feet are usually happy feet unless load is contraindicated.) In the pelvis to head area, have we supported the posterior aspect of the pelvis, and have we respected the sacrum? (We know what happens when we don't; we all fall into a posterior pelvic tilt with reduced lumbar lordosis in the absence of support and respect.) Have we provided the shape in the back support to allow for maximum contact area in the lumbar thoracic region? If using a head support, have we optimally loaded the occipital area, or have we just asked for a headrest? Be careful what we ask for—we might get it!

If the goal is occipital loading and contact, we need to be specific in our request and documentation. The end result is that we have fully

assessed the client, identified the presenting postures and figured out whether or not he or she is tolerant of correction. We have identified the desired and necessary posture for safety and function. We have identified the risk for skin integrity issues, and we have matched the technology angles, shapes and orientation to the client findings. The next step is a trial, and the big question is: "Have the original identified goals been met?"

**Second:** For supporting documentation, clearly ARTICULATE AND CONNECT the diagnoses and presenting posture, function and skin analysis to the treatment plan put forward. Use the correct clinical terms and descriptors, pointing out how the plan fits with policy.

Our documentation for this section of the assessment might read like this: "Client who a diagnosis of X has presented in his/her existing seating system a sacral sitter who is sliding out of the chair, needing constant repositioning. Due to this, the client is unsafe; falling is a risk, as well as skin integrity issues. On evaluation, the client has stage one pressure ulcers on the sacral area, bilateral limitations in hip flexion, which are not tolerant of correction and means that the seat-to-back angle on the chair needs to be at X degrees. To overcome the impact of gravity in this angle, the client also needs X degrees of tilt. For optimal stability, function and safety, as well as for skin integrity preservation, the client needs a cushion with the following: contour, materials and cover. A back support with shape for optimal loading and contact area in the pelvic/lumbar and lumbar/thoracic areas is also essential."

**Third:** DETAIL which equipment is essential to meet the need and state that anything else would have a high likelihood of

*The letter of Medical Necessity has to be accurate, to-the-point, diagnoses-driven and clinically worded.*

to the client's funding pot?

Did we not just reach for the bandages without actually having a clear understanding of the cause of the symptom? There could be many causes for sliding. Quite often we slide with our body's angles, shapes and relationship with

gravity have not been adequately assessed and therefore addressed.

Let's look at limited hip flexion. Imagine for a moment that when we got the client out of the chair and onto a plinth or mat table, or some firm surface that is safe, and did a hands-on assessment (a critical piece of the process), we found that bilaterally and symmetrically, the clients hips could not reach 90 degrees relative to the pelvis. We could get 90 degrees relative to the mat table, but at the cost of the pelvis rocking back into a posterior pelvic tilt and a flattening of the lumbar lordosis. This tells us that unless we match the technology angles (seat-to-back angle) to the anatomical angles (femur to pelvis), we will be forcing the client to

failing. Include an explanation of potential consequences of failure.

Documentation in this area should be as informative as this example: "The following equipment features have been tried: X in the absence of the required and requested features, the client will slide, encounter safety issues and experience skin breakdown. X is the least costly equipment that provides essential features for this client.

The intent of this summary is to look at the issue of sliding, address the symptom versus the cause and recognize the benefit of solutions versus the use of bandages.

Among the changes taking place in the industry has been the need for fact-based supporting documentation. The letter of Medical Necessity has to be accurate,

to-the-point, diagnoses-driven and clinically worded. It also has to simply connect the diagnoses and subsequent "treatment plan" with plain logic. In fact, one major reason for rejection and/or down coding is reported as "poorly" written Letters of Medical Necessity.

When we all follow the three steps presented in this article, we can successfully perform an evaluation and provide the necessary supporting information in our Letters of Medical Necessity. **D**

*ABOUT THE AUTHOR:*

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## FORMER NRRTS REGISTRANTS

The NRRTS Board determined RRTS™ and CRTS® should know who has maintained his/her registration in NRRTS and who has not. Names included are from 1/8/2008 through 3/2/2008. For an up-to-date verification on Registrants, visit [www.nrrts.org](http://www.nrrts.org), updated daily.

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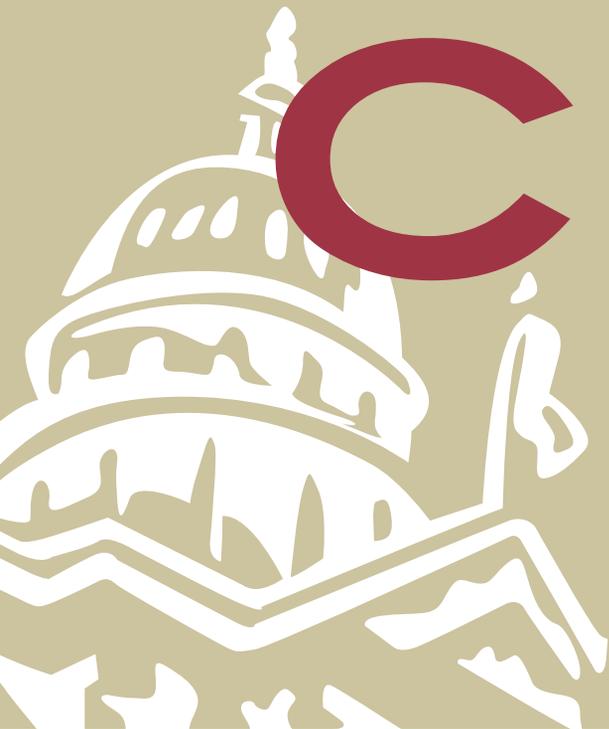
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### Registration Fees

NRRTS Registrants: \$125  
Friends of NRRTS & NCART Members: \$175  
All others: \$250  
Registration Fee includes all course materials; Opening Reception; continental breakfasts; transportation to/from Capitol Hill; and appointment scheduling with your Members of Congress.

## PROGRAM

### Wednesday, April 23, 2008

11:00am - 1:00pm

Registration

1:00pm - 1:10pm

Welcome - Weesie Walker, CRTS®  
NRRTS President

1:10pm - 1:40pm

Consumer's Perspective (TBD)

1:40pm - 3:00pm

Keynote Address  
Mark Schmeler, PhD

3:00pm - 4:30pm and  
4:30pm - 6:00pm

Break-out Sessions

Standing: Principles and Practices  
Ginny Paleg, Andy Hicks

Destructive Postural Tendencies  
Tom Hetzel

6:30pm - 7:30pm

Welcome Reception  
Hors D'oeuvres and Open Bar

7:30pm - 9:00pm

Orientation and Training for  
Capitol Hill Visits  
Sharon Hildebrandt

### Thursday, April 24, 2008

8:00am - 9:00am

Continental Breakfast

9:00am

Buses Depart Hotel for Capitol Hill

10:00am - 4:30pm

Capitol Hill Visits

5:00pm

Buses Depart Capitol Hill for Hotel

### Friday, April 25, 2008

7:00am - 7:30am

Continental Breakfast

7:30am - 8:00am

Capitol Hill DeBriefing  
Sharon Hildebrandt

8:00am - 9:00am

Medical Rationale for Tilt, Recline and  
Elevating Legrests  
Brad Dicianno, MD

9:15am - 11:00am

Break-out Sessions

Bariatric Seating  
Patrick Meeker

Powered Mobility from  
Cognitive to Technology to  
Clinical Application  
Ann Eubank, Kevin Phillips,  
Teresa Plummer

11:00am - 11:30am  
Lunch

11:30am - 12:30pm

Selene Faer Dalton-Kumins  
Disability Advocate  
Director of MetroAccess  
Washington Metropolitan Area  
Transit Authority

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# [NRRTS] 2008 TeleSeminar Series

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The TeleSeminars' faculty members are among the most well-known and talented people in our industry and profession. They will present state of the art information and answer questions from participants. Prior to each TeleSeminar the presenter's Power Point presentation and other course material will be uploaded to a special section of the NRRTS website ([www.nrrts.org](http://www.nrrts.org)). Registered participants may download and print these or follow along, in real-time online during the TeleSeminar.

## TeleSeminar Series Registration Fees

NRRTS Registrants	\$75
Friends of NRRTS	\$100
All Others	\$150

## Individual TeleSeminar Registration Fees

NRRTS Registrants	\$20
Friends of NRRTS	\$25
All Others	\$35

Register on-line at [www.nrrts.org](http://www.nrrts.org) or by phone at (800) 976-7787.

Long distance charges may apply.

**Cancellation Policy: No refunds will be provided.**

*Thursday, March 20, 2008 • 5:00pm to 7:00pm Eastern Time*  
**PRESSURE MAPPING WHEN, WHO AND HOW TO GET PAID FOR IT**

**Sharon Pratt, PT, Sunrise Medical**

AUDIENCE: ATs, ATPs, physical therapists, occupational therapists (intermediate to advanced)

This session will review clinical best practices in the use of interface pressure mapping from around the world, as they exist today. Their pitfalls and strengths will be discussed. The presentation will explore the real world concerns of funding this evaluation modality.

Sharon Pratt has specialized in the field of seating and mobility for over 20 years. Graduating from Trinity College, Dublin, Ireland as a Physical Therapist, Sharon has experienced many aspects of the seating and mobility service delivery model. She has given over 400 presentations on seating and positioning to physical and occupational therapists, nurses and case managers, worldwide. In Toronto, Canada, she managed her own clinical practice, and then managed the seating and mobility devices category as the senior policy coordinator for the Ontario government's Assistive Devices Program. Joining Sunrise Medical in 1996, she developed and managed the education department and lectured extensively on seating to varied audiences worldwide. In 1999, she became the global product manager for Jay seating products.

*Tuesday, April 1, 2008 • 5:00pm to 7:00pm Eastern Time*  
**THERE'S MORE TO POWER SEATING THAN "TILT OR RECLINE?"**

**Stephanie Tanguay, OTR, ATP, ATS, Motion Concepts**

AUDIENCE: ATs, ATPs, physical therapists, occupational therapists (intermediate to advanced)

The ability to design a mobility device specifically for maximizing function is the art that seems to be forgotten in the shadows of codes and margins. This session will utilize case studies to illustrate how much more our industry has to offer the power mobility user.

Stephanie Tanguay's career has focused on seating and mobility for more than eighteen years. She worked as an Occupational Therapist for thirteen years and as a Rehab Technology Supplier for almost seven. She has both ATP and ATS Certifications. Stephanie is currently the Clinical Education Specialist for Motion Concepts.

*Thursday, May 29, 2008 • 5:00pm to 7:00pm Eastern Time*  
**THE MEDICAL BENEFITS OF TILT**

**Jane Fontein, OT, PDG**

AUDIENCE: ATs, ATPs, physical therapists, occupational therapists (intermediate to advanced)

What are the medical benefits of tilt? The session will include a review of studies about tilt-in-space wheelchairs. Case studies demonstrating benefits will spur discussion from the audience about their experiences with tilt.

Jane Fontein has been an Occupational therapist for over 20 years, working in a variety of areas including long-term care and rehab, and as a manufacturer, educator and supplier. She worked at GF Strong Rehab Centre on the spinal cord unit and coordinated the outpatient-seating program. For several years Jane provided education seminars and in-services across North America for wheelchair cushion manufacturers. She has spoken at the International Seating Symposium on several occasions as well as RESNA and the Canadian Seating and Mobility Conference. Jane is the Clinical Specialist for PDG, providing education seminars across North America.

*Thursday, June 26, 2008 • 5:00pm to 7:00pm Eastern Time*  
**HOW IS REHAB FARING IN WASHINGTON?**  
**Rita Hostak, Vice President for Government Affairs, Sunrise Medical**

AUDIENCE: ATs, ATPs, physical therapists, occupational therapists (intermediate to advanced)

Discover exactly what is happening concerning Complex Rehab and Assistive Technology in Washington, DC and what you can and need to do about it.

Rita Hostak is Vice President of Government Relations for Sunrise Medical. She has been with Sunrise since 1982. She has twenty-three years of experience in the home healthcare industry ranging from sales and sales management to government relations. She has twelve years of experience involving the regulatory and legislative side of reimbursement. Rita is the current president of the National Coalition for Assistive and Rehab Technology (NCART), serves on the Regulatory Committee at the American Association for Homecare and is the co-chair of the CMS Program Advisory and Oversight Committee regarding competitive bidding.

*Thursday, July 24, 2008 • 5:00pm to 7:00pm Eastern Time*  
**SPEAKER & SUBJECT TO BE DETERMINED**

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