DIRECTIONS

Stay HOT ON THE TRAIL

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CLAUDIA AMORTEGUI

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 as a DMEPOS Medicare a supplier, a contractor and currently as a consultant. Her experiences enable her to assist ATPs, referrals, reimbursement staff and funding sources in understanding the reimbursement process as it relates to Complex Rehab Technology.
SEE PAGES 12 & 44

MIKE BARNER, ATP, CRTS®

Barner is president of NRRTS. Barner works for the University of Michigan Wheelchair Seating Services in Ann Arbor, Michigan.
SEE PAGE 8

ALEXANDRA (ALEX) BENNEWITH

Bennewith is vice president of government relations for United Spinal Association. Bennewith advocates for legislation and regulations regarding disability and health policy at the federal and state levels. 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. SEE PAGE 42

DON CLAYBACK

Clayback is executive director of the National Coalition for Assistive and Rehab Technology (NCART). He has more than 25 years of experience in the Complex Rehab Technology and Home Medical Equipment industries as a provider, consultant and advocate, and is actively involved in industry issues and a frequent speaker at state and national conferences. SEE PAGE 26

DELIA "DEE DEE" FRENEY, OTR/L, ATP

Freney has been an occupational therapist since 1978 in the San Francisco Bay area, California. She is an ATP who presently works at Kaiser Permanente as an occupational therapy clinical specialist with high mobility in the Durable Medical Equipment department. Freney participates in seating and mobility clinic evaluations that include a variety of neurological and orthopedic diagnoses such as spinal bifida, cerebral palsy, spinal cord injury, multiple sclerosis, muscular dystrophy and amyotrophic lateral sclerosis. Her primary interest has been as a pediatric therapist but presently her primary population consists of adults, frail elderly, geriatrics and bariatrics. SEE PAGES 18 & 38

ANGIE KIGER, M.ED., CTRS, ATP/SMS

Kiger is the clinical strategy and education manager for Sunrise Medical. She earned a Master of Education in Assistive Technology from George Mason University and a certificate in Assistive Technology from California State University at Northridge. Kiger has worked with infants, children and adults in inpatient and outpatient settings. Kiger also has served as an adjunct instructor at George Mason University and has presented at numerous conferences in United States and abroad. SEE PAGE 30

MICHELLE L. LANGE, OTR/L, ABDA, ATP/SMS

Lange is an occupational therapist with 30 years of experience and has been in private practice, Access to Independence, for 10 years. She is a well-respected lecturer, nationally and internationally, and has authored six book chapters and more than 200 articles. She is the editor of "Fundamentals in Assistive Technology, Fifth Edition" and clinical editor of DIRECTIONS magazine. Additionally, she serves as the continuing education curriculum coordinator for NRRTS. Lange is on the teaching faculty of RESNA and a member of the Clinician Task Force. Lange is a certified ATP, certified and SMS and is certified as a Senior Disability Analyst through the American Board of Disability Analysts. SEE PAGE 28

BLAKE PERKINS

Perkins is a consumer advocate who lives in Hermitage, Tennessee. SEE PAGE 10

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Stay HOT ON THE TRAIL

WRITTEN BY: MIKE BARNER

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We are fresh off the National CRT conference (CELA) in Washington and feeling as though it was very successful. To top it off, my company received an affirmative verdict for a 2012 Medicare ALJ hearing. I once again feel hope for our industry.

I hope people truly do understand what Complex Rehab Technology (CRT) is and what it does for the people who need it daily. I hope they are starting to understand that to provide this level of technology it must be done by qualified individuals who are credentialed and maintain a level of competency in clinical and equipment technology. All of this costs money to maintain.

With that said, I also understand now is the time that we must truly press forward and not rest on one visit to Washington to solve all of our challenges. We must be hot on the trail of getting the accessory bill passed and then focus on the CRT separate benefit. It appears the members of congress that we spoke with understood the issue, were concerned, and are willing to try and do something about it before June 30, 2017. But we need everyone in the industry focused on the target in this hunt and hot on the trail.

We need all CRT stakeholders to be reaching out to their Members of Congress to secure as many co-sponsors as we can get. The more co-sponsors, the greater chance for us to get our bills passed. You can see a current list of co-sponsors by state and use the links to send an email and make a phone call at www.protectmymobility.org.

I remember years ago I used to go rabbit hunting with my best friend. He had this beagle that was an outstanding rabbit hunting dog. When the rabbit was spooked, it would take off at what seemed like 100 miles an hour. Rarely did we ever get a shot off at that time. But then the dog would get on the trail and would be so incredibly focused on following the scent. Nothing, and I mean nothing, would get him off that trail until he reached the goal of running the rabbit back to you. I won't go into detail on what happened next, but the point is how focused the dog was when it was hot on the trail of its mission. Nothing was going to stop it.

We need to be hot on the trail of getting this bill passed. It starts by you and your staff picking up the phone and making a call right now. You must do it again and again and again until your congressperson signs onto the bill. You must be appropriately relentless and not let anything break your focus until the goal has been reached. You can do it, and it does work. Before I left the office for Washington, I prepped the staff to start making calls up to the day we would be on the Hill making visits. It paid off. We had a couple of the offices state they had recently had several phone calls regarding the bill we were there to discuss. We even had one office commit to signing on right then. You can make this happen.

Don Clayback issued us all a challenge, and I would like to extend that to all CRTS®s and RRTS®s. The challenge is to obtain the trifecta, which is getting your one representative from the House and senators to sign on to the accessory bill. You can even do it for your home and work if you happen to have different districts. If you can achieve this, please be sure and contact your NRRTS office and let us know.

To accomplish our goal of getting the accessories bill passed, we will have to be consistent and persistent. It's not a hard thing to do, but it is extremely frustrating. You have stay focused and keep the pressure on your congressional representatives. Currently Congress has a lot going on, probably more than usual, so it's important that you keep this on their minds by emailing, calling and showing up in their local offices. You could also get them to your office to let them know that this is important, including how it's going to affect people. Let them know you are hot on the trail and will not be distracted or give up until they sign onto this bill.

It's always inspiring to go out to Washington and see the amazing buildings that our forefathers built to represent a vision for the greatest nation on earth. When you walk the hallways and feel the excitement of participating in a great American privilege of representing a cause for other people, it really gives you hope that our country will eventually do the right thing when consistently presented with the facts. The fact is that the accessory bill must be passed or people will go without the medically necessary equipment needed to live as independently as possible and not be harmed. That is something you can be HOT ON THE TRAIL about.

Let your NRRTS office know how we can help you get started or continue to pursue the goal.

With boots on the ground, in the hunt, and hot on the trail,

Michael B.

CONTACT THE AUTHOR

Mike may be reached at mkbarner@med.umich.edu.

DON'T FORGET TO VISIT

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BOLDLY REPRESENT YOURSELF AS A WHEELCHAIR USER

WRITTEN BY: ROSA WALSTON LATIMER

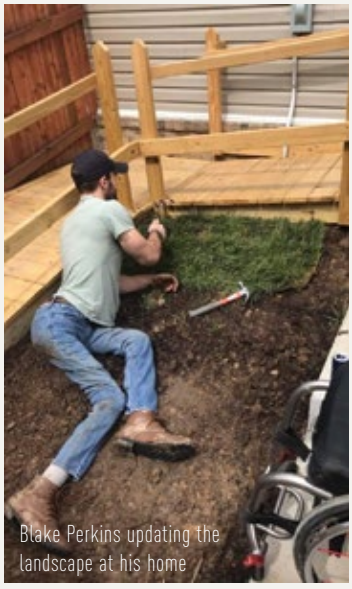
"I just can't say this enough: make the best of what you've got," Blake Perkins declared. "It may not be beautiful. It may not be poetic. It is what it is, and you just have to do your best." These are words Perkins lives by, and this positive example is one of the reasons he was honored as a "Hometown Hero" in 2016 by WBKO, an ABC affiliate television station in his hometown of Bowling Green, Kentucky.

Without this optimistic view of life, there's no way to know what Perkins' life would be today. Following a motorcycle accident in 2011, he was paralyzed from the waist down. At the time he was attending Western Kentucky University with the intention of becoming a physical therapist. In an interview for WBKO, Perkins explained that immediately following the accident he broke down and was emotional for about a day. "After that it was about how do I get better, how do I get back to living life the way I want to?"

The accident and Perkins' injuries didn't alter his dream of becoming a physical therapist. However, after completing his requirements for a degree in exercise science, professors at Western Kentucky University questioned whether he could meet the demands of the physical therapy program since he couldn't stand or walk. After meeting with Perkins and initially working with him, the instructors were convinced he could overcome any obstacle. Perkins now plans to return to Western Kentucky University and graduate with his doctorate in physical therapy in 2018. He will also sit for his ATP certification in July of this year.

Perkins has produced instructional videos (www.youtube.com/user/bperky31/videos) covering subjects such as "Social Boozing with a Spinal Cord Injury" and "Handicapable Fitness" as well as entertaining videos of him singing while accompanying himself on guitar.

Blake Perkins touring in downtown Nashville.



Blake Perkins updating the landscape at his home

"I came to Nashville in 2016 because of a clinical rotation with Star Physical Therapy in neighboring Brentwood," Perkins said. "Star was understanding and open minded about my being in a wheelchair. An added bonus of living in this area is being part of the music scene in Nashville. I love writing music and performing."

Perkins and his band play in and around Nashville in familiar places such as Opry Mills. "We also play lots of marinas," he said. "Performing is fun and I'd love to do it professionally, but that's a far-off dream."

Perkins' matter-of-fact, optimistic attitude is genuine and that is obvious to those who know him personally, work with him or simply observe him as he interacts with others. The individual who nominated him for the Hometown Hero honor is a former athletic coach who noticed Perkins at work as a personal trainer at an athletic club. The man explained, "I've seen so many people who have had accidents like he had, and they just give up. But Blake has a fighting spirit, and it really impressed me."

"When I went back to work after the accident as a personal trainer, I had to get better at explaining exercises and techniques," Perkins said. "I could no longer show how to do every move. That was very challenging."

However, as in every facet of this 26-year-old's life, Perkins turned that challenge into a positive. "I believe that, unfortunately, many folks with injuries adopt an attitude of not wanting to be defined by their disability," he said. "I feel I've embraced my situation and accept it as part of my identity. I believe that enables me to help, and perhaps inspire, others.

"Identifying with being a 'wheelchair' guy has helped me stay sane and figure out my niche in life. Whatever gives you the edge you need, as long as it is constructive and isn't detrimental to you or others - use it!"

Perkins also said he expects to fail at some things and feels it is essential to also embrace failure and vulnerability. "I realized after the accident that I still had a place as a physical therapist, but I had to figure out what I could offer the world with what I'd been dealt. Actually, I'm still figuring that out."

Perkins doesn't deny or minimize the difficulty of transitioning from being mobile and self-sufficient to living in circumstances that require occasional dependence on others. However, without question, his choices on how to handle his situation are an inspiration to others.

Here's a summary of Perkins' personal advice to someone who has faced a life-changing disability:

- It can take years to get over the initial psychological shock of your injuries. Don't let yourself become discouraged.
- You are still the same person as you were before.
- Focus on the "why not" instead of "why." This is especially true when working with doctors and clinicians regarding your injury.
- Focus on the "why not" instead of "why." Focus on rehab, peer support and ask for help. Fully appreciate any support network you may have, and if you don't have one – find one. They are everywhere!
- Be patient with your body as your neurological system restarts (spinal shock). Allow yourself time to heal.
- Persistence leads to progress, with rehab, career aspirations and independence. Keep working. It will pay off!

"I would add that it is important not to be ashamed to embrace your disability," Perkins said. "Try to view it as portraying your talent to the world through a different lens and a different perspective. Associate with people who respect you and don't be afraid to boldly represent yourself as a wheelchair user."

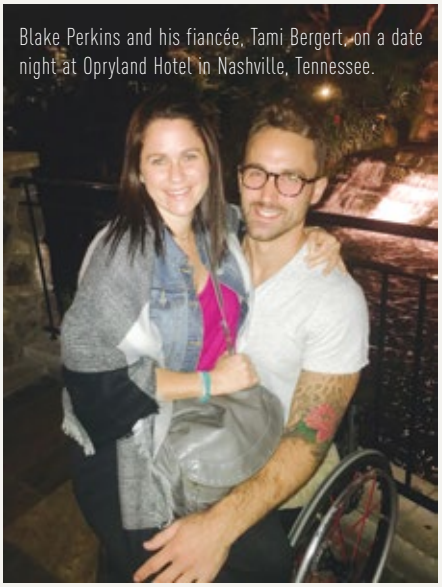
Perkins currently works as a customer care coordinator at Numotion, a national Complex Rehab Technology provider, in a Nashville Metroplex location. He is also a consumer lobbyist and attended his first National CRT Leadership and Advocacy Conference this year. "As a wheelchair user and aspiring clinician, I experience the effects of Medicare's handling of reimbursement funding, and I hope my perspective can be valuable," he said.

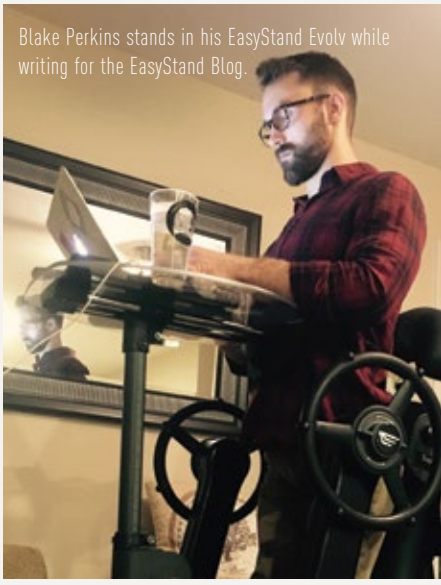
An even more important event for Perkins this year will be his marriage to his fiancée Tami Bergert. The couple met after Perkins moved to Nashville and has set a June 3, 2017, wedding date. The couple has given serious consideration to their "needs versus wants" and agrees they don't have many "needs" but are certain they do want to have a family. The couple realizes this will require a large financial commitment and has established a fund (www.honeyfund.com/wedding/marryingmybestfriend) to provide an opportunity for others to help them see this come true.

CONTACT

Blake may be reached at blake.perkins@numotion.com.


Picnic with the pups near Percy Priest Lake in Hermitage, Tennesse.


Blake Perkins and his fiancée, Tami Bergert, on a date night at Opryland Hotel in Nashville, Tennessee.


Blake Perkins stands in his EasyStand Evolv while writing for the EasyStand Blog.

INDUSTRY LEADER

A VIEW FROM WITHIN

AMORTEGUI USES ACROSS-THE-BOARD EXPERIENCES TO BOOST INDUSTRY SUCCESS RATES, END USER OPTIONS

WRITTEN BY: DANETTE BAKER

A familiar adage refers to there always being two sides to every story. No one knows that better than Claudia Amortegui, whose diverse background — first working for a funding source (Medicare), then for a supplier, a manufacturer and now as a consultant — is an asset to her clients.

As president of The Orion Group (www.orionreimbursement.com), Amortegui counsels individuals and companies on how to successfully navigate the reimbursement process and gain a competitive edge in durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), with a strong focus in Complex Rehab Technology (CRT). Her work has included everything from assisting manufacturers on understanding Medicare coding so new products in development can get funded to advising private, international firms on the sourcing and funding process so they can make solid investment decisions. She and her team, two additional consultants and the company's support staff, also provide training, education and file reviews for funding on a case-by-case basis. They are also in the process of launching a new web-based reimbursement tool to allow its users to become funding experts as they perform their daily job responsibilities.

Like many others, Amortegui discovered the DME/CRT industry by happenstance. She graduated from the University of South Carolina with a Master of Business Administration, focusing on international business, and was one week into her new job when Amortegui said she realized she was in the wrong field of work. Searching for a new career path, she came across an opportunity that fit her credentials.

"Medicare had just begun to create the DMERCs (Durable Medical Equipment Regional Carriers), which needed people with professional backgrounds who also spoke Spanish," she explained. "I had always had an interest in the health care industry, and I am fluent in Spanish, so I threw my name in."

Amortegui accepted an ombudsman position with Palmetto Government Benefits Administrators (DMERC Region C) helping DMEPOS providers work through medical policies and claims submissions. While there, she also became acquainted with various manufacturers. Sunrise Medical was one of those companies. Her experiences with Sunrise led to Amortegui's position as a sales representative with the company, responsible for Quickie Designs and Jay Medical product lines. Her short time in this position allowed Amortegui to truly learn the equipment and make the correlation on how it was reimbursed by Medicare.

Afterward, Amortegui moved to the Chicago suburbs to become a director of reimbursement for American Pharmaceutical Services, a national long-term care supplier. Here, Amortegui said she learned what it was like to be on the other side of the industry, specifically in billing and collections. Amortegui then returned to Sunrise in the late 1990s and introduced a new service line for the group as director of consulting services. In this role, she led the management of a national consulting group specializing in Medicare reimbursement. Several years later, Amortegui took the consulting business out on her own and in 2002 formed The Orion Group.

The Orion Group may be small in number, but they make a significant impact on reimbursement and clinical consulting for DMEPOS, Amortegui said, with the ultimate goal of giving clients the knowledge needed to provide appropriate products to the end user and receive adequate compensation. Although they focus primarily on Medicare claims, The Orion Group can also assist with Medicaid and private insurance reimbursement issues, she said.

"It's getting back to what the heart of this industry has always been," Amortegui said. "But it has continually become more difficult in the constantly changing world of funding. It takes someone who understands the challenges providers face with reductions in reimbursement and who also understands how the funding side works."

(CONTINUED ON PAGE 14)

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A VIEW FROM WITHIN
(CONTINUED FROM PAGE 12)

Advantage goes to team Amortegui. Having worked on the supplier, provider and manufacturer side, she understands that business is about the bottom dollar and the impact just one product can have on a client's livelihood. The equipment, for many end users, means the difference between existing and living. Amortegui has seen firsthand Medicare deny reimbursement for needed equipment, but she also understands from the funding standpoint the need for policies and oversight on funding to keep abuse of the system in check.

"Unfortunately, there have been some bad apples in our industry who have tarnished the image for most DMEPOS suppliers. From the funding side, I've seen many things including claims billed for enough surgical dressings that would easily mummify someone. It is understandable as to why the policies need to exist, but they also need to make sense.

"We also need to make sure our industry is doing the right things. This will allow us to request what is right and fair from the funding sources. Providers need to remember that even the little things count, such as treating those within the funding source customer service teams as human beings. They are forever getting beat up because there are a lot of things out of their control and training is minimal. Sometimes it just may take some patience on both ends to understand what each person means."

Amortegui said she would like to see an "overhaul" in the mindset of many of those at the Centers for Medicare and Medicaid Services, taking it back to the day when there was the opportunity for education between the funding sources and suppliers and manufacturers.

"When I worked for Medicare, I got to know people in the industry like Rita Stanley. She, and others, helped open my eyes as I sat on the funding side. There was a time in there where they would come and train us on products, and we could have a dialogue about funding; it was much more hands on. Now, the turnover is high, their tasks are very time driven, and the doors are not very open taking away that opportunity for education on both sides."

Nevertheless, Amortegui is a staunch industry advocate, working in collaboration with NCART and NRRTS's efforts to affect change from behind the scenes and supporting people like Don Clayback who are leading the charge. As such, she supports the separate benefit category for CRT. "It just makes sense, and it's a proven model," she said. "Orthotics and prosthetics are evidence that such complex equipment should not be a part of a standard group. Amortegui also recently attended the CRT conference in Washington, representing her home state of Colorado.

Understandably, Amortegui's work requires a conscience balance of rights, responsibilities and rewards, which has developed a skillset in high demand. "I've been offered jobs within the industry to work just for one company, but I think I'm doing more good for them and hopefully for the industry by staying independent. One of my greatest assets is to be able to stay involved in all aspects of the business."

Amortegui also is a member of the Medicare MAC Jurisdiction C Council and has presented on various topics at state and national meetings. She has been published numerous times in national industry publications, including as a regular contributor to DIRECTIONS.

(CONTINUED ON PAGE 16)

A VIEW FROM WITHIN
(CONTINUED FROM PAGE 15)

"There is nothing better than seeing a person in the proper wheelchair and seating system. That's why we all put so much effort into working with companies driven by doing the right thing by the client and helping ensure that they are properly reimbursed."

This past year, Amortegui also gained some experience in balancing career with being a new mom. "Lack of sleep was the greatest obstacle," she said. "As all mothers know, you don't get much sleep in the first year."

"I'm very fortunate to have my own business — and an incredible team. It makes that balance a little easier. The team, and many of my customers, have been through this and have been very supportive, even through the unplanned background noises only a baby can make."

At the end of the day, Amortegui said, it's all worthwhile to get all parties to come to the table with the common goal of getting the end user the proper equipment needed and getting it funded.

CONTACT

Claudia may be contacted at info@orionreimbursement.com.

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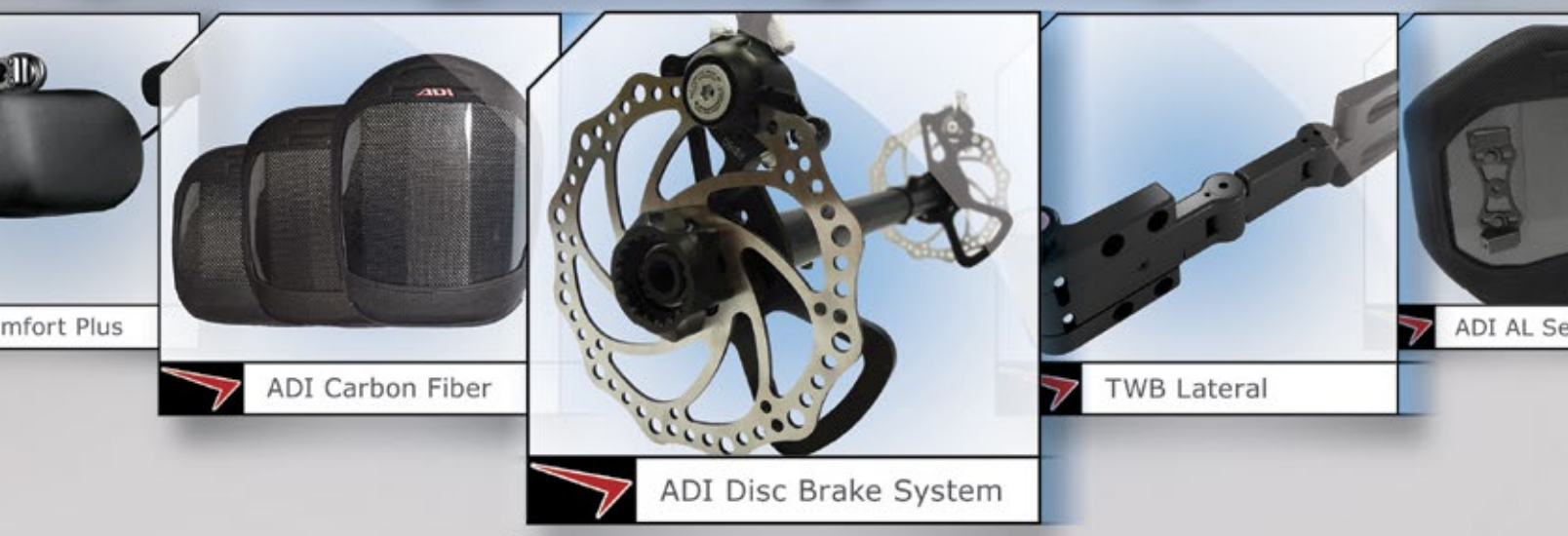

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DEE DEE FRENEY — A LIFELONG THERAPIST

WRITTEN BY: ROSA WALSTON LATIMER

Delia "Dee Dee" Freney, OTR/L, ATP, is planning to retire in June but says she is a "lifer" in the wheelchair rehab world. The therapist explained, "I'll always be a rehab therapist at heart, but at this time I'm leaving my clinical practice. I plan to continue to do educational presentations, submit papers for conferences and travel both personally and for wheelchair distributions around the world."

Currently Freney is a clinical specialist for high mobility durable medical equipment with Kaiser Permanente in the San Francisco East Bay area, and her retirement will top off almost 40 years as an occupational therapist. Freney explained that within two years she is planning to be a team leader with a group of rehab specialists and a photo journalist who will travel to Western Kenya to do volunteer work at the Matibabu Clinic. The Matibabu Clinic was founded and supported by Kaiser physicians who responded to the medical needs of a small village whose residents were dying of AIDS and physically challenged by polio and other orthopedic and neurological diagnoses. The physicians brought funds raised through the Tiba Foundation to the local people to build a clinic and to personally ensure the funds were used appropriately.

Freney has worked with other nonprofit groups involved with wheelchair distribution including a recent trip to Jamaica with Mustard Seed Communities; a Peru distribution with Eleanore's Project; a distribution in Nicaragua with Familias Especialas; and distributions in Trinidad, Uganda, Costa Rica, Ukraine, Vietnam and China Tibet with Wheels for Humanity. Most of these groups take wheelchairs that were headed to a landfill and ship them to the host country along with cushions and other rehab wheelchair parts. When the teams arrive they help with building, fitting and distributing wheelchairs. The Matibabu Clinic will have wheelchairs provided by local manufacturers waiting for Freney's team who will help with seating, maintenance and repairs. "We also provide education, so there can be seating specialists there once we've left," she said.

When asked how these personally enriching experiences had influenced her professional life, Freney explained:

> "These experiences have given me a broader appreciation of the scope of what rehab therapy is all about in a global sense. We have many programs available in the United States, and the people who live here have opportunities to benefit from the technology that others in developing countries don't have.
>
> "It is a wonderful experience to be able to bring these technologies such as foam-in-place seating, pressure management cushions and tilt-in-space wheelchairs to these developing countries who have little or no rehab equipment. In America, we can donate whatever wheelchairs and seating equipment we are no longer using to people who have nothing. This creates a 'win/win' situation for everyone.
>
> "People who live across the world have touched my life and made me more humble. I'm reminded that challenging diseases I see in America are also worldwide. A 'CP' child in California looks like a child in Nicaragua who also has cerebral palsy. After we leave a country, I am reminded there is still more need — especially for wheelchairs.
>
> "When my daughter was 11 and my son 15 they traveled with me to North Vietnam for a wheelchair distribution. This was a wonderful opportunity for them to understand how privileged they are to live in the U.S. with all of its resources. Being children of a therapist has helped them better exhibit empathy to those with disabilities and develop an attitude of wanting to help when they see someone in need."

This experienced therapist also told DIRECTIONS about the biggest challenge she had faced in her career.

"One of the biggest challenges has been being in this career long enough to see the changes the end user faces regarding access to assistive technology. I have patients, who are also my friends, with spinal cord injuries who have used assistive technology, such as power wheelchairs with power positioning features, for years. Their condition has not progressed, but their needs have changed often due to aging.

"Coding for funding has become limiting, because the funding criteria has changed. This situation makes it

more difficult for end users to continue to have the assistive technology they may have used for years even though there is a continuing need to allow for basic activities of daily living and functionally active lives. With these changes too often it is necessary to pay out-of-pocket for features on wheelchairs that are now considered upgrades.

"Another challenge came when I transitioned from being a pediatric therapist to working with adults. The number of bariatric patients in both children and adults is growing. There are many challenges to properly fitting the bariatric adult end user in a heavy duty chair that accommodates their dimensions and also allows them accessibility in the home."

"The many different experiences I have had as a therapist have helped me find creative solutions to many challenges and enabled me to become a clinician with a broader scope of service to my patients. I hope that my work with manufacturers who recognize and address the needs of the end users along with my clinical input will provide a good perspective to help produce well thought-out, functional assistive technology."

"Working as a provider for a period of time, then as an educator for various manufacturers and now as a clinical therapist, I have a total appreciation for what it takes to make it all work! Because of these experiences, I am better able to understand the big picture of how you get from a prescription to delivery of the product to the end user. There are so many factors!"

Finally, Freney shared helpful advice she would offer to other therapists.

"I strongly recommend therapists to use the resources of a mentor. Find someone who has 'been there' and can share the successes and the challenges they have had. As they say, there's no need to reinvent the wheel. Our industry has a very strong bonding among therapists, and we are all happy to share what we've learned. Be sure to network and use the resources available so you don't have to start at the very beginning to solve a problem alone. Partner with other clinicians who have already faced similar situations and remember to share with your peers when you discover a solution."

"Also, learn from our mistakes to prevent from making them again. I'll always be open to learning and this often happens when I get together with my friends in the industry. Sessions and presentations are valuable, but you can also learn during lunch with your peers."

Dee Dee and her husband, Paul at a recent Tiba Foundation Benefit for the Matibabu Clinic.

Dee Dee and her dad, George Dong, a World War II Vet on an Honor Flight to Washington, D.C.

Dee Dee with her dog, Riley, at Lake Tahoe.

"We are a big rehab family who is willing to share and teach. I also have another family in my wheelchair distribution work. Many opportunities were presented to me by someone who was familiar with my work or I've teamed with on a previous trip. These 'families' are important to your work because they share the same passion. That passion shows in everything you do in your work and personally as many become your friends for life."

In a couple of years, instead of riding into the sunset of retirement, Freney will move to northern Idaho where she is building a home on waterfront property. "I'll spend my retirement on a beautiful piece of land by a river. I will have family nearby in Spokane and will share the beautiful countryside with my husband and my father, a World War II veteran who is now 92. I also have trips planned just after retirement with my family to China and a possible river cruise or a trip to Bali with my best friend."

(CONTINUED ON PAGE 20)

DEE DEE FRENEY – A LIFELONG THERAPIST
(CONTINUED FROM PAGE 19)

"I've had the best ride in my career!" Freney said. "Along the way I've gathered so many friends – end users, patients, other clinicians, providers and manufacturers."

Freney looks forward to maintaining these friendships as she continues with what she considers her life's work. These associates will be very pleased that Freney has chosen to be a lifelong therapist and that she will continue to share her leadership and knowledge.

CONTACT

Dee Dee may be reached at ddfreney@aol.com.

Dee Dee Freney and her late mother, Laura, at High Tea.

Dee Dee Freney with her children, Michael Freney and Lauren Freney.

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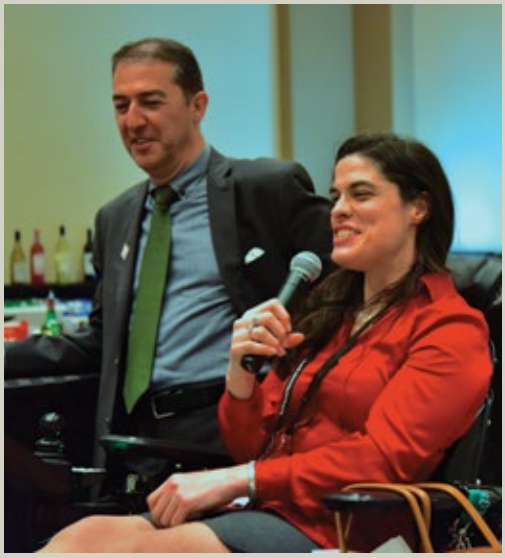


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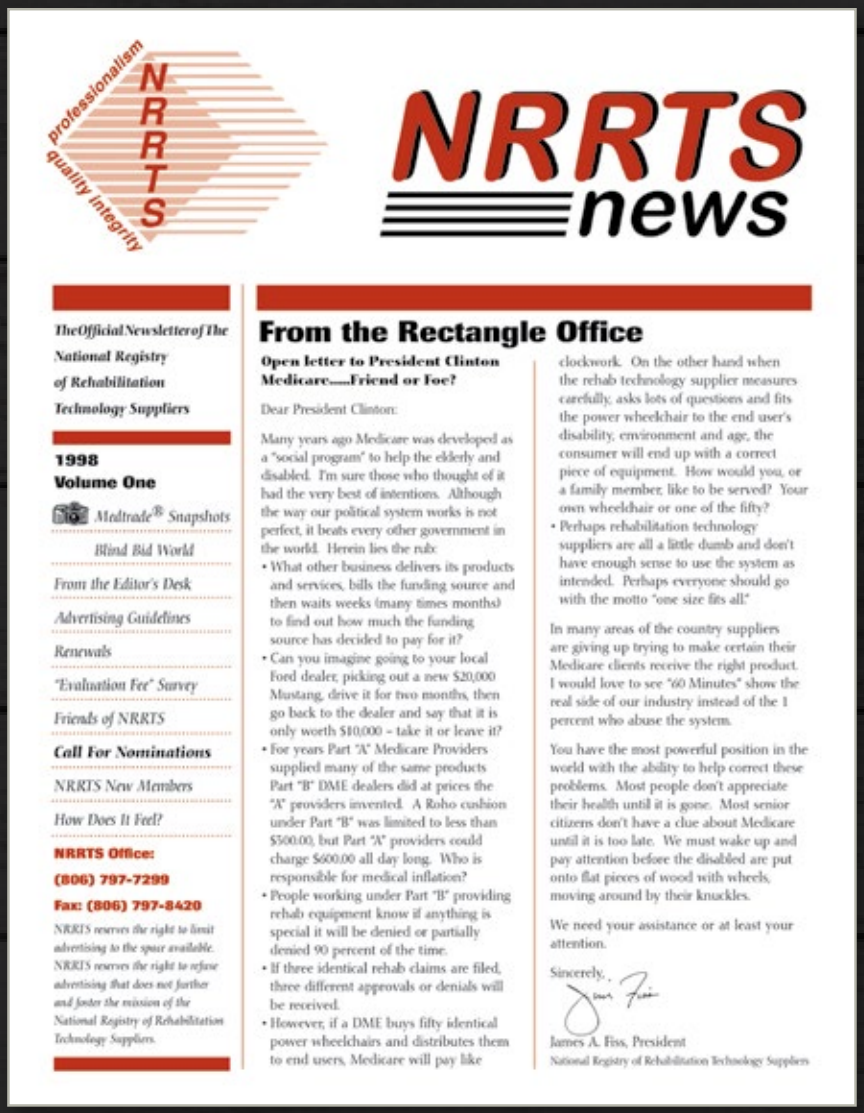

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From the Rectangle Office

Open letter to President Clinton
Medicare.....Friend or Foe?

Dear President Clinton:

Many years ago Medicare was developed as a "social program" to help the elderly and disabled. I'm sure those who thought of it had the very best of intentions. Although the way our political system works is not perfect, it beats every other government in the world. Herein lies the rub:

- What other business delivers its products and services, bills the funding source and then waits weeks (many times months) to find out how much the funding source has decided to pay for it?
- Can you imagine going to your local Ford dealer, picking out a new $20,000 Mustang, drive it for two months, then go back to the dealer and say that it is only worth $10,000 – take it or leave it?
- For years Part "A" Medicare Providers supplied many of the same products Part "B" DME dealers did at prices the "A" providers invented. A Roho cushion under Part "B" was limited to less than $500.00, but Part "A" providers could charge $600.00 all day long. Who is responsible for medical inflation?
- People working under Part "B" providing rehab equipment know if anything is special it will be denied or partially denied 90 percent of the time.
- If three identical rehab claims are filed, three different approvals or denials will be received.
- However, if a DME buys fifty identical power wheelchairs and distributes them to end users, Medicare will pay like clockwork. On the other hand when the rehab technology supplier measures carefully, asks lots of questions and fits the power wheelchair to the end user's disability, environment and age, the consumer will end up with a correct piece of equipment. How would you, or a family member, like to be served? Your own wheelchair or one of the fifty?
- Perhaps rehabilitation technology suppliers are all a little dumb and don't have enough sense to use the system as intended. Perhaps everyone should go with the motto "one size fits all."

In many areas of the country suppliers are giving up trying to make certain their Medicare clients receive the right product. I would love to see "60 Minutes" show the real side of our industry instead of the 1 percent who abuse the system.

You have the most powerful position in the world with the ability to help correct these problems. Most people don't appreciate their health until it is gone. Most senior citizens don't have a clue about Medicare until it is too late. We must wake up and pay attention before the disabled are put onto flat pieces of wood with wheels, moving around by their knuckles.

We need your assistance or at least your attention.

Sincerely,

James A. Fiss, President
National Registry of Rehabilitation Technology Suppliers

#THROWBACK
FROM THE '90S TO NOW

The EVOLUTION OF

how we've come

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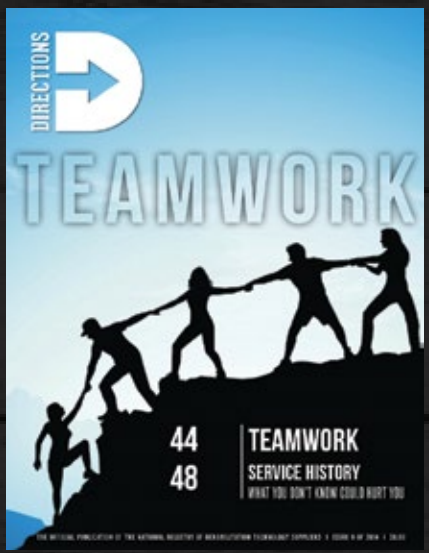
NRRTS 25th anniversary 1992-2017



CRT UPDATE

FOCUS ON FEDERAL LEGISLATION

WRITTEN BY: DON CLAYBACK

If you're a Complex Rehab Technology (CRT) stakeholder or friend, hopefully you're keeping your focus on Congress and Washington.

While there are major discussions and activities regarding national health care taking place, we have a June 30 deadline fast approaching and with it comes a major threat to CRT access that Congress needs to take action to stop.

Our immediate CRT priority remains getting legislation passed to stop the Centers for Medicare and Medicaid Services (CMS) from inappropriately using Medicare competitive bid program information to cut payments for accessories used with CRT manual and power wheelchairs. The current temporary delay in cuts to CRT power wheelchair accessories expires June 30, so a permanent fix is needed to stop the July 1 payment reductions.

The legislative solution lies with the CRT Wheelchair Accessories bill reintroduced this year in the House (HR 1361), being led by Reps. Lee Zeldin, R-N.Y., and John Larson, D-Conn., and in the Senate (S 486), being led by Sens. Bob Casey, D-Pa., and Rob Portman, R-Ohio.

As of this writing, the House bill has 44 members signed on, with 96 cosponsors from last year that we need to quickly get re-signed. The Senate bill has 15 members signed on, with 10 cosponsors from last year that we also need to quickly get re-signed.

Our second CRT priority is to secure co-sponsors and pass the "Ensuring Access to Quality Complex Rehabilitation Technology Act of 2017." This bill will create a Separate Benefit Category for CRT and make needed improvements in coverage, coding and supplier standards. Reps. Jim Sensenbrenner, R-Wis., and Joe Crowley, D-N.Y., have reintroduced it in the House of Representatives as bill number HR 750.

The CRT Separate Benefit Category bill has 44 members signed in the House, with 117 co-sponsors from last year still to get re-signed.

We need all CRT stakeholders to be reaching out to their Members of Congress to secure as many co-sponsors as we can get. The more co-sponsors, the greater chance for us to get our bills passed. You can see a current list of co-sponsors by state and use the links to send an email and make a phone call at www.protectmymobility.org.

SUCCESSFUL NATIONAL CRT CONFERENCE

More than 150 CRT stakeholders from across the country came together at the 2017 National CRT Leadership and Advocacy Conference on April 26 and 27 in Arlington, Virginia. The theme of the conference was protecting access to CRT for people with disabilities. As we all know, people depend on CRT to manage their medical needs, minimize their health care costs and maximize their independence.

This long-standing annual conference is a partnership of the NCART and NRRTS. The event brings CRT stakeholders together in one place for high value education, networking and advocacy. A key program component is taking the CRT access message directly to Members of Congress.

Attendees represented all sectors of the CRT community. That included providers, manufacturers, consumers and consumer organizations, clinicians and clinical organizations, families and caregivers, researchers, and other advocates from a total of 35 states. Thirty attendees were CRT wheelchair users.

The first day of the conference started off with "Health Care Policy – What's in the Air?," a panel presentation providing an overview of the issues, options and politics in Washington regarding health care reform. Attendees heard directly from legislative veterans from the National Health Council and Washington Council Ernst & Young about the dynamics in play as the president and congress look to improve health care at the national and state levels.

Attendees also heard from representatives from the ITEM Coalition (Independence through Enhancement of Medicare and Medicaid), the National Multiple Sclerosis Society, and the United Spinal Association. These panelists provided updates on other "non-CRT" issues and legislation that are in play. It's important to be informed and supportive of other issues and bills that are a priority for people with disabilities, and this presentation provided a great overview.

A highlight of that day's "Capitol Hill Preparation" session was the opening speech from Steve Saling, a nationally recognized champion for accessible residential environments and assistive technology for people with disabilities. Saling was diagnosed in 2006 with amyotrophic lateral sclerosis, also known as ALS or Lou Gehrig's disease and uses a CRT power wheelchair and a speech generating computer.

Saling is the founder of the ALS Residence Initiative, an advocacy and

fundraising organization based on the motto "Until medicine finds an answer, technology IS the cure." You could not pick a better motto for our ongoing quest to protect access to CRT.

He shared his powerful personal story and encouraged conference attendees to share their CRT stories with Congress to aggressively protect and promote access. A video of his speech can be found at https://youtu.be/2xxJxCoNKbU.

The second day of the conference was Capitol Hill Day, which centered around CRT stakeholders taking our message to Congress. During the course of the day, attendees made visits to 245 Congressional offices covering 36 states.

The CRT message was twofold. First and foremost, communicating the urgent need to co-sponsor and pass HR 1361 and S. 486 by June 30 to stop the major Medicare payment cuts to CRT wheelchair accessories. The second request was to co-sponsor and pass HR 750, the "Ensuring Access to Quality Complex Rehab Technology Act," to create a Separate Benefit Category for CRT within Medicare and make needed improvements to access.

Both these bills enjoyed broad bipartisan support in the House and Senate in 2016 and initial reports indicate that support continues in 2017. Advocates are in the process of following up on their member office visits to secure co-sponsors for the CRT bills. For CRT stakeholders unable to attend last month's conference, you can email and call your Members of Congress using the information and links at www.protectmymobility.org.

We want to thank all of the attendees, especially the consumers, for taking the time to come to Washington and carry the CRT flag. It's this commitment that results in an increase in CRT understanding and support in the halls of Congress.

We also want to thank the conference sponsors, without whose financial support the event would not be possible. Please see the "Thank You Sponsors" page (p. 23) in this issue that recognizes these important and generous organizations, and please keep their support in mind when making your purchasing decisions.

Access to CRT is significantly dependent on federal legislation and policy. To effectively be promoting and protecting access, stakeholders need to have a strong annual presence in our nation's capital. So if you couldn't join us this year, please plan on being with us at next year's program.

In closing, remember to use the information, tools and links available at www.access2crt.org and www.protectmymobility.org. They have been created to make advocacy work easier for everyone. Thanks for staying informed and engaged!

CONTACT THE AUTHOR

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PRESSURE RELIEF GUIDELINES

WRITTEN BY: MICHELLE L. LANGE, OTR/L, ABDA, ATP/SMS

When working with clients who use wheelchair seating and mobility, it is critical to consider the latest pressure research and guidelines. This information directs the assessment team in understanding any past or current pressure injuries, determining pressure injury risk, matching these factors to correct product selection, and designing a client-specific weight shift program.

The National Pressure Ulcer Advisory Panel (NPUAP) is the primary source of current pressure injury terminology and definitions. The definition of pressure injuries was redefined during the NPUAP 2016 Staging Consensus Conference in Chicago. The terms "pressure sore" and "pressure ulcer" have been replaced by "pressure injury."

DEFINITION:

"A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (NPUAP, 2016)."

STAGING:

The following are the current pressure injury staging definitions. More detailed information is available at NPUAP.org.

- Stage 1: Non-blanchable erythema of intact skin
- Stage 2: Partial-thickness skin loss with exposed dermis
- Stage 3: Full-thickness skin loss
- Stage 4: Full-thickness skin and tissue loss
- Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
- Deep Tissue Pressure Injury: Persistent non-blanchable, deep red, maroon or purple discoloration

RISK ASSESSMENT:

Part of the Wheelchair Seating Assessment includes pressure injury risk assessment. A variety of factors increase pressure injury risk, including immobility, fragile skin, existing or past pressure injuries, impaired circulation, and pain in body areas exposed to pressure. Contributing factors include pressure, shear, hygiene, incontinence, heat, moisture, nutrition and repositioning.

PRESSURE REDISTRIBUTION GUIDELINES:

Once a risk assessment is complete and appropriate seating surfaces are selected, the assessment team must design a pressure relief/redistribution program specific to the individual. A primary resource is "Pressure Ulcer Prevention and Treatment Following Spinal Cord Injury: a clinical practice guideline for Health-Care Professionals, Second Edition, Consortium for Spinal Cord Medicine Clinical Practice Guidelines." These guidelines are specific to clients with spinal cord injuries and so must be modified by the team to meet not only individual needs, but also the needs of clients with other diagnoses.

The current guidelines (2014) recommend a weight shift every 15 to 30 minutes for approximately two minutes. This may be achieved manually or by using a mechanical or power tilt and/or recline system. Standing systems can also be used to provide weight shifts. A tilt of more than 45 degrees is required to provide any measurable pressure relief. Optimal pressure relief is achieved using a combination of 25-35 degrees of tilt in combination with 120 degrees of recline, which is sometimes used as justification for a combination tilt and recline system (Jan, et al., 2013).

CONTACT THE AUTHOR

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RESOURCES:

1. NATIONAL PRESSURE ULCER ADVISORY PANEL, WWW.NPUAP.ORG
2. PRESSURE ULCER PREVENTION AND TREATMENT FOLLOWING SPINAL CORD INJURY: A CLINICAL PRACTICE GUIDELINE FOR HEALTH-CARE PROFESSIONALS, 2ND ED., CONSORTIUM FOR SPINAL CORD MEDICINE CLINICAL PRACTICE GUIDELINES, 2014.
3. JAN, Y. K., CRANE, B. A., LIAO, F., WOODS, J. A., & ENNIS, W. J. (2013). COMPARISON OF MUSCLE AND SKIN PERFUSION OVER THE ISCHIAL TUBEROSITIES IN RESPONSE TO WHEELCHAIR TILT-IN-SPACE AND RECLINE ANGLES IN PEOPLE WITH SPINAL CORD INJURY. ARCHIVES OF PHYSICAL MEDICINE AND REHABILITATION, 94(10), 1990-1996.

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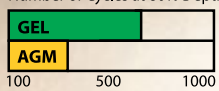

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CEU ARTICLE

NAVIGATING THE TRANSITION FROM MANUAL TO POWER MOBILITY

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WRITTEN BY: ANGIE KIGER, M.ED., CTRS, ATP/SMS

Imagine yourself making plans to take a road trip to a new destination. While you've never been to the exact location, you have a basic understanding of what to expect and a few simple goals in mind for what you would like to accomplish. In preparation for the trip, you do your due diligence by updating your GPS app on your smartphone, envisioning an overview of the trip, researching the destination, checking over your vehicle, and packing all the essentials.

As you slide into the driver's seat ready to embark on the adventure and feeling completely prepared for what lies ahead, you enter the address of the destination into your GPS app only to realize there are many unexpected obstacles and options you had not previously considered. Should you select the route that is listed as the shortest, fastest, without tolls or the one that will allow you to avoid the interstates and drive the scenic back roads?

Just as you confidently decide on the route and crank the engine of your automobile, two passengers show up outside of your vehicle with luggage in hand and plans to join you as teammates on your trip. Suddenly you have an entirely different list of options to consider, all while still trying to reach your destination.

Have you ever noticed the similarities between the journeys of a road trip and the experiences had during the wheelchair provision process? As a clinician or rehabilitation technology supplier, from the moment you first hear the name and diagnosis of a new client, odds are high you are already mapping out a plan to help the client reach his or her destination. That individually tailored plan likely includes factors for achieving improved independence, health and overall quality of life. Even though the paths taken and experiences had throughout each client's journey may not be the same, the goals that the destination affords for all potential clients are likely similar.

This article will take a closer look at a variety of route options including benefits to each, potential roadblocks and considerations to keep in mind when the journey to improved independence, health and overall quality of life potentially requires a client to transition from a manual wheelchair to a power wheelchair.

FINAL DESTINATION EQUIPMENT OPTIONS

We live in a very techy world. In fact, odds are your smartphone is within arm's reach as you read this article. The latest and greatest gadgets for making everyday aspects of life more convenient and fun are constantly being sought by consumers. Home automation and having the world at our fingertips has transitioned from concepts dreamed up by the creators of Hanna Barbera's "The Jetsons" to what is expected by consumers today.

Canadian inventor, George Klein, is widely credited with initiating the design of the first electric motor powered wheelchair in the 1950s; however, there are some sources that report motors were first utilized in the development of mobility devices for individuals with physical disabilities in the early 1900s. Over the past several decades the innovation in power mobility systems has continued to evolve. From power add-on systems for a manual wheelchair to power wheelchairs with power seat functions driven via a miniature light-touch joystick controlled by the user's chin, the range of equipment options for power mobility is rather large.

POWER ASSIST AND POWER ADD-ON

Power assist and power add-on devices are commonly thought of as options to bridge the gap between a manual wheelchair and a power wheelchair. Power assist systems are designed to provide an individual who uses a manual wheelchair with an added boost of power while manually propelling a wheelchair. Some manual users report that power assist devices have decreased pain and fatigue while propelling their manual wheelchairs, thus positively impacting all areas of their life; however, the systems are not for everyone. There are different styles of power assist systems, all of which have distinct benefits and features to meet the needs of different users. The market currently includes a couple of frame

(CONTINUED ON PAGE 32)


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NAVIGATING THE TRANSITION
(CONTINUED FROM PAGE 30)

attachment methods. One example includes a separate component attached to the frame of the wheelchair, such as provided in the SmartDrive system from Max Mobility. Another example embeds motors in the rear wheels of a chair as in the case of the Quickie® Xtender™ (see Picture 1). The look, weight, size, assembly method and skills/abilities needed for basic operation of each system varies greatly.

A power add-on system allows the client to transform a manual wheelchair from only being moveable via manual propulsion from the user or a caregiver to being propelled by electric motors and operated by a joystick and/or alternative driving method. Similar to the power assist category of devices, there are a different varieties of power add-on systems. For example, some power add-on systems can be mounted on an ultra-lightweight wheelchair and use an independent setup with a standard joystick, while others use a tilt-in-space wheelchair operated via an alternative driving method.

Due to the variability in the systems, it is essential for a client to trial multiple power assist and power add-on systems prior to ordering one. As a part of the trial experience, it is highly recommended that the user be educated on not only the basic operation of the device, but also assembly/disassembly for transporting the system as such factors can often play a big role in determining a client-appropriate system. While the flexibility of transforming a manual wheelchair into a power mobility system might be appealing, the complete operation of the system may entail too many steps or simply not meet the need of the user and/or caregiver.

MOBILITY SCOOTERS

Scooters are personal mobility devices most often utilized by people who have difficulty with ambulating or propelling a manual wheelchair long distances and who have minimal support needs. A client who may be considered appropriate to transition from a manual wheelchair to a scooter could be an individual with multiple sclerosis who only uses a manual wheelchair independently for short distances, but requires assistance from a caregiver for propulsion for long distances due to fatigue. Scooters are known for being driven via a handle bar/tiller style system and having only basic options such as style, color, portability and number of wheels (three or four). Scooters are not intended to be utilized by clients who cannot transfer onto the device independently or need complex seating support. In addition, scooters are not typically considered as easy to maneuverer in tight spaces.

POWER WHEELCHAIRS

When the destination for a given client points in the direction of a power wheelchair, an entirely different world of options opens. Understanding the client's seating and positioning needs is an excellent starting point. Power wheelchair seating options range from Captain's style (see Picture 2) to custom molded with everything in between. In addition to the seating components (e.g., seat cushion, back, head support, lateral supports, positioning belts, etc.), the need for and type of seat functions should be assessed. A power wheelchair can be configured with seat functions such as tilt, recline, elevating leg rests and seat elevator. For more information on the clinical needs and recommended utilization of seat functions, it is suggested that you review the RESNA Position on the "Application of Tilt, Recline and Elevating Legrests for Wheelchairs Literature Update" (Dicianno, B. E., et al., 2015).

Power wheelchair drive wheel bases are available in three styles: rear-wheel, front-wheel and mid-wheel (see Picture 3). Each style of drive wheel base has benefits and drawbacks that can impact not only successful driving, but also the space required for maneuverability. In addition to the drive wheel position, consideration should also be given to other aspects of the power wheelchair base including suspension, size/footprint, lights and motors.

Another major category to consider in the selection of a power wheelchair involves the electronics and programmability. The electronics package on a power wheelchair can allow a client to use different driving methods, control external devices (computers, phones, tablets, televisions, etc.) and have independent access to power seating functions, including memory seating (see Picture 4). With the variety of options, styles and accessories available for power wheelchairs, a thorough evaluation should include the analysis of each component of the wheelchair to customize the most appropriate system to meet the needs and goals of the client. After all, our industry is called custom Complex Rehab Technology (CRT) for a reason.

GOALS VS. NEEDS: DO THESE ROUTES INTERSECT?

High tech innovative equipment is being developed at what seems like lightning fast speeds in the CRT world. This begs the question… If having the most high-tech and intelligent smartphone on the market is a status symbol of sorts, wouldn't having a super fancy power wheelchair with the latest and greatest gadgets to make life "easier" be more desirable than a lower tech alternative manual wheelchair? Not exactly. To unpack the idea of transitioning from a

PICTURE 1

Quickie Xtender Power Assist Device

PICTURE 2

Captain's style seating on Quickie Pulse

manual wheelchair to a power wheelchair, we must first consider why a client may need to consider making the shift to power.

Independent mobility can have a tremendous impact on the development and/or rehabilitation of learning, communication, mobility, socialization, recreation, vision and self-care (Anderson, D., et al., 2013). In addition, independent mobility can help maintain a quality of life and enhanced feelings of self-worth in the aging population that otherwise becomes dependent upon others (Pettersson, Tornquist, Ahlstrom, 2006; Brandt, Iwarsson, Stahl, 2004). Innovative technologies for wheelchairs are constantly coming onto the market and enabling individuals with a wide spectrum of abilities and limitations to become independent via wheeled mobility. Achieving independent mobility can vary greatly from one individual to another, which is why completing all steps of the evaluation process is so crucial.

EVERYONE HAS GOALS

Identifying the goals of the client and/or the caregiver should be a top priority early in the wheelchair provision process. The clinical needs and self-identified (or caregiver-identified) goals of the client may not always be in alignment. For example, a client who sustained an incomplete spinal cord injury at the sixth cervical spinal level (C6) and has been using an ultra-lightweight rigid frame manual wheelchair since the injury 18 years ago may simply want to obtain a new ultra-lightweight manual wheelchair similar to the one he has. However, due to reports of significant pain in his upper extremities and the impact this has on the client's everyday life, the clinical team believes the client is more appropriate for a power wheelchair. Another example is a 2-year-old diagnosed with spinal muscular atrophy Type 2 who demonstrates strong potential for independent mobility through the utilization of a power wheelchair, but her parents are not sure if power mobility is a good idea. Instead, they believe their daughter needs to receive a dependent manual tilt-in-space wheelchair.

What about cases when a client and/or caregiver's desire for power mobility does not meet the client's true medical needs? A circumstance such as this may present itself when a caregiver expresses a goal to obtain a power mobility system because of difficulty pushing a fully dependent loved one who is in a wheelchair because of size. In situations such as this, it will be helpful to discuss medical necessity and examine the guidelines of funding approval to determine if funding from a third-party source is probable.

WHAT IS TRULY NEEDED AT THE FINAL DESTINATION?

As each of the clients move through the assessment stage of the wheelchair provision process, it will be essential for the entire evaluation team, including the client, family/caregivers, physical therapist, occupational therapist and rehabilitation technology supplier, to discuss the pros and cons of each of the route options that will lead to improved independence, health, and overall quality of life. There are numerous factors the entire team needs to take into consideration while navigating through the sometimes-arduous wheelchair provision process, especially when it relates to transitioning a client from a manual wheelchair to a power mobility system.

For an individual who has been propelling himself independently in a manual wheelchair, transitioning to a power wheelchair may be a necessity when facing physical hardships including injury and pain. There are some strategies a client can take, including proper equipment selection and set-up of the manual wheelchair, muscle strengthening protocols, and various additional precautions. Nonetheless, the upper extremities, especially the wrists, elbows and shoulders, can often be at significant risk for injury. The incidence

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of injury to the shoulder is most likely since, while extremely mobile, it is not as strong or stable as the joints of the lower extremities, thus making the shoulder more vulnerable to developing musculoskeletal issues including impingement, tendinitis and rotator cuff tears (Hastings, J., et al. 2011). If the client reaches a point at which he can no longer propel himself in his wheelchair, complete activities of daily living, engage in desired leisure activities, perform required vocational responsibilities, and/or lead an overall healthy life without pain or at all, it is likely time for the treatment team to initiate the exploration of alternative routes for independent mobility including power mobility options.

Research supports theories surrounding the utilization of power mobility with babies as young as 7 months (Lynch, A., et al. 2009). Studies have also revealed independent mobility can have a significant impact on a child's overall development including areas such as cognition, communication, socialization, and mobility.

Programs such as "Go Baby Go" out of the University of Delaware have shined a light on evidenced based reasons that power mobility should be explored for young children and have also generated resources for creating power systems and training for treatment teams including therapists, rehabilitation technology suppliers, educators and families.

Even though there has been an increase in overall acceptance and understanding of the utilization of power mobility with young children among some professionals in the field of complex rehabilitation technology, embarking on the route of transitioning a young child from a manual wheeled mobility system, such as an adaptive stroller or wheelchair, can involve navigating a course just as involved as transitioning an adult from an ultra-lightweight manual wheelchair to a power wheelchair.

The potential for an increase in other developmental areas may help tip the scale for caregivers in the direction of exploring power mobility for a young child, but transitioning older children and adolescents involves another set of factors to consider. Let's take, for example, a 17-year-old individual with cerebral palsy (CP) at Gross Motor Function and Classification System (GMFCS) level III who has historically utilized a manual wheelchair to propel short distances around home and at school and is preparing to attend college after graduating from high school. Transitioning from a manual wheelchair to a power wheelchair would potentially increase his ability to not only get across the college campus independently to attend required academic activities, but also could have a positive impact on his overall quality of life as he moves into living on his own and spreading his wings into adulthood by decreasing reliance on others.

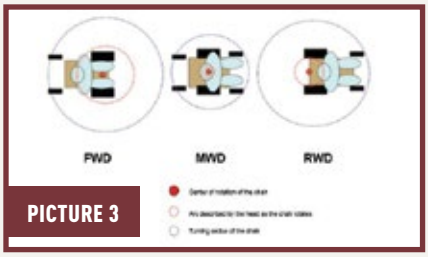
NAVIGATING THE BUMPS AND TWISTS ALONG THE WAY

Knowing the options available for power mobility and that a client needs to transition from a manual wheelchair to power mobility doesn't mean that you and the rest of your team members will be able to simply speed to the final destination of your recommendation. As you may recall reading earlier in this article, a client's needs do not always align with the client's and/or the caregiver's goals in relation to a wheelchair. There are numerous real life factors to consider and potential obstacles that may be lurking at every crossroad.

ACCEPTANCE OF NEED

The only constant in life is change; however, accepting the need for and navigating through change can be extremely difficult no matter the situation. A common perception among individuals who utilize wheelchairs is that a power wheelchair makes a person look more disabled. In a research study focused on self-esteem, function and quality of life of adults with low cervical spinal cord injuries, participants reported believing that people who utilize a manual wheelchair are more physically fit. The researchers conducting the study hypothesized that this belief likely manifests into other areas of life including better physical function, greater independence, an overall more active and social lifestyle, and ultimately, higher self-esteem (Hastings, J., et al. 2011). The belief that a power wheelchair will lead to the perception of looking more disabled has led to some clients choosing to remain in a dependent tilt-in-space wheelchair as opposed to learning to drive a power wheelchair that would provide independent mobility.

Accepting that a young child needs a wheelchair of any type, much less a power wheelchair, can be very difficult for a parent. Some parents are concerned about the perception of friends, family and society regarding their child's use of a wheelchair, as well as how this translates to the parents themselves. Most parents do not enter into parenthood with the expectation that their child will have a disability. As such, it is not surprising that accepting each aspect of an unplanned for reality, including the need for a wheelchair, requires some level of processing. From concerns about a child's ability to learn to drive a power wheelchair, to safety of the child and those around him, to the unknown impacts a power wheelchair may have on the child's development and well-being, the anxiety a parent may face when presented with



PICTURE 3

Captain's style seating on Quickie Pulse

PICTURE 4

Power Seating Functions on Quickie QM-7

the idea of transitioning a child from a manual mobility device can seem overwhelming.

Perceptions and personal beliefs are real and should be addressed with respect and support by the entire team. No matter if the client or caregiver is dealing with acceptance, as a member of the treatment team it is important that you address each concern in a supportive and fact-based way.

IMPACT ON DAILY LIFE

When first presented with the idea of transitioning to a power wheelchair, common responses include: "If I get a power wheelchair, my entire life is going to have to change;" "There is no way that thing is going to fit in my house;" "My son is going to gain a lot of weight and lose function;" and "Maintaining a power wheelchair is so much more work than my manual wheelchair." The reality is many aspects of an individual's life - and potentially the caregiver's life - will be impacted, some of which may be negative and others that will be very positive.

TRANSPORTATION

Transporting a power mobility system is quite frequently the first barrier that comes to mind for clients and caregivers. Unfortunately, technology is not at the place where we simply push a button and our vehicles fold up into a small brief case like George's did during the opening credits of "The Jetsons;" however, as discussed earlier in this article, there are power add-on options for manual wheelchairs that can be assembled and disassembled. These products may not be the ideal solution or meet the client's clinical needs, but exploring the possibility may be helpful.

If a full power wheelchair is required to meet the client's clinical needs and the client desires/requires a personal vehicle, discuss the avenues for pursuing a wheelchair-accessible vehicle including resources for locating dealers, funding assistance (e.g. programs for veterans, specialized loans, etc.), customization ideas and driver training programs. As you talk through specific wheelchair options, review the securement options (as a passenger and driver), footprint and turning radius. Providing resources for local public transportation options such as buses, taxis, subway systems and wheelchair-accessible transport services would be helpful. In addition, providing accessibility information for long-range or specialized travel accommodations (e.g., airlines, cruise ships, trains, etc.) could be beneficial to the clients.

ARCHITECTURAL BARRIERS

An individual in a wheelchair typically designs and sets up every aspect of their home and work environment for success. If a person in a manual wheelchair is preparing to transition to a power wheelchair, ensuring he is still able to access his environments is crucial. While a wheelchair trialed in clinic may seem like the ultimate solution, if the person cannot get in and out of his home, then alternatives, whether it be the wheelchair or adaptations to the environment, need to be explored.

The home and office are just two places that architectural barriers may be encountered.

In cases when an individual is out in the community in her manual wheelchair and encounters a couple of unexpected stairs along the path of her peers, it may be feasible for her friends to bump her up the stairs with little impact on the evening out. However, a situation such as this is likely a different ballgame if the client is in a power wheelchair. Making the client aware that these situations will most definitely arise and talking through ways to potentially navigate them may be helpful. It may also be beneficial to provide resources such as apps or websites that are designed for users to learn about areas that are accessible. Many apps include a social media element built-in for user feedback on specific destinations.

OVERALL LEVEL OF FUNCTION

"If you provide him a power wheelchair he's going to gain the freshman 50 as opposed to the freshman 15!" The potential of weight gain and decrease of overall level of function for the client is a very real fear of the individual using the manual wheelchair and his caregivers. There is research on both sides of the fence when it comes to reported activity levels of individuals who utilize manual wheelchairs versus those who use power wheelchairs. In one study, the participants who used manual wheelchairs were shown to have a higher level of physical function; however, the same study revealed that there was not a significant difference in the BMI (Body Mass Index) between the groups of manual and power wheelchair users (Hastings, J., et al. 2011).

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Over the past five years, activity trackers have become the rage in the weight loss industry, and there are now options specifically for people who use wheelchairs. However, a person's decision to wear a fitness tracker doesn't mean she is going to magically move any more than she did prior to owning the device. Committing to an exercise program is essential for people of all ability levels. Fitness programs designed for people with physical disabilities are popping up all over the country, including hospitals providing gym memberships for discharged patients to return to the facility to utilize the adaptive equipment. Prior to recommending any program or activities to any client, it is important to involve the client's physician and clinical team.

In addition to the client's level of fitness and weight as it relates to transitioning to power mobility, it's also important to look at the client's level of function in other areas of life. Prior to transitioning from a manual wheelchair to a power mobility system, some users have experienced pain and injuries so significant that they can no longer perform responsibilities at work, tasks around the house, and/or previously enjoyed leisure and social activities. For some users, the utilization of a power mobility device has allowed them to resume personally valued responsibilities, interests, and roles. In addition, the user's ability to perform work-related and other tasks can be restored, thus increasing self-esteem and feelings of competence (Buning, M. E., Angelo, J. A., & Schmeler, M. R., 2001).

MAINTENANCE

Some degree of maintenance is required for all forms of technology including complex rehabilitation solutions. While in general manual wheelchairs may require limited day-to-day maintenance as compared to the daily maintenance of a power wheelchair, no solution is truly maintenance free. Similar to the operation and basic care guidelines you provide to clients who utilize manual wheelchairs, it will be important to review operation and maintenance recommendations to individuals who use power mobility. It is beneficial to discuss the type of care needed for each of the power mobility options being considered for the client because there are pros and cons to all systems. Providing the best possible picture on the front end will likely decrease unexpected issues upon reaching the final destination of delivering the wheelchair.

Along the same line of maintenance, reviewing care and preventative maintenance suggestions for the client on his manual wheelchair even after delivery of a power wheelchair is recommended. Due to funding limitations, it is unlikely that a client will have the ability to get a back-up manual wheelchair. Therefore, prolonging the life of the current manual wheelchair is crucial in situations where transportation, access, or maintenance arise and having a back-up would be beneficial.

CONCLUSION

The journey from manual wheelchair to power mobility solution will involve uniquely planning a destination that is customized for each different client. The wide variety of equipment options, including power assist and/or power add-on devices, mobility scooters, and power wheelchairs with a host of potential features should all be considered as possible destinations. By effectively balancing the goals and needs of a client and his caregivers, meaningful guidance for selecting the best route for each different client can be offered. In addition, taking the time to address potential roadblocks such as acceptance of need and impact on daily life in areas including transportation, architectural barriers, level of function and/or maintenance can set up a client for success as he embarks on the exciting wheelchair provision voyage toward independence, health and overall quality of life.

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Claudia Amortegui, MBA

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Amber Ward, MS, OTR/L, BCPR, ATP/SMS

REHAB CASE STUDY

TRANSITIONING FROM A MANUAL TO A POWER WHEELCHAIR

A CASE STUDY

WRITTEN BY: DELIA "DEE DEE" FRENEY, OTR/L, ATP

President Theodore Roosevelt's wood and cane wheelchairs come to mind when we think of the early American wheelchair. In 1933, Everest (who was physically disabled) and Jennings, also known as E&J, manufactured the first folding wheelchair. The "electric" powered wheelchair was invented in 1953 by George Klein to assist injured veterans after World War II. In time, new developments such as belt drive, electromagnetic and gyro powered wheelchairs were manufactured for patients unable to self-propel the manual wheelchair.

Today, custom wheelchairs feature a variety of innovative designs and lightweight materials. Mechanical and power assist provide a broader range of clients with the ability to use a manual wheelchair and reduces risk of injury secondary to self-propulsion. Current power wheelchairs offer advanced electronics such as alternative driving methods, infrared transmission and Bluetooth technology to access computers and mobile technologies. Power positioning features include tilt, recline, precline, standing and seat elevation.

Despite these advances, the end user's transition from a manual wheelchair to a power wheelchair is often challenging. Although appropriate seating can be provided in either a manual or power base, many other factors must be considered when making the transition. Some of the challenges of power wheelchairs include size, footprint, accessibility and even stigma. Many active end users with lightweight folding manual wheelchairs have adapted their lifestyle, environment and vehicles to this mobility base.

A power wheelchair typically has a larger base, is heavier due to motors and batteries, needs to be charged, has a definitive range on a charge, and is not as easily transported as a manual wheelchair. Vehicles with ramps or lifts are necessary to transport a power wheelchair. End users who self-propel are active in their manual wheelchair and are more physically passive in driving a power wheelchair.

Funding sources need justification as to why a power wheelchair is necessary for mobility. The most common reason is that the end user is unable to self-propel any (including ultra-lightweight) manual wheelchair. In medical documentation, clinical and functional reasons why an end user is unable to push the manual wheelchair must be provided. These reasons may range from shoulder pain to paralysis of the upper extremities. End users who may require a power wheelchair have diagnoses including, but are not limited to, cerebral palsy, muscular dystrophy, spinal cord injury, traumatic brain injury, amyotrophic laterals sclerosis, multiple sclerosis and many other orthopedic or neurological diagnoses.

LINDA

In 1980, Linda had a fall from the second story ledge of her house that resulted in a T7-T10 incomplete spinal cord injury (see Picture 1). She stated that she simply blacked out and found herself on the ground, barely conscious, talking to her 8-year-old son, and then remembers being in the hospital for a lengthy stay. After discharge, she went to a rehabilitation facility for more than two months to work on all aspects of her Activities of Daily Living and transfers, as well as to be fitted for her first wheelchair.

Linda was discharged from the rehabilitation facility with a heavy, standard rental manual wheelchair. Soon thereafter, she received her first lightweight custom manual, a Quickie. As a wife and mother she needed a lightweight wheelchair to keep up with her busy life. Eventually, she would replace her first lightweight Quickie with similar models. In 2005, she developed severe pressure injuries resulting in a coccyx flap surgery and her physician, being very concerned about her seating, recommended an appropriate pressure management seat cushion.

In 2009, she was referred to our clinic for a wheelchair evaluation. Linda informed us that she also had rotator cuff surgery on one shoulder. Her

physician requested an evaluation for a power wheelchair. Linda resisted the idea of a power wheelchair and insisted on a replacement lightweight custom manual wheelchair.

Many long-term manual wheelchair users have difficulty transitioning to power wheelchairs. Linda was no exception – she informed both our clinic team and her physician that she did not want power and she continued to use her manual wheelchair with a new pressure management seat cushion – a high profile single valve ROHO (see Picture 2).

Many years later, she contacted her physician to request a replacement manual wheelchair, since her third Quickie was in disrepair. It has been 37 years since her accident, and Linda continued to push her manual wheelchair throughout the day as much as she could. However, there were many days that she would ask her husband Roger to push her when she fatigued, was in pain, or while crossing challenging terrain such as gravel or grass.

Now at 75 years old, Linda realized that, due to many years of self-propulsion, shoulder surgery and the natural aging process, her goals needed to change. Her new goal in clinic was to gather information about the latest mechanical and power assist technologies. She was hoping that these "power" wheels would ease the pain she was experiencing in her shoulders while self-propelling, as she wanted to continue to be mobile in a manual wheelchair.

During Linda's clinic evaluation, many options were discussed: mechanical assist such as the Widget and Magic Wheels, as well as power assist such as Smart Drive, Extender, e-Motion and Twion. Typically, long term manual wheelchair users are ideal candidates for power assist. These end users have developed certain daily routines including how they negotiate throughout their environments and transport their manual wheelchairs. The latter is often the main reason manual wheelchair users don't want to transition to power wheelchairs. Transportation is always discussed in clinic, and we inform our clients that most power mobility devices don't fold like manual wheelchairs and alternate transportation, such as accessible vans with ramps or lifts, is indicated. Linda already has an accessible van with a ramp, so transportation was not an issue for her.

Linda's primary concern when coming to clinic to discuss wheelchairs was her shoulder pain. In our Seating and Mobility clinic, we did a task analysis of Linda's stroke when pushing the wheels of her manual wheelchair. The movements were broken down in terms of body mechanics with focus on the upper extremity. Starting with the backward reach, hand to wheel contact, push and follow through, we analyzed and demonstrated each stage (see Pictures 3 and 4).

Picture 1: Linda

Picture 2: Linda in her third generation Quickie custom manual wheelchair with ROHO post coccyx flap surgery

Picture 3: Push analysis: "hand on the wheel" position on the backward reach, starting the push

Picture 4: Push analysis: follow through at the end of the push cycle

Picture 5: "Custom footrest" replacement in progress; Linda successfully driving her power wheelchair

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TRANSITIONING FROM A MANUAL ...
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It was determined that the same shoulder motions were used for pushing a manual wheelchair with or without power assist and neither the mechanical nor the power assist wheels would minimize Linda's shoulder pain. The assisted wheels increase the distance achieved from a push, reducing energy exertion, however the same shoulder motion is required. The gear assist wheel has a ratchet feature that prevents backwards rolling, especially helpful on a grade, but does not change the biomechanics of self-propulsion.

Once again, her physician recommended a power wheelchair, but the thought of a larger wheelchair with batteries and motors, increasing the footprint of her chair, along with the stigma of a more disabling "look," made a power wheelchair undesirable to Linda, and she did not embrace the transition.

The supplier did a home visit to show her the smallest, most lightweight power wheelchair that disassembled and fit her petite 5-foot stature. A pressure management cushion would be provided for seating. She agreed to this power wheelchair when he demonstrated the maneuverability and the accessibility throughout her home. However, when it was time to order this power wheelchair, Linda decided to order another custom manual wheelchair instead.

Pushing continued to be more difficult and painful over the next few years. Finally, Linda made the decision to order the Group 2 power wheelchair. In the process of funding, ordering and just about the time of delivery, Linda had a stroke and was hospitalized. Her weaker side prevented efficient self-propulsion and her endurance was compromised, especially in the community.

After her stroke, she spent two weeks in rehabilitation. When the physical therapist transferred her into a power wheelchair, Linda was encouraged to drive, but instead burst into tears when the reality hit that a power wheelchair would provide her better independent mobility than her manual wheelchair. Linda said that she went back to her room and turned circles in the power wheelchair just to burn off her stress and disappointment. However, now more than ever, a power wheelchair would be more functional than a manual wheelchair after this second rehabilitation experience and a new diagnosis of upper extremity weakness.

In the beginning of 2016, Linda accepted the power wheelchair to keep her independent mobility due to her change in condition after the stroke (see Picture 5). She's had her power wheelchair for about a year now. Soon after receiving her power wheelchair, she quickly adapted to driving and was happy to find her shoulder pain manageable. In a recent visit to her home, Linda demonstrated safe, skillful driving in and around her home. Linda says she often goes back to her custom manual in the home to keep as active as possible. Her positive attitude and bright spirit keep her going strong no matter what her physical challenges may be.

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TECHNOLOGY IS THE CURE

WRITTEN BY: ALEX BENNEWITH

In honor of Steve Saling's heartfelt presentation at NCART/NRRTS' conference at the end of April and pulling a quote from that presentation "…until medicine proves otherwise, technology is the cure."

From someone who was diagnosed 11 years ago with amyotrophic laterals sclerosis, (when prognoses for ALS were very often a lot shorter) and from someone who is still actively advocating to hold on to his own rehab technology and assistive tech so that he can engage in society, just as you or I as non-wheelchair users, it is the responsibility of all of us to make sure Saling, and everyone else like him, in need of customized rehab and assistive technology, is able to keep that window open to the world you and I take for granted. In Steve's own words:

> ***"Not only can I breathe on my own but if I get my chair positioned at just the right angle, I can find a sweet spot where my head has a little mobility … I have complete control of all functions of my wheelchair with the four switches around my head … You can understand why it infuriates me that some bean counter at CMS (Centers for Medicare and Medicaid Services) is trying to save money by taking away critical tools. I am not a bean to be counted. I am a real person … ."***

Paraphrasing what Saling goes on to say, his inability to use his mouth and legs were two things ALS thought it had stolen from him. Prior to his diagnosis, he was a landscape architect. Since his diagnosis, he has been a leader in the design of the Leonard Florence Design Center for Living in Chelsea, Massachusetts, which is a 30-bed facility where one can operate doors, lights and elevators with eye blinks and facial movements. He has been able to do this because of his rehab and assistive technology.

"NOT ONLY CAN I BREATHE ON MY OWN BUT IF I GET MY CHAIR POSITIONED AT JUST THE RIGHT ANGLE, I CAN FIND A SWEET SPOT WHERE MY HEAD HAS A LITTLE MOBILITY...I HAVE COMPLETE CONTROL OF ALL FUNCTIONS OF MY WHEELCHAIR WITH THE FOUR SWITCHES AROUND MY HEAD...

United Spinal continues to be a consumer leader in advocating for greater access to CRT. In this Congress, the relevant CRT bills are: HR 1361/S 486, Protecting Beneficiary Access to Complex Rehab Technology Act of 2017, and S 750 the Ensuring Access to Quality Complex Rehab Technology Act of 2017. United Spinal, along with many other consumer organizations, is also leading consumer efforts expanding Medicare coverage for speech-generating devices, which is the Augmentative and Alternative Communication (AAC) device that Saling uses. United Spinal supported the Steve Gleason Act of 2015, which was signed into law by President Barack Obama. The law amends the Social Security Act to provide Medicare beneficiary access to eye-tracking accessories for speech generating devices (SGDs) and to remove the rental cap for durable medical equipment under the Medicare program with respect to those devices. United Spinal is supporting the bill again, which is expected to be reintroduced in May. The new bill provides for permanent coverage of SGDs after the previous bill's October 2018 expiration date.

Saling continued to say in his presentation, referring to the Steve Gleason Act of 2015, "[t]hey tried once before to take computers away from the people who need them most. We rallied, and Congress listened. "It is time to rally again!"

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DID WE REALLY DODGE A BULLET?

WRITTEN BY: CLAUDIA AMORTEGUI

If you have been in this industry long enough, you should not be surprised when Medicare does something that makes absolutely no sense. Once again this occurred in early April. I cannot give you the exact date, since there was never a formal announcement. I learned about this change when providers started noticing a drastic drop in Medicare reimbursement for custom seats and backs (E2609 & E2617). However, it was discovered this was only in two of the four jurisdictions (B & C) – both handled by CGS.

As soon we realized this was not just single error, many of us within the Complex Rehab Technology (CRT) industry reached out to different people within CGS and made our thoughts very clear. We were told that CGS had developed a set reimbursement amount per state for each of the two codes. The contractor stated they were applying a specific Centers for Medicare and Medicaid Services' regulation. As a group of us researched this information, we were hard-pressed to find the actual correlation on how this could apply to custom items.

I certainly do not agree with the drop in reimbursement or how the contractor went about implementing it. However, I do appreciate the quick action taken by CGS once the CRT community became involved. In less than two weeks, the payment structure was back to how it has been for many years (individual consideration). This does not mean that we can now just sit back and pat ourselves on the back. Going back to the way things have been does not mean it will be permanent. Per CGS, they are "still evaluating the establishment of local fees for these two codes."

I LEARNED ABOUT THIS CHANGE WHEN PROVIDERS STARTED NOTICING A DRASTIC DROP IN MEDICARE REIMBURSEMENT FOR BOTH CUSTOM SEATS AND BACKS (E2609 & E2617). HOWEVER, IT WAS DISCOVERED THIS WAS ONLY IN TWO OF THE FOUR JURISDICTIONS (B & C) – BOTH HANDLED BY CGS.

In my opinion I certainly believe that making our voices heard was key not only as a group through NCART and NRRTS but also as individuals. Shortly after learning of these reimbursement changes, I happened to be attending a meeting (for different reasons) with some CGS employees. Several of them made it very clear that our voices were very much heard. This is a reason I always say you must be loud. Do not just scream, but be sure to be clear as to why something is not right.

For many years, CGS was "developing" most of the claims that contained codes E2609 and/or E2617. This means that they were having to stop the claim in question and then ask the provider for additional information. The Medicare contractors must have all the pricing information to properly calculate the reimbursement of these codes – again, the codes are custom for a reason. As providers, you must do your part. First, you must roll/group all items related to the seat and the back within each code. For some products, this may mean grouping many line items together and for other items this may just be a couple of line items. Either way, when you bill code E2609 and/or E2617 all related items must fall under that one claim line. You should not be billing for anything associated to the seat/back on separate claim lines. On May 5, CGS published the following article:

> "When billing for a brand name, custom-fabricated seat (E2609) or seat back cushion (E2617), that has received a written coding verification from the PDAC, the supplier must provide the following information using loop 2400 (line note), segment NTE02 (NTE01=ADD) of the ANSI X12N, version 5010A1 professional electronic claim:
>
> • Manufacturer and model name/number of the cushion;
> • The name/number of any modifications to that cushion; and back
> • The price list for the item(s).
>
> For example: Billing for a E2609 – Finished Custom Seat Cushion, your note description should look something like this:
>
> Finished Custom Seat Cushion - X Medical, PT # 1234567, PL – $500.00.

(You may, as we have in this example, abbreviate "part" as PT and "price list" as PL.)

Suppliers who are manufacturing the custom fabricated seat or seat back, and who are not using a brand name item, must provide an invoice or itemized list of the materials and labor involved in the fabrication. The itemized list should include:

- A list of each part used to make the item;
- How much of each part was used to make the item;
- The price list(s) for the parts;
- A breakdown of the labor involved in making the item.

In most cases, the requested information will fit within loop 2400 (line note), segment NTE02 (NTE01=ADD) of the ANSI X12N, version 5010A1 professional electronic claim. Suppliers who need additional space may submit the information in PWK (paperwork). The PWK option can be used when all of the required information cannot be submitted in the claim narrative (NTE segment). Refer to the Supplier Manual, PWK (paperwork) Segment or the related information link below for instructions.

Failure to provide the appropriate documentation will result in a claim denial for missing information. If you receive a denial for missing documentation, refile your claim. CGS will not be sending ADR (additional documentation request) letters requesting the information. When responding, be sure to include all of the information you provided previously and include the information that was missing. You do not need to request a reopening or redetermination. Our MR WIZARD online, self-service tool is an excellent resource to use to identify the missing information. Simply enter the 14-digit CCN (claim control number) to view the information.

SHORTLY AFTER LEARNING OF THESE REIMBURSEMENT CHANGES, I HAPPENED TO BE ATTENDING A MEETING (FOR DIFFERENT REASONS) WITH SOME CGS EMPLOYEES. SEVERAL OF THEM MADE IT VERY CLEAR THAT OUR VOICES WERE VERY MUCH HEARD. THIS IS A REASON I ALWAYS SAY YOU MUST BE LOUD. DO NOT JUST SCREAM, BUT BE SURE TO BE CLEAR AS TO WHY SOMETHING IS NOT RIGHT.

In addition to the above instructions, you need to be certain you have obtained qualifying justification for the custom seat/back. The clinical records must not only include a qualifying diagnosis, but also why off-the-shelf seating will not meet that specific client's medical needs. This statement alone is not sufficient, it needs to be detailed. The documentation may include items such as specific deformities, measurements and trial and failure of other seats and backs.

If you provided custom seats and backs within Jurisdictions B or C and had claims process in March and April, you need to be certain that you track these codes. CGS was going to reprocess the claims that were paid at the lower rates, but you need to be sure this was done. Also, if you did not know about this issue, it should be a flag within your business. Your staff would have not seen a denial – the claims were paid. However, did they catch that you were paid at a much lower rate than normal? If not, be sure to review your internal systems.

Going back to the title of this article … Did we really dodge a bullet? Yes, for the time being, but this very easily could change and could affect other items. The industry needs to provide the education to the funding sources all the way to the top. They must understand what such changes mean and how any change must be announced and not just be "found out." Keep in mind that this is not a practice that could only be applied to the custom seat and back codes, this is something they could look at for other codes.

As an update to my last article, CMS has come back and stated that K0856 and K0861 power wheelchairs that are going through the initial PMD Prior Authorization program (Illinois, Missouri, New York and West Virginia) will have the same six-month delivery time that is offered under ADMC. This had been questioned at the time of my last article, but has been clarified. This PMD PA program is scheduled to go into effect for all other states in July. Be sure to stay up-to-date, as this will be a required process for these CRT power wheelchair claims.

CONTACT THE AUTHOR

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NEW NRRTS REGISTRANTS

Congratulations to the newest NRRTS Registrants. NAMES LISTED ARE FROM MARCH 25 THROUGH MAY 15, 2017.

Louis Chiappelli, III, RRTS®
St. Marys Home Health Care
4 Railroad St
St. Mary's, PA 15857-1729
Telephone: 814-834-2225 x.116
Toll Free: 800-876-3442
Fax: 814-834-5383
Registration Date: 4/18/2017

Christopher Ford, RRTS®
Numotion
6350 Regency Pkwy Ste 540
Norcross, GA 30071-2338
Telephone: 678-392-4202
Fax: 678-392-4212
Registration Date: 3/31/2017

James Hutchinson, ATP, RRTS®
Dressen Medical Supply
7980 Chapel Hill Rd Ste 101
Cary, NC 27513
Telephone: 919-606-3487
Fax: 252-758-5575
Registration Date: 4/24/2017

Robert Rex Johnson, ATP, RRTS®
National Seating & Mobility, Inc.
3930 S Perkins Rd
Memphis, TN 38118-7029
Telephone: 901-336-2988 x0
Fax: 423-286-9690
Registration Date: 5/10/2017

Hector Rocha, OTR, ATP, RRTS®
Numotion
120 N 20th St
McAllen, TX 78501
Telephone: 956-708-1417
Fax: 956-687-2281
Registration Date: 4/25/2017

Steven Shipley, RRTS®
National Seating & Mobility, Inc.
7050 N Guion Rd Ste A
Indianapolis, IN 46268
Telephone: 317-454-7670 x.210
Fax: 844-260-2701
Registration Date: 5/4/2017

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NAMES LISTED ARE FROM MARCH 25 THROUGH MAY 15, 2017.

Karen Bussey, ATP, CRTS®
Glasgow Prescription Center
Glasgow, KY

Scott Litton, ATP, CRTS®
St. Vincent Medical Supply & Mobility
Billings, MT

Richard Walls, ATP, CRTS®
Hometown Healthcare Equipment
Armory, MS

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 LISTED ARE FROM MARCH 25 THROUGH MAY 15, 2017.

Brenda Brown, ATP, Maplewood, MN
Russell E. Collins, ATP, Soddy Daisy, TN
Kistra Damaso, Natick, MA
Linda Dew, Norfolk, VA
Robert Doss, Hudsonville, MI
Brent Dye, ATP, Lewisville, TX
Eric Franco, Lubbock, TX
Gregory M. Ganger, Hendersonville, NC
Mark Gil, Carson, CA
Richard Harrison, ATP, Charlotte, NC
Divya H. Kapadia, PT, ATP, San Jose, CA
James L. Keating, ATP, Alpharetta, GA
Timothy Keller, ATP/SMS, Traverse City, MI
David M. Lewis, Lexington, SC
Brian Peacock, ATP, Waco, TX
Jason A. Sharpe, ATP, Fayetteville, GA
Brian Thomas, Brandon, MS

CURRENT NRRTS REGISTRANTS

The NRRTS board determined RRTS® and CRTS® should know who has maintained his/her registration in NRRTS, and who has not. The following individuals elected to maintain his/her registration in NRRTS.

NAMES INCLUDED ARE FROM MARCH 25 THROUGH MAY 15, 2017.
(Please note if you renewed AFTER MAY 15, your name will not be listed until the next issue of DIRECTIONS.)

For an up-to-date verification on Registrants, visit www.nrrts.org, updated daily.

James B. Albring, ATP, CRTS® Pittsburgh PA
Kathleen P. Anderson, ATP, CRTS® Chatsworth CA
Sarah Anderson, ATP, CRTS® Morton MS
Amy Askelson, ATP, CRTS® Grand Forks ND
David Bachelder, ATP, CRTS® Tucson AZ
Jodi Baumgard, ATP, CRTS® Brooklyn Park MN
Michael Bavaro, ATP, CRTS® Newington CT
Alan F. Bettencourt, ATP, CRTS® Ceres CA
J. Gregg Blanchard, ATP, CRTS® Plainview NY
Randall J. Brethauer, ATP, CRTS® Mt. Vernon WA
Christopher E. Bridgeman, ATP, CRTS® Tifton GA
Kimberly F Cooper, ATP, RRTS® Knoxville TN
Trish Couch, ATP, CRTS® Mt. Vernon WA
Pamela Crutchfield, ATP, CRTS® Chattanooga TN
Thomas A. Daddino, ATP, CRTS® Garden City South NY
James Dauber, OTR/L, ATP, CRTS® Springfield MO
Linda Donaldson, ATP, CRTS® Eugene OR
Scott P. Dyson, ATP, CRTS® Newington CT
E. Scott Filion, ATP, CRTS® Ann Arbor MI
Donald R. Flewellyn, ATP, RRTS® Tifton GA
Robert Ford, ATP, CRTS® Mobile AL
Stephen A. Frangione, ATP, CRTS® Erie PA
Richard Evan Franklin, ATP, CRTS® Vestavia Hills AL
Rick Frelke, RRTS® San Diego CA
Joseph Matthew Garcia, RRTS® Temple TX
Matthew A. Gonzalez, ATP, CRTS® Brighton MI
Wayne Gould, ATP, CRTS® Anchorage AK
Scott Grant, ATP, CRTS® Hurricane WV
Mark Grillo, ATP, CRTS® Sacramento CA
Lance C. Guest, ATP, CRTS® Tifton GA
Michele A. Gunn, ATP, CRTS® Orlando FL
Rustom E. Hallett, ATP, CRTS® Hayward CA
Raoul K. Harlan, ATP, CRTS® Norcross GA
James W Hayes, ATP, CRTS® Columbia, SC
James Hearn, ATP, CRTS® Eureka CA
Mark Hebert, ATP, CRTS® Hampton VA
Thomas O. Henley, ATP, CRTS® Chattanooga TN
Joseph Carroll Hill, III, ATP, CRTS® Hickory NC
Mary Hitt Young, ATP, CRTS® Middleburg FL
Edward B. Homan, ATP, CRTS® Coldwater OH
Blaine Hunt, ATP/SMS, CRTS® Carlsbad CA
Debbie Huston, ATP, CRTS® Maplewood MN
Ryan Jewell, RRTS® Broadview IL
Randall B. Keith, ATP, CRTS® Birmingham AL
Jeffrey M. LaRosa, ATP, CRTS® Newington CT
Jason LaTray, ATP, CRTS® Billings MT
Brian Leitner, ATP, CRTS® Oak Creek WI
Richard L. Liley, ATP, CRTS® Temperance MI
Scott Litton, ATP, CRTS® Billings MT
Jose Lopez, ATP, CRTS® Worcester MA
Jason S. Lovato, ATP, CRTS® Albuquerque NM
Jay Lujan, ATP, CRTS® El Paso TX
Robert Lyles, ATP, CRTS® Greenville MS
Jamie Magar, ATP, CRTS® Lubbock TX
Carmelo Markray, ATP, CRTS® Chino Hills CA
Ryan A. Martin, OTR., ATP, CRTS® Houston TX
Michelle McMahon, ATP, CRTS® Cheyenne WY
Jason Ray Miller, ATP, CRTS® Madison AL
Jerry T. Mitchell, ATP, CRTS® Arlington Heights IL
Kevin Moser, RRTS® Cedar Rapids IA
Eric Newell, ATP, CRTS® Portland OR
Jerry N. Newman, ATP, CRTS® Valdosta GA
Colleen Oberley, ATP, CRTS® Mobile, AL
Hugh O'Neill, ATP, CRTS® Berkeley CA
Justin Keith O'Young, ATP, CRTS® Broadview IL
M. Will Olstad, ATP, CRTS® Billings MT
Kalin Omo, ATP, CRTS® Wichita KS
Valerie A. Pagan, ATP, CRTS® White Plains NY
Marcus Page III, PTA, ATP, CRTS® Maumee OH
Joseph F. Perrault, ATP, CRTS® Chicopee MA
Michael F. Peterlin, ATP, CRTS® Brooklyn Heights OH
Candace Poe, MSW, ATP, RRTS® Springfield IL
Clarence Douglas Praytor, ATP, CRTS® Trussville AL
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Ryan Read, ATP, RRTS® Fayetteville AR
Kendall Richards, ATP, CRTS® Earth City MO
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Mahmoud Salarkia, ATP, CRTS® Santa Monica CA
Richard Samay, ATP, CRTS® Chicopee MA
Diane Schoepp, RRTS® Melbourne FL
Timothy A. Schrag, ATP, CRTS® Tarentum PA
Tom Simon, ATP, CRTS® Dallas TX
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Robert Slenske, RRTS® Phoenix AZ
Jason Smith, ATP, RRTS® Mobile AL
Pat Soffredine, ATP, CRTS® Largo FL
Jon Starich, ATP, CRTS® Wauwatosa WI
Shannon L. Summers, ATP, CRTS® Indianapolis IN
Daniel P. Swain, ATP, CRTS® Chicopee MA
Stephen Talbot, ATP, CRTS® Starkville MS
Chris Thompson, ATP, CRTS® Savannah GA
Matthew C. Traynor, ATP/SMS, CRTS® Ann Arbor MI
Alicia Truebenbach, ATP/SMS, CRTS® St. Paul MN
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