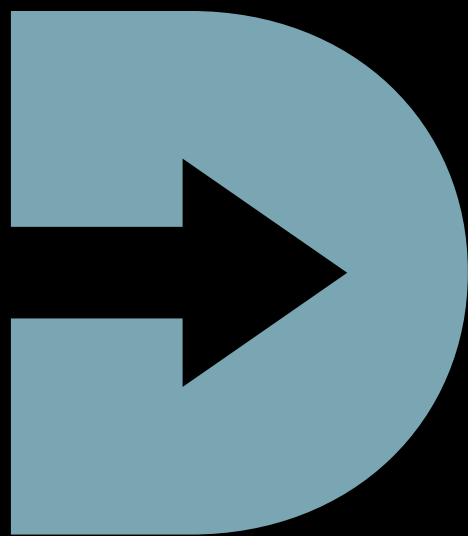


DIRECTIONS



MOVEMENT and **NEUROPLASTICITY**

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NRRTS AMNESTY PROGRAM AND WASHINGTON, D.C.

Written by: **ELAINE STEWART**, ATP, CRTS®

I am very happy to report that the Amnesty Program has brought dozens of complex rehab suppliers interested in joining NRRTS and earning the CRTS® designation. Thanks to each one of you. We have processed close to 50 applications. The CRTS® designation represents experience and ATP certification for an actively employed supplier. These Registrants bring notice to what we as an organization offer our members. The NRRTS Board has extended the Amnesty Program until June 30, 2018.

NRRTS promotes professional suppliers by participating at conferences in related fields. We can gauge the success of this outreach by increased traffic at www.nrrts.org. It is exciting that our website has over 4,200 visits each week.

NRRTS works to cross-pollinate and expose different disciplines and venues via education. Our CEU program continues to offer the availability to go to one place for required learning. Our goal is to provide support for our manufacturers, clinicians and Registrants by offering great course content. NRRTS provided over 2,400 CEUs in 2017.

We will continue to work as advocates for our consumers and to assist with establishing needed legislation to create a Separate Benefit Category. Protecting access to the much-needed equipment our clients require to function daily remains a top priority. The CRT conference is just around the corner in Washington, D.C., April 25-26. Please consider joining us on the Hill to voice our concerns and offer solutions. Due to the generosity of our conference sponsors, about 20 CRT consumer advocates will join us in our Hill visits.

This year, for the first time in a very long time, I will have a consumer to roll with me on the Hill in hopes of obtaining support. During the conference, we will recognize outstanding service and dedication with NRRTS awards. Hope to see you in D.C.!

Register for the National CRT Conference TODAY!

<http://www.nrrts.org/news/2018-national-crt-leadership-advocacy-conference>

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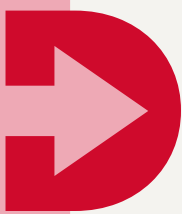


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YOU CAN MAKE TOMORROW A GREATER PLACE

Written by: ROSA WALSTON LATIMER

There was a time in John Morris' life when he could not envision his "tomorrow" much less imagine it as a "greater" place. Now, a dozen years later, this has become his mantra. Morris has used his personal catastrophic experience to help develop a retrofit suspension system for manual wheelchairs that is helping many others, and he is helping to make tomorrow a greater place.

Morris is a C-4 quadriplegic as the result of a snowboarding accident when he was 18 years old. He is very familiar with the difficulties of life in a wheelchair. "Five years after the accident while attending Colorado State University (CSU) I made the switch from an attendant operated tilt-in-space wheelchair to a power chair," he said. "When I experienced the much smoother ride of the power chair I wondered why it had suspension but the manual wheelchair did not." A business idea was born.

Morris knew from experience that when a typical manual wheelchair rolls over a small bump, cracks in the sidewalk or any rough surface the vibration is directly transferred to the individual sitting in the chair causing sharp jolts and pain. A shock absorbing suspension system eliminates this sensation. He believed this innovation was desperately needed especially for wheelchair users who are nonverbal and can't express the pain they feel. "The addition of rear suspension also provides greater independence for individuals by increasing the duration of time they can spend in a wheelchair," Morris explained.

Soon after his recognition of the need for manual wheelchair suspension, Morris was able to begin transforming the idea into a reality. "One of my favorite quotes is 'Today's dreams are tomorrow's reality,' and the opportunities at CSU began to shape my dream into my reality," he said. "I enrolled in 'Introduction to Entrepreneurship' as part of the requirement for my business minor. When I told my professor, Burton Deines, about my idea and its purpose, he strongly encouraged me to participate in the Venture Accelerator Program

through the College of Business Institute of Entrepreneurship at Colorado State.

"I founded my company, QuadshoX in 2014 for the purpose of producing the suspension system. My experience with the institute propelled me to a point where within a year I had a viable product," Morris said. "The program partnered me with a mentor, William R. Cobb, who is a retired Fortune 50 executive along with two engineering students."

Accelerator Showcase. Along with this recognition came some prize money to help get a provisional patent as well as some engineering and design work. All of this allowed us to put the entire puzzle together."

Ten years after his life-altering accident, Morris was well on his way to a fulfilling career that would provide help and comfort to others. Morris acknowledges it would have taken him a very long time, if ever he could, to put everything together to eventually make his product available. "I was confident in the need for the manual wheelchair suspension system, but not so sure how to work through all the steps to make the idea a reality.

"The team that has helped me throughout this journey believed this was work worth doing," Morris said. "Everyone involved wanted to bring this product to life. We never really got paid during the development, but we sincerely wanted to help individuals with mobility issues." Morris' support has been much broader than the QuadshoX team. "My family has been incredible, and I owe Colorado State University and the community of Fort Collins so much!"

Asking for help was not always easy for Morris. "When I broke my neck, I felt helpless. I was stuck in the 'ways of John Morris' prior to the accident, and I couldn't see my way forward," Morris said. "My family finally told me to 'knock it off' and get some help! I got involved with the Spinal Cord Injury Project and met people with disabilities who were accomplishing many things I never

"WHEN I BROKE MY NECK I FELT HELPLESS. I WAS STUCK IN THE 'WAYS OF JOHN MORRIS' PRIOR TO THE ACCIDENT, AND I COULDN'T SEE MY WAY FORWARD. MY FAMILY FINALLY TOLD ME TO 'KNOCK IT OFF' AND GET SOME HELP!"

Eventually Cobb left his responsibilities at CSU to become chairman of QuadshoX and work with Morris full time. "You simply can't do these things alone," Morris said. "We put a pitch together and won the 2015 Venture



ABOVE: John with his family following graduation from Colorado State University in 2015.

BELOW: QuadshoX Team and friends: Arianna Kilmer, John Morris, Karen Lillie, William Cobb and Rodney.



thought possible. That was when I realized I could shape my future and enrolled in college with a major in economics and a minor in business. And that led to QuadshoX.”

Perhaps the most important member of Morris’ team – both personal and business – is his fiancé, Arianna Kilmer. “We met in 2012 at a Spinal Cord Injury Project fundraiser and became really good friends. One thing led to another, and we’ve been together over five years,” Morris said. “In addition to our personal relationship, Arianna is now finance director and secretary of QuadshoX. She guided us through the process of getting approval for reimbursement from Medicaid and Medicare for the retrofit suspension device. Arianna was previously director for a company that worked with intellectually and developmentally disabled individuals, but I stole her from that job. She’s a wonderful partner, and I couldn’t do this without her.”

It isn’t all work for the couple. They enjoy attending all types of sporting events and traveling. “We especially like baseball, football and college basketball. We also enjoy being a part of Fort Collins, especially being involved with organizations that help others with disabilities,” Morris said. The couple also enjoys daily walks with Morris’ therapy dog, Buddy. “He’s my best friend. I’ve had him six years. He used to go to school with me, and now he’s always at work with me.”

Morris acknowledges the biggest challenge with his start-up company was trying to put money together. “I had to prove that I was in this for the long haul and that I would use investors’ money wisely,” he explained. “It was difficult to show that there is a market for this product because so much of our research findings were HIPAA protected.”

YOU CAN MAKE TOMORROW ...
(CONTINUED FROM PAGE 7)

However, he believes the rewards far outweigh the challenges. “It is wonderful to help others! The reward is seeing an individual’s face light up when they can go off-road in their wheelchair or watching someone go down a path to go fishing for the first time.”

Recently QuadshoX entered into a relationship with Seating Dynamics in Centennial, Colorado, to offer the Dynamic Suspension System (DSS) product line. (<https://www.seatingdynamics.com/suspension/>)

“Now our product will have distribution nationally, and we’re considering international distribution as well,” Morris said. “This is a much needed expansion, and we’re very pleased with this opportunity.” The retrofit suspension systems for manual tilt-in-space wheelchairs are now available for the Quickie and Zippie Iris models. The systems will soon be available for additional chair models.

When accepting the Fort Collins Mayor’s Award in 2015 for his dedication to improving the quality of life for those with disabilities, Morris said, “I want to show the world that if you have any type of mobility issue, you do not have an ability issue.” he has proven his mobility challenges have not inhibited his abilities. “QuadshoX is a dream come true! I never thought I would be where I am today.”

CONTACT

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J.MORRIS@QUADSHOX.COM



John and Zachery Scott test their QuadshoX Kits at the Horsetooth Reservoir, Fort Collins, Colorado.



John Morris with Eden Rawley, one of the first QuadshoX Beta Testers showing her support at the 2015 QuadshoX Fundraiser.



QuadshoX Team at International Seating Symposium: William R. Cobb, Arianna Kilmer, John Morris

John Morris is founder of QuadShoX and lives in Colorado.



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AMY JENSEN CUNNIFFE GOES TO WASHINGTON ...

AND JUST LOOK AT WHAT'S SHE'S DONE SINCE SHE GOT THERE

Written by: DANETTE BAKER

A typical day in Washington, D.C., can be, well, anything but typical. Ask Amy Jensen Cuniffe. She has worked in the capital city for 23 years, building a successful career while influencing health care policy. Today, Cuniffe is Numotion's government relations leader, working diligently to protect Complex Rehab Technology (CRT). She also advocates for a number of other bipartisan health issues through her consulting firm, SplitOak Strategies, which she co-founded in September 2017 with Sarah Kuehl Egge, a colleague at Ernst and Young LLP's Washington Council, a legislative and regulatory advisory services group.

The duality of her career, Cuniffe said, "Allows me to have visibility with multiple disability issues that are moving through the congressional process. My visibility to that broad, cross-section of issues allows me to be more effective because I can understand the broader environment in which we are working and that allows me to get things done."

Cuniffe spends her workdays keeping abreast of issues relevant to key decision makers or in meetings with them or their representatives via conference calls or face-to-face; she may attend a congressional hearing to hear testimonies or arrange appointments with officials at the U.S. Health and Human Services Administration. Her workday often extends into the evening; in Washington, there's never a lack of fundraisers or receptions, which present an opportunity to support or network with key legislators.

"I LOVE THE ISSUES I'M DEALING WITH AND, DESPITE WHAT YOU MAY READ OR HEAR, THE TYPE OF PEOPLE WHO COME TO WASHINGTON TEND TO BE, IN MY EXPERIENCE, VERY THOUGHTFUL, VERY INTERESTED IN DRIVING RIGHT OUTCOMES."

"The days are each unique, but fun, and I enjoy that about Washington," Cuniffe said. "You can never really predict where any given day is going to take you."

In fact, Cuniffe thought she'd stay just a couple of years when she moved to D.C. in 1994 after earning an undergraduate degree in political science from Truman State University. She had secured a congressional intern position with then Rep. Dennis Hastert, R-Ill., a congressman from her hometown of Wheaton,

Illinois. During the internship, Cuniffe caught the proverbial political bug, which eventually led to positions as a legislative aide for Hastert when he was Speaker of the House during the Clinton presidency. Cuniffe also served as President George W. Bush's special assistant for legislative affairs, leading efforts in the House on his

behalf to pass the Medicare Prescription Drug Modernization Act of 2003.

"That (Medicare Part D) was such a fascinating issue and one I truly enjoyed working on," Cuniffe said. "There were many similarities (between it) and our CRT legislation. It took years to accomplish and bipartisan support, and it was a huge win for the consumer. I'm very proud to have had a part in providing our seniors access to the drugs they need to keep well."

In theory, the CRT industry's win against competitive bidding did as much for CRT users, Cuniffe said. "It was an incredible victory, and it took years to accomplish. I have never really seen an issue pull together Republicans and Democrats, consumer groups, providers, caregivers and others who care about the issue in such a compelling way.

"I thought it was a positive example of how you can effectively make a change in Washington when you come together. Often you will see industry groups on other issues fighting amongst themselves, unable to come to a consensus on policy. There were times along the way that we struggled to identify the right approach and the right strategy, but we had a common end goal and were able to come together and resolve a very big, very important issue.

"It was frustrating to us that it took as long as it did to get resolved; but once complete, I think the whole community felt so fulfilled and so happy that we

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were able to achieve an outcome that would make such a difference to so many consumers."

A key factor not only in the successful defeat of competitive bidding for CRT, but also for other impending CRT legislation, and for Cuniffe personally, are the consumers. Cuniffe's first interaction with a CRT user came in 2014 at the annual National CRT Leadership & Advocacy Conference, within the first couple of months after she began working with Numotion.

"I watched him roll into the office and recognized how our experiences were so similar but realizing how much I take for granted each day that he has to overcome," said Cuniffe about the consumer, a quadriplegic and former congressional staffer who uses a power chair and CRT and is now an inspiration to her and many others on Capitol Hill. "Without the very personalized assistive devices he uses, he wouldn't be able to work. He is a fantastic guy and an amazing colleague. Knowing him helps me connect in a very real way with the challenges that CRT helps him overcome.

"It has been inspiring to me to meet our consumers, people who every day deal with struggles that would frustrate most people and yet they keep getting up and keep fighting. They are some of the coolest people I've ever met.

"And when the legislators see CRT consumers with their own eyes, you can see in their faces, just like it was with me the first time. There is this realization that we could never convey in our own words."

And that's why, Cuniffe said, "I'm still here."

"I love the issues I'm dealing with and, despite what you may read or hear, the type of people who come to Washington tend to be, in my experience, very

CONTINUED ON PAGE 12

AMY JENSEN CUNNIFFE GOES TO ...
(CONTINUED FROM PAGE 11)

thoughtful, very interested in driving right outcomes. They care a lot about the world that they live in, and for the most part they want to make the world a better place. I found that to be very appealing very early on."

Her work, Cunniffe said, fulfills a lifelong dream of a career in politics, which started at the family dinner table. Her father followed current events and the daily news and made it a side dish for the evening meal, Cunniffe said. That was during the Cold War era, and Cunniffe said resolving the global conflict in a way that still protected the American people easily captured her attention. As a student at Wheaton High, Cunniffe delved into activism, volunteering in local political campaigns, which she continued into her college career.

It was, however, the opportunities afforded her as a 20-something intern, that convinced Cunniffe she could make an impact and a career in D.C.

"I was impressed by what I found to be a very meritorious environment where if you are very young and eager and work hard you can be given a lot of responsibility at a very young age. I found that to be very fulfilling."

Following the internship, Cunniffe landed a position as a legislative assistant and policy analyst for a member of the House's Energy & Commerce Committee. She then managed the health care policy portfolio for the Chief Deputy Whip and served as chief health care policy staff for the Speaker of the House of Representatives, according to her bio with Numotion, before joining "the dark side" of lobbying.

Cunniffe made the switch, she said, to avoid burnout and in doing so, gained a skill set that has made her even more effective. "I've learned to be effective

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by understanding the perspective of the person who is making the decision. If we don't understand and anticipate their concerns and respond, when we put forward a policy solution, then we are just not going to be as effective.

"I wake up every day passionate about getting things done in a way that is very similar to the way it was when I was working on the Hill or working at the White House."

That is due in part, she said, to individuals such as Numotion's CEO Mike Swinford. "I find his enthusiasm to be infectious, and it encourages me to do my best every day to make sure we are keeping the consumers first and foremost in our work and remembering that if we are not doing our best those who really need us will suffer."

That's why, even with the CRT victory against competitive bidding, Cunniffe and others within the industry press on to prevent additional Medicare cuts and improve regulations that impact CRT to ensure the technology available is accessible to those who need it.

"The federal budget will always be a challenge. Anytime you ask the federal government to implement a new policy to improve access that requires spending money, they have to come up with a way to pay for it to advance that policy change. I think we are going to continue to see challenges from payers, including CMS (Center for Medicare and Medicaid), and all aspects of health care will continue to be under the microscope.

"In such an environment, it becomes harder and harder to make changes that help consumers. We will have to be very diligent and creative to get that done."

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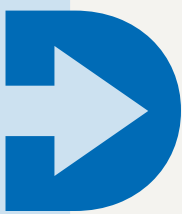
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NRRTS STAFFER ANNETTE HODGES:

ADVOCATE FOR LIFE-LONG LEARNING

Written by: ROSA WALSTON LATIMER

Many NRRTS Registrants are familiar with Annette Hodges through webinars, online courses and other continuing education opportunities. During the three years she has been the continuing education program organizer with NRRTS, Hodges has made a positive impact on the organization's online presence and service to members. "Annette is a dedicated staff member who pays close attention to detail. She is extremely organized and goes above and beyond to take care of the NRRTS Registrants and her fellow staff members," said Amy Odom, NRRTS director of marketing and operations.

Hodges and her husband, Manley, live in LaGrange, Georgia, in the same neighborhood as Weesie Walker, executive director of NRRTS. "During a conversation with Weesie at a neighborhood Christmas party in 2014, I told her I was enjoying retirement but felt my technology experience and knowledge was going to waste," Hodges said. "Things change quickly and I didn't want to get behind." Weesie told me she thought she had an opportunity for me with NRRTS, and after hearing her description of the job, I gladly accepted the offer. I began my responsibilities with NRRTS mid-January 2015."

"I TRULY ENJOY EVERYTHING ABOUT MY JOB AND HOW IT ALL WORKS TOGETHER. WORKING WITH WEESIE, AMY AND MICHELLE HAS BEEN A BLESSING. WE MAKE A GREAT TEAM! IT IS FULFILLING TO SEE GOOD RESULTS FROM OUR PROGRAMS, AND I APPRECIATE HAVING THE ABILITY TO OFFER OUR REGISTRANTS THE CHANCE TO HAVE HIGH QUALITY EDUCATION AVAILABLE TO THEM."

"Annette's knowledge regarding online learning is a godsend to NRRTS. Her experience has brought NRRTS Continuing Education to a higher level," Walker said. "The positive experience of the presenter and attendee is a huge factor in the growth of this program. Annette is always thinking of better ways to promote NRRTS Registrants through social media. Her creative brain is amazing! What fun to work with someone who truly believes in NRRTS' mission."

HODGES JOINED THE STAFF OF NRRTS AFTER RETIRING FROM 25 YEARS OF TEACHING. WE ASKED HOW HER EXPERIENCE AS A TEACHER PREPARED HER FOR HER CURRENT RESPONSIBILITIES WITH NRRTS.

My previous experience and my current responsibilities are both a learning environment but of course the students are very different. I taught technology the

last 14 years of my teaching career in a very small rural town in Alabama. We were involved with an online learning environment with the Oracle ThinkQuest competition. The purpose of this competition is to teach young students to use technology not only as an instrument of learning, but as a means of creating educational content. Our students were able to complete projects with students from Brazil, India and Slovakia to produce educational web sites. That team of students placed either in the top three or earned honorable mention four out of the five years they competed. The last year they won the entire competition. Each year the team placed they won a trip to San Francisco, and the students who had been working online met face-to-face. It was very exciting!

In addition to the experience of bringing this diverse group of students together to successfully complete projects, it was very important to encourage my students to be lifelong learners and to understand that learning doesn't stop when you reach a certain age. You have to take charge of your learning and always be looking for opportunities to learn something new. One of the skills we encouraged was to be self-directed and to make your own opportunities to learn. Those principles carry over into my responsibilities with continuing education with NRRTS. The main difference now is that the participants are adults who recognize the importance of continuing education and the value it brings to their profession. We

have a responsibility to nurture their educational goals and provide an engaging atmosphere for participants. One of our goals is to support their desire to be lifelong learners.

WOULD YOU GIVE US A BETTER UNDERSTANDING OF YOUR SPECIFIC RESPONSIBILITIES WITH NRRTS?

Primarily, I manage the continuing education program. Michelle Lange, who is our continuing education curriculum coordinator, determines what our webinar topics will be for the coming year and makes sure that the core areas of our curriculum are covered. Once Michelle determines who the presenters will be, I create a calendar and set up the webinars. I help make sure that our registrants know about our live, on-demand and CEU articles. Additionally, I host webinars and manage registration. I also manage the records for participants so they can have a proper record of their earned CEUs. We make sure to have everything they need for their professional development requirements. I am also involved with the NRRTS website (www.nrrts.org) that we recently redesigned. I like helping registrants, participants and presenters if they experience any technological problems with our continuing education benefits.

TELL US MORE ABOUT WHAT YOU ENJOY ABOUT YOUR JOB AND WHICH OF YOUR RESPONSIBILITIES ARE ESPECIALLY FULFILLING.

I truly enjoy everything about my job and how it all works together. Working with Weesie, Amy and Michelle has been a blessing. We make a great team! It is fulfilling to see good results from our programs, and I appreciate having the ability to offer our members the chance to have high quality education available to them. I especially enjoy working with our suppliers. I believe NRRTS offers benefits and services that our suppliers appreciate and value. Our suppliers are so committed to what they are doing and are very dedicated and sincere. I think it is important for us to try to make their jobs easier. Suppliers have so many things they need to focus on, it is important for us to make sure that the education itself and the essential records are readily available to them.

WHAT ADVICE WOULD YOU GIVE NRRTS REGISTRANTS THAT WOULD HELP THEM MAKE BETTER USE OF THE BENEFITS AVAILABLE TO THEM?

All of our benefits are first-rate, and the NRRTS' priority is service to our registrants. My focus is on education, and I want our registrants to take advantage of the education NRRTS offers. The content is great, our presenters are experts and webinars are free to registrants. I encourage registrants to visit our website often and keep abreast of what NRRTS is offering.

NOW THAT WE KNOW YOUR RESPONSIBILITIES WITH NRRTS, TELL US ABOUT WHAT YOU DO WHEN YOU AREN'T WORKING.

I became reacquainted with my high school sweetheart, and in 2011 we married and made our home LaGrange, Georgia. I took it easy for a couple of years, took golf lessons and played a lot of golf. My husband and I play regularly at a local golf club here, The Fields. We have the Robert Trent Jones Trail card, and we hope to play every course on the Trail. Our favorite Robert Trent Jones Trail course is Cambrian Ridge in Greenville, Alabama. It is actually in the middle of nowhere and the scenery is beautiful and peaceful. It is a bit challenging, and Manley and I enjoy that. We play together on the weekends, but during the week I try to get several rounds in by myself. We also love to hike, and we enjoy the beach. We are pretty adventurous!

CONTINUED ON PAGE 16



The family (l to r): Annette's son, Alan; Annette; grandsons Jasper, Jaxon and Jace; daughter Kristin and her husband, Jeremy and the "doggie babies" Mulley and Cam.



Annette and Manley Hodges at Robert Trent Jones Ross Bridge, Birmingham, AL.



Golf Tournament at our home course, The Fields Golf Club in LaGrange, Georgia, Annette Hodges' husband, Manley, is wearing the skirt.

RRTS STAFFER ANNETTE HODGES ...
(CONTINUED FROM PAGE 15)

We have two Boxers – Mulley and Cam – that are a very important part of my life. Mulley was the best Christmas present I’ve ever received, and Cam came from my daughter for a ‘visit’ and has been with us for two years.

“AT 9:00 P.M. EVERY NIGHT WHEN THE BOYS ARE VISITING US, WE PLAY A GAME OF UNO, AND IT GETS PRETTY HEATED SOMETIMES. I AM VERY COMPETITIVE! I BELIEVE THE GRANDSONS THINK MANLEY AND I ARE ‘KIDS.’ WE HAVE SAID THEY DON’T REALIZE WE AREN’T YOUNG ANYMORE, BUT WE HAVE A LOT OF FUN AND WE CAN REST UP WHEN THEY GO HOME!”

My three grandsons are involved in baseball and football. When our family gets together, we are always playing dodgeball, football, water ball or some kind of outdoor activity. At 9:00 p.m. every night when the boys are visiting us, we play a game of UNO, and it gets pretty heated sometimes. I am very competitive! I believe the grandsons think Manley and I are ‘kids.’ We have said they don’t realize we aren’t young anymore, but we have a lot of fun and we can rest up when they go home!

Hodges brings this same energy to her responsibilities with continuing education at NRRTS. “I love working with Annette!” Michelle Lange said. “She is so organized and always has new and wonderful ideas for NRRTS. She is also one of the nicest and kindest people I have the privilege of knowing.”



Annette Hodges hiking in the Great Smokey Mountains National Park.



Annette Hodges with her two “boys,” Mulley and Cam.



“I AM LOOKING FORWARD TO MAKING A PERSONAL CONNECTION WITH SO MANY THAT I HAVE ONLY MET ONLINE.”

If you are attending the National CRT Leadership & Advocacy Conference in Washington, D.C., this year you will have the opportunity to meet Hodges and personally experience her enthusiasm for helping lifelong learners reach their goals. “I am very excited to attend this conference,” she said. “I am looking forward to making a personal connection with so many that I have only met online.”

CONTACT

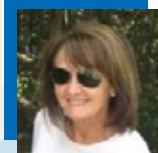
Annette may be reached at AHODGES@NRRTS.ORG.

Annette and Manley Hodges hiking at Stone Mountain, Georgia, with grandsons (l to r) Jace, Jasper and Jaxon.

“WE HAVE TWO BOXERS – MULLEY AND CAM – THAT ARE A VERY IMPORTANT PART OF MY LIFE.”



Annette Hodges is the continuing education program coordinator for NRRTS. She lives in LaGrange, Georgia.





CRT MANUAL WHEELCHAIR ACCESSORIES

Written by: **DON CLAYBACK**

Congress continues to deal with multiple national priorities, and it's within that environment we continue to push for passage of HR 3730, our CRT Manual Wheelchair Accessories bill.

The House bill is being led by Reps. Lee Zeldin, R-N.Y., and John Larson, D-Conn., Our Senate champions, Sens. Bob Casey, D-Penn., and Rob Portman, R-Ohio, also remain committed to resolving this issue.

Complex Rehab Technology (CRT) activities center around securing additional cosponsors and working with our House champions to get our bill attached to a larger piece of legislation that is moving to a vote. As of this writing, the focus is for potential inclusion in the Omnibus Spending bill that Congress is looking to pass by March 23.

Although this spending bill relates to funding the operations of the federal government, there is a variety of other legislation that may be included in it. In that regard Zeldin and Larson have been petitioning congressional leaders to add our CRT bill.

In addition to industry outreach, consumer organizations have written Congress encouraging that inclusion. This includes a recent letter from the ITEM Coalition (representing over 70 consumers and clinical groups). These letters have been backed up by in-person congressional visits.

The bill continues to enjoy strong bipartisan support with 87 cosponsors, 43 Republicans and 44 Democrats. This is a solid foundation but increasing that number to at least 100 cosponsors will send a strong message to House and Senate leadership that this needs legislative action.

We need to continue to add cosponsors and ask Members to tell congressional leadership that this is must-pass legislation. Visit www.protectmymobility.org to see if your Member is signed on and to access contact information to reach out.

CURES ACT MEDICAID PROVISION

Advocacy work is increasing across the country relating to the Medicaid provision in the 21st Century Cures Act. This provision limits federal "Medicaid reimbursement" to state Medicaid programs for certain Durable Medical Equipment (DME) to "Medicare payment rates" and was effective January 1, 2018.

The implementation of this provision by Centers for Medicare & Medicaid Services (CMS) has been very poorly executed. To start, it did not provide state Medicaid agencies initial details until late December 2017 and early January 2018.

Most states have spent the past two months starting to analyze the details and the potential impact it may have on their state, and this has been done with limited and

confusing CMS information. The lack of clear information continues to create confusion at the state level.

This provision has risks to both CRT and DME access, and we have been collaborating with the American Association for Homecare, state associations and others on individual state discussions. Educational materials and assessment tools have been created and are being shared with states to assist in their analysis and evaluation of any potential action.

While this does not require states to change their Medicaid rates, the risk is that states who are paying more than 2018 Medicare rates may look to reduce their 2018 Medicaid fee schedule in response to a potential decrease in federal reimbursement.

Our initial objective is to ensure state Medicaid officials fully understand the details of the regulation, its limited scope and the various options they have before any action is taken.

The core message is that a proper assessment, incorporating the key factors below, will protect a state from cost shifting, increasing overall state health care costs and violating federal statutes:

- **Access Must Be Protected**– The state has an obligation to ensure Medicaid beneficiaries have adequate access to the medical equipment and services they require.
- **Limited Number of Codes**– CMS' annual Medicaid versus Medicare comparison only applies to 244 specifically identified DME HCPCS

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NCART IS LEADING THE EFFORTS TO PROTECT ACCESS TO CRT ON THE FEDERAL AND STATE LEVELS. BUT WE NEED THE SUPPORT FROM ADDITIONAL MEMBERS TO CONTINUE THE FIGHT.

codes, and these include 34 CRT codes. This act should not affect any other HCPCS codes.

- Total Aggregate Payments and No Requirement to Change— CMS' annual comparison is based on the state's total aggregate payments for the 244 identified codes, not on individual code payments, and there is no requirement that a state modify its existing Medicaid fee schedule.

- Avoid Cost Shifting and Increasing State Expenses— Reasonable Medicaid payment rates for CRT are critical to ensuring access and independence and to reducing overall health care costs for children and adults with significant disabilities and chronic medical conditions. Reduced payments for CRT will cause increased health care costs and cost shifting to other areas.

If you are running into issues regarding the Cures Act in your state, please email me and we can share information and coordinate how best to move forward.

NATIONAL CRT CONFERENCE

Will you be joining other CRT stakeholders on April 25 and 26 in Arlington, Virginia, for the 2018 National CRT Leadership & Advocacy Conference? We need you or someone from your organization there.

A major part of the conference is visiting Members of Congress to push for passage of our CRT legislation and

CRT MANUAL WHEELCHAIR ACCESSORIES
(CONTINUED FROM PAGE 19)

continue the CRT education process. We built important momentum last year thanks to everyone's efforts. This year's visits are critical to getting passage of permanent fixes and comprehensive improvements.

By attending you'll benefit from industry-driven topics, unique networking opportunities, regulatory and legislative updates and Capitol Hill appointments with Congress. You can get more details and sign up at www.ncart.us/crtconf. We look forward to seeing many of you there!

NCART MEMBERS NEEDED

If you are a CRT provider or manufacturer, is your company an NCART member? NCART is leading the efforts to protect access to CRT on the federal and state levels. But we need the support from additional members to continue the fight.

Increased membership will provide the resources needed to combat the growing number of CRT access challenges. Our 2018 priorities are:

- Prevent Medicaid cuts to CRT from the provision of the 21st Century Cures Act;
- Stop application of competitive bid pricing to CRT manual wheelchair accessories;
- Pass our federal legislation to create a Medicare Separate Benefit Category for CRT;
- Continue state Medicaid advocacy and secure passage of selective state CRT legislation;
- Respond to other federal and state threats to coverage and payments as needed; and
- Deepen collaboration with consumers and clinicians (individuals and organizations.)

For us to be successful in these and other initiatives, additional industry support is needed. You can get membership details and apply online at www.ncart.us/ membership or contact me directly. You can also learn more about NCART at www.ncart.us.

CONTACT THE AUTHOR

Don may be reached at DCLAYBACK@NCART.US

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Don Clayback is executive director of the NCART. NCART is national organization of Complex Rehab Technology (CRT) providers and manufacturers focused on ensuring individuals with disabilities have appropriate access to these products and services. In this role, he has responsibility for monitoring, analyzing, reporting and influencing legislative and regulatory activities. Clayback has 28 years of experience in the CRT and Home Medical Equipment industries as a provider, consultant and advocate. He is actively involved in industry issues and a frequent speaker at state and national conferences.



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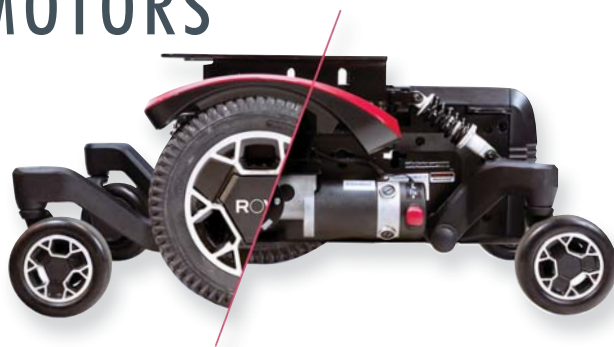
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CLINICIAN TASK FORCE:

THERE IS VALUE IN DIFFERENT PERSPECTIVES

Written by: **LAURA COHEN** PHD, PT, ATP/SMS, EXECUTIVE DIRECTOR, CLINICIAN TASK FORCE

Perspective ...

"What you see depends not only on what you look AT, but also, on where you look FROM." James Deacon

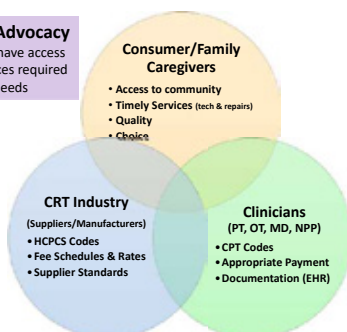
People with different perspectives can have wide-ranging points of view and offer creative ideas to solve problems. Unique perspective and examining problems from multiple angles helps to better understand issues at hand, creates room for innovation and novel solutions, and is critical for growth and success.

Federal and state Complex Rehab Technology (CRT) advocacy work involves a variety of stakeholders. Whether a consumer, family member or caregiver, clinician (therapist, physician, non-physician practitioner), or CRT industry supplier or manufacturer, each CRT stakeholder contributes a critical voice. Each CRT stakeholder group comes to the collaborative table with different urgencies and priorities. And, each CRT stakeholder group defines success and desired outcomes differently. (Figure 1)

FIGURE 1

CRT Stakeholders Perspectives and Priorities

Purpose of Collaborative Advocacy
To ensure people with disabilities have access to quality CRT & CRT related services required for medical and functional needs



An essential part of a collaborative process is incorporating differing stakeholder needs and priorities into a unified balanced purpose and strategy. Reconciling tensions that exist among stakeholder needs and priorities can be challenging calling for tough group decisions and tradeoffs.

For years, CRT stakeholders have worked together united around one common basic goal – collaborative CRT Advocacy: To ensure people with disabilities have access to quality CRT and CRT related services required for medical and functional needs.

PERSPECTIVES AND PRIORITIES

Throughout the years, professional provider organizations, trade associations, coalitions, manufacturers, companies, clinical advocates and grassroots consumer groups have represented CRT stakeholders by organizing and focusing on many of the same issues and activities. Other times CRT stakeholders have been faced with urgent matters for their respective constituency.

It is not always feasible or appropriate for all CRT stakeholders to focus time and resources on identical priorities. It is however critical that each stakeholder group remain aware of other group's key initiatives, comprehend their issues and concerns, and when possible lend support to their efforts to advance the overall success of the common goal

For example, much like HCPCS coding and related fee schedule issues faced by CRT companies, suppliers and manufacturers, clinicians face CPT

PERSPECTIVE ...

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FOR YEARS, CRT
STAKEHOLDERS HAVE
WORKED TOGETHER UNITED
AROUND ONE COMMON
BASIC GOAL - COLLABORATIVE
CRT ADVOCACY: TO ENSURE
PEOPLE WITH DISABILITIES
HAVE ACCESS TO QUALITY CRT
AND CRT RELATED SERVICES
REQUIRED FOR MEDICAL AND
FUNCTIONAL NEEDS.

coding and related fee schedule issues relating to the provision of clinical-related CRT services required by consumers to qualify for a CRT device. While it is not likely or necessary that suppliers and manufacturers 'carry the water' on issues surrounding clinical CPT coding and payment issues, understanding the context of the larger picture and how all of the pieces fit together is necessary. Appreciating how barriers to CRT clinical services negatively impacts the collaborative group purpose to ensure consumer access to CRT devices is key. Consequently, barriers to CRT clinical services is a topic that CRT industry stakeholders and consumers should comprehend to enable them to articulate issues and advocate when appropriate.

Likewise, when consumer/family/caregiver stakeholders identify that access to the community (AKA - only in the home restriction) remains a major barrier to remove, it is important that clinician and CRT industry stakeholders provide shared support.

As CRT stakeholders dig deep in 2018 to push legislation across the finish line to establish a Medicare benefit category for CRT while simultaneously staving off a multitude of other regulatory and policy concerns, it will be necessary for us to reaffirm our commitment and activities to support the CRT stakeholders goal of collaborative advocacy.

THERE IS VALUE IN DIFFERENT PERSPECTIVE (CONTINUED FROM PAGE 23)

While there have been many regulatory and legislative changes since initial discussions began regarding the need for a separate Medicare benefit category for CRT, it will take ongoing collaboration to achieve the goal. The progress has been important but impacting access to CRT for people with disabilities will require all stakeholders bring full passion to push this over the finish line.

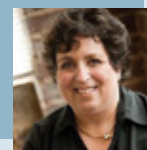
THE FINANCIAL SUPPORT OF OUR SUPPORTERS IN 2018 IS CRITICAL TO ENABLING THE CTF TO CONTINUE TO PRESENT THE VOICE OF THE CLINICIAN ON IMPORTANT CRT MATTERS.

The Clinician Task Force is a nonprofit independent national coalition of 50 seating and wheeled mobility clinicians that advocate for professionally sound, clinically based public policies that ensure individuals with mobility impairments have appropriate access to seating, positioning, and mobility products and services. The financial support of our supporters in 2018 is critical to enabling the CTF to continue to present the voice of the clinician on important CRT matters.

CONTACT THE AUTHOR

Contact Laura at LAURA@REHABTECHCONSULTANTS.COM

Laura Cohen is the executive director of the Clinician Task Force (CTF), a national group of seating and mobility clinicians working to influence Medicare and Medicaid coding, coverage and payment policies for complex rehab and assistive technology devices. The CTF provides clinically relevant information about seating and wheeled mobility device assessment and decision making to policymakers to ensure appropriate access for individuals with disabilities.



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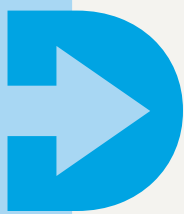


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THE FINISH LINE

Written by: **ALEX BENNEWITH**, MPA

ADVOCACY ALLIANCE

So, here we are in March 2018 and what with the 2018 Winter Olympics in Pyeongchang, South Korea, having just finished and the 2018 Winter Paralympics now coming to an end, my sports analogy is apt. It is time for, hopefully, one last advocacy push to get manual Complex Rehab Technology (CRT) exempted from the competitive bidding program over the finish line. I think Toyota's Mobility For All advertisement, shown during the Olympics, does a very good job of showcasing human mobility and its importance in creating a welcoming society, showing individuals from ages 1-100 in all walks of life and activities. Here's a portion of the transcript:

"... movement is a human right; it's something we all deserve, whether we're taking our first steps or our victory laps because when we're free to move, anything is possible. Start your impossible."

I say getting improved access to my members and all your customers is not impossible, it is possible and it is a right that we can surely fix. Also, to help with the advocacy push and for your clients and customers to get involved in self-advocacy, they can visit United Spinal's Advocacy Action Center <https://www.unitedspinal.org/action-center/> for background on CRT and other issues along with advocacy tools and tips. Please also note that you will be hearing from more of us across the country with more state and local voices in addition to our federal footprint. We have designated six regional advocacy coordinators across the country who will be

in close communication with United Spinal Association chapter advocacy representatives at each of our 50 chapters. This will help both facilitate and promote increased advocacy action at both the federal and state levels.

"... MOVEMENT IS A HUMAN RIGHT; IT'S SOMETHING WE ALL DESERVE, WHETHER WE'RE TAKING OUR FIRST STEPS OR OUR VICTORY LAPS BECAUSE WHEN WE'RE FREE TO MOVE, ANYTHING IS POSSIBLE. START YOUR IMPOSSIBLE."

disabilities and chronic conditions from Medicare's Competitive Bid Program (CBP). This important legislation will protect Medicare beneficiary access to manual CRT as well as essential components known as wheelchair "accessories." United Spinal has long supported access to manual CRT and all types of CRT for Medicare beneficiaries living with physical disabilities of all kinds and supports

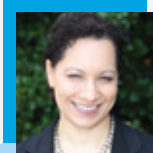
the inclusion of this legislation into the omnibus spending bill.

Thanks to all the wheelchair manufacturers and providers, therapists, assistive technology professionals, and seating and mobility specialists out there for all your advocacy support over the years. United Spinal urges everyone to include HR 3730 in the omnibus spending bill expected to be passed by March 23. Once this goes to print, hopefully, we will have some good news to report; otherwise, we will just keep pushing forward together. So, get on your starting blocks, and let's get to the finish line!

CONTACT THE AUTHOR

Alex may be reached at ABENNEWITH@UNITEDSPINAL.ORG

Alex Bennewith is vice president of government relations for United Spinal Association. Bennewith advocates for legislation and regulations regarding disability and health policy at both the federal and state level. She works closely with a range of stakeholders in the durable medical equipment and supplies, prescription drug, public health and disability communities. She graduated from Brandeis University and received a Master of Public Administration from American University.



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MOVEMENT and NEUROPLASTICITY

Written by: **SUZANNE PAYNE EASON**, OT/L

Movement in a seating system and mobility device is essential for neuroplasticity in the neurologically challenged client. I have worked with neurologically challenged children and adults for 30 years and have observed the changes in our professional/medical understanding of how the brain develops and copes with these issues and the resultant changes in treatment. Most of the individuals I work with have very limited motor skills and require mobility devices to support their daily needs. Early on, our treatment adapted the client's world to overcome the challenges created by damage to the brain. Now, with our understanding of how the brain changes, we can enhance their skills and neuroplasticity through enriched environments.

Neuroplasticity is defined as the brain's ability to reorganize itself by forming new neural connections throughout life. It is the creation of new neurons and the ever-changing wiring that happens through interactions with our environment. Enriching and enhancing one's environment has been shown to positively affect neuroplasticity in numerous research studies. While the

CONTINUED ON PAGE 30

MOVEMENT AND NEUROPLASTICITY (CONTINUED FROM PAGE 29)

exact definition of enriched environments is still open ended, one of the most important characteristics of enrichment is movement. Movement is defined as an act of changing physical location or position. Movement encourages our brains to understand how our world is set up and how we form relationships with our world. Movement can be something that is done to us or, more important, is something that is intrinsic or intentional to that individual, done under one's own desire, intent or motivation. The type of movements referred to here is either vestibular, the sense of our body moving through space or movement of joints that is self-initiated. The vestibular system is always 'on,' has connections throughout the central nervous system that effects reflexive and planned movement, and effects our state of arousal and cognition. Self-initiated movement, also called experience dependent activity, feeds our brain, creating new connections and possibly improving sensorimotor performance. Experience-dependent activities enhance brain-derived neurotrophic factor, a protein that enables a brain's recovery at the structural and chemical level. This factor is imperative in allowing new wiring and connections between neurons. The more experience-dependent activities, the more brain derived neurotrophic factor. Enriched environments that stimulate an individual to move and explore enhance neuroplasticity. We all are familiar with the research studies that provide one group of animals with lots of opportunities to move and play while another group of animals has limited access. The animals with enriched environments have more axons and dendrites at their neurons than the comparison groups.

Our seating systems and mobility devices are a perfect starting point to look at enriching environments for individuals. In most cases these systems are used daily and are a vital part of a person's life. Movement in these systems, while still encouraging postural control and pressure relief, is one way of enriching the environment. This movement can be as simple as adding an air bladder to a seat or a back or as complex as a manufactured dynamic add-on part or a full frame. Enriching environments for our neurologically challenged clients, including movement within the system, should be a goal for most seating clinicians.

CONTACT THE AUTHOR

Suzanne may be reached at SEASON@SMHDC.ORG.

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Suzanne Eason has been an occupational therapist for over 25 years and the director of Occupational Therapy Support Services at St. Mary's Home in Norfolk, Virginia, for 19 years. Eason has found her calling as an advocate for individuals with complex medical conditions. Her motto: "We provide the foundations for function" has evolved into a small private practice. When not at SMHDC, she can be found at her busy home with her husband and two legged and four legged children.



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DOES A POWER ADJUSTABLE SEAT HEIGHT SYSTEM MEET THE DEFINITION OF DURABLE MEDICAL EQUIPMENT, AND IS IT MEDICALLY NECESSARY?

– WHAT DOES THE RESEARCH SAY?

Written by: **JULIE PIRIANO**, PT, ATP/SMS

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The answer to this question, based on extensive formal research, proves a resounding, yes. As the following data shows, power adjustable seat height plays a vital role in the medical device needs of those with permanent disabilities who require a complex rehabilitative power wheelchair.

42 CFR § 414.202 (The Code of Federal Regulations, Title 42 – Public Health, Chapter 4 – Centers for Medicare and Medicaid Services, Department of Health and Human Services, Subchapter B – Medicare Program, Part 414 – Payment for Part B Medical and Other Health Services, Subpart D – Payment for Durable Medical Equipment and Prosthetic and Orthotic Devices, Section 414.202 – Definitions) defines durable medical equipment as equipment, furnished by a supplier or a home health agency that meets the following conditions:

“AS THE FOLLOWING DATA SHOWS, POWER ADJUSTABLE SEAT HEIGHT PLAYS A VITAL ROLE IN THE MEDICAL DEVICE NEEDS OF THOSE WITH PERMANENT DISABILITIES WHO REQUIRE A COMPLEX REHABILITATIVE POWER WHEELCHAIR.”

1. CAN WITHSTAND REPEATED USE.

In 2016, the REARLab at Georgia Tech (2017) conducted a survey of power wheelchair (PWC) users who had a power adjustable seat height system (PASH) on their current wheelchair to solicit information as to when, where and why this feature is used. One hundred of the 112 respondents (89.3%) that answered the

question, “Approximately how often do you engage the seat elevating feature to raise or lower the seat?” reported using the PASH feature more than once per day; 56 (50%) respondents indicated they use the feature “a few,” “several” or “over 10” times per hour demonstrating that PASH can withstand repeated use. For example: 10 elevations/day x 365 days/year x 5 years=18,250 lifts over the five-year reasonable useful lifetime (RUL) of the power wheelchair it is used

on. This exceeds the standard 6,667 testing cycles by 11,583 cycles.

2. EFFECTIVE WITH RESPECT TO ITEMS CLASSIFIED AS DME AFTER JANUARY 1, 2012, HAS AN EXPECTED LIFE OF AT LEAST THREE YEARS.

The Food and Drug Administration (FDA) deems power wheelchairs as a Class II medical device. It is required to meet ANSI/RESNA testing standards, as verified by an independent testing facility and be code verified by the Medicare Pricing, Data Analysis and Coding (PDAC) contractor prior to entering the marketplace. A power adjustable seat height system is a FDA Class II medical device that is an accessory to a power wheelchair, which is also required to meet or exceed the minimum reasonable useful lifetime expectation of three years or greater.

3. IS PRIMARILY AND CUSTOMARILY USED TO SERVE A MEDICAL PURPOSE.

The Social Security Program Operations Manual Equipment HI 00610.200 states that “Equipment Presumptively Nonmedical ... serves comfort or

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convenience functions or is primarily for the convenience of a person caring for the patient such as elevators, [and] stairway elevators ... [and] do[es] not constitute medical equipment.”

A power adjustable seat height system (see Figure 1) that raises and lowers a seated individual with a permanent disability, as a component or accessory of a power wheelchair, is neither an elevator (see Figure 2) nor a stairway elevator (see Figure 3). It is recognized that elevators and stairway elevators allow an individual to move from one floor of the home to another, where the bedroom and/or bathroom is located, and may serve a medical purpose for an individual with mobility challenges. However, there is consensus among the general population that the primary and customary use of these “elevators” is non-medical and as such would not be deemed medical equipment.

In contrast, a PASH system is similar in function to the seat lift mechanism incorporated in a lift chair, which serves a medical purpose as it raises and lowers an individual with specific limitations while they are in a seated position. The primary and customary use of the chair component of a lift chair is a nonmedical one and it cannot be deemed medical equipment. Conversely, the PASH system can **ONLY** be used on a medically necessary power wheelchair and should be considered “Equipment Presumptively Medical” under the Social Security Act.

The Medicare National Coverage Determination (NCD) 280.4, entitled “Seat Lift” allows for coverage of a seat lift mechanism in certain situations as it states, “Reimbursement may be made for the rental or purchase of a medically necessary seat lift when prescribed by a physician for a patient with severe arthritis of the hip or knee and patients with muscular dystrophy or other neuromuscular diseases when it is determined the patient can benefit therapeutically from use of the device.”

In establishing medical necessity for the seat lift, the evidence must show that the item is “included in the physician’s course of treatment, that it is likely to effect improvement, or arrest or retard deterioration in the patient’s condition, and the severity of the condition is such that the alternative would be bed or chair confinement.”

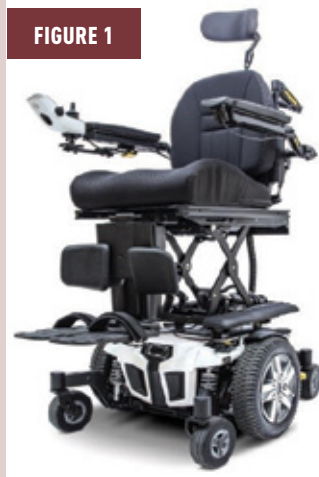
The NCD further states, “Coverage of seat lifts is limited to those types which operate smoothly (see Figure 4), can be controlled by the patient, and effectively assist a patient in standing up and sitting down without other assistance.”

The Medicare Local Coverage Determination (LCD) for Seat Lift Mechanisms (L33801) states that a seat lift mechanism is covered if the beneficiary is “completely incapable of standing up from a regular armchair or any chair in their home.”

Individuals with permanent disabilities and significant medical conditions such as, but not limited to, amyotrophic lateral sclerosis (ALS), cerebral palsy (CP), cerebral vascular accident (CVA), multiple sclerosis (MS), muscular dystrophy (MD), spina bifida, spinal cord injury (SCI), or traumatic brain injury (TBI) who use a power wheelchair to ameliorate their mobility limitation may also have a need for a medical device that operates smoothly, can be controlled

CONTINUED ON PAGE 34

FIGURE 1



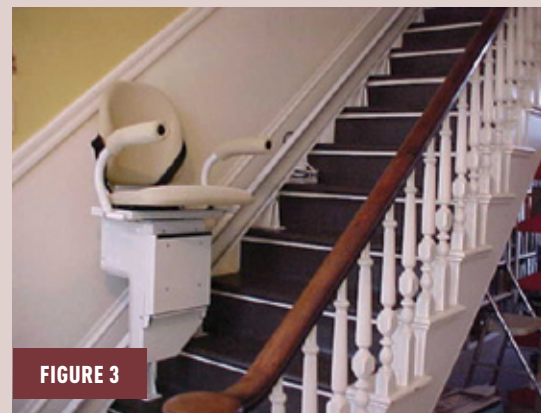
Power Adjustable Seat Height

FIGURE 2



Elevator

FIGURE 3



Stair Glide

FIGURE 4



Smooth Operation of a Lift Chair

DOES A POWER ADJUSTABLE SEAT ... (CONTINUED FROM PAGE 33)

by the patient, and effectively assists them in raising and lowering their position along the vertical continuum (see Figure 5) when prescribed by their physician to arrest or retard deterioration of their condition.

If the power wheelchair is the medically necessary item of mobility assistive equipment to replace the loss of function in the lower extremities (LEs) for ambulation, as well as the loss of function in the upper extremities (UEs) for manual wheelchair self-propulsion, then it stands to reason that the power adjustable seat height system would replace the loss of function in the LEs to transfer to/from the PWC and/or the loss of function in the UEs to reach and function to perform or participate in one's mobility related activities of daily living (MRADLs).

4. GENERALLY, IS NOT USEFUL TO AN INDIVIDUAL IN THE ABSENCE OF AN ILLNESS OR INJURY.

Comparable to a power tilt or power recline feature, the PASH feature can ONLY be used as an accessory on a medically necessary power wheelchair. As such, this component is ONLY useful to an individual with an illness or injury who also meets the coverage criteria for the PWC it will be used with.

While the power wheelchair replaces a beneficiary's loss of upper and/or lower extremity function by allowing them to move from points A – Z in a two-dimensional plane independently, safely and in a timely manner throughout the day, we live in a three-dimensional world. For an individual with a permanent disability who uses a complex rehab power wheelchair, the addition of a power adjustable seat height system may be a medically

Kiel Actively Elevating in a PASH System



necessary power seat option to replace loss of function in the vertical plane and “significantly improve the beneficiary’s ability to participate in MRADLs ...” in accordance with the Power Mobility Device Local Coverage Determination.

The Medicare Power Mobility Device (PMD) Local Coverage Determination (LCD) (L33789) states, “all of the following basic criteria (A-C) must be met for a power mobility device (K0800 – K0898) ... to be covered.

- a) The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:
 - i. Prevents the beneficiary from accomplishing an MRADL entirely; [independently] or
 - ii. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; [safely] or
 - iii. Prevents the beneficiary from completing an MRADL within a reasonable time frame [timely].
- b) The beneficiary’s mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.
- c) The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day.
 - i. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
 - ii. An optimally-configured manual wheelchair is one with an appropriate

wheelbase, device weight, seating options and other appropriate nonpowered accessories.”

In addition, a power wheelchair is covered if, “use of a power wheelchair will significantly improve the beneficiary’s ability to participate in MRADLs and the beneficiary will use it in the home.”

Further, the National Coverage Determination (NCD) for Mobility Assistive Equipment (MAE), 280.3 asks, “are the additional features provided by a power wheelchair needed to allow the beneficiary to participate in one or more MRADLs?” This may comprise “the ability to accommodate a variety of seating needs” including power seat functions.

The Medicare Power Mobility Device – Policy Article (A52498) defines the power options on a power wheelchair, which are covered under the durable medical equipment (DME) benefit as follows:

- a) “Single Power Option – A category of PWCs with the capability to accept and operate a power tilt or power recline or ... for Group 3, 4 and 5, a power seat elevation system
- b) Multiple Power Option – A category of PWCs with the capability to accept and operate a combination power tilt and recline seating system. It may also be able to accommodate ... a power seat elevator ...”

Neither a power wheelchair, nor its accessories would be useful to an individual in the absence of an illness or injury. However, in the presence of an illness or injury, both the power wheelchair and the appropriate, critical components used with it, are essential to replace the loss of function individuals with permanent disabilities and complex medical needs experience.

5. IS APPROPRIATE FOR USE IN THE HOME.

In the 2016 survey conducted by Georgia Tech when respondents were asked to “estimate the relative frequency of using seat elevation in the locations listed,” 102 of 109 respondents (93.6%) indicated that they use it in the home often or sometimes.

	Often	#	Sometimes	#	Rarely	#	Never	#
At Home	78.9%	86	14.7%	16	4.6%	5	1.8%	2

A POWER ADJUSTABLE SEAT HEIGHT SYSTEM IS NOT ONLY APPROPRIATE FOR USE IN THE HOME, IT IS A MEDICALLY NECESSARY COMPONENT OF A COMPLEX REHABILITATIVE POWER WHEELCHAIR THAT MAY BE ESSENTIAL FOR THE INDIVIDUAL’S HEALTH, SAFETY, WELL-BEING AND INDEPENDENCE.

Wheelchair mobility is often only considered from the perspective of people moving from one point to another in a two-dimensional plane. Vertical movement is necessary in order for people to function and participate in a three-dimensional world. A common intervention that provides vertical mobility within a wheelchair is a seat-elevating device. (Arva, J., Schmeler, M.R., Lange, M.L., Lipka, D.D., & Rosen, L.E., 2009). Hence, the provision of a power adjustable seat height (PASH) system is medically necessary to:

1. ENABLE TRANSFERS

“Transferring from a wheelchair to other surfaces such as a bed, toilet or other surface is a necessary part of the daily routine. Transferring is a means to accomplish MRADLs (mobility related activities of daily living), and therefore it is considered a medical necessity” (Arva et al., 2009). In the survey conducted by Georgia Tech, 84 of 105 respondents (80%) indicated that they used the seat elevation feature “often” or “sometimes” during transfers to or from the wheelchair.

Wheelchair users must transfer a minimum of twice each day, yet Kim, Her and Ko (2015) found that “among the basic ADL, transfer is a task that is performed by each patient 15 – 20 times per day, on average.” Regardless of the method used, the ability to adjust the height of the seat, in conjunction with transfer training using an appropriate method and proper technique, may be an essential component for independent, safe and efficient transferring to/from the wheelchair.

SIT-PIVOT METHOD

Sitting pivot transfer (SPT) is the most common transfer method using the upper extremities (Kim et al., 2015). In fact, wheelchair users with absent or significantly impaired use of their lower extremities “must use their upper extremities for almost all activities of daily living (ADLs), such as getting in and out of bed, transferring to a shower or toilet, and transferring in and out of a car” (Tsai, et al., 2014).

[Sit-pivot] transfers are one of the most strenuous wheelchair activities performed, and incorrect transfer skills may predispose wheelchair users to developing upper limb pain and

DOES A POWER ADJUSTABLE SEAT ... (CONTINUED FROM PAGE 35)

overuse related injuries, such as rotator cuff tears, elbow pain and carpal tunnel syndrome (Tsai et al., 2014). Kim et al. (2015) not only report “pain prevalence rates [of] 58.5% – shoulder: 71%, elbow: 35%, wrist: 53%, hand: 43%” – they also state that SPT is “the most burdensome task for the musculoskeletal system, the nervous system and the cardiovascular system among wheelchair related ADL.”

Kim et al. (2015) “compared the changes in trunk and shoulder angles and reaction forces under each hand at two different seat heights in 18 unimpaired males during independent siting pivot transfer. They found significant increases in the trunk angles of forward and lateral flexion, even though rotation decreased while transferring in the lower hand position. Increased shoulder flexion, anterior/posterior forces and reduced lateral forces were also shown. Hence, placing the hands of the supporting arms lower than the seat position during sitting pivot transfer was identified as having biomechanical advantages.” They suggest that the results of the study “can be applied as guidelines for effective and safe methods for ... spinal cord injury patients’ SPT, and can be utilized as reference data when considering the appropriate heights of aids for wheelchairs.”

Clinical evaluation and observation should take into consideration UE, core and LE strength, range of motion, muscle tone and balance when determining the difference between the seat height of the wheelchair and the height of the surface to be transferred to or from.

Tsai et al. (2014) looked at whether using proper transfer skills as measured by the Transfer Assessment Instrument (TAI) is associated with reduced loading on the upper extremities in 23 wheelchair users [that] performed transfers to a level-height bench while a series of force plates, load cells and a motion capture system recorded the biomechanics of their natural transferring techniques. While Part 1, item 5 of the TAI states, “the subject performs a level or downhill transfer, whenever possible” the study removed the height differential and had all participants perform level transfers to validate that the TAI is an effective tool for evaluating transfers on a 15-point scale. The study concluded that, “the transfer skills that can be measured by the TAI are closely associated with the magnitude and timing of joint movements. As such, the TAI may be useful for measuring the effects of a training intervention on upper limb joint loading.” This may include the recommendation of a power adjustable seat height system for power wheelchair users who must perform level or downhill transfers.

STEPHANIE

Stephanie was born with spina bifida. She does not have use of her legs and, as a person who has self-propelled a manual wheelchair her entire life, she is now experiencing pain, reduced strength, muscle fatigue and decreased function in her upper extremities such that she is now using a power wheelchair for mobility.

In the morning, she is unable to perform a sit-pivot transfer from her bed at 23 inches high to her wheelchair at 25 inches high, as it is an uphill transfer that she does not have the capacity to perform (see Figure 6). Without the ability to lower the seat to 21,” Stephanie is rendered bed-bound and subject to all the complications associated with that, such as muscle atrophy, increased risk of pressure injuries, pneumonia, bladder infections and malnutrition. By lowering the wheelchair seat height to 21,” she is able to perform an independent sit-pivot transfer, minimizing the risk for UE damage or loss of balance (see Figure 7).



FIGURE 6



FIGURE 7

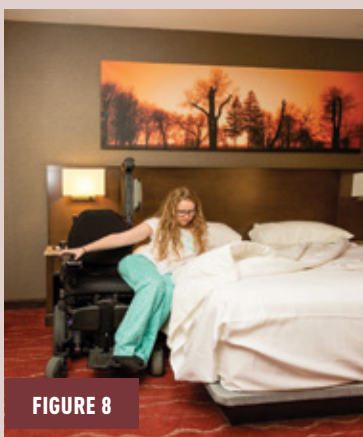


FIGURE 8

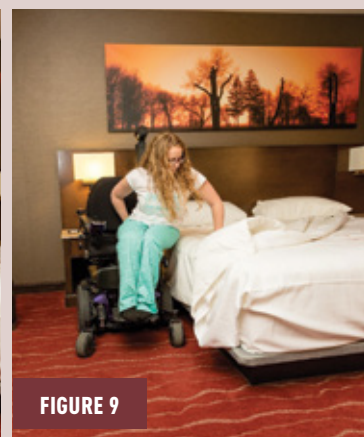


FIGURE 9

Stephanie stuck in bed

Stephanie transferring from bed to w/c

Stephanie attempting to transfer to bed

Stephanie transferring from w/c to bed

The reason the seat is at 25 inches high in the morning is because Stephanie requires that height to transfer from her wheelchair to the bed at the end of the day. With fatigue exacerbating the challenge of transferring uphill to her bed at 23 inches high from a low, static seat height of 21,” Stephanie is at high-risk for an adverse occurrence from a fall in her attempts to transfer (see Figure 8). This may include, but is not limited to, fractures, dislocations, head and/or spinal injuries, lacerations and contusions, all of which increase health care costs. By adjusting the height of the wheelchair seat up to 25,” she creates a 2 inches height difference between the chair and her bed for a downhill transfer (see Figure 9).

STAND-PIVOT METHOD

A sit-to-stand (STS) movement, which is defined as a movement of standing up from a chair to an upright posture, is a frequently performed activity of daily living according to Yoshioka, Nagano, Hay and Fukushima (2014). They found that “community dwelling people stand up from a chair approximately 60 times each day.” However, “many people with weakness, pain, or other disabilities of the lower extremities have difficulty rising from a standard seat height” (Burdett, Habasevich, Pisciotto & Simon, 1985).

Janssen, Bussmann & Stam (2002) performed an extensive review of literature from 1980 to 2001 (n=39) on STS movement. They report the “minimum height for successful rising ... appears to be 120% of lower leg length” and “lowering the height of the seat makes the STS movement more demanding or even unsuccessful.” Hence, attempting to transfer from a seat height that is too low may be associated with an increase in fall risk.

While a minimum chair height standing (MCHS) ability test has been shown to be effective as a fall risk screening instrument for older individuals (Reider, 2012), the research has not included individuals with disabilities or those who use power wheelchairs.

Yoshioka et al. (2014) examined “the large range of seat heights on peak joint moments of the lower limbs during STS movement” using eight healthy, young subjects. They were studied standing up from seat heights of 10 cm (3.93 inches), 20 cm (7.87 inches), 30 cm (11.81 inches), 40 cm (15.7 inches), 50 cm (19.68 inches) and 60 cm (23.62 inches). The study confirmed that, “the peak mechanical load and the peak knee to hip joint movements increase inversely to seat height within the range of high to normal seat height (60 to 40 cm).” The study concludes that “the findings are useful for the design of chair [and] the improvement in the evaluation standard of minimum sit-to-stand height tests.”

Nakamura, Nagasawa, Sawaki, Yokokawa & Ohira (2016) cite previous studies that report “the vastus lateralis, rectus femoris and tibialis anterior muscles showed a tendency toward higher activity levels with decreasing seat height” and indicate “standing up from a lower seat height would be more demanding.” To confirm this, they examined “the effect of different seat heights on peak oxygen uptake (peak VO₂) during incremental sit-to-stand exercise” with 13 healthy young women. “The seat heights were adjusted to 100%, 80%, 120%, and 140% of knee height distance.” They found that

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peak VO₂ on the incremental sit-to-stand test increased as seat height decreased.” This may have significant implications for individuals who are aging with a disability, and/or exhibit respiratory compromise as a result of their diagnosis or disability.

Clinically, when evaluating stand-pivot transfers, every sit-to-stand transition can be split into four main phases: flexion (leaning forward), momentum-transfer (seat-off), extension (coming to the upright position) and stabilization (standing). This is followed by pivoting or stepping and the stand-to-sit transition. While sit-to-stand transfers have been widely studied, there is a significant lack of information concerning stand-to-sit transfers, especially at varying seat heights.

JOSH

Josh was diagnosed with limb-girdle muscular dystrophy at the age of 8. At age 25, he presents with poor strength in all four extremities and poor to fair core strength. He has poor sitting balance and does not have the ability to perform a sit-pivot or sliding board transfer. His standing balance is also poor, and he is non-ambulatory; however, by standing with his hips and knees hyperextended he is able to “lock” the joints and use the structural integrity of his ligaments to do a stand-pivot transfer independently while holding on to the armrests of the chair (see Figure 10).

With the wheelchair seat elevated to 31,” Josh

DOES A POWER ADJUSTABLE SEAT ... (CONTINUED FROM PAGE 37)

is still able to perform a stand-pivot transfer independently to and from his bed, which is also elevated to 31 inches regardless of whether he is in his own apartment or in his old room at his parent's house. At any lower seat height, he is fully dependent on a personal care attendant to transfer. In addition, Josh also remains fully independent in managing his bladder needs as he is able to stand from his wheelchair at a seat height of 31 inches to use the toilet.



FIGURE 10

Josh independently transferring using a stand-pivot method

Corey Hickey, doctor of osteopathic medicine in his fourth year of residency at the University of Pittsburgh Medical Center, completed a study entitled Seat Elevators: How to Utilize the Functional Mobility Assessment Tool to Track Function and Justify Medical Necessity, which was presented at the 32nd International Seating Symposium on March 3, 2016.

The objective of the study was to determine trends in the procurement of seat elevation (SE) and their association with function. It was a retrospective analysis of the university's client database and medical chart

review for individuals where a seat elevator (SE) was recommended from Jan. 26, 2012, to May 8, 2014, (N=61).

The measures were only calculated for individuals that had complete demographic data, procurement information, validation of the functionality of the SE, and Functional Mobility Assessment (FMA) scores at baseline and follow-up (N=22).

To assess the impact of the SE on transfers, data was analyzed for Question # 6 on the FMA which reads, "My current means of mobility allows me to transfer from one surface to another: (e.g., bed, toilet, chair)." Participants responded based on a 6-point scale where 6=completely agree, 5=mostly agree, 4=slightly agree, 3=slightly disagree, 2=mostly disagree and 1=completely disagree.

The most telling information regarding the viability of a PASH system can be found when the wheelchair user had a seat elevation feature on their previous chair and did not receive the same feature on their new chair. The baseline transfer score significantly dropped from a median of 5/6 (mostly agree) to a median of 1.5/6 (between completely disagree and mostly disagree) at follow-up (see Figure 11), which likely rendered the individual dependent in their transfers due to the loss of this feature.

For individuals who did not have a SE at base line and then received one on their new chair, their pre-intervention transfer score improved from a median of 3.5/6 (between slightly disagree and slightly agree and mostly agree) (see Figure 12). The individual is now able to move toward a response of "completely agree" as they become more proficient with the new feature and possibly a new transfer technique.

SE at baseline, did not receive a SE with new PWC

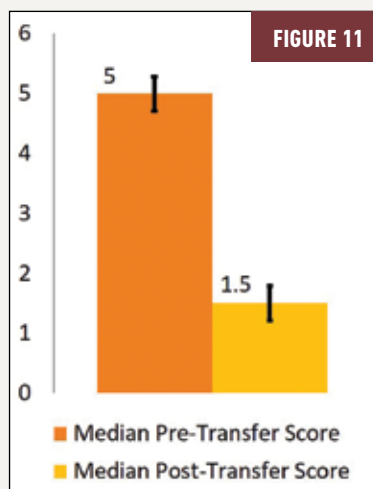


FIGURE 11

No SE at baseline, received SE on new PWC

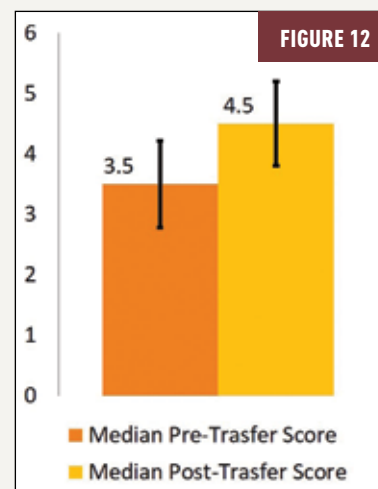


FIGURE 12

2. FACILITATE REACH

Item number 12 of 30 on the power wheelchair skills test (WST) is "reaches high object." As stated in the Wheelchair Skills Training Manual, "skill in wheelchair use is not an end itself, it is a means to an end." The manual further asserts, "the characteristics of the wheelchair, its features, fit and setup can have

	Often	#	Sometimes	#	Rarely	#	Never	#
To help reach things	81.9%	86	13.3%	14	3.8%	4	1%	1
While dressing	16.3%	17	26%	27	17.3%	18	40.4%	42
While grooming (brushing teeth, combing hair, etc.)	39.4%	41	23.1%	24	16.3%	17	21.2%	22
While eating or preparing a meal	59.2%	61	24.3%	25	6.8%	7	9.7%	10
During toileting activities	27.2%	28	17.5%	18	22.3%	23	33%	34
During bathing activities	21%	22	10.5%	11	17.1%	18	51.4%	54

major effects on skill performance.” It should be noted that “the skills chosen for inclusion in the Wheelchair Skills Program are intended to be representative of the range of skills that wheelchair users and/or caregivers may need to regularly perform,” such as reaching.

Reaching a high object is included in the WST because “a combination of upward and sideways or forward reaching is often needed when reaching for a light switch, elevator button or cupboard.” The target for the test is 2.5 cm (1 inches) in diameter and 1.5 m (60 inches) from the floor. To pass the test “the subject reaches up under control, touches the target and then resumes the normal sitting position.” Chair height, and the ability to reposition the seat height, can have an impact on the wheelchair user’s ability to touch the target. Passing the reach test is only the first step in assessing whether an individual can actually reach to perform or participate in their ADLs from the wheelchair.

In the survey conducted by Georgia Tech (2017), 100 of 105 (95.2%) respondents indicated that they use their seat elevating feature “often” or “sometimes” to help reach things. However, the activities in which they are engaged in while elevated, such as dressing, grooming, eating/meal preparation, toileting and bathing, differ. The survey did not obtain information as to why the results differ, but seat elevation does reduce the effect of environmental barriers to the vertical space.

Access to the vertical environment is essential for a wheelchair user to perform or participate in their ADLs. Either by building code or convention the standard height of objects an individual must interact with on a daily basis are as follows:

Kitchen counter top height = 36 inches

Kitchen upper cabinet height = 54 inches at the bottom, 84 inches at the top

Freezer height = 50 inches – 72 inches

Stove top height = 36 inches

Over stove microwave height = 50 inches – 54 inches at the bottom, 66 inches at the top

Height for a closet rod = 66 inches, top shelf = 80 inches

Washer/Dryer height = 36 inches, stacked = 75 inches

Height of a light switch = 48 inches

Height for a thermostat = 60 inches

Fire alarm pull height = 42 inches – 54 inches

When compared to the mean shoulder height in sitting for women (n=2208) at 21.87 inches and men (n=1774) at 23.53 inches (Gordon, C.C., Churchill, T., Clauser, C.E., Bradtmiller, B., McConville, J.T., Tebbetts, I & Walker, R.A., 1988), it is clear seated individuals must reach above shoulder height to access any of these areas of the home. Anthropometric measurements also show that the mean vertical grip reach in sitting for the same women is 47.73 inches (43.01- 52.32 inches) and 51.57 inches (46.36 – 56.38 inches) for men, which fall short of the heights needed to safely perform or participate in ADLs, even at the top range of the reach. This places seated individuals, such as power wheelchair users, as substantial risk for injury and increased health care costs from adverse occurrences in their quest for independence.

HOWEVER, THE ACTIVITIES IN WHICH THEY ARE ENGAGED IN WHILE ELEVATED, SUCH AS DRESSING, GROOMING, EATING/MEAL PREPARATION, TOILETING AND BATHING, DIFFER. THE SURVEY DID NOT OBTAIN INFORMATION AS TO WHY THE RESULTS DIFFER, BUT SEAT ELEVATION DOES REDUCE THE EFFECT OF ENVIRONMENTAL BARRIERS TO THE VERTICAL SPACE.

CONTINUED ON PAGE 40

DOES A POWER ADJUSTABLE SEAT ... (CONTINUED FROM PAGE 39)

MADONNA

Madonna sustained an incomplete spinal cord injury (SCI) at the T10 level at age 18. She used a manual wheelchair for 35 years but at 53, as she ages with a disability, she is experiencing significant pain and strength limitations in her neck, shoulders and upper back from overuse injuries. As a single parent, she found herself reaching overhead hundreds of times each day to cook, clean and do laundry from a low, static seat height, exacerbating her pain (see Figure 13). In addition, she sustained third-degree burns twice while removing a hot, cooked item from the stove due to the poor biomechanical position of her upper extremities from a low seat height. Medical care for Madonna may have been prevented by adjusting her wheelchair seat to the appropriate height for the task she was performing, thereby saving thousands of dollars for each occasion.

Requejo, P.S., Mulroy, S.J., Haubert, L.L., Newsam, C.J., Gronley, J.K., & Perry, J. (2008) assert that it is imperative for wheelchair users to “minimize extreme or potentially injurious positions at the shoulder by avoiding extreme positions such as hand over the shoulder.” They indicate “based on ergonomics literature, there is a strong association between working above overhead height and shoulder pain in the work environment” and that “use of a wheelchair increases a person’s need for overhead activity to access the environment.”

Their study compared the frequency and duration of overhead arm activity between wheelchair users and occupationally matched non-wheelchair users during an eight-



Madonna in her kitchen elevating to mitigate the number of times she must reach overhead.

hour workday. They found that non-wheelchair users performed an average of **53** (9 – 88) episodes of overhead arm activity while wheelchair users performed an average of **297** (44 – 798) episodes of arm activity during the same time period. The total time spent in an overhead position was five times greater for wheelchair users (mean = 34.6 minute, range = 7.9 to 106.6 minute) as compared to standing adults (mean = 6.6 minute, range = .4 – 15.5 minute).

Extrapolated out, a wheelchair user that reaches overhead 297 times/day x 365 days/year will reach overhead **542,025** (80,300 – 1,456,350) times during the five-year reasonable useful lifetime of the power wheelchair. During the same five years a person at standing height that reaches overhead 53 times/day x 365 days/year will only reach overhead **96,725** (7,300 – 160,600) times. The researchers concluded the increased overhead use documented in the study “may contribute to the development of shoulder pathology” and “individuals with SCI should avoid extreme shoulder positions, particularly overhead arm activities.”

It is likely that a PWC user in a chair with a low, static seat height will need to reach overhead as many times as a manual wheelchair (MWC) user, but will have a much more difficult time executing it. In evaluating beneficiaries with disabilities for the appropriate mobility base, if a manual wheelchair is reasonable and necessary, the expectation is that the individual has sufficient balance, strength, range of motion, coordination, endurance and UE function to self-propel and perform or participate in their MRADLs, including the ability to reach overhead as many times per day as necessary.

Sabari, J., Shea, M., Chen, L., Laurenceau, A., & Leung, E. (2016) declare that “the upper limb and neck are common sites for the development of repetitive strain injuries (RSI)” and hypothesized that “the addition of a seat elevation device may alleviate the risk factors that lead to the development of RSI.” They observed 60 ambulatory adults age 18 – 65, seated symmetrically in a power wheelchair, who were asked to perform a functional vision task and a functional reach task. Each task was performed at the minimum wheelchair seat height and the maximum seat height.

Results “revealed a statistically significant difference between AROM required for shoulder abduction to complete the reaching task, when comparing performance with the wheelchair at minimum seat height and at maximum seat height.” They contend “the power seat elevator at its maximum height may allow wheelchair users to perform functional tasks without excessive AROM at the shoulders, thereby decreasing their risk for developing RSI.” While “further



FIGURE 14

Kiel is able to reach the thermostat and see what temperature he is adjusting it to.

investigation would need to test a sample population of long-term wheelchair users,” they conclude that their “findings provide preliminary support for considering [seat elevation] as a medical necessity for wheelchair users who are at risk of developing chronic pain syndromes associated with the shoulder girdle and/or cervical spine.”

KIEL

Kiel sustained an incomplete SCI at the C5/6 level. In addition to an increased risk for shoulder and neck RSI, Kiel has a critical use for his power seat elevation system as he reaches and adjusts the thermostat in his home. Kiel experiences thermoregulatory dysfunction secondary to his SCI. Thermoregulation is the process that allows the human body to maintain its core temperature. Thermoregulatory dysfunction in individuals with SCI refers to the fact that their body cannot perform this function properly. As a result, Kiel needs to be able to adjust the thermostat independently for his health and safety.

While he can reach the thermostat at a height of 48 inches from a low, static seat height, he is unable to see what temperature he has adjusted it to without the capability of adjusting the height of his wheelchair seat. Vertical adjustment (see Figure 14) provides him the visual access he needs to support this reaching activity, independently manage this condition and not incur additional personal care assistance (PCA) hours or medical costs from an adverse occurrence.

In 2016, Vince Schiappa, a graduate student researcher at the University of Pittsburgh in the School of Health and Rehabilitation Sciences conducted a study entitled “Functional Satisfaction with Power Seat Elevators,” which was

presented at the 33rd International Seating Symposium on March 2, 2017. The study was designed to assess the difference in satisfaction of function while using seat elevators on power wheelchairs among individuals with disabilities through a retrospective analysis of two databases that included time one and time two Functional Mobility Assessment (FMA) scores. To assess satisfaction with reach, FMA Question # 5 was used which reads, “my current means of mobility allows me to reach and carry out tasks at different surface heights as independently, safely and efficiently as possible (e.g., table, counters, floors, shelves, etc.) (see Figure 15). It should be noted that the sample size in this presentation (n=139) was larger than the sample size (n=123) reported in his master’s thesis defended on March 21, 2016, and the median FMA scores differ, although the direction of change in scores for the task is consistent.

For participants that had a SE on their previous chair and did not receive one on their new chair, the reach score dropped from a median 5/6 (mostly agree) to 3.5/6 (between slightly agree and slightly disagree) with the larger (n=139) sample size. For the smaller sample size (n=123), the median FMA reach score dropped to 2.5/6 (between mostly disagree and slightly disagree) when a SE was not provided on the new PWC.

For participants who did not have a SE at base line and then received one on their new chair, the pre-intervention reach score improved from a median of 4/6 (slightly agree) to a post intervention median score of 6/6 (completely agree). This likely improved the person’s ability to perform or participate in their activities of daily living; however, verification of this was outside the scope of the study. A SE may also

DOES A POWER ADJUSTABLE SEAT ... (CONTINUED FROM PAGE 41)

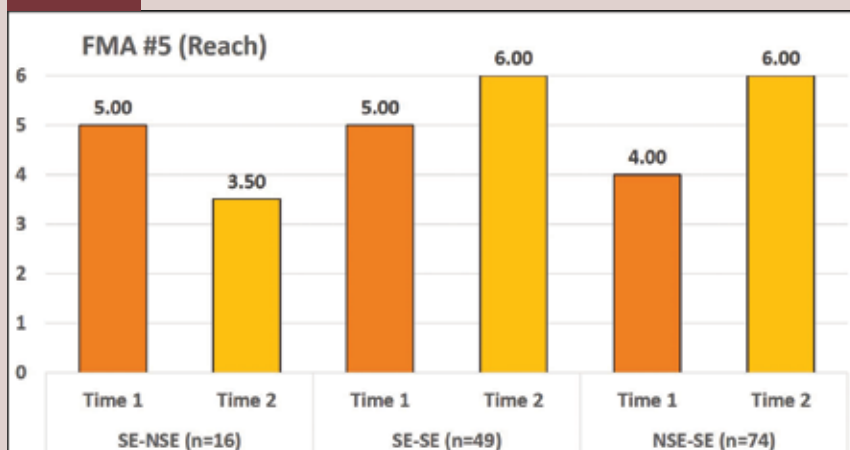
significantly reduce the risk for an adverse occurrence during attempts to engage in reaching activities.

Nutrition and hydration are both medically necessary to sustain life. “Feeding” as a mobility related activity of daily living is far more than getting to the table where a prepared meal is placed before the beneficiary to eat, followed by them moving away from the table so someone can clean up. Stephanie can be fully independent in all aspects of “feeding” as she prepares herself a grilled cheese sandwich and tomato soup (see Figures 17, 19 & 21). However, in her attempts to do so from a low, static seat height, she is at very high risk for injury secondary to a fall, burns, lacerations, contusions, etc. (see Figures 16, 18 & 20).

3. SUPPORT PSYCHOLOGICAL AND PHYSIOLOGICAL HEALTH, SAFETY AND WELL-BEING.

Wu, Y., Lie, H., Kelleher, A., Pearlman, J., Ding, D. & Cooper, R.A. (2017) assert that “wheelchair discomfort is a very common problem for wheelchair users” and suggest that “increasing the frequency of using PSFs (power seat functions) may decrease wheelchair discomfort.” The chairs used in the study were outfitted with encoders “to record angle changes for tilt, recline, legrests and seat elevation.” The 13 individuals with disabilities that completed the eight-week study in their home and community filled out the Tool for Assessing Wheelchair discomfort (TAWC) each day. The results showed that “wheelchair discomfort intensity is correlated with the frequency of using tilt, recline and legrest functions” and the frequency of using these functions “were not correlated with each other.” While the study does not discuss what impact

FIGURE 15



FMA Reach.



FIGURE 16

Stephanie attempting to turn the stove on in a low, static seat height.



FIGURE 17

Stephanie safely turning the stove on, in an elevated position.



FIGURE 18

Stephanie cooking a grilled cheese sandwich in a compromised and unsafe position from a low seat height.



FIGURE 19

Stephanie safely cooking for herself at an elevated seat height.



FIGURE 20

Stephanie attempting to retrieve hot tomato soup from the microwave in a low seat height.



FIGURE 21

Stephanie safely accessing the microwave in an elevated seat position.



FIGURE 22A

Kiel experiences significant pain and fatigue in his neck following his C5/6 SCI, especially when attempting to speak with an average height standing male.

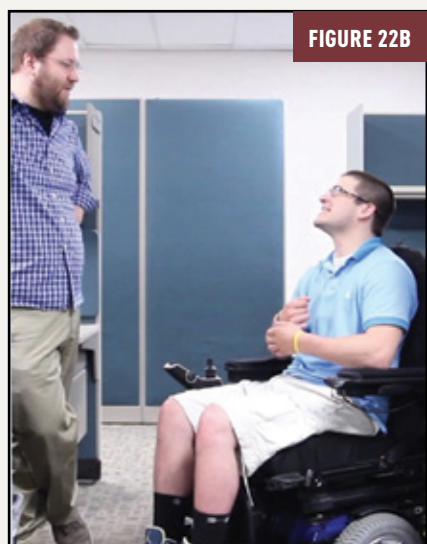


FIGURE 22B

Kiel's neck position in a low seat

wheelchair design" (see Figure 22a and 22b).

Sabari, et al. (2016) suggest "frequent hyperextended cervical positions are likely to lead to fatigue of the soft tissue structures of the cervical region, and significant discomfort can be expected when these positions are sustained." Results of their study "reveal a statistically significant difference between AROM requirements for cervical extension to complete the computer viewing tasks, when comparing performance with the wheelchair at minimum seat height and at maximum seat height." They state that their study findings "provide support for the potential benefit of a seat elevation feature in reducing the arcs of motion required to extend the neck, and thereby minimizing the risk for RSI at the neck." Their data supports

power seat elevation may have on discomfort, it does state "wheelchair discomfort might result from other medical or physiological factors and the maximal improvement of wheelchair comfort that PSFs can achieve should be further investigated."

Clinical observation of wheelchair users sitting at a low seat height highlights the fact that they are forced to extend the cervical spine to levels that contribute to pain when interacting with other people or objects in their environment. Kirby, R.L., Fahie, C.L., Smith, C., Chester, E.L., & Macleod, D.A. (2004) studied 20 wheelchair users who assumed and maintained four neck positions for five minutes each to determine if they experienced more discomfort in an extended or rotated position as compared to their self-selected most comfortable position (MCP). "The MCP for wheelchair users is straight ahead with the neck slightly flexed." However, to make eye contact with the average height seated male, the wheelchair user had to extend their cervical spine 11°. Cervical extension increased to 27° when looking up at an average height standing male. They conclude "sustained extension and rotation of the neck, alone or in combination, increase the neck discomfort of wheelchair users" and contend "these findings have implications for

"previous recommendations that wheelchair users of all physical statures may benefit from the various advantages of a power seat elevation device, especially in minimizing the risk for the development of pain in the neck and secondary complications" such as cervical myelopathy.

One additional, adverse implication of neck hyperextension that may be observed in individuals who look up from a low seat height is the elicitation of the symmetric tonic neck reflex (STNR). The STNR is triggered by flexion or extension of the neck. When the neck flexes, the arms flex and the legs extend; conversely when the neck extends, the arms go into extension and the hips and legs flex. This may result in a loss of seated position, and discomfort in individuals with cerebral palsy who have retained the STNR, on in individuals that have suffered a stroke or traumatic brain injury where the STNR has re-emerged. Unfortunately, there is no research that has looked at the effect a symmetric tonic neck reflex has on seated position, discomfort in the seated position as a result of an STNR, or whether the application of a power seat elevation system minimizes the effect of an STNR on posture by maintaining a neutral neck position. However, observing and detailing the impact of seat elevation for the one person (n=1) being evaluated for a power wheelchair is what is ultimately required to establish the medical need for the feature.

CONTINUED ON PAGE 44

**RESULTS OF THEIR STUDY
"REVEAL A STATISTICALLY
SIGNIFICANT DIFFERENCE
BETWEEN AROM
REQUIREMENTS FOR CERVICAL
EXTENSION TO COMPLETE
THE COMPUTER VIEWING
TASKS, WHEN COMPARING
PERFORMANCE WITH THE
WHEELCHAIR AT MINIMUM
SEAT HEIGHT AND AT
MAXIMUM SEAT HEIGHT."**

DOES A POWER ADJUSTABLE SEAT ... (CONTINUED FROM PAGE 43)



FIGURE 23

Mark exhibiting a symmetric tonic neck reflex when extending his neck.

MARK

Mark (see Figure 23) was born with cerebral palsy. He is fully independent in all his activities of daily living at the wheelchair level even though he presents with spasticity in all four extremities. When Mark looks up from a low seated position, he elicits a significant STNR that triggers spasticity and involuntary movement that results in him flexing his legs (right greater than left) and extending his arms (left greater than right). This causes him to lose his positioning in the wheelchair and appropriate contact with his cushion and back, which can result in injuries, especially on the seated surface, due to shearing forces. In addition to the discomfort it causes him, this reflexive response also negatively impacts his ability to reach and function to perform his ADLs throughout the day.

CONCLUSION

The position taken by the Centers for Medicare & Medicaid Services (CMS)

that seat elevation does not primarily serve a medical purpose is inconsistent with coverage policy on Mobility Assistance Equipment and ignores the fact that individuals with permanent disabilities use seat elevation to replace a loss of function, perform MRADLs, mitigate deterioration of their health and function and minimize the risk of preventable adverse occurrence.

A PASH system is an accessory to a power wheelchair and is integral to its function for a person who needs to adjust their vertical seat position to achieve the full therapeutic benefit of the power wheelchair.

In 1996, Health and Human Services (HHS) stated that accessories to wheelchairs are part of the DME benefit in its HCFA Ruling 96-1 which states, "to the extent that a wheelchair seating system or other equipment may or may not function properly or not achieve its full 'therapeutic benefit' without attached components supporting or restricting motion in a body part, the attachments are appropriately viewed as a necessary accessory that is an integral part of the durable medical equipment and is, accordingly, payable as durable medical equipment, provided that the other prerequisites for classification as durable medical equipment are met."

The research presented continues to support RESNA's position that seat elevators are often medically necessary for wheelchair users by enabling them to reach, improving MRADL abilities, facilitating or enabling transfers, providing peer height at different ages, enhancing independence and productivity, and delaying or preventing pain and secondary complications of the upper extremities established in 2009 by Arva et al. It clearly meets the definition of DME as required by 42 CFR § 414.202 and should be considered as a reasonable and necessary accessory to a complex rehab power wheelchair as a replacement of loss of function for persons with disabilities and complex medical needs.

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Julie Piriano has worked in the seating and wheeled mobility industry for the past 33 years. She is VP of Clinical Education, Rehab Industry Affairs and serves as Pride's Compliance Officer. She presents nationally on seating and wheeled mobility with a focus on the evaluation, documentation and clinical application of available technologies.



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TUESDAY, APRIL 17, 2018

7 – 8 PM EASTERN TIME

Trends in Funding Policy and How It Impacts Access to CRT

Rita Stanley

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WEDNESDAY, APRIL 18, 2018

11 AM – 12 NOON EASTERN TIME

Seating – Using the Science of Materials to Compare Wheelchair Cushions

W. Darren Hammond, PT, MPT, CWS

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THURSDAY, APRIL 19, 2018

7 – 8 PM EASTERN TIME

Custom Molding – Stepping Outside the Molding Box

Lindsey Veety, PT, DPT, ATP/SMS

TUESDAY, MAY 8, 2018

7 – 8 PM EASTERN TIME

Ethics in the Trenches

Michele Gunn, ATP/CRTS®

THURSDAY, MAY 10, 2018

7 – 8 PM EASTERN TIME

Leaving on a Jet Plane—

Hope I See My Chair Again!

Jessica Presperin Pedersen, OTD, MBA,
OTR/L, ATP/

TUESDAY, JUNE 5, 2018

7 – 8 PM EASTERN TIME

You Can't Make This Stuff Up!

Lauren Rosen, PT, MPT, MSMS,
ATP/SMS

WEDNESDAY, JUNE 6, 2018

11 AM – 12 NOON EASTERN TIME

Maintaining Independence: Tips to Keep the Wheelchairs Rolling!

Tim Robinson, ATP/SMS, RRTS®

THURSDAY, JUNE 7, 2018

7 – 8 PM EASTERN TIME

Pediatric Stander Selection for Fun and FUNction!

Katherine Clark, MOT, OTR/L, ATP
and Erin Pope, PT, MPT

WEDNESDAY, JULY 11, 2018**11 AM – 12 NOON EASTERN TIME**

Wheelchair Supports:

Pull, Push, Hold and Fix

Amber Ward, MS, OTR/L, BCPR,

ATP/SMS

WEDNESDAY, JULY 18, 2018**11 AM – 12 NOON EASTERN TIME**

What Happens When You Sit?

Explaining Seated

Buttocks Deformation

Sharon Eve Sonenblum, PhD

WEDNESDAY, JULY 25, 2018**11 AM – 12 NOON EASTERN TIME**Pivot, Shift, Slide or Lift: How Transfer
Techniques Impact Wheelchair and

Seating Equipment Selection

Angie Kiger, M.Ed., CTRS, ATP/SMS

*Sponsored by Quickie***TUESDAY, AUGUST 14, 2018****7 – 8 PM EASTERN TIME**

The Mat Assessment: Where to Begin?

Barbara Crume, PT, ATP

THURSDAY, AUGUST 16, 2018**7 – 8 PM EASTERN TIME**

Body Segment Angles:

The Key to Better Understanding

Postural Deviations

Kelly Waugh, PT, MAPT, ATP

TUESDAY, SEPTEMBER 11, 2018**7 – 8 PM EASTERN TIME**

Integration of Mobile Devices with

Advanced Powered Wheelchair

Electronics

Emma Smith, MScOT, ATP/SMS

THURSDAY, SEPTEMBER 13, 2018**7 – 8 PM EASTERN TIME**

Cortical Visual Impairment (CVI) and

How It Can Deter Power Mobility

Kihmberly Hymore, MOT, OTR/L, ATP

TUESDAY, OCTOBER 16, 2018**7 – 8 PM EASTERN TIME**The Benefits of Dynamic Seating
for Individuals With Abnormal Tone
Patterns

Jill Sparacio, OTR/L, ATP/SMS, ABDA

*Sponsored by Seating Dynamics***WEDNESDAY, OCTOBER 17, 2018****11 AM – 12 NOON EASTERN TIME**

I'm an Advocate, You're an Advocate —

We're all Advocates!!

Weesie Walker, ATP/SMS, NRRTS

Executive Director

TUESDAY, NOVEMBER 6, 2018**7 – 8 PM EASTERN TIME**

Posterior Pelvic Tilt: Causes,

Challenges, and Seating Interventions

Becky Breaux, MS, OTR/L, ATP

WEDNESDAY, NOVEMBER 7, 2018**11 AM – 12 NOON EASTERN TIME**

Car Seats and Vehicular Transport for

Children with Special Needs

Amber Yampolsky, PT, ATP, CPST and

Erin Baker, PT, ATP, CPST

THURSDAY, NOVEMBER 8, 2018**7 – 8 PM EASTERN TIME**

Wheelchair Seating Clinics: Strategies

and Methodologies for Success

Theresa Berner, MOT, OTR/L, ATP

TUESDAY, DECEMBER 4, 2018**7 – 8 PM EASTERN TIME**

Pushing for Success

Andrina Sabet, PT, ATP

WEDNESDAY, DECEMBER 5, 2018**11 AM – 12 NOON EASTERN TIME**

Providing Power Mobility

Training for Children with

Multiple Severe Disabilities

Lisa K. Kenyon, PT, DPT, PhD, PCS

THURSDAY, DECEMBER 6, 2018**7 – 8 PM EASTERN TIME**

Seating Considerations for Clients with

Spinal Cord Injury

Jill Monger, MS, PT, ATP



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ALISON'S WORLD – ELEVATED

Written by: **MICHAEL FREEHILL**

THIS ARTICLE IS SPONSORED BY QUANTUM REHAB.

I would like to share the story of Alison, a 37-year-old woman with cerebral palsy (CP).

Like a lot of kids born with CP, Alison received her first reverse walker at the age of 7, which she used until sixth grade. By then the school hallways became too much for her to navigate safely, trying to ambulate to class. Shortly thereafter she was approved for her first power wheelchair. This was a huge asset for Alison but, as time would tell, it was only the beginning of the challenges she would face as a power wheelchair user. The first thing she had to learn was how to navigate the busy halls throughout her school in a power chair without running into other kids or them running into her. She could keep up with their speed, but being a foot “shorter” than the average student made it hard for her to see and be seen. While her new freedom allowed her to go more places, she found that the challenges she was experiencing at school carried over in society. Moving at seated height was something new. People coming and going would step in front of her, cut her path of travel off or just stop, especially in big crowds. She could go to the mall, but the ability to reach things was a major challenge. Despite these challenges, Alison persisted.

Fast forward six years. After high school, Alison started the next chapter of her life: college. She faced many of the same challenges, but now she had to navigate through bigger halls, longer distances, additional obstacles, and more people. She was still stuck at “belt height.” Despite this, she worked hard and, in 2003, earned her Associates Degree in Human Services.

This accomplishment afforded her many new opportunities, although she still had physical barriers she had to overcome with her wheelchair. She continued to rely on personal care attendants and family to help her with everyday tasks. Anything that was above her head was out of reach and required assistance. Simple things we all take for granted, like cooking, cleaning or doing her own laundry, required help from others. Her life was on track, but her power chair still held her back in so many ways.

Alison moved to an accessible apartment in the city, with her service dog. She is resourceful and, while it is a fantastic opportunity for her to reside in an area with a diverse culture, she found that city living presented additional challenges. Her number one concern was being seen by drivers when she crossed streets. Her power chair had a standard power seat elevator, but she rarely used it because it slowed life down to a snail's pace. She had to stop her forward progression to elevate a mere 6 inches, it took “forever” to get all the way up, and the chair's speed dropped to 1.5 mph once she got there. In reality, this meant that crossing a busy street in an elevated position so she could be seen could take up to two light sequences. It was unsafe, unproductive and unrealistic.

All of this led Alison to pursue a highly functional power adjustable seat height system on her next chair. She reached out to me via Facebook and mutual



PICTURE 1

Alison confidently entering the stadium with the crowd to watch her favorite team win!

acquaintances to ask if I could help with some seating needs. She had heard about new technology and she loved her current power chair, but it was starting to show signs of disrepair from very active use and hard city living.

Alison had seen social media posts I shared highlighting one of Quantum Rehab's power wheelchairs and the benefits of this new technology. The more I posted, the more she researched it. She really could see all the benefits of what power adjustable seat height could do for her in all aspects of her world as she knew it. She was on a mission to get the new chair so she could benefit from all it had to offer and perhaps go to places she had only dreamed of. In Alison's words, she was “stuck going through life waist high.”

As she would explain to me, her worst nightmare was navigating through public crowds which she would try to avoid

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because, "people don't even notice you when you are that low, and if they do they look, they look down on you, like you are beneath them." I wanted to find a way to help Alison achieve her goals and get her out of a world where she had gone unnoticed for almost 30 years. On top of that, I wanted to do something special for her, as I try to do with all users I work with.

I knew Alison was a huge St. Louis Blues hockey fan from her personal Facebook page, and when she let me know she was getting a new power wheelchair with power adjustable seat height, I wanted to give her the option to deck out a chair to fit her personality. I brought the idea up to her and her provider of choice to see how she would feel about a St. Louis Blues themed wheelchair. Luke Moore, ATP/SMS, CRTS® for Therapeutic Specialties, Inc. was on board with the idea. My biggest concern was going too far with my creativity and have her be stuck in a themed chair she hated. I asked her how extreme she wanted to go, and her response was, "I trust your judgment!" Off I went.

With all the power wheelchair and seating color options, it was easy to match fabric to the back, decking out the unit in her favorite team colors.

She was beyond excited at the time of delivery, got in and took off. She now tells me, "this chair is making me famous!" She is able to elevate quickly while driving, and move at 3.5 mph, faster than average walking speed, in the elevated position. She gets compliments everywhere she goes and her confidence level has soared. But, as "awesome" and "cool" as the chair looks, it still didn't equal what iLevel has been able to add to her life. On her social media pages, she posts her life's adventures. One of Alison's recent posts on social media reads:

ALLISON'S WORLD - ELEVATED (CONTINUED FROM PAGE 49)

"I think this needs to be posted so people understand about my technology, and why it's a safer option than standard wheelchairs.

Let me ask you a question. How does it feel to give a hug?? Pretty cool, huh? Well, as a wheelchair user, most of us only hug belt loops or the 'hugee' comes down to our level.

Well, with new technology, that ALL changes.

I can hug at eye level, take cool selfies and not break anyone's knees; I feel included. Before, I could elevate, but I most of the time wouldn't, because it took so long. Now, I can drive and elevate. It means confidence, inclusion and independence.

And most recently, safety. I can be seen by cars, when other wheelchair users can't, because of the height of a car versus the height of a standard wheelchair. Believe me when I tell you that my safety is my top priority, and I've never felt safer in a wheelchair. So, God willing, there might be fewer accidents because of technology that allows wheelchair users to do everyday things like crossing a street."

I had the pleasure of accompanying Alison to her first hockey game with her new power chair (see Figure 1). She was hesitant at first to drive around at eye level, but after some encouragement, you could see the difference in her confidence entering and exiting the game, especially when the crowds parted as she was driving elevated. She could see where she was going and plan her route, but most importantly, she was seen and quickly became the coolest hockey fan in the stadium.

Of course, beyond social and emotional benefits, the functional aspects of power adjustable seat height dramatically changed her life as well (see Figure 2). Alison posted:

"I love how easy everything is in my house with this chair! Laundry going, about to cook, do dishes and get ready for another chillier yet, day tomorrow;" and

"I'm so amazed still at how easy doing life is with this new chair. Laundry's done and hung, transferring while changing is no sweat, and getting around the kitchen. Seriously. Changes the game. Come observe if you don't believe me. I'll bake cookies!

Thank you to everyone who made this technology a reality for not only me, but so many others."

If you ever have questions whether power adjustable seat height should be justified, remember Alison's story or just talk to someone who has experienced its life-inspiring benefits. After all, it's a technology that truly elevates lives.

CONTACT THE AUTHOR

Mike can be reached at MFREEHILL@QUANTUMREHAB.COM

PICTURE 2



Alison is now able to do the "mundane" chores most people take for granted without assistance.

"I LOVE HOW EASY EVERYTHING IS IN MY HOUSE WITH THIS CHAIR! LAUNDRY GOING, ABOUT TO COOK, DO DISHES, AND GET READY FOR ANOTHER CHILLIER YET, DAY TOMORROW."

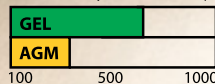
Mike Freehill is a rehab product specialist for Quantum Rehab and Stealth Products. He has more than 30 years of industry experience working with people with disabilities at a non-profit organization, as a provider and as a manufacturer representative.



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AREN'T EXPANDABLE ELECTRONICS ALWAYS COVERED FOR CRT?

Written by: **CLAUDIA AMORTEGUI**, PRESIDENT, THE ORION CONSULTING GROUP, INC.

As the new year started it seemed as if I was getting a lot of questions that I had considered to be “old” news. I am finding that many people are still having a lot of issues with those darn expandable electronics. When do I bill? How do I bill? Why can't I bill?

It would seem like common sense that in the Complex Rehab Technology (CRT) world expandable electronics would be automatically reimbursed when providing high-end CRT power wheelchairs (PWC). However, as we all know, when it comes to Medicare reimbursement common sense is not the norm; codes and policy were written without much thought to CRT.

Simply put, CRT PWCs are considered Group 2 PWCs with any type of powered seating or any Group 3 PWC and above. Although a large portion of the CRT population has significant needs in mobility, Medicare policy does limit their coverage in quite a few areas.

When it comes to the billing and reimbursement of expandable electronics, we should be able to break this down into very simple pieces.

- Medicare will separately reimburse expandable electronics (E2377) when there are three or more actuators on the PWC being billed and/or alternative drive controls are being used. Keep in mind that these three actuators need to be on covered options; the actuator for a seat elevator will not count.
- When expandable electronics are billed, the harness code (E2313) should automatically be billed as well. Per Medicare policy, code E2313 is separately billable in addition to an expandable controller (E2377). Meaning, if you bill one code you should automatically bill the other. I like to think of them as “married” codes.
- Regarding the justification needed, there really does not need to be anything specific to the controller and/or harness. The key to coverage is the three actuators or alternative drive control; which means the power options and/or the alternative drive controls are what need to be justified. The electronics are a given if the required items are deemed medically necessary.

With the above in mind, this means that if you are providing a PWC with tilt only (or recline only), then the expandable electronics and harness will not be covered as the system would likely only have one actuator. If you provide a PWC with tilt, recline and a seat elevator you will meet the requirement of three actuators, however, one of those is considered non-covered so again, the expandable electronics and harness would be denied (only two covered actuators).

For Medicare coverage the expandable electronics and harness would be covered if a PWC is provided with tilt, recline and power legs and/or if there are alternative drive controls. This is the case whether the manufacturer has the option for non-expandable electronics.

A secondary question that stems from this topic is the issue of clients whose condition is progressing. Would Medicare consider coverage of the expandable electronics knowing that they will be needed sometime in the future? Unfortunately, the answer to this is “no.” Medicare and many other insurances will cover items that are currently needed. They do not necessarily investigate the future. When the client's medical needs do progress, Medicare will cover modifications to add the needed equipment to meet their needs at that time with the proper documentation. As we all know, this is more expensive in the long run, but it is how Medicare will handle such cases.

If you or the client choose to go on and add the expandable electronics and harness when the coverage criteria are not met, you will either provide them as a free upgrade or as a self-pay option (or paid by a secondary insurance). If you, as the provider, will receive any payment for this you will need to be sure to obtain a completed Advance Beneficiary Notice (ABN). The denial reason will be that the client does not meet the coverage criteria of having three actuators or alternative drive

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ONE LAST ITEM TO KEEP IN MIND IS IF THE EXPANDABLE ELECTRONICS ARE DENIED, THE HARNESS CODE SHOULD DENY - AGAIN, THESE CODES GO TOGETHER.

control. It is strongly recommended you inform your client that repairs to the expandable electronics and harness will not be covered.

One last item to keep in mind is if the expandable electronics are denied, the harness code should deny - again, these codes go together. In the same breath if one pays, the other will as well. The only reason one would pay and another deny would be a modifier issue. That topic is its own article that can be discussed in the future.

CONTACT THE AUTHOR

Claudia may be reached at
CLAUDIA@ORIONREIMBURSEMENT.NET

Claudia Amortegui has a Master of Business Administration and more than 20 years of experience in the DMEPOS industry. Her experience comes from having worked on all sides of the industry, including the DMEPOS Medicare contractor, supplier, manufacturer and consultant. For many of these years Amortegui has focused on the rehab side of the industry. Her work has allowed her to understand the different nuances of complex rehab versus standard DME. This rare combination of industry experiences enables Amortegui and her team at The Orion Group to assist ATPs, referrals, reimbursement staff and funding sources in understanding the reimbursement process as it relates to complex rehab.



NEW NRRTS REGISTRANTS

Congratulations to the newest NRRTS Registrants. NAMES INCLUDED ARE FROM JAN 26 THROUGH MARCH 20, 2018.

Reggio Blackwell, RRTS®

National Seating & Mobility, Inc.
2101 W Cermak Rd
Broadview, IL 60155
Telephone: 708-345-2466
Fax: 708-223-7131
Registration Date: 3/13/2018

Sue Bryant, ATP, CRTS®

American Medical Rentals
6701 West 12th St Ste 14
Little Rock, AR 72204-1556
Telephone: 501-376-6922 x.108
Fax: 501-537-1979
Registration Date: 2/19/2018

Steven Edwards, ATP, CRTS®

Numotion
102 Oxnoor Rd
Birmingham, AL 35209-5979
Telephone: 205-833-0284
Toll Free: 866-227-5800 x.167
Fax: 205-833-0284
Registration Date: 2/2/2018

Sidney Glover, CAPS, CEAC, ECHM, ATP, CRTS®

ATF Medical
2239k Tacketts Mill Dr
Woodbridge, VA 22192-3026
Telephone: 703-497-0333
Fax: 703-497-0377
Registration Date: 3/8/2018

Chad E. Hayes, COE, ATP, CRTS®

All Medical Inc.
2011 Hampton St
Columbia, SC 29204-1001
Telephone: 803-779-2011 x.8787
Toll Free: 877-801-3527
Fax: 803-779-2011
Registration Date: 2/21/2018

Corey Hileman, ATP, CRTS®

Alliance Rehab & Medical Equipment
2205 Petrus Cir
Ozark, MO 65721
Telephone: 800-813-1656
Toll Free:
Fax: 417-581-5762
Registration Date: 3/8/2018

Michael Hohler, ATP, CRTS®

Freeman Health Essentials
1130 E 32nd St Ste F
Joplin, MO 64804-4072
Telephone: 417-347-7400 x.7438
Fax: 417-347-9483
Registration Date: 3/14/2018

Rashid Khan, RRTS®

Whitesell Home Medical
622 N Market St
Frederick, MO 21701
Telephone: 301-663-6464
Fax: 301-663-3207
Registration Date: 2/13/2018

Joseph Loza, ATP, RRTS®

Numotion
4500 E Speedway Blvd
Tucson, AZ 85712
Telephone: 520-343-3613
Fax: 520-323-0387
Registration Date: 3/5/2018

John Petter, ATP, CRTS®

National Seating & Mobility, Inc.
4493 Robertson Rd
Madison, WI 53714-3124
Telephone: 608-223-1927 x.216
Fax: 608-223-1932
Registration Date: 2/5/2018

Casey Stephens, PT, MPT, ATP, CRTS®

National Seating & Mobility, Inc.
1517 W North Carrier Pkwy
Grand Prairie, TX 75050
Telephone: 972-206-7345
Registration Date: 2/13/2018

Kevin Wallace, ATP, CRTS®

ATF Medical
2239 Tackett Mill Dr Ste K
Woodbridge, VA 22192
Telephone: 877-860-4283
Fax: 703-497-0377
Registration Date: 3/14/2018

Ronald Whiting, ATP, CRTS®

National Seating & Mobility, Inc.
6553 S Cottonwood St
Murray, UT 84107-7007
Telephone: 801-281-6601 x.200
Toll Free: 800-861-3211 x.184
Fax: 877-263-9918
Registration Date: 3/1/2018

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 JAN 26 THROUGH MARCH 20, 2018.

FOR AN UP-TO-DATE VERIFICATION ON REGISTRANTS, VISIT WWW.NRRTS.ORG, UPDATED DAILY.

Josh Burton, ATP, Gilbert, AZ

Ken Green, ATP, Lexington, KY

Matthew S. Howard, ATP, Dothan, AL

Gary Keith, Alhambra, CA

Brian Metz, ATP, Phoenix, AZ

NEW ATP

Congratulations to NRRTS Registrants who earned the ATP credential. Depending upon their registration date, they will be awarded CRTS® upon completion and approval of the renewal following fulfillment of required registration.

NAMES INCLUDED ARE FROM JAN 26 THROUGH MARCH 20, 2018.

Johnathan Grimes, ATP, CRTS®

Hometown Healthcare

Tupelo, MS

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Congratulations to NRRTS Registrants recently awarded the CRTS® credential. A CRTS® receives a lapel pin signifying CRTS® or Certified Rehabilitation Technology Supplier® status and guidelines about the correct use of the credential. NAMES INCLUDED ARE FROM JAN 26 THROUGH MARCH 20, 2018.

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Professional Respiratory & Rehab
Chattanooga, TN

Sue Bryant, ATP, CRTS®
American Medical Rentals
Little Rock, AR

Gregory Chilcott, ATP, CRTS®
Blackburn's
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Steven Edwards, ATP, CRTS®
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Sidney Glover, CAPS, CEAC, ECHM, ATP, CRTS®
ATF Medical
Woodbridge, VA

Johnathan Grimes, ATP, CRTS®
Hometown Healthcare
Tupelo, MS

Christopher Harwell, ATP, CRTS®
Hometown Healthcare
Hattiesburg, MS

Corey Hileman, ATP, CRTS®
Alliance Rehab & Medical Equipment
Ozark, MO

Michael Hohler, ATP, CRTS®
Freeman Health Essentials
Joplin, MO

James Hutchinson, ATP, CRTS®
Dressen Medical Supply
Cary, NC

Robert Rex Johnson, ATP, CRTS®
National Seating & Mobility, Inc.
Memphis, TN

Angela Naranjo, ATP, CRTS®
DGR Medical
Aventura, FL

James Parnell, ATP, CRTS®
Professional Respiratory & Rehab
Knoxville, TN

Ben Peters, ATP, CRTS®
Mobility Central
Vestavia Hills, AL

John Petter, ATP, CRTS®
National Seating & Mobility, Inc.
Madison, WI

Candace Poe, MSW, ATP, CRTS®
Personal Mobility
Springfield, IL

Ryan Read, ATP, CRTS®
Presidential Conversions
Fayetteville, AR

Todd Richardson, ATP, CRTS®
National Seating & Mobility, Inc.
Asheville, NC

Hector Rocha, OTR, ATP, CRTS®
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McAllen, TX

Jason Smith, ATP, CRTS®
Rehab Medical Inc.
Mobile, AL

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National Seating & Mobility, Inc.
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Matthew Tarrant, ATP, CRTS®
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Martinez, GA

RENEWED NRRTS REGISTRANTS

The following individuals renewed their registry with NRRTS between Jan. 25 and March 20, 2018.

PLEASE NOTE IF YOU RENEWED AFTER MARCH 20, YOUR NAME WILL APPEAR IN A FUTURE ISSUE OF DIRECTIONS.

IF YOU RENEWED PRIOR TO JAN. 24, YOUR NAME IS IN A PREVIOUS ISSUE OF DIRECTIONS.

FOR AN UP-TO-DATE VERIFICATION ON REGISTRANTS, PLEASE VISIT WWW.NRRTS.ORG UPDATED DAILY.

Shelby Bass, ATP, CRTS® Evansville IN
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Conference Schedule

Leadership Day

Wednesday, April 25

8:30-9:30- CRT Consumer Panel

10:00-11:30- Healthcare Reform

1:00-3:00- Industry Update

3:30-5:00- Congressional Prep

6:00-8:00- CRT United Reception

Capitol Hill Day

Thursday, April 26

9:00-4:00- Congressional Visits

6:00-8:00- Debriefing Reception



To Register, Visit:

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