DIRECTIONS

BREAKING THE CODE:
SEATING AND WHEELED MOBILITY SERVICE DELIVERY CODES

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For all advertising inquiries, contact Amy Odom at aodom@nrrts.org.

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THE PROFESSIONAL CRT SUPPLIER

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

In the midst of the mobility or seating evaluation, are you concentrating on the pertinent demographics, doctor information, insurance, home evaluation, and equipment features, and not listening to the client or the caregiver's needs? Have you spoken with the referral source and developed a plan even before you see your client? How often do you rush through your evaluation due to a time crunch in your schedule? Have you been concerned with reimbursement of the funding source? Have you listened to the therapist, teacher, doctor, etc. but overlooked the most important person — the client or their representative? I must admit, yes.

How much time should we spend with our clients? It is paramount to involve our client in the decision process. Slowing down to listen to their input, situation, wants and needs can only aid in the delivery of appropriate equipment that will have positive impact.

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CONTACT THE AUTHOR
Elaine may be reached at
ESTEWART@NSM-SEATING.COM

Elaine Stewart is president of NRRTS and works for National Seating & Mobility in Fort Wayne, Indiana.

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LEAVE EXCUSES AND FEARS BEHIND

Written by: **ROSA WALSTON LATIMER**

When you first encounter Gabe Adams, you may wonder how he is going to get where he wants to go in life. Once you talk with him or observe him for a short while, you do not doubt this confident, thoughtful young man has the strength and determination to accomplish whatever he desires.

Adams' extraordinary circumstances and the journey of the first 20 years of his life have taught him valuable lessons. "I sincerely believe you can never give up," he said. "In the darkest moments of your life, stars can shine. We are bigger than we think we are, and there will always be someone to help you."

This young man knows this to be true, because he has lived it.

When Adams was a baby, born without arms or legs, lying in a crib in Brazil, there was someone in Utah who would reach out and help him. "My adopted mom was pregnant with her 11th child, and while standing in line at the grocery store, a lady began talking to her," Adams said. "The lady told her about a family who was adopting a little girl from Brazil, but there was also a little boy there who was born without arms or legs and had been abandoned by his birth mother. The lady said, 'He also needs a family.' My mom's immediate thought was she would adopt that little boy in a second if she could." Adams' parents are strong members of the Church of Jesus Christ of Latter-Day Saints and, although they realized the economic challenge of having a large family, the couple felt strongly they should try to adopt the baby. After much consideration, the Adams called the adoption agency in Brazil. "The agency didn't consider my parents good candidates to adopt because of the amount of care a baby born with Hanhart syndrome, a rare birth defect, might require in relation to the family's income," Adams said. However, within a few weeks, the Utah couple received a letter from the agency telling them God had intervened on their behalf. "The Brazilian courts waived a six-week residency requirement for adopting parents, American Airlines flew me to Salt Lake City, Utah, and I met my family!"

"I SINCERELY BELIEVE THAT YOU CAN NEVER GIVE UP, IN THE DARKEST MOMENTS OF YOUR LIFE, STARS CAN SHINE. WE ARE BIGGER THAN WE THINK WE ARE, AND THERE WILL ALWAYS BE SOMEONE TO HELP YOU."

Adams has thrived and maintained a healthy life although he admits it has not always been easy. Growing up he was expected to do things for himself, the same as his brothers and sisters. His parents created a rigorous exercise routine to increase his strength. "My mother especially realized the importance of my being as independent as possible," Adams said. "She told the family there would be times when it would be hard but that we would all get through it together."

From a young age, Adams could make his bed and get his milk and cereal for breakfast. Now, as a young adult, he is capable of living independently. "I can do everything on my own — I shower and dress myself; I cook, I do laundry, I text." Adams also dances and enjoys participating in community fundraising events.

His parents were committed to helping their only adopted child develop into an individual who could go forth in life and do what he wanted to do. And, as often happens with independent children, the time came when Adams' way of "going forth in life" was in opposition to his parents. "I had attempted several times, since I was in the seventh grade, to talk to my parents about the fact I am gay," Adams said. "When the time came for me to move away from home and live

Gabe Adams, as a high school senior in 2017. Photo by Rex Jones.

Gabe Adams, March 2019. Photo by his brother, Landon Adams.

independently, I had to speak frankly with my parents about this. I told them if they wanted to be a part of my life, they would need to accept me for who I truly am. Otherwise, I knew we couldn't maintain a close relationship. I also knew that I couldn't be a role model for others if I weren't honest about who I am."

Adams reminded his parents they had always taught him to follow his heart, and that is what he was going to do. "My mother was the first to respond. She told me if I choose to marry a man, she will be at my wedding, and if I wanted to have a family with a man, she will be there for me. She also assured me what mattered most was that I was a good person, and she was proud of me."

Soon after, Adams had the same conversation with his dad. "It was wonderful to hear my dad say he'll always be with me, not because he agrees with what I'm doing, but because he loves me. My parents true acceptance of who I am was a huge burden lifted. From my spiritual perspective, I know God loves me. If God can love a murderer, he can definitely love me!"

Now Adams is moving forward with the knowledge that he will continue to have the support of a family who has seen him through many highs and lows.

One of Adams' most significant challenges is not related to physical disabilities. "Most of my life, it has been difficult to know who my true friends are," he said. "Some kids wanted to be with me because they felt sorry for me or because they thought it would bring attention to them. Even now that I'm older, it is difficult for me to have real, true friends — friends who will stick around and not take advantage of what I have or who I am."

After an overwhelming response on social media following an article in People magazine, Adams has taken more control over the telling of his story. "I realize good can come with my platform, and I can be a voice for those who don't have a voice," he said. "But, there can also be a lot of negative that comes with it as well. When someone reaches out to me with a problem, even though I feel that I want to step in and help, I realize it isn't my place. I can't meet everyone's expectations.

"I don't usually think of my story as being particularly interesting, but I've learned others see it as inspiring," Adams said. This realization prompted him to begin giving motivational presentations when he was a junior in high school. Since graduating from high school in 2017, Adams has been traveling throughout the United States sharing his story. He was one of the featured speakers at the 2019 National CRT Leadership & Advocacy Conference in Washington, D.C.

CONTINUED ON PAGE 10

LEAVE EXCUSES AND FEARS BEHIND
(CONTINUED FROM PAGE 9)

We asked Adams what he thought his life would be like in five years. "I hope to be married and continue with motivational speaking," he said. "Eventually I plan to either pursue a career in interior design or go to school, so I can be a psychiatrist."

Adams lived in an apartment with roommates for a time and now lives with one of his older brothers and his family. "This is a good situation for all of us at this time. My brother has four kids, so I can help with babysitting. If I continue to travel, it makes sense for me to live with family rather than invest in a place of my own." Adams shares creative endeavors with all of his family – nine brothers and four sisters. He is an accomplished artist who spends his free time drawing, creating artwork and writing songs.

"I enjoy speaking to groups and especially like the interactions during the 'meet and greet' time after a presentation," Adams said. "That is when others share their experiences with me. Often I learn about difficult times someone has experienced and how they keep going. This re-energizes me and helps me remember everyone has to find their strength. You have to leave excuses and fears behind and follow your dreams."

CONTACT

Gabe can be reached at LIMBITLESSGABE@GMAIL.COM

Gabe Adams, Easter, 2018. Photo by Gabe's niece, Ari Adams.

Gabe on the "jumbo screen" while speaking to an audience of 10,000 in 2016.

LEFT: Gabe Adams, 10th grade, has just received a new wheelchair at Shriners Hospital in Salt Lake City, Utah.

RIGHT: Gabe Adams, 2018, in a new, replacement wheelchair that was needed after his chair was damaged by the airlines.

Gabe with his parents, Ron and Janelle Adams, following his graduation from LDS Seminary.

Gabe Adams is a consumer advocate and motivational speaker who lives in Salt Lake City, Utah.

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HEART OF A CHAMPION

Written by: **DANETTE BAKER**

"I was volunteering for the shot put and javelin event at the Adaptive Sports USA Junior Nationals in 2017, and I came to deeply admire this little guy! With every throw, he broke his previous year record and simply stole my heart with his tenacity and true athleticism! I told him mid-session that I might need to get his autograph now before he is famous and forgets me. Unbeknown to me, he asked his coach to help find me later that day to sign my badge and get that very coveted autograph! (The photograph) hangs proudly in front of my desk, and I look at it every single day! What a champion!!!"

Sometimes we forget a champion describes more than the one who gets to stand on the podium as a winner. A champion is also that person who does battle for another's rights or honor. Steve DuFresne is that type of person. He refers to his product development team at Permobil as "secret warriors." "We're fighting for the person who has no voice. I'll tell them, 'See the face of disability in your mind and fight for it today, tomorrow and every day you get to do this.'"

His inspiring words are not spoken just to motivate a team at work but lived out daily. The commentary above came via email with one of the photos DuFresne submitted, upon request, to publish with this story. I chose it as the introduction to this interview because it conveys, I believe, the very essence of the person who spoke with me for more than an hour by phone. DuFresne didn't shy away from real, raw emotion when talking about the highest of highs in his career, or the lowest of lows. Our conversation covered his arduous journey to vice president of product development for Permobil Seating and Positioning, but even more than that, a career that has invaded his very soul.

OTHER THAN THE OBVIOUS NEED TO EARN A LIVING, WHAT INSPIRES YOU TO GET UP EACH DAY AND GO TO WORK?

I take tremendous pride and find it to be an absolute honor to try and help improve people's lives through my efforts at work. When we hear stories from the field about how a user lived because of a unique design feature we built into a sitting device, it almost always brings a happy tear to our eye followed by the "Let's do this!" spirit and man do we dig into our work right after that. Positive outcomes and genuine patient comfort fuel our desire to try harder.

Seating is seemingly a very small part of what goes into giving a user mobility, access to inclusion and comfort, but to us, it is very intimate and extremely personal. People's sitting comfort differs as much as their taste in food so designing options and features to help their unique needs keeps us sharp and ever evolving.

WHAT DOES A "TYPICAL" WORKDAY LOOK LIKE FROM YOUR OFFICE?

I am proud to have been able to spend the past 10 years of my career with a laser focus on seating and positioning products. Everything I have worked on and developed over this time has been focused on providing the most adjustable, comfortable, ergonomically appropriate seating products to individuals with the most complex needs on the planet. Because of this, my daily activity revolves around working with my teams to innovate and continually evolve our products. If I am not in the office at a design review meeting, I could be anywhere around the globe walking an industry or a non-industry tradeshow. I try to balance my time at these events taking education classes and networking with the key opinion leaders within that industry. Many people cringe at the thought of going to tradeshows, but I genuinely get excited when I walk into the hall. I treat it like a treasure hunt. You can't innovate staring at the wall in your office. You need inspiration, and for me, it comes from walking up and down the aisles and listening to educators articulate the problems they face. If you listen carefully and free your mind, the solutions may come pouring in. I am a lucky guy; I get to scour the earth looking for the next big thing!

WHO HAS HAD THE MOST SIGNIFICANT IMPACT ON YOU/YOUR CAREER?

Without a shadow of a doubt, the end users. Meeting them, hearing them, and working with them and their seating team to deliver the best solution over and over has coached me to where I am at today. We all have a more in-depth story as to what got us into this industry and mine is pretty common to others: someone in your life is/was living with a disability, and you felt the need to contribute to the cause and try to make a change. My uncle, Bob, was that person for me. He contracted a very severe case of Guillain-Barré syndrome when I was a very young that caused lifelong disabilities. His hands presented like a high-level quadriplegic, and he was relatively paralyzed from the waist down. He could ambulate using a walker, but not without a challenge. I spent a great deal of time working with him in his landscape business. I would marvel as this man would crawl and drag himself onto the tractors and industrial pieces of equipment to earn a living. Through these years I was unknowingly being taught to see what the true meaning of ADLs (activities of daily living) was by a man who wouldn't settle for a disability check. There are very few products I sit in on for design review that I don't think about how uncle Bob would interact with that product.

My uncle Bob and all of our end users fuel my passion, but as for how my 16 years of patient wherewithal and seating knowledge came to be, well, that has, until now, been my secret list of heroes, educators and industry gurus. I am proud to mention everyone by name and wish I had more space to keep the list going. These individuals profoundly influenced my passion and drive to design products that address tissue integrity, biomechanical sitting principles and genuine patient comfort: Bengt Engstrom, Dr. Joyce M. Black, Kelly Waugh, Lauren Rosen, Stacey Mullis, Jeff Auter, Dr. Rory A. Cooper, Dr. David M. Brienza, Michael Duda, Dr. Kenneth Lee, Susan Johnson Taylor, Ted Cassette, Dr. Alexander Siefert …

AS A CHILD, WHAT DID YOU WANT TO BE WHEN YOU GREW UP?

For as long as I can remember I wanted to be an inventor. My favorite phrase was, "I've got an idea." I went to school to be a mechanical engineer. My junior year, I chose to leave the university for a job, because I needed the money. They paid me well, and it eventually led to a career that used everything I had learned.

CONTINUED ON PAGE 14

With support from the Permobil Foundation, his family and his lake community, Steve DuFresne's goal to host an adaptive watersports event, At the Lake, came to fruition last summer. Visit www.atthelake.com to learn more about this year's event.

At the Lake 2018 volunteers, Ryan Irene and Brynn Bartlett, take Jess Hope on a trip around the lake.

Steve DuFresne and Ashley Detterbeck help At the Lake 2018 participant Bryce Summer prepare for his first-ever watersports experience.

HEART OF A CHAMPION
(CONTINUED FROM PAGE 13)

WHAT CAREER ACCOMPLISHMENTS ARE YOU MOST PROUD OF?

Wow. There are a few. First, bringing a power wheelchair to market in the U.S. before the age of 30 by designing the Acta-Relief Back, still claimed as one of the most unique backs in the world. Then I'd say starting an adaptive watersports program. Add to that, being trusted to represent not only the Comfort brand of products but truly ROHO as well. I remember being in a hotel room in Poland and talking to Tom Borcherding about taking on this role with Permobil. I asked him if the offer meant I was responsible for ROHO as well. When he said yes, I immediately had tears well up, but I did my best to hide it! I was instantly overwhelmed with the responsibility, grandeur and impact that the ROHO brand of products means to the world of seating. Saying yes that day to the position was not something that I took lightly. I still feel a deep sense of honor in working with our team to innovate and build the next generation of globally accepted skin protection and positioning products.

WHAT ARE THE BEST THINGS/WORST THINGS ABOUT THE INDUSTRY?

The people who work in this industry are the best thing about it! I was recently at ISS, and I can't tell you how many times I got choked up listening to our industry leaders and realizing all of our accomplishments over the last 30 years. The people at that show and all around the world in our industry have made a positive impact for so many people living with disabilities. The number of people who have benefited from their pioneering efforts is staggering, and I applaud you all. My heart felt full when I left the event knowing there are so many like-minded people who want to make a change.

The worst things in the industry are the people making changes, or should I say cuts to the funding system with what seems to be no understanding or care in the world. They have made such a negative impact on human lives! I have yet to hear one person in our industry tell me one single positive impact that competitive bidding did for our users.

WHAT WERE THE DEFINING MOMENTS/DECISIONS/SITUATIONS THAT SET YOU ON YOUR CAREER PATH?

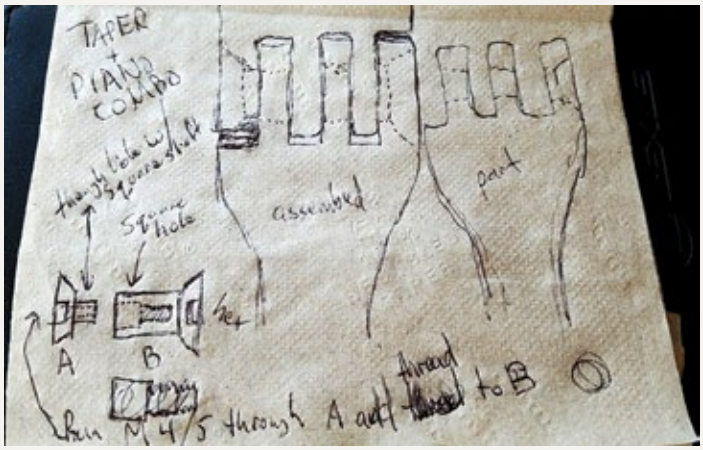
In 2002, I was working as a CAD jockey for a phenomenal DC Gearmotor designer in southeastern Wisconsin, but I was also being mentored in business development by our chief operating officer. In the business development role, I traveled the country meeting with large corporations trying to gain the business of anyone – from diesel fuel transfer pumps on pickup trucks and baseball pitching machines to pottery wheels and, my favorite, power wheelchair motors. My most significant show of the year was to attend Medtrade and try to sell my way into Invacare, Sunrise and, yes, even Permobil. I wanted their right-angle gear motor business so badly, it hurt.

Unfortunately, a falling out between the owners left me without a job a year later. Cleaning out my desk, I came across one of the most unique products I had ever seen at Medtrade: the design of a very petite powerchair base with a

Steve DuFresne receives an autograph from athlete Aidan Caims at the 2017 Adaptive Sports USA Junior Nationals. Also pictured, Aidan's coach, Trisha Yurochko, and Joey Chiavaroli.

15" seat elevator, built by a guy in his garage. It was unique in that it was super light, a word never applied before to powerchairs. It also had a higher lift than the rest to give true environmental inclusion. At this point, a 6-inch elevator was novel, and only 21st Century Scientific was leading the way in this feature with a 12- to 13-inch lift, and iBot boasted an eye-level lift but at a hefty $30,000 price tag, which seemed unsustainable. I stared at the manila folder holding the literature for this new chair and knew without a shadow of a doubt that I was going to leave that day and try to make the best power wheelchair in the world. I was hooked on DME!

Unfortunately, the investor I had found, Ken Hendricks, died in a tragic accident in 2007 before we could get it off the ground. The investment got tied up in court with his estate, and I wasn't able to raise the capital needed and couldn't find another investor. I ended up going from top of the world to full bankruptcy. Then I met my wife, Janna, and I landed a job with the Comfort Company, and eventually was offered a position back in product development. When Permobil acquired the company in 2017, I was fortunate to join Permobil.



Permobil's No. 1 selling accessory, BodiLink Head Support, utilizes parts born from a dream Steve DuFresne had during a family camping trip in April 2017. He presented the sketch to Permobil's engineering team, asking "Can we do something like this?"

WHAT ARE YOUR CURRENT/FUTURE CHALLENGES/OPPORTUNITIES?

True innovation is very challenging in this industry. There are products we have created that articulate, mount and fit to a user very differently. These products, however, will never be realized because they don't follow the exact and very basic print within the three or four checkboxes found on a PDAC submission form. This form often doesn't give us the freedom to bring innovation to life because it won't be reimbursed. If you want seating to fit better and do more, well then, we need the reimbursement room to do so. That said, we are working on a facelift for Ottobock this summer as well as an innovation that we'll reveal in 2020.

WHAT ACTIVITIES/CAUSES FILL YOUR TIME OUTSIDE OF WORK?

My wife, Janna, and I have two amazing boys, Devin, 8, and Ethan, 7. We live on a quaint and very neighborly lake about 30 minutes west of Milwaukee, so we try to get as much water time as possible when there is no ice on the lake. The people who live on this lake are so caring and welcoming that it almost seems like a fairytale. They, along with my family and the Permobil family, allowed me to launch an adaptive watersports event last year called "At the Lake." I had volunteered at a previous event, and the joy of being in the water and participating brought so much happiness to the children as well as their parents. I wanted to share something like it with my end users and my community. After five years of planning, I pulled it off, and we're hoping to have it again this year. To have my work, family and community come together and support this cause with me is still emotionally overwhelming. I feel like I am the luckiest man in the world. My wedding day and birth of my children will always be the top of my list, but this event falls in right after those.

CONTACT
Steve may be reached at
STEVE.DUFRESNE@PERMOBIL.COM

Steve DuFresne is V.P. Product Development Business Unit Seating & Positioning at Permobil.

NO DAY-TO-DAY GRIND HERE!

Written by: **ROSA WALSTON LATIMER**

An inventive, enthusiastic occupational therapist (OT), Amber Ward believes she brings "the common sense gene" to her work. After talking with her recently, I discovered she also brings versatility and genuine dedication to whatever task is before her. Ward's clients know they can depend on her to fashion a way for them to use a television remote with tiny buttons. Or, she can make it possible for you to hold a guitar pick so you can play in church worship, even if you aren't able to speak or your movement is very limited. Ward is a singer, a quilter and a gardener and volunteers at a therapeutic horseback riding facility. She is also co-editor of an occupational therapy assistant's textbook, "Adult Physical Conditions: Interventions for the Occupational Therapy Assistant," published. It doesn't matter what game you're in, you want Ward on your team!

YOU HAVE A VARIETY OF SKILLS THAT COMPLIMENT YOUR EDUCATION AND TRAINING AS AN OCCUPATIONAL THERAPIST. IS THERE SOMEONE IN PARTICULAR WHO INSPIRED YOUR WORK ETHIC?

From an early age my grandfather, Wilbur Austin, had a meaningful influence on me. He was what is often called a renaissance man, and I was his oldest grandchild. He was an engineer, a farmer, a professional photographer, a woodworker … he could fix anything. I spent many, many hours with my grandfather. He taught me how to work with tools and how engines work. He had me on the tractor with him when I was about 3 years old and taught me how to drive a stick shift car out in the pasture when I was 13. He gave me my first camera and taught me how to use it. My grandfather was a meticulous craftsman who paid attention to detail. Most of all, he taught me it doesn't matter if you are a girl, you can do anything you want. He was an amazing person!

I WAS FORTUNATE THAT ALL OF THE CLASSES I HAD TAKEN IN THOSE FIRST COUPLE OF YEARS FIT PERFECTLY WITH THE REQUIREMENTS FOR OT, SO I SORT OF SLID RIGHT INTO IT, AND IT WORKED OUT IN A GREAT WAY!

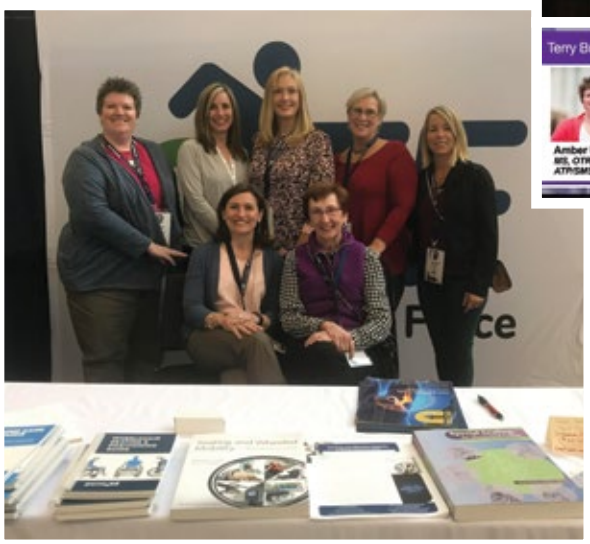
AS YOU SAID, WITH THAT KIND OF POSITIVE INFLUENCE, YOU REALIZED YOU COULD DO ANYTHING YOU WANTED. WHAT INITIALLY DREW YOU TO THIS CAREER AND WHERE DID YOU BEGIN?

Initially, I wanted to be a music therapist, because I sing and play the piano. That seemed like a natural fit; however, the practical side of me took over when I realized that music therapy is not usually reimbursed by insurance. I realized in the good times I might have a job as a music therapist, but in bad times, maybe not! Someone suggested I look into occupational therapy as an option. About two years into classes at the University of Wisconsin in Madison when I was still figuring out what I wanted to do, I took an OT 101 class, simply to learn more about this option. About 10 minutes into the first day of class I was hooked! I knew this is where I needed to be, and it would match my skill set. I was fortunate all of the classes I had taken in those first couple of years fit perfectly with the requirements for OT, so I sort of slid right into it, and it worked out in a great way!

Now I'll soon be celebrating my 25th anniversary of working for what is now called Atrium Health. This is one of the largest health care systems in the southeast, and all of my years as an occupational therapist have been in Charlotte, North Carolina, for this same health care system. My very first day as an OT was Memorial Day working in inpatient rehab, and that is where I was for the first nine and a half years of my career working with all types of inpatient folks – brain injuries, strokes, spinal cord injuries – a variety of experience.

AFTER ALMOST 10 YEARS, YOU MADE A SIGNIFICANT CHANGE IN YOUR CAREER. HOW DID THIS COME ABOUT, AND WAS IT A DIFFICULT DECISION?

Within the same health care system, I applied to be the first full-time OT in an ALS (amyotrophic lateral sclerosis) clinic they were establishing. When I was offered the job, I had a dilemma, because I was happy in my current position and had to decide if I



TOP: This double sided, king-sized quilt make of T-shirts is one of Amber Ward's creations.

MIDDLE LEFT: Amber Ward (left) with co-editor Amy Mahle holding their text book, "Adult Physical Conditions."

MIDDLE RIGHT: Fresh flowers from Amber's garden.

BOTTOM LEFT: Amber Ward (left) with the Clinician's Task Force Executive Board at the 2019 International Seating Symposium.

BOTTOM RIGHT: Amber Ward and Mary Shea presenting at 2019 AOTA Conference on OT management of clients with ALS.

wanted to make a change. In inpatient rehab, I worked with a large staff of occupational and physical therapists, and in the new job, I would be the only OT. Another consideration was that, in inpatient rehabilitation, many clients improve and with progressive neurological disorders, not so many. That shift would be significant, and the pace of work would be very different. I realized working in the outpatient clinic would have more flexibility, so after considering all of this I accepted the job as OT in the ALS clinic, and I've been here ever since. Those early years in inpatient rehabilitation were significant. I could not do my present job without that previous experience.

TELL US MORE ABOUT HOW YOUR JOB, AND THE CLINIC, HAS EVOLVED.

Our facility is near another, much larger, outpatient seating clinic; however, our physician wanted to have therapists in our clinic who understood ALS and muscular dystrophy to do the seating for his patients. A dozen or so years ago, the only physical therapist in the clinic and I studied and sat for the ATP and then she left for a job opportunity in Boston. As a result, I am now running our seating clinic which is a little larger than it was initially; however, we are still dealing with primarily the same type of clients. The ALS/muscular dystrophy clinic has combined with multiple sclerosis, Parkinson's disease, epilepsy and all of the other neurological departments and is now the Neurosciences Institute Neurology. I'm still the only OT!

We are a regional clinic, and often our clients don't live in Charlotte. Usually, after I do an evaluation or consultation for clients and then, if needed, I refer them to therapy closer to their home. I may not see them again for

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NO DAY-TO-DAY GRIND HERE!
(CONTINUED FROM PAGE 17)

three to six months. With wheelchair seating, I will see a client through the evaluation, the fitting and then as much training as needed. I also oversee client care regarding appropriate home health occupational therapy.

YOU MENTIONED ONE CONSIDERABLE DIFFERENCE BETWEEN WORKING IN AN INPATIENT REHAB SETTING AS OPPOSED TO THE ALS OUTPATIENT CLINIC WAS THAT MOST OF YOUR CLIENTS HAVE A TERMINAL DIAGNOSIS. HOW DO YOU PERSONALLY COPE WITH THIS?

I must admit the transition was difficult. I believe the variety of opportunities and responsibilities give me an advantage in dealing with the death of clients. There is no day-to-day grind. Every day is different and, honestly, every day is what I make it. Since there had never been an OT in this position, I've had the joy of creating it into exactly what I wanted and needed it to be, and I am well-supported in this. Because the clinic was established through some fundraising and endowments, I have more options. I do my scheduling so I have the opportunity to write articles, and I have two research projects going right now as well as serve as a research evaluator on several others. I also teach as an adjunct at an OT assistant program and a master's OT program at Cabarrus College of Health Sciences.

Having a strong support team you can talk to and process with helps a great deal when you lose a client. I believe just about everyone on our team has their own personal therapist as well. While all of this is definitely a challenge, the positives outweigh the negatives a thousand times!

FIGURING OUT HOW TO GET THROUGH THE CHALLENGES THAT LIFE THROWS AT YOU AND STRENGTH OF SPIRIT ARE AMAZING GIFTS MY CLIENTS SHOW ME. NO MATTER WHAT HAPPENS, THEY TAKE THE HIT AND FIGURE OUT HOW TO GET THROUGH IT.

WHAT IS SOMETHING IMPORTANT THAT YOU'VE LEARNED FROM YOUR CLIENTS?

Figuring out how to get through the challenges that life throws at you and strength of spirit are amazing gifts my clients show me. No matter what happens, they take the hit and figure out how to get through it. In the beginning, I wanted my clients to sit perfectly in their wheelchairs and have amazing positioning. But, I had much, much better results when I began to truly listen to my clients. I realized I needed to let them tell me what they needed their chairs to do.

The folks I meet are amazing, and it is a true blessing I can be a part of their lives and have the opportunity to help them. If someone comes to me because they can't feed themselves, there are many options I can offer. I'm always thinking about function and asking how we can maximize a person's ability to live a fuller, more independent life. That's a pretty amazing gift to be able to keep people independent for as long as possible. Also, there's no guarantee that just because a client doesn't have ALS they will have a long life. My work is a nice reminder to live every day to the best of my capacity.

CONTACT
Amber may be reached at AMBER.WARD@ATRIUMHEALTH.ORG

Amber Ward is a treating occupational therapist. She has treated a wide variety of patients, of all ages and functional levels. She currently is an adjunct professor at the OTA program at Cabarrus College of Health Sciences in addition to working in the clinic. She received the RESNA Assistive Technology Professional certification in 2004, the Seating and Wheeled Mobility certification in 2014, and became AOTA board certified in physical rehabilitation in 2010. She runs the seating clinic at the Neurosciences Institute Neurology in Charlotte, North Carolina. She is involved with multiple research projects and is the author of two peer-reviewed journal articles about power wheelchairs with persons with ALS.


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A SIXTY-HOUR-A-WEEK HOBBY

Written by: **ROSA WALSTON LATIMER**

How would you like to have an extra 21 hours a week? Bob Harry, owner of Aabon Home Health Care Supply, Inc. in Ozark, Alabama, can tell you how to do it. Harry has also successfully negotiated his way through an everchanging industry and has transitioned his marketing to connect with current trends. The retired helicopter pilot recently took time to talk with us about his business philosophies and how he manages his "60-hour-a-week hobby."

When Harry retired from the Army as a lieutenant colonel, he had his eye on a career in real estate; however, an offer to help get a home medical equipment business off the ground took him down a different path. "That was 29 years ago, and here I am," Harry said with a laugh. "Of course, we've been through many changes during this time. Early on, our focus was hospital beds, oxygen and bedside commodes. We still offer those things, but mobility has become our focus. I spend 98% of my time qualifying people for wheelchairs."

After Harry earned his RESNA Assistive Technology Professional (ATP/SMS) certification and NRRTS Certified Complex Rehabilitation Technology Supplier® (CRTS®) designation, his responsibilities shifted to more personal interaction with his patients. "Now I spend a lot more time in patients' homes discussing very private things with them about qualifying for electric wheelchairs. That can get very emotional. When you talk frankly about capabilities and limitations, an individual often faces the reality of their situation for the first time. Many times, there are tears."

"I HAVE A SIGN OVER THE DOORS THAT COME INTO MY BUILDING THAT SAY: 'YOU LIMIT YOUR PATIENT IF YOU LIMIT YOUR KNOWLEDGE,' I AM A FIRM BELIEVER IN THAT STATEMENT."

Along with a shift in focus to the mobility needs of his patients, Harry also realized he needed to make other changes. "At one time we had five locations. I was living in front of the windshield driving from one to the other," he said. "We were also challenged to find the quality of people we needed to staff those locations, and I decided to close everything but one location in Ozark. After we made that change, our revenue increased by 14% with much fewer headaches." Aabon's one location now has a staff of eight; six have worked with Harry for over 16 years. "Now I have the quality of people we need," he said. "They don't need me to answer every question that comes up, and that frees me to be out of the office visiting patients in their homes. I'll often drive 800 miles in a week, but I'm taking care of our patients, not managing a staff in several locations."

A longtime NRRTS Registrant, Harry understands the importance of ongoing education and has completed almost 100 NRRTS courses. "I have a sign over the doors that come into my building that say: 'You limit your patient if you limit your knowledge.' I am a firm believer in that statement. Most of the people I help don't realize what is available to them or what insurance will and will not fund. It is my responsibility to bring all of the information together and apply it to each situation."

The seasoned businessman puts a great emphasis on trust with his patients and his staff. "I have 25 rules that we follow as a company," Harry said. "One of those rules is: 'You have to develop absolute trust in your staff. If you can't do this, you've got the wrong staff.' I believe, and am certain I can have absolute trust in my current staff. We all know that there is no single MVP here, we need each other. I also respect my patients and work hard to win their trust. I assure them they can call the number on my business card at any hour, any day, I will answer, and I will take care of them. I've been on call every night since I've been in this business."

Of course, getting the word out year after year that your company can, and will, provide the quality of service a patient needs is a challenge. However, Harry has had a firm grasp of the importance of advertising from the beginning, when printed telephone directory Yellow Pages were

a fundamental way of growing a business. "I wanted to be first in the Yellow Pages, so I created the name 'Aabon.' When someone asks what 'Aabon' stands for, I tell them it stands for, 'first in the Yellow Pages!'"

When this type of advertising became obsolete, Harry began running 30-second commercials on television. Now he is taking that presence on television a step further by creating "Mobility Monday." He explained, "Each Monday on a local television station, we will feature one piece of equipment in a two-minute vignette. These short pieces will show how to use the equipment, how to qualify and how to get the proper size and fit. We have a total of 11 of these covering a variety of equipment. In addition to the Monday segment, these will air at various times throughout the month. I'm confident this will be well-received. We also know even if someone watching doesn't need the equipment at this time, they will likely come to us when they, or a family member, do need it."

I asked Harry what he did for fun, and his surprise answer was, "I flip houses! I've been doing that for about 10 years." The 76-year-old oversees two crews who do the work on the houses. "There is a great deal of satisfaction for me in this. It gives me the opportunity to create something." He also admitted that he and his wife, Mary Lou, usually take a few days off a couple of times a year and spend time at the beach. "When I'm at the beach, all I do is read. I take a complete break from business."

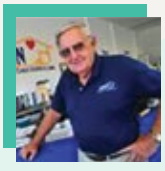
"WHEN I WALK AWAY AFTER HAVING ESSENTIALLY GIVEN SOMEONE THEIR LEGS BACK, I KNOW I'VE CHANGED THEIR LIFE IN A VERY POSITIVE WAY. I LIKE WHAT I DO, BUT IT CAN BE HARD. FIVE O'CLOCK COMES, BUT I CAN'T JUST TURN A SWITCH AND FORGET WHAT I'VE DEALT WITH ALL DAY."

My next question, was "Where do you find the time to do all that you do?" (Now we learn about how to add 21 hours to each week.) "I go to bed between 7 and 8 o'clock each night (and I get up at 3 a.m.," Harry explained. "Most people watch television for a while and go to bed around 10 p.m. and get up around 6 or 7 in the morning. My routine gives me about three more productive hours each day. Multiply that by seven days a week, and that gives me 21 more hours. That is almost a whole day! Multiply that by 52 weeks in a year, and I've got two extra months. My lifestyle keeps me busy mentally and physically, and after all these years, it's still working for me!"

After a satisfying military career, Harry took skills he learned – integrity and leadership – and applied them to the building of a successful business that is making a difference in the lives of people in southern Alabama. He has never taken a paycheck from the business, and he has no plans to retire. "Our business struggled until we found our niche, but we found it, and we take good care of the people in that niche," Harry said. "When I walk away after having essentially given someone their legs back, I know I've changed their life in a very positive way. I like what I do, but it can be hard. Five o'clock comes, but I can't just turn a switch and forget what I've dealt with all day."

CONTACT
Bob may be reached at AABON@TROYCABLE.NET

Bob Harry is a NRRTS Registrant who lives in Ozark, Alabama. Harry is an at-large board member of NRRTS.



CRT UPDATE

Written by: **DON CLAYBACK**

To tweak an old phrase, April showers bring May CRT legislation. It's been a very busy time over the past few months with behind-the-scenes work on the re-introduction of two important pieces of Complex Rehab Technology (CRT) legislation. As result, we have some great news to report on congressional developments to protect access for the people with disabilities who depend on CRT. Read on to get informed and to get engaged.

CRT WHEELCHAIR LEGISLATION

On April 12, 2019, the "Protecting Access to Complex Rehab Wheelchairs Act," HR 2293, was introduced in the House of Representatives. The bill is being led by longtime CRT champions Reps. John Larson, D-Conn., and Lee Zeldin, R-N.Y., on behalf of people who depend on complex rehab wheelchairs. We are very thankful for their continued leadership.

They were joined in this bipartisan re-introduction by 21 additional co-sponsors. Not only was the introduction bipartisan, but it included seven members from the important Energy and Commerce and Ways and Means committees. Having 23 representatives on board out of the gate is a great start.

This legislation follows the text in the bill that was passed last December in the House of Representatives by a vote of 400 to 11. Unfortunately, the bill was not ultimately passed in 2018 as it stalled in the Senate when no action was taken before they adjourned for the year.

The 2019 bill has two provisions: (a) it will permanently exempt complex rehab manual wheelchairs from the Medicare Competitive Bidding Program; and (b) it will stop Medicare from applying Competitive Bidding payment rates to critical components (accessories) used with Complex Rehab Manual Wheelchairs for an 18-month period (July 1, 2019, through December 31, 2020). This suspension will allow for further discussions with the Center for Medicare and Medicaid Services (CMS) on this issue and the development of a permanent policy change like that implemented in 2017 for the critical components (accessories) used with complex rehab power wheelchairs.

A similar bill is expected to be re-introduced shortly in the Senate. The Senate bill will again be led by Sens. Bob Casey, D-Penn., and Robert Portman, R-Ohio. We sincerely appreciate their ongoing support and look forward to building on the near-passage of the CRT wheelchair bill at the end of 2018 and getting it over the finish line in 2019.

CRT SEPARATE BENEFIT CATEGORY LEGISLATION

We are expecting the "Ensuring Access to Quality Complex Rehabilitation Technology Act of 2019" to be introduced in the House of Representatives within the next few days of this writing. This bill contains updated language to create a Separate Benefit Category (SBC) for CRT within the Medicare program and make other needed improvements in Medicare coverage and safeguards.

The legislation will again be led by Rep. Jim Sensenbrenner, R-Wis., a longtime CRT leader. The additional good news is the bill introduction will be bipartisan as he will be joined by Rep. Brian Higgins, D-N.Y. We are very happy to have the increased CRT support of Higgins, who is an eight-term Member of Congress and serves on the important Ways and Means Committee.

As reported in the last last issue of DIRECTIONS, members of the Medicare Separate Benefit Category Steering Committee have been working on reviewing and updating last year's legislative language to best conform to today's access issues and congressional environment. The objective was to re-introduce the Separate Benefit Category bill in a form that retains the core objectives, incorporates congressional and CMS input, is easier to follow, and increases the chances for passage. That work has been completed.

The new legislative language remains centered on covering the core objectives of the Separate Benefit Category initiative: (a) to establish a separate category for CRT within the Medicare DMEPOS benefit to provide the needed segregation from standard DME; and (b) to provide pathways for product identification, coding, coverage policies, payment,

and supplier standards that will allow appropriate access for Medicare beneficiaries and others with significant disabilities and chronic medical conditions.

Once the House of Representatives bill is introduced, we will begin pursuing a Senate companion bill and holding discussions with potential Senate champions.

NATIONAL CRT CONFERENCE

As of this writing we are one week out from the National CRT Leadership and Advocacy Conference at the Renaissance Arlington Capital View Hotel in Arlington, Virginia. With our new CRT bills, this will be a great kick-start to secure co-sponsors and begin the push for passage of our Complex Rehab Wheelchair and CRT Separate Benefit Category legislation. Thanks to the conference sponsors for their support and to all the attendees who will be with us in D.C. Watch for the conference report in my next CRT Update.

TIME FOR ADVOCACY ACTION

Now that we have the CRT bills re-introduced in Congress (with new bill numbers), it's time to fully engage our national grassroots advocacy efforts. The first objective is we need everyone to reach out to their representatives and senators and get them to sign as co-sponsors to the new CRT bills. Remember, the higher number of co-sponsors on a bill, the higher its credibility and visibility within Congress.

We've made contacting your representatives and senators simple. You'll find updated advocacy links, messaging and materials at www.protectmymobility.org to make your outreach as easy as possible. Visit the site and use the email and

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CRT UPDATE
(CONTINUED FROM PAGE 23)

call links to start the communication with your members' offices. At the site you can also view/download the related position papers and list of current cosponsors.

Remember, polite persistence is the key to a successful outcome. Don't accept a generic response to your request that he/she will "keep your thoughts in mind if the bill comes up for a vote." You need them to formally sign on as a co-sponsor to show their support now, not when it comes up for a vote.

Thanks for your continued engagement in our CRT advocacy efforts. Please help spread the word to others in your circle so we can increase the CRT voice with Congress and other policymakers and make progress this year.

CONTACT THE AUTHOR
Don may be reached at
DCLAYBACK@NCART.US

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

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STANDING
A CALL TO ACTION

Written by: **LORRI BERNHARDT,** PT, MPT, ATP, AND **PENNY J. POWERS,** PT, MS, ATP

Those who grew up in a farming community learned about "priming the pump." When your well was low, you needed to send a bucket of water down to facilitate the suction valve and activate the pumping action to get the water flow started. Recently, Lorri Bernhardt, PT, MPT, ATP, CTF Executive Board Member and RESNA Wheeled Mobility and Seating SIG Co-Chair sent out an informal survey to "prime of the pump" and inject a renewed discussion on the topic of standing and standing wheelchairs. The RESNA Position on the Application of Wheelchair Standing Devices (2013) is under revision. Since 2013, there are new manufacturers and updated devices that provide the mechanisms necessary for standing in our clinical practice. Thus, a renewed need for discussion and research is upon us about the medical necessities of standing. Whether this standing takes the form of using a static device or a dynamic mobility device, the medical necessities associated with standing are of great importance to the health of the end user.

SINCE 2013, THERE ARE NEW MANUFACTURERS AND UPDATED DEVICES THAT PROVIDE THE MECHANISMS NECESSARY FOR STANDING IN OUR CLINICAL PRACTICE. THUS, A RENEWED NEED FOR DISCUSSION AND RESEARCH IS UPON US ABOUT THE MEDICAL NECESSITIES OF STANDING.

How does the seating and mobility team deal with the subject of standing? How and when are we recommending such devices? What do we as clinicians really think are the positive attributes of standing? Is it worth the fight? These are some of the questions we should be asking.

This survey provided some interesting "pump priming" data, that may serve to facilitate refreshed activity in a low well.

This survey of convenience was completed online by 89 seating and mobility professionals. Professional demographics included representation in physical and occupational therapy and, of these, 52 reported having an ATP certification.

Forty-five percent of these clinicians reported 20-plus years of practice related to seating and mobility. The respondents reported seeing a rich variety of client diagnoses, with the top three being: paraplegia, traumatic brain injury and cerebral palsy.

When respondents were asked about the medical necessities of standing, there were 17 outcomes that have been reported to funding sources by these therapists that worked to establish the medical necessity for a standing wheelchair. The top five health benefits reported were:

1) Pressure injury prevention/healing
2) Maintain/improve vital organ capacity related to bowel function
3) Maintain/improve vital organ capacity related to pulmonary function
4) Reduce spasticity
5) Reduce the occurrence of skeletal deformities

Based upon these and the other important medical necessities, 88 respondents stated that a total of 1,348 of their client evaluations would have resulted in a recommendation for a standing wheelchair in the last year.

In this survey therapists were asked to note how many users received a standing wheelchair via their clinics in the last 12 months. It was reported that approximately 167 users received a standing wheelchair using insurance funding sources and approximately 41 users received a standing wheelchair using cash/self-pay in the last 12 months. Many in our field would say that the well is nearly dry – there is "no funding" for standing. Perhaps we need to "prime our pump."

Consider the following:

It is accepted that criteria for the recommendations we provide are based on a client's need of Durable Medical Equipment (DME).

IF WE STOP REQUESTING AND ADVOCATING FOR STANDING, HOW WILL WE EVER MAKE PROGRESS TOWARD FUNDING SOLUTIONS FOR A MEDICALLY NECESSARY COMPONENT? FIGHT FOR STANDING WITH YOUR CLIENTS AND KEEP ASKING. PRIME YOUR PUMP AND AS THEY SAY IN THE SOUTH "HAVE AT IT."

It is accepted that a wheelchair meets the criteria of DME. Furthermore, as with a wheelchair:

> DME is expected to be utilized for a medical purpose.
>
> A standing feature is primarily used to serve a medical purpose
>
> DME is expected to be used in the home.
>
> A standing feature will be used in the home.
>
> DME is not a consumable or disposable item, it is used repeatedly.
>
> A standing feature is intended to be used repeatedly.

Further, if the standing feature is to be used repeatedly, throughout the day, it is expected that the client would have immediate and safe access to the medically necessary feature. Thus, a feature of the wheelchair would be the most effective, utilized and safe medical option for the client to promote and sustain health.

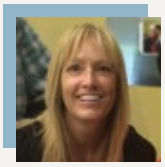
Individuals of all ages and ethnicities find themselves without the ability to stand either because of trauma, injury, disease, or congenital abnormalities. Most therapists understand and accept that standing is essential for normal growth and development and is medically necessary.

Third party payers are not motivated, eager or willing to approve and fund CRT with standing capabilities. If we stop requesting and advocating for standing, how will we ever make progress toward funding solutions for a medically necessary component? Fight for standing with your clients and keep asking. Prime your pump, and as they say in the South "have at it." The need for discussion and data collection is upon us, and our clients deserve to stand.

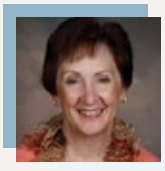
CONTACT THE AUTHORS

Lorri may be reached at LORRI.L.BERNHARDT@VUMC.ORG
Penny may be reached at PENNY.POWERS@VUMC.ORG

Lorri Bernhardt, PT, MPT, ATP, has 18 years of experience is a physical therapist. She spent 17 years at Rancho Los Amigos Rehabilitation Center in California, where she worked as an outpatient physical therapist. The last seven years at Rancho were dedicated to providing wheelchair and assistive technology assessments in the Seating Center. Lorri moved with her family to Nashville, Tennessee, where she now works in the Seating and Mobility Clinic at the Pi Beta Phi Rehabilitation Institute at Vanderbilt Medical Center. Lorri has provided lectures and education to a wide variety of audiences. Lorri is an executive board member and the co-chair for the RESNA Wheeled Mobility and Seating SIG, a Friend of and a member of the APTA.



Penny J. Powers, MS, PT, ATP, is a Level IV physical therapist (PT) at Pi Beta Rehabilitation Institute at Vanderbilt University Medical Center. Powers is the lead PT for the Adult Seating and Mobility Clinic. Her practices involve specialty seating for a diverse adult population. She has had presentations accepted at national conferences including RESNA and APTA Combined Sections meetings as well as the International Seating Symposium. She serves as adjunct faculty at Belmont University, DPT program. She has had IRB approved research projects in collaboration with Belmont University for the past seven years. Powers sustains membership in APTA including the Neuro Section and RESNA. She currently serves on the executive board of the Clinician Task Force.



METABOLIC DISORDERS

Written by: **MICHELLE L. LANGE,** OTR/L, ABDA, ATP/SMS

METABOLISM

Metabolism is the process used to maintain life and produce energy. For example, through metabolism, the body converts the food we eat into energy. Metabolism is the total of all the chemical processes that occur in the body each day. These chemical reactions break down food or chemicals for use or storage. Other chemical processes break down substances that are no longer needed or make substances that are lacking in the body.

METABOLISM HAS THREE MAIN PURPOSES:

1. Conversion of food to energy to power cells
2. Conversion of food/fuel to build or synthesize proteins, lipids, nucleic acids and carbohydrates
3. Elimination of nitrogenous wastes

METABOLISM IS THE TOTAL OF ALL THE CHEMICAL PROCESSES THAT OCCUR IN THE BODY EACH DAY. THESE CHEMICAL REACTIONS BREAK DOWN FOOD OR CHEMICALS FOR USE OR STORAGE.

DEFINITION

A metabolic disorder occurs when these processes do not work properly due to a hormone or enzyme deficiency. Metabolic disorders are categorized by whether a specific substance builds-up in harmful amounts, is too low or is missing.

Metabolic disorders are sometimes classified as disorders of carbohydrate, amino acid or organic acid metabolism or lysosomal storage diseases. More recently, other classifications have emerged including disorders of the urea cycle, fatty acid oxidation, mitochondrial function and peroxisomal function, as well as disorders of mitochondrial, porphyrin, purine, pyrimidine or steroid metabolism. Many metabolic disorders do not fall into any of these categories.

Examples of metabolic disorders include glycogen storage disease, phenylketonuria, glutaric acidemia, porphyria, Lesch-Nyhan syndrome and Zellweger syndrome.

MORE RECENTLY, OTHER CLASSIFICATIONS HAVE EMERGED, INCLUDING DISORDERS OF THE UREA CYCLE, FATTY ACID OXIDATION, MITOCHONDRIAL FUNCTION AND PEROXISOMAL FUNCTION, AS WELL AS DISORDERS OF MITOCHONDRIAL, PORPHYRIN, PURINE, PYRIMIDINE OR STEROID METABOLISM.

ETIOLOGY

Metabolic disorders are caused by inherited genetic defects, typically from both parents. There are hundreds of inherited metabolic disorders. Some metabolic disorders are part of newborn routine screening, such of phenylketonuria (PKU), and others are identified once symptoms emerge. One study estimated that metabolic disorders occur in 1 of 1,400 births.

TREATMENT

Treatment varies by the specific metabolic disorder and may include limiting the diet to avoid chemicals that an individual cannot appropriately metabolize, supplementing the diet to compensate for the metabolic issue, or replacing missing enzymes. If the metabolic disorder has led to other medical conditions, each condition will also require treatment.

PROGNOSIS

Prognosis also varies by specific metabolic disorder; however, some disorders can lead to significant medical complications and functional deficits. In some cases, seating and wheeled mobility, as well as other assistive technologies, may be indicated.

Health care professionals treating a patient with a metabolic disorder can often find detailed information about the specific disorder through credible internet sites. The patient and caregivers are frequently very knowledgeable about the condition, as well, and can be an invaluable source of information.

CONTACT THE AUTHOR

Michelle may be reached at MICHELLELANGE1@OUTLOOK.COM

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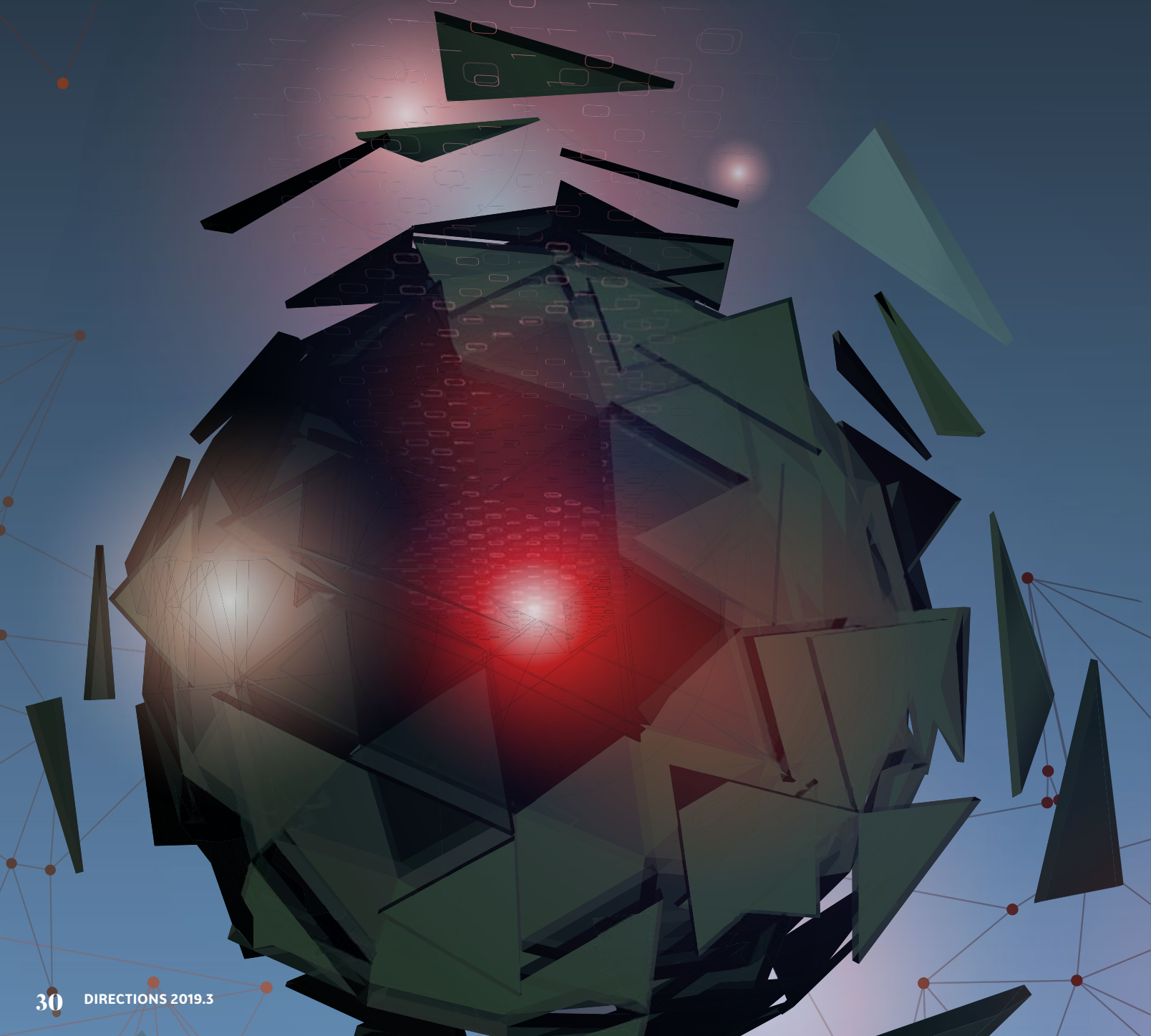
Michelle Lange, OTR/L, ABDA, ATP/SMS, is an occupational therapist with 30 years of experience and has been in private practice, Access to Independence, for more than 10 years. She is a well-respected lecturer, both nationally and internationally, and has written numerous texts, chapters and articles. She is the co-editor of "Seating and Wheeled Mobility: A clinical resource guide;" editor of "Fundamentals in Assistive Technology, Fourth Edition;" NRRTS continuing education curriculum coordinator and clinical editor of DIRECTIONS magazine. Lange is on the teaching faculty of RESNA and is a member of the Clinician Task Force. She also is a senior disability analyst of the ABDA.

BREAKING THE CODE:

SEATING AND WHEELED MOBILITY SERVICE DELIVERY CODES

Written by: **BARBARA S. CRUME, PT, ATP**



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Provision of therapy services to provide excellent care is billed using Current Procedural Terminology (CPT ®) Codes.[1] These codes fit together like a puzzle and you have to know the codes and how they work together to "break the code" and successfully receive reimbursement. Your documentation must support the skilled services provided for each code. Every time you think you figured out how to use CPT® Codes for billing therapy for seating and wheeled mobility services, a component changes: a code is eliminated or a new one added, a description changes, a Local Coverage Determination changes, or an insurance company decides not to cover that code. Correct coding for therapy services is critical to the success of any outpatient SWM clinic. This article explains the policies regarding the codes and reimbursement and descriptions of the specific codes based on information available from the American Medical Association on CPT® Codes, courses that I have attended,[2] articles online regarding CPT® Coding, as well as my personal experience as a therapist providing these services since before and after CPT® codes were introduced.

CODING POLICIES

The Healthcare Common Procedure Coding System (HCPCS) provides a standardized coding system for describing specific items and services.[3] The American Medical Association maintains the Level 1 CPT® Codes, which are used to report medical services. Each CPT® Code is valued for an allowable reimbursement amount using the Resource Based Relative Value Scale. The relative value units for each CPT code are comprised of "physician work," "practice expense" and "malpractice insurance."[4] The physician's (this includes therapist) work includes pre-service, intra-service and post-service time required to perform the service and includes the technical skill, physical effort mental effort and judgment as well as psychological stress and concern about the patient. The practice expense is based on the location in which the service is provided: facility (hospital, skilled nursing facility) versus non facility (physician's office, patient's home). The relative value of each service is multiplied by Geographic Practice Cost Indices for each Medicare locality and then translated into a dollar amount by a conversion factor ($36.0391 for 2019). The Centers for Medicare & Medicaid Services (CMS) divided America into a total of 112 different geographic regions, therefore one state may have two to three different relative value unit rates. Thus, the same service provided in one geographical area is reimbursed at a different rate than another area (Crume 2019). CMS publishes relative value units for CPT® codes in the Federal Register.[5]

The National Coverage Determination describes the criteria for Medicare coverage nationwide for medical services, procedures and devices. The National Coverage Determination regulates the Local Coverage Determination and the Local Coverage Determination operationalizes the NCD by specifying requirements for coverage, medical necessity, documentation, coding and modifiers. Providers of medical services must adhere to the Local Coverage Determination to qualify for payment from Medicare. Other funding sources may or may not follow Medicare's National Coverage Determination and Local Coverage Determination as they may have their own medical policies. The Local Coverage Determination for therapy services may differ depending on your geographical location since the Part A/Part B Medicare Administrative Contractors may issue different policies and policy articles. Therefore, it is very important that you check the Local Coverage Determinations for the state where you provide therapy services. To do so, utilize the following link, select your geographical area and enter physical or occupational therapy: http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.[6] Medicaid programs may follow Medicare policy or have their own limitations, therefore review your state Medicaid Policy Manual regarding provider clinical services. To find your state Medicaid website, a good place to start is https://www.ncart.us/state-issues/medicaid-links.[7]

Another important document regarding standards of practice and documentation is contained in your state's Practice Act for Physical Therapists or Occupational

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Therapists. For example, in the state of North Carolina, the Practice Act requires a Progress Note every 10 visits or every 60 days and, per the Local Coverage Determination, an updated Plan of Care is required every 90 days or when a change in the plan occurs or a new diagnosis or problem is identified requiring a change in goals. For seating and wheeled mobility services, the 'every 60 days' Progress Note may not be required; but if the person is also receiving regular therapy in the same facility with the same discipline, then the seating clinic visit has to be counted towards that 10 visits. A new Progress Note or more likely a new Plan of Care, is often required at every visit due to the time lapse between visits.

The Medicare National Correct Coding Initiative includes Procedure-to-Procedure edits for when more than one CPT® code should not be reported together by the same provider for the same beneficiary on the same date of service.[8] National Correct Coding edits are updated quarterly. When a code has a Correct Coding Modifier Indicator of "0," only the Column 1 code will be paid, and the Column 2 code will be denied (see Figure 2). For example, an evaluation code cannot be billed on the same date of service as 97755 (Assistive Technology Assessment) or 97750 (Physical Performance Test or Measurement) The Plan of Care may include a recommendation for an assistive technology assessment or physical performance test or measurement. Other codes with PTP edits that have a CCMI of "1" may be reported together in defined circumstances and require the use of Modifier 59.

The CPT® Manual defines Modifier 59 as "Distinct Procedural Service," meaning the codes are not normally reported together but if the two procedures are performed during distinctly different 15 minute intervals, they may be reported and will be reimbursed. Documentation in the medical record must support the fact that the services were provided at distinctly different times.[9] For example, the provision of 97755 (Assistive Technology Assessment) on the same day of service as 97542 (Wheelchair Management, which includes assessment, fitting and training) requires the use of Modifier 59 with start and end times documented for each code. Overuse of Modifier 59 is a 'red flag' for auditors to then review documentation. For National Correct Coding Initiative edits of codes commonly used by therapists providing seating and wheeled mobility services in a summarized version, please refer to the CPT® Code Summary Table available on the NRRTS website.[10]

Speaking of time, most of the therapeutic procedure CPT® codes used by therapists providing seating and wheeled mobility services are time-based codes requiring direct one-on-one contact with the patient. The amount of time providing a service is translated into units based on the number of service minutes. Medicare adds up the total minutes of skilled, one-on-one therapy and divides that total by 15. If eight or more minutes are left over, you can bill for one more unit; if seven or fewer minutes remain, you cannot bill an additional unit (see Figure 3). If any timed service is performed for seven minutes or less on the same day as another timed service that was also performed for seven minutes or less, and the total time of the two is eight minutes or greater, then bill one unit for the service performed for the most minutes. This same logic applies to larger amounts of time. For example, a therapist provides 24 minutes of 97760 (Orthotic Management) and 23 minutes of 97542 (Wheelchair Management). The total time is 47 minutes, which equals three units. In this case, the therapist spent more time providing 97760 and therefore can bill two units of 97760 and one unit of 97542.

REIMBURSEMENT POLICIES

Payment for services through Medicare is based on an allowed charge, private insurance companies may contract to pay a percentage of the Usual Customary Charge, and Medicaid may be based on a fee schedule. Medicare beneficiaries are responsible to pay their annual deductible plus 20% of the allowed charge for therapy services (secondary insurance may cover the 20%). Currently, once the beneficiary reaches the therapy cap amount ($2,400 for occupational therapy and $2,400 for physical and speech therapy combined), the therapist must apply the KX Modifier to the CPT® codes. A Medicare contractor may review the recipient's medical records for medical necessity of services provided beyond the current $3,000 medical review cap. Therefore, make sure as a therapist that you complete defensible documentation of the skilled care provided including your clinical decision-making process and how the treatment provided relates to the person's functional goals documented in your Plan of Care.

Since April 1, 2013, Mandatory Payment Reductions in the Medicare Fee-for-Service program include a sequestration payment cut of 2% that is applied to the Medicare payment for services.[11] In addition, the Multiple Procedure Payment Reduction went into effect on January 1, 2011. This applies to the "Practice Expense" relative value units of each CPT® code and is currently a 50% reduction. When a therapist reports more than a single procedure (CPT® code) during a single visit, Medicare payment is reduced by 50% of the practice expense relative value unit for the second and subsequent procedures. So, for example, provision of 97542 (Wheelchair Management) for one hour is billed as four units. In the state of North Carolina, the allowable for one unit is $32.04, but the allowable for four units with 2% wequestration and the 50% MPPR calculated, is $106.53. The same applies to the billing of two different therapeutic service codes. The allowable for the second code will be reduced. The reasoning behind the MPPR is that the pre-procedure and post-procedure services overlap.

Unfortunately, this is in effect for all therapy services provided on a single day. So, if the patient receives occupational and physical therapy on the same day, CMS will pay the highest value procedure at 100% and reduce all subsequent procedures for that day. One other policy to consider is the Merit-Based Incentive Payment System.[12] Some therapists in private practice are required to participate while others may do so by choice in 2019. For further information on the Merit-Based Incentive Payment System, refer to both the American Physical Therapy Association (APTA) and American Occupational Therapy Association (AOTA) websites as well as WebPT.

Units of service in excess of medically reasonable daily allowable frequency may be denied and are called Medically Unlikely Edits.[13] These services may not be billed to the beneficiary and cannot be waived or subject to an Advanced Beneficiary Notice. This notice is a form that a provider may request the beneficiary to sign and agree to pay for services that are not covered by Medicare. An example of an Medically Unlikely Edit occurs when a therapist provides 180 minutes or 10 units of 97542 (Wheelchair Management Fitting and Training) for a person with a complex power wheelchair and seating system, thus the entire bill is denied. Although Modifier 22 (unusual procedural service) exists to allow a provider to recover reimbursement above and beyond the regular payment for a difficult or time-consuming procedure, Modifier 22 does not apply to CPT® codes with Medically Unlikely Edits. This modifier was created for use by physicians performing surgical procedures. Currently for Medicare beneficiaries, CPT® Code 97760 has a limit of six units and CPT® Codes 97542, 97750, 97755 have a limit of eight units (see Figure 4). Keep in mind that private insurance carriers may have different guidelines but most likely follow CMS regulations. The recommendation for best practice is to contact the insurance company to determine coverage of therapy services prior to provision.

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FIGURE 1 CPT CODE PUZZLE

Using a combination of numbers 0123456789 fill in the highlighted blocks with CPT codes used for therapy services.

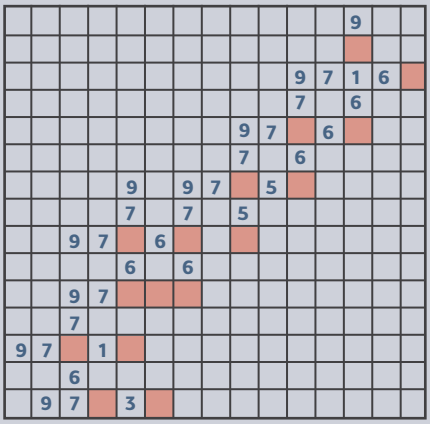

FIGURE 3 TIME BILLED

Units	Number for minutes
1 unit	≥ 8 minutes through 22 minutes
2 units	≥ 23 minutes through 37 minutes
3 units	≥ 38 minutes through 52 minutes
4 units	≥ 53 minutes through 67 minutes
5 units	≥ 68 minutes through 82 minutes
6 units	≥ 83 minutes through 97 minutes
7 units	≥ 98 minutes through 112 minutes
8 units	≥ 113 minutes through 127 minutes

FIGURE 2

109134	97750	97004		19990101	19990101	9	Standards of medical / surgical practice
109135	97750	97150		19990701	*	0	More extensive procedure
109136	97750	99091		20190101	*	0	Misuse of column two code with column one code
109137	97750	99457		20190101	*	1	Misuse of column two code with column one code
109138	97755	97035		20061001	*	1	More extensive procedure
109139	97755	97110		20061001	*	1	More extensive procedure
109140	97755	97112		20061001	*	1	More extensive procedure
109141	97755	97127		20180101	*	1	More extensive procedure
109142	97755	97140		20061001	*	1	More extensive procedure
109143	97755	97530		20061001	*	1	More extensive procedure
109144	97755	97532		20061001	20171231	1	More extensive procedure
109145	97755	97533		20061001	*	1	More extensive procedure
109146	97755	97535		20061001	*	1	More extensive procedure
109147	97755	97537		20061001	*	1	More extensive procedure
109148	97755	97542		20061001	*	1	More extensive procedure
109149	97755	97545		20061001	*	1	More extensive procedure
109150	97755	97750		20040701	*	0	More extensive procedure
109151	97755	97760		20061001	*	1	More extensive procedure
109152	97755	97761		20061001	*	1	More extensive procedure
109153	97755	97762		20060101	20171231	0	Mutually exclusive procedures
109154	97755	97763		20180101	*	1	More extensive procedure

FIGURE 4 - MEDICALLY UNLIKEY EDITS

1	Current			
2	HCPCS/	Outpatient Hospital Services MUE Values	MUE Adjudication Indicator	MUE Rationale
8691	97535	8	3 Date of Service Edit: Clinical	Clinical: Data
8692	97537	8	3 Date of Service Edit: Clinical	Clinical: Data
8693	97542	8	3 Date of Service Edit: Clinical	Clinical: Data
8694	97545	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruct
8695	97546	2	3 Date of Service Edit: Clinical	Clinical: Data
8696	97597	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
8697	97598	8	3 Date of Service Edit: Clinical	Nature of Service/Procedure
8698	97602	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
8699	97605	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
8700	97606	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
8701	97607	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
8702	97608	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
8703	97610	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruct
8704	97750	8	3 Date of Service Edit: Clinical	Clinical: Data
8705	97755	8	3 Date of Service Edit: Clinical	Clinical: Data
8706	97760	6	3 Date of Service Edit: Clinical	Clinical: Data
8707	97761	6	3 Date of Service Edit: Clinical	Clinical: Data

THERAPY EVALUATION CPT® CODES

Physical and Occupational Therapy Evaluation CPT® Codes are utilized on the first visit for the evaluation services provided. The evaluation codes are service codes and are untimed. Only one unit of a specific code is billed no matter how much time is spent with the beneficiary. Although the American Medical Association has typical times associated with each of the codes, time is not the determining factor in selection of the code. Both physical and occupational therapy have three levels for the Evaluation Procedure Code: Low, Moderate and High. While the codes are not valued differently, accurate code selection by all physical and occupational therapists is critical to provide the necessary data to support re-valuing in the future.[14]

The four components of complexity and severity must ALL be included in the decision regarding code selection:

1. Patient history (medical and functional, including relevant comorbidities and personal factors).
2. Examination with the use of standardized tests and measures.
3. Clinical presentation of the patient.
4. Clinical decision making (including the use of a standardized patient assessment instrument and/or measurable assessment of functional outcome.)

Note these components are NOT followed by the word OR which appears, for example, in the Local Coverage Determination criteria for wheelchair seating.

FOR PHYSICAL THERAPISTS[15]:

Low Complexity Code, 97161:

- The patient's history has no personal factors and/or comorbidities that impact the plan of care;
- The therapist provides an examination of body system(s) using standardized tests and measures addressing one to two elements from any of the following: body structures and function, activity limitations, and/or participation restrictions;
- The clinical presentation of the patient has stable and/or uncomplicated characteristics; AND
- The clinical decision making is low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome.
- Typically, 20 minutes are spent face-to-face with the patient and/or family.

Example: A person who presents with a diagnosis of osteoarthritis of several joints including shoulders, knees, hands and is unable to ambulate or propel a manual wheelchair. Examination may include Range of Motion Testing, Manual Muscle Testing and a Timed Up and Go test. The person's condition is stable, they obviously cannot grasp the push rims of a manual wheelchair or propel with their feet, but they have good trunk control, symmetrical posture and safe ability to transfer. The person is cognitively intact and quickly demonstrates safe and independent use of a Power Mobility Device. As the therapist, your decision is to recommend a Power Operated Vehicle or Group 2 power wheelchair with van style seat. You complete all of the documentation and the supplier provides final fitting and training to use and care for the device.

Moderate Complexity Code, 97162:

- The patient's history has one to two personal factors and/or comorbidities that impact the plan of care;
- The therapist provides an examination of body system(s) using standardized tests and measures addressing three or more elements from any of the following: body structures and function, activity limitations, and/or participation restrictions;
- The clinical presentation of the patient is evolving with changing characteristics; AND
- The clinical decision making is moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome.
- Typically, 30 minutes are spent face-to-face with the patient and/or family.

Example: A person with diagnosis of paraplegia, complete or quadriplegia C5-7, onset 17 years ago, who is now having difficulty propelling a 6-year-old ultra lightweight rigid manual wheelchair. The person now has rotator cuff issues and joint contractures. Examination may include Manual Muscle and Range of Motion testing, transfer skills, postural alignment, sensation and skin assessment. As the person ages with a disability, their condition is evolving. Standardized tests to assist in your clinical decision making may include the Wheelchair User's Shoulder Pain Index and/or Wheelchair Skills Test.

High Complexity Code, 97163:

- The patient's history has three or four personal factors and/or comorbidities that impact the plan of care;
- The therapist provides an examination of body system(s) using standardized tests and measures addressing four or more elements from any of the following: body structures and function, activity limitations, and/or participation restrictions;
- The clinical presentation of the patient has unstable and unpredictable characteristics; AND
- The clinical decision making is high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome.
- Typically, 45 minutes are spent face-to-face with the patient and/or family.

Example: A person with a diagnosis of traumatic brain injury) onset 20 years ago with resultant muscle weakness and mild cognitive issues with progressive scoliosis requiring spinal fusion, but due to cardiac issues is not a candidate for surgery. Weakness is progressive due to compression of spine. The person's ability to utilize the standard joystick on their power chair has worsened. This person has developed pressure injuries due to change in range of motion and functional mobility. Examination may include Manual Muscle Testing, detailed Range of Motion Testing, sensation and skin assessment, and extensive postural assessment. The person's condition is unstable, and it is difficult to predict future changes. To assist in your clinical decision making you may utilize standardized tests such as Wheelchair Skills Test and pressure mapping and include in your Plan of Care to complete a more extensive assistive technology assessment.

FOR OCCUPATIONAL THERAPISTS[16]:

Mild Complex Code, 97165:

- The person's occupational profile and medical and therapy history includes a brief review of medical and/or therapy records relating to the presenting problem.
- The examination includes an assessment(s) that identifies one to three performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions.
- The person presents with no comorbidities that affect occupational performance.
- Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component.
- The clinical decision making includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options.
- Typically, 30 minutes are spent face to face with patient and/or family.

Example: Same as the PT Low Complexity as the person with osteoarthritis has no comorbidities affecting their performance, they are able to transfer safely to a power mobility device and use a tiller or standard joystick with no modification to the seating or for access to maneuver the device, and the options to consider are limited.

Moderate Complex Code, 97166:

- The person's profile and history includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance.
- The examination includes an assessment(s) that identifies three to five performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions.
- The person presents with comorbidities that affect occupational performance.
- Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete the evaluation component.
- Moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options.
- Typically, 45 minutes are spent face-to-face with the patient and/or family.

Example: Same as the PT Moderate Complexity as the person with the diagnosis of SCI, 17 years post, now has rotator cuff injuries and joint contractures which require expanded additional review of history from previous therapy visits and/or physician notes. The person has deficits in strength, endurance, range and/or posture which require new actions to resolve problems. The person may have loss of function socially or may require changes to their environment. Modifications are required to complete the examination and there are several treatment options to consider including external postural support, power assist, or a power mobility device.

High Complex Code, 97167:

- The person's profile and history includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance.
- The examination includes an assessment(s) that identifies five or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions.
- The person presents with comorbidities that affect occupational performance.
- Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component.
- High analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options.
- Typically, 60 minutes are spent face-to-face with the patient and/or family.

Example: Same as the PT High Complexity as the person with traumatic brain injury and progressive scoliosis compressing his/her spine requires extensive additional review of their medical record and may require gathering of documentation from other medical providers. Examination identifies muscle weakness, limited range of motion, postural asymmetries, pressure injuries, and the person now relies more on caregivers and may not be interacting appropriately to direct their care. Due to additional comorbidities, the person requires physical assistance from the therapist, a caregiver, aide, or supplier to complete the evaluation. Multiple treatment options need to be considered to address the person's medical and functional goals including the need for an assistive technology assessment.

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CPT® CODE SUMMARY TABLE

PHYSICAL MEDICINE AND REHABILITATION 97000 SERIES CPT® CODES ©AMA

Code	Description	NC Allowable (estimated fee schedule for NC in 2019; amt. varies by geography) Includes 50% MPPR & 2% sequestration	Recommendations	Not allowed on same day as:	Requires Modifier -59, if provided on same day as:
97161 min 97162 mod 97163 max	PT Evaluation No time attached	$81.76	Use for first visit. May bill with 1-2 units of 97112, 97535, or 97542	97164, 97750, 97755, 97763	NA
97165 min 97166 mod 97167 max	OT Evaluation No time attached	$87.70	Same as above	97168, 97750, 97755, 97763	NA
97164 97168	PT Re-Evaluation No time attached OT Re-Evaluation No time attached	$55.40 $65.57	May be used for subsequent visit every 30 days, but documentation must reflect changes in exam findings, goals and plan of care	Eval, 97750, 97755, 97760, 97763	97112, 97530, 97535, 97537, 59742, 97760
97112	Therapeutic procedure, neuromuscular reeducation of movement, balance, coordination kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities; Direct one-on-one patient contact, each 15 minutes	$33.74	Assessing and training for postural stability, control and balance for access	NA	Re Eval, 97760, 97761, 97750, 97755
97530	Therapeutics activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	$38.22	Primarily used for throwing, squatting, lifting. Can be used for w/c transfer training, 97542 preferable	NA	Re Eval, 97535, 97537, 97542, 97750, 79755
97535	Self-care/home management training (eg activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes	$32.96	Safety issues in the home. Parent/caregiver training For SWM preferable to use 97542	NA	Re Eval, 97530, 97755
97537	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes	$31.71	For access and/or control training involving AT for transportation as well as worksite training. Not covered by Medicare. For SWM preferable to use 97542	NA	Re Eval, 97530, 97755

Special thanks to Ron Boninger, Three Rivers Holdings, LLC for assistance in designing this table

Code	Description	NC Allowable (estimated fee schedule for NC in 2019; amt. varies by geography) Includes 50% MPPR & 2% sequestration	Recommendations	Not allowed on same day as:	Requires Modifier -59, if provided on same day as:
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes	$32.04 1 unit $56.82 2 units $81.60 3 units $106.38 4 units	Utilize for assessment, fitting and instruction in the use of SWM incl. measuring, propulsion skills, skin integrity, transfers, balance, etc	NA	Re Eval, 97530, 97755
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes	$33.62	For functional performance testing to assess needs and identify problems. May include pressure mapping. Clinical decisions and plan of care based on results.	Eval, Re Eval 97755	97530, 97581 (ROMT)
97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and /or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes	$37.01	For use when assessing a patient who has high tech, complex, multiple interface needs. Utilize after PT or OT Eval leads to referral for AT assessment	Eval, Re Eval, 97750 97763	97112, 97530, 97535, 97537, 97542, 97760,
97760	(Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes)	$45.63	Molding and fitting for custom molded seating systems, initial visit only	Re Eval, 97763	97112, 97755, 97761(Initial Pros Train)
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes	$48.22	For subsequent visits orthotic and prosthetic training. For training in use of custom seating system, recommend use 97542	Eval, Re Eval, 97760 97761	97112

Abbreviation Key

AMA American Medical Association
CMS Centers for Medicare & Medicaid Services
CCMI Correct Coding Modifier Indicator
CPT® Current Procedural Terminology Codes
GPCIs Geographic Practice Cost Indices
HCPCS Healthcare Common Procedure Coding System
LCD Local Coverage Determination
MUE Medically Unlikely Edits
MAC Medicare Administrative Contractor
MIPS Merit-based Incentive Payment System
MPPR Multiple Procedure Payment Reduction
NCCI National Correct Coding Initiative
NCD National Coverage Determination
POC Plan of Care
PTP Procedure-to-Procedure
RVUs Relative Value Units
RBRVS Resource Based Relative Value Scale
SWM Seating and Wheeled Mobility
UCC Usual Customary Charge

The physical or occupational therapy evaluation of a person is always a dynamic process that involves making clinical judgments based on the data gathered and "putting the pieces of the puzzle together." The therapist documentation should address all of the findings and support how a particular evaluation level is chosen, including the complexity of clinical reasoning. In order to move to a higher level of evaluation, all four components must be of that higher level. The Medicare allowable for a therapy evaluation performed in a facility in North Carolina is currently $81.76 for physical therapy and $87.70 for occupational therapy, while in Manhattan the allowable is $95.75 and $103.29, respectively. Remember the difference is due to variance in Relative Value Units and Geographic Practice Cost Indices.

To establish a Plan of Care, the information gathered during the evaluation is utilized. For Medicare, the Plan of Care must contain, at a minimum, the patient's diagnosis, functional goals, type of therapy service, specific intervention/procedure/training, number of visits/frequency, duration, and the therapist's and physician's dated signature. According to Medicare, treatment may begin prior to the Plan of Care being established in writing IF the treatment is performed or supervised by the therapist who establishes the Plan of Care. Payment for services provided before the Plan of Care is established may be denied by a Medicare contractor, therefore always complete the Plan of Care on the day of evaluation! Physician's/Non-Physician Provider's Certification (with or without an order) satisfies all certification requirements for the duration of the 90-day Plan of Care from the date of evaluation/initial treatment. Timely certification is met when Physician/Non-Physician Provider certification of Plan of Care is documented by signature and dated within 30 days of establishment of the plan. Medicare requires a Plan of Care every 90 days or when a new diagnosis is determined, a significant change is made in the treatment plan, and/or new goals need to be established. Private insurance companies may require documentation of specific treatment techniques and/or exercises to be used in the treatment. For patients in North Carolina with Medicaid primary, or secondary to a commercial insurance, prior authorization may be obtained for up to six months from the date of the physician order. However, the first prior authorization for an adult, 21 years or older, may only be obtained initially for one month. Therefore, it is important to know requirements of the person's funding source before you schedule further treatment.

SPECIFIC CPT® CODES FOR SEATING AND WHEELED MOBILITY SERVICE PROVISION

Therapeutic procedure CPT® Codes require direct (one-on-one) patient contact. These services reduce impairments and improve function through the application of clinical skills and/or services. The goals documented in the Plan of Care define whether these procedures are reasonable and necessary. Local Coverage Determinations for physical and occupational therapy include these CPT® Codes and guidelines regarding their provision. For the provision of seated and wheeled mobility services, the primary codes utilized are presented below.

97542, Wheelchair Management (e.g., assessment, fitting, training), each 15 minutes. Utilized for assessment, fitting, and instruction in the use of mobility devices and seating systems, including skin integrity, transfers, balance, measuring, propulsion skills, etc. This service is not recommended to be provided on the same day as a Re-evaluation (97164 or 97168), Therapeutic Activities (97530) or Assistive Technology Assessment (97755) due to the CCI edits, which require the use of Modifier 59. This therapeutic service is often provided on the same day of service as the evaluation, for both manual and power wheelchair assessments. In the state of North Carolina, the allowable for one unit is $32.04, two units $56.82, three units $81.60 and for four units $106.53. The MUE for this service is eight units. Your documentation should describe the interventions provided and why the skills of a therapist were required. For example, describe the various wheelchair models or seat cushions trialed and the patient's response to the intervention. When adjustments are made to the wheelchair or seating system, document the problem presented and how the adjustment resolved the problem, such as: "Person's pelvis is low to the right with right convex spinal curvature, therefore added a pelvic obliquity build-up to the underside of the seat cushion and their pelvis is now level and their spine is positioned in midline." When training is provided, describe the type of training, the amount of assistance required, and the person's response to the training.

97750, Physical Performance Tests or Measurements, (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes. Utilized for functional performance tests to assess needs and identify problems. May include pressure map measurement, Tinetti, TUG, Berg, and/or Sitting Functional Reach if done on a day subsequent to the evaluation. Specify test and measures used, describe the data collected and the implication the data has on the patient Plan of Care. Document clinical decisions made based on the results. An Local Coverage Determination may require a separate report. Documentation is done with the patient in the room with you – remember "one on one, direct hands-on." Do not use on the same day of service as an Evaluation, Re-evaluation, or Assistive Technology Assessment (97755) since these services are mutually exclusive. This code is not recommended on the same day as Range of Motion Testing (97581) or Therapeutic Activities (97530) due to the

CCI edits, which require use of Modifier 59. With Medicare, this is a form of evaluation done on a separate day. In the state of North Carolina, in 2019, the allowable for one unit is $33.62. The MUE for this service is eight units.

97755, Assistive Technology Assessment, (e.g., to restore, augment, or compensate for existing function, optimize functional tasks, and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes. This service is intended for use with persons who have multiple technology requirements or significant physical impairments that require identification of alternative controllers and system integration (i.e. Augmentative communication device mounted to power wheelchair operated by alternative controller, computer access with non-keyboard input, etc.) This service may not be approved for coverage under some Medicaid programs and private insurances. This code is normally utilized following a Physical or Occupational Therapy Evaluation during which a referral is made for Assistive Technology Assessment. Some Local Coverage Determinations state "Provider performs an assessment for the suitability and benefits of acquiring any assistive technology device or equipment that will help restore, augment, or compensate for existing functional ability in the patient (i.e. provision of large amounts of rehabilitative engineering). Coverage is specifically for assessment of mobility and seating systems that require high level adaptations, not for routine seating and mobility systems (e.g. manual/power wheelchair evaluations). This can include testing multiple components/systems to determine optimal interface between client and technology applications and determining the appropriateness of commercial (off the shelf) or customized components/systems. This assessment may require more than one patient visit due to the complexity of the patient's condition and his/her decreased tolerance for activity at one session. Utilization of this service should be infrequent."

Do not use 97755 on same day of service as an Evaluation, Re-evaluation, Physical Performance Test or Measurement (97750), or Orthotic(s)/Prosthetic(s) Management and/or training subsequent encounter (97763). The services will not be reimbursed as they are mutually exclusive; 97755 is not recommended on same day as 97530, 97535, 97537, 97542 or 97760. If provided on the same day, add Modifier 59. In North Carolina, the current allowable for one unit is $37.01. The Medical Unlikely Edits for this service is eight units.

97760, Orthotic Fitting and Training, (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes. This code is often utilized for interventions involving splints, corsets, molding and fitting for custom-molded seating systems, but not fabrication. This code can only be used on the initial encounter of clinically working with the patient on the custom shape capture, fit, and functional use; 97760 is not recommended on the same day of service as Re-evaluation, 97112, 97755, 97761 (Prosthetic training), or 97763. Doing so does require Modifier 59. In North Carolina, the current allowable for one unit is $45.63. The Medical Unlikely Edits for this service is six units.

SUMMARY

Utilization of the above puzzle pieces for CPT® coding to receive reimbursement for therapy services are the foundation to providing quality care for a successful outcome for the user and the therapist. As you gather medical history, perform tests and assess function to develop a Plan of Care, you are building the puzzle. As you problem solve and recommend solutions to improve a person's mobility and function and then provide the final fitting and training, you complete the puzzle and "break the code!"

CONTACT THE AUTHOR

Barbara may be reached at
BARBARA.CRUME@HCAHEALTHCARE.COM

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Barbara Crume, PT, ATP, earned her bachelor's degree in physical therapy from the Medical University of South Carolina in 1982, became Pediatric NDT Certified in 1988 and RESNA Certified as an Assistive Technology Professional in 1997. She has been employed with CarePartners Health Services in Asheville, North Carolina, for almost 34 years. Crume provides evaluations, fittings and training for clients of all ages and diagnoses to obtain manual and power wheelchairs with custom seating. She works closely with a variety of suppliers and consults with manufacturers on product development. She has presented courses on CPT® Coding and Reimbursement at the International Seating Symposium, RESNA Annual Conferences and as a Webinar for NRRTS and RESNA. She is an active participant in the Coalition to Modernize Medicare Coverage of Mobility Products and the Clinician Task Force. She is also a friend of NRRTS.

EMERGENCY PREPAREDNESS

Written by: **AMBER WARD,** MS, OTR/L, BCPR, ATP/SMS, FAOTA

It seems to be human nature to spring into action after an emergency or event and to set plans and policies into motion to address identified needs, but how many of us actually look around on an airplane when directed to see where the exit is? We know emergencies on the plane are a possibility, yet we do not act. I suspect for many of our clients with disabilities, this is also the case. Does a client with a wheelchair have a plan for a second exit if the way to the ramp is blocked by fire? Or the elderly client with a scooter who is alone when the batteries die a mile from home? Or the client who relies on power for technology to run/charge all of their equipment, but does not have a generator? One recent news story covered a gentleman who lived alone and almost died in a home fire when he could not get out with his wheelchair. Another recent news story reported that caregivers were unable to get a person in a wheelchair out of a burning vehicle in time, resulting in the client's death. These emergencies are probably as horrifying to consider for you as for me, as most of us personally know clients who would be trapped in case of an emergency.

WHAT IS OUR ROLE?

What can we, as mobility experts, do to facilitate emergency preparedness in our clients? We can assist with an emergency plan in every setting whenever we interact with a client. It may take just a minute to address with a statement such as "I know none of us wants to think about this, but can we talk about what to do if there is an emergency in your home or vehicle?" These concerns may be addressed as simply as providing a handout with resources or may include discussion about a referral for an in-depth planning session as part of a therapy treatment plan.

EMERGENCIES AT HOME

The home should have smoke, fire and carbon monoxide alarms on all levels. Hazards such as space heaters, cooking safety, and falls (and how to get help) need to be addressed. I believe it is of utmost importance for all of us to discuss having two viable exits, consideration of doors opening outward easily, what to do if the wheelchair breaks down in an unsafe position/place, and making sure clients who are alone can either get out of the home or have someone who they can contact quickly. Another potential topic might be what to do if the safety ideas are financially or otherwise out of reach. Have clients consider meeting the staff at the nearest fire station (often first responders) and calling 911 as a non-emergency to alert them of special needs of a client at that address. Keeping a phone always accessible (even after a fall from a wheelchair) is vital, especially if the client falls away from the phone which might be attached to the chair.

Many clients we serve have a caregiver or multiple caregivers who assist with MRADLs. What if the caregiver has a medical emergency, or falls with the client to the floor during a transfer? Clients need to consider an emergency plan that is not dependent entirely on one person or one strategy. Caregivers may not show up for work, may also have health issues (i.e. an aging spouse or parent), or could experience an unexpected medical issue or injury. Are there alternatives to the missing caregiver in case of a power outage that stops Alexa™ from working? What if there is a fire, and the primary caregiver lives 15 minutes away? Perhaps a neighbor could be an emergency contact, or a rotating list of friends. The client needs a plan for if the power goes out, if the water shuts off for days, or if there is a fire. We can encourage clients to plan ahead and have emergency options in place by creating a safe home — a working fire extinguisher on every level; caregivers/client who know how to turn off water, electricity and gas; and as working detectors/alarms for fire, smoke, and carbon monoxide.

EMERGENCIES IN THE COMMUNITY

Potential emergency scenarios away from home to consider include a flat tire on the side of the road, vehicle fire, transportation break downs (bus, train, plane) or the airport crushing custom equipment. A recent situation occurred with a client and caregiver who had a Group 3 power wheelchair on the back of the car on a hitch-lift. The lift failed and began dragging on the ground at an angle. They pulled over and called 911 as well as my seating clinic where they were headed.

When the police arrived, the officer had no idea how to assist or who to call (nor did the client), especially since the client could not ride in a standard tow-truck or taxi. Luckily, the supplier and I were able to head over in his van and pick up the chair, while the lift was removed, and the client came in her car to the clinic. Other scenarios to consider include if the client is in the power wheelchair miles from home and has a mechanical issue, or if there is a 40-car pile-up on the expressway with hours of delay. We also all know clients who do not secure their mobility device in transportation and increased educational efforts and problem solving are vital for safety.

NATURAL DISASTERS

Some of us live and work where there are hurricanes, tornadoes, wild fires, avalanches, power outages, flooding and other natural disasters. During natural disasters, even if the family alerts authorities that there is a person with special needs in a certain location, it may take emergency workers significant time to reach that location and/or the family may be without power for many days. We can encourage clients and caregivers to take measures to improve safety in a large-scale community emergency. The first step is to know the risks of the community in which the client lives. Certainly, a blizzard in Florida is not the most important risk to prepare for, but a hurricane with flooding would certainly be. The second step is to make a plan. This involves:

- Where to meet and how to contact family if separated in various situations, such as evacuation.
- Work with neighbors to identify those who may need extra help in an emergency.
- Plan out emergency exits from every room and plan exits if the elevator or ramp cannot be used.
- Make copies of important documents.
- Plan for children if at school or day care - authorize someone else to pick them up, as needed.
- Plan for pets/service animals – does the animal have special needs? What if a hotel/shelter will not accept the animal?
- Write down details about the client's specific needs and information - accommodations, insurance, allergies, medical conditions, emergency contacts, medications, vaccinations, etc.
- Think about a "grab and go" bag with medications, medical supplies, copies of medical documents, and other urgently needed items.
- Determine steps to take if asked to evacuate — emergency kit, ID for everyone, essential documents, phones/chargers and email emergency contacts if possible.
- Keep instructions/information for all medical equipment with the equipment, if possible.

The third and final step is to make an emergency kit with basic supplies as well as supplies specific to that client's needs (www.getprepared.gc.ca). Be prepared to be self-sufficient for at least 72 hours without power, water and food. The kit should be in an easy-to-reach place, such as the front hall closet. Items to include, at the minimum, are water (2 liters per person per day), food and/or formula that will not spoil, crank or battery powered flashlight, cash, first aid kit, copy of emergency plan and information, medications and equipment for the client with disabilities (two weeks, if possible), and water and medications for pets or service animals. Other items to consider are hand sanitizer, garbage bags, toilet paper, and basic tools.

The website www.ready.gov is about planning ahead for disasters and specifically notes tips for clients with mobility issues such as:

- If you use a power wheelchair, if possible, have a lightweight manual chair available as a backup.
- Know the size and weight of your wheelchair in addition to whether or not it is collapsible, in case it has to be transported.
- Show others how to operate your wheelchair.
- Purchase an extra battery for a power wheelchair or other battery-operated medical or assistive technology devices. If you are unable to purchase an extra battery, find out what agencies, organizations or local charitable groups can help you with the purchase. Keep extra batteries on a trickle charger at all times.
- Consider keeping a patch kit or can of sealant for flat tires and/or extra inner tube if wheelchair or scooter tires are not puncture proof.
- Keep an extra mobility device such as a cane or walker, if you use one.
- If you use a seat cushion to protect your skin or maintain your balance, and you must evacuate without your wheelchair, take your cushion with you.

CONCLUSION

Some may consider it out of our purview to address these emergency issues, but I believe as manufacturers, suppliers, and evaluators of mobility products, it is our responsibility. Could a one-page emergency information sheet simply go with the paperwork at the wheelchair delivery or repair for a quick discussion? Maybe this could be a marketing "hook" as clients and caregivers may appreciate the extra effort the company or personnel are giving to ensure their safety. The mobility industry could consider advocacy efforts by pairing with other businesses, community organizations, therapists, schools, or client groups

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to fundraise; the support could go to update and check smoke alarms, provide generators, educate on emergency preparedness, provide safety tools to cut a seatbelt/break glass, provide wheelchair tie-downs, or to build ramps. The following are wonderful resources to direct clients and caregivers to, with information and checklists that could be used for planning:

- www.nfpa.org/Public-Education
- www.getprepared.gc.ca
- https://www.fema.gov/disability
- https://www.redcross.org/get-help/how-to-prepare-for-emergencies/disaster-safety-for-people-with-disabilities.html.

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CONTACT THE AUTHOR
Amber may be reached at
AMBER.WARD@ATRIUMHEALTH.ORG

Amber Ward is a treating occupational therapist. She has treated a wide variety of patients, of all ages and functional levels. She currently is an adjunct professor at the OTA program at Cabarrus College of Health Sciences in addition to working in the clinic. She received the RESNA Assistive Technology Professional certification in 2004, the Seating and Wheeled Mobility certification in 2014, and became AOTA board certified in physical rehabilitation in 2010. She runs the seating clinic at the Neurosciences Institute Neurology in Charlotte, North Carolina. She is involved with multiple research projects and is the author of two peer-reviewed journal articles about power wheelchairs with persons with ALS.

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BEHIND THE EIGHT BALL

TOP EIGHT REASONS EQUIPMENT MAY BE DENIED

Written by: **KAY ELLEN KOCH,** OTR/L, ATP, RESNA FELLOW & FRIEND OF NRRTS

The client assessment performed by the therapist is a key component in getting equipment justified and provided. As an integral member of the team, the therapist's assessment provides the medical necessity and portrait of the client to a funding source's reviewer who may not even have a medical background, 'know' the client, or be familiar with the technology being requested. The documentation provided from the supplier is equally important to ensure the client gets what is medically needed and the supplier gets paid for what is being provided. Good documentation and justification is essential but so is understanding the coverage criteria, what the funding source considers 'medically necessary' and what documentation is required. Our goal should be to have the equipment being requested be approved and provided with the first submission. Here are eight reasons the goal may not be achieved.

#1- LACK OF KNOWLEDGE OF THE COVERAGE CRITERIA

Have knowledge of what's covered and the funding source's definition of "medically necessary." Most funding sources follow Medicare's guidelines. Medicare covers equipment, such as seating for positioning and pressure redistribution, using the patient's diagnosis as part of the coverage criteria. Some equipment, like bath benches are considered 'hygienic' and not medically necessary.

#2- JUSTIFICATION DOES NOT IDENTIFY THE MEDICAL NECESSITY

"Medical Necessity" as defined by Centers for Medicare and Medicaid Services (CMS) states:

- That the service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition, or disability.
- That the service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition or disability.
- That the service or benefit will assist the individual to achieve or maintain maximum functional capacity in performing daily activities (Mobility Related Activities of Daily Living or MRADLs) in the home.

CMS usually has a trickledown effect to state Medicaid systems and most third-party insurance coverage.

#3- INCOMPLETE OBJECTIVE ASSESSMENT PERTAINING TO THE EQUIPMENT BEING REQUESTED

Complete clinical presentation and level of function of client including educational, social/emotional development, cognitive skills, ambulation, activities of daily living, mobility, joint range of motion, muscle strength, endurance, muscle tone, reflexes, school/home/work requirements, transportation and peer interactions. Describe your client's seating, positioning, mobility and medical needs. Describe any additional information that is relevant to the request.

#4- DESCRIPTION OF SEPARATELY BILLED COMPONENTS NOT PROVIDED

On a manual wheelchair, for example, Medicare considers an armrest standard and bundled into the allowance for the base of the wheelchair. If a removable height adjustable armrest (E0973) is requested, justification for this component is required. This can be to assist with positioning the upper extremities and to assist with transfers, but needs to be supported as described above in #3 with objective information. If the objective assessment (Licensed Certified Medical Professional or LCMP) documents the client is dependent for transfers or has upper extremity strength documented as 1/5, this component may be denied. If the objective assessment (LCMP) documents the client has upper extremity strength of 4/5 and transfers to the commode, the justification can be supported for the removable height adjustable armrest.

#5- JUSTIFICATION AND GETTING TO THE "WHY" – THE SPECIALTY EXAM

The specialty evaluation is a written report providing a detailed explanation of why a particular wheelchair base and each specific option or accessory is needed to address the client's mobility limitation. The assessment should include lower cost or lower technology options and why they cannot be utilized.

POWER MOBILITY DOCUMENTATION REQUIREMENTS

REFERENCE CHART: PMD/ MWC **EVALUATION / ASSESSMENT REQUIREMENTS**

PMD/MWC Group	HCPCS Code Range	Face-to-Face Exam	Specialty Exam	Home Evaluation**	ATP In-person Appraisal
Ultra Lightweight / Manual Tilt in Space	K0005/ E1161	Yes	Yes	Yes	Yes
Group 1 POV	K0800-K0802	Yes	No	Yes	No
Group 2 POV	K0806-K0808	Yes	No	Yes	No
Group 1 PWC	K0813-K0816	Yes	No	Yes	No
Group 2 PWC – NPO	K0820-K0829	Yes	No	Yes	No
Group 2 PWC – SPO	K0835-K0840	Yes	Yes	Yes	Yes
Group 2 PWC – MPO	K0841-K0843	Yes	Yes	Yes	Yes
Group 3 PWC – NPO	K0848-K0855	Yes	Yes	Yes	Yes
Group 3 PWC – SPO	K0856-K0860	Yes	Yes	Yes	Yes
Group 3 PWC – MPO	K0861-K0864	Yes	Yes	Yes	Yes
Group 5 PWC	K0890-K0891	Yes	Yes	Yes	Yes

Abbreviation Key

PMD = Power Mobility Device
POV = Power Operated Vehicle
PWC = Power Wheelchair

K0005= Ultra Light-weight Manual Wheelchair
E1161 = Manual Tilt in Space Wheelchair

MPO = Multiple Power Options
NPO = No Power Options
SPO = Single Power Option

**A Home Assessment for the manual wheelchair and all levels of powered mobility, is required before or at delivery, according to Medicare policy. The person conducting this assessment should verify and document, in a written report, that the patient's typical environment supports the use of the mobility device. The home assessment can be performed by the supplier (or supplier's employee) or a practitioner (physician, physician's employee or LCMP, etc.). The policy does not specify a particular format or form to use.

The home assessment for a manual wheelchair may be done directly by visiting the beneficiary's home or indirectly based upon information provided by the beneficiary or their designee. When the home assessment is based upon indirectly obtained information, the supplier must, at the time of delivery of the manual wheelchair, verify that the item delivered meets the requirements specified by the funding policy. This would include that the home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided. Home assessment addresses issues such as the physical layout of the home, surfaces to be traversed, and obstacles to maneuvering within the home. Home assessment is fully documented in the medical record or elsewhere by the supplier.

For powered mobility, the policy does state that the assessments and measurements should include physical layout of the home, doorway width, doorway thresholds, and surfaces the device will have to move over. Additionally, if the home assessment should indicate that if the patient is unable to access one or more rooms, e.g. the bathroom, while in the wheelchair, an explanation as to how this issue will be mitigated to allow the patient to complete his/her MRADLs must be provided.

ADAPTED FROM:
Power Mobility Documentation Requirements | https://www.cgsmedicare.com/jc/pubs/news/2008/0708/cope7962.html
Manual Mobility Information added by Kay Koch, OTR/L, ATP, RESNA Fellow

The specialty exam must be performed by a licensed/certified medical professional, such as a physical or occupational therapist, or physician who has specific training and experience in rehabilitation wheelchair evaluations. The clinical person performing this exam may, but is not required to be, a RESNA-certified Assistive Technology Professional (ATP). REMINDER: The physical or occupational therapist, or physician performing the specialty exam may not have a financial relationship with the supplier. The supplier may create a document that states this or it can be documented as part of your exam.

Medicare policy does not prescribe a specific format for reporting the specialty exam findings. However, the report should be in the facility's usual medical record form; it should not be on a supplier-generated form. If "check box" style documentation is

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BEHIND THE 8 BALL ...
(CONTINUED FROM PAGE 45)

used to identify or list issues pertaining to the MRADL and mobility limitations, an objective, written narrative that matches the issues needs to support what is checked. For example, if the "box" is checked that identifies "weak upper extremities" objective assessments like a manual muscle test should also be included in documentation to justify why a wheelchair base and the accessories are being recommended for that specific client.

#6- ILLEGIBLE DOCUMENTATION

If the funding source cannot read the documentation due to illegible hand writing, faded documentation from multiple faxing or a fax that is unclear due to the way it was transmitted to the reviewer, it may be denied. If the identity of the person who created or wrote the documentation cannot be ascertained, a denial may also occur. This could include illegible signatures or illegible signature dates. Medicare will accept a printed name under the signature to identify the author of the documentation. Medicare requires that services provided or ordered be authenticated by the author. The method used can be a handwritten or electronic signature. If the signature is illegible or missing from the medical documentation (other than an order), the review contractor may request a signature log or attestation statement to determine the identity of the author of a medical record entry.

A signature log identifies the author associated with initials or an illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. In order to be considered valid for Medicare medical review purposes, the log must be a part of the client's medical record.

An attestation statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information to be considered valid for Medicare medical review purposes

Should a provider choose to submit an attestation statement, the following statement can be used:

"I, _____[print full name of the physician/practitioner]___, hereby attest that the medical record entry for _____[date of service]___ accurately reflects signatures/notations that I made in my capacity as _____[insert provider credentials, e.g., M.D.]___ when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

#7- INCORRECT 'CORRECTIONS'

Medicare has policy on what they consider valid corrections to the medical document. Clearly indicate the date and author of any amendments, corrections or addenda. Clearly identify all original content and do not delete or use white out. Any correction made should have a single line through what is being corrected and the initials or signature of the person making the corrections as well as the date the correction was made.

#8- SUPPLIER WRITTEN JUSTIFICATION AND THE ATP REQUIREMENT

The supplier ATP evaluation is required by Medicare for certain Group 2 and Group 3 power wheelchairs, ultra lightweight manual wheelchairs and manual tilt in space wheelchairs. Please see the reference chart attached. The intent of this evaluation is to show how the ATP supplier was involved in the direct assessment. This assessment can include measurements of the client and or include a description of the equipment that was provided for a trial, for example.

The documentation must be complete and detailed enough so a third party would be able to understand the nature of the ATP involvement and to show that the Medicare requirements identified in the policy for this documentation was met. Just "signing off" on a form completed by another individual would not adequately document direct, in-person involvement. Also, merely signing a statement such as, "I am a RESNA-certified professional specializing in wheelchairs and had direct, in-person involvement in the wheelchair selection for this client" does not sufficiently verify that this policy requirement was met. Finally, a home assessment completed by a supplier-employed ATP would not meet the ATP requirement unless the documentation showed how the ATP applied the assessments and measurements to the wheelchair selection process.

The therapist is responsible for writing the medical necessity for the mobility base and accessories requested. The supplier can write which accessories will be needed to have the equipment function to meet the medical needs identified in the mat assessment or technology evaluation, but the supplier cannot write the justification for the accessories and then have the therapist agree and sign the document. This will be considered invalid.

The requirement for the supplier to employ an ATP and for this person to have direct, in-person involvement in the wheelchair selection process is not waived if the specialty exam is performed by a clinical ATP. The person performing the specialty exam cannot work for the supplier and the person involved in the ATP in-person appraisal must have a financial relationship with the supplier. Therefore, one individual cannot meet both requirements.

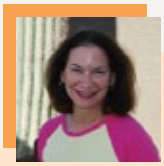
Getting the documentation requirements correct, accurate and in line with the Medicare or funding source requirements will result, in theory, in fewer denials and faster delivery to your beneficiaries. If the team – therapists, supplier and physician – understand what is required, addendums and corrections can be minimized as well. Isn't that something we all should strive for?

HELPFUL LINKS AND RESOURCES:

https://www.cgsmedicare.com/
https://med.noridianmedicare.com/
https://www.cms.gov/medicare/medicare-contracting/contractorlearningresources/downloads/ja6698.pdf

CONTACT THE AUTHOR
Kay may be reached at
KKOTRCHOA@YAHOO.COM

Kay Ellen Koch, OTR/L, ATP, has more than 36 years seating and wheeled mobility experience. She is a graduate of the Occupational Therapy program at the Ohio State University in Columbus, Ohio. She has been an Assistive Technology Professional (ATP) since 1996. Her focus has been on pediatric seating positioning, wheeled mobility, assistive technology solutions and accreditation. Koch has spent her years as an occupational therapist in various roles, from clinician to manufacturer's representative. She has presented at various national and international conferences and webinars.



DOCUMENTATION, ADMC, AND PMD PA ...

HOW DOES IT ALL TIE TOGETHER?

Written by: **CLAUDIA AMORTEGUI**

Two things that always seem to go together are Complex Rehab Technology (CRT) and documentation. There is no way around this when it comes to obtaining proper (or sometimes improper) reimbursement. This is true no matter the funding source. By all means, it makes sense. Any insurance claim should be supported by appropriate clinical documentation; but sometimes it seems more like an encyclopedia than a medical file.

First and foremost, anyone involved with providing CRT (supplier or clinician) needs to understand that more is not always better. Meaning, the thicker the stack of documents is not a guarantee of payment. I always tell people, that actually reading ALL the documentation obtained is key; it's amazing what contradictions you may find. I also run into people who feel they need both a full-blown seating evaluation AND a letter of medical necessity (LMN) to comply with the documentation requirements. This is actually not the case for certain insurances – including Medicare.

As we all know, clinical documentation does need to support all the items being billed to insurance. This could be done on the same seating evaluation document that is already being completed. Meaning, therapists may not always have to complete a separate LMN. Of course, this may differ with each insurance requirement, but I can tell you for Medicare a separate LMN is not on their "list." I can't count the number of times I tell people this, and they look at me amazed. The look on their face is "this can't be true." Simply put, for Medicare this is true, but this does not eliminate what documentation is required. For many, this means they just need to add a little more detail to their current evaluation forms, but they do not necessarily need to write a separate document.

I CAN'T COUNT THE NUMBER OF TIMES I TELL PEOPLE THIS, AND THEY LOOK AT ME AMAZED. THE LOOK ON THEIR FACE IS "THIS CAN'T BE TRUE."

People will normally defend the need for the LMN to justify all the options selected. However, in many cases the therapist has already justified many of the options within their standard evaluation. The easiest way to explain this is if your evaluation documents the client is unable to complete functional weight shifts, the powered seating could be justified within that section, and there would not be a need to write anything more. The justification does not always need to state word for word "a power tilt is medically necessary due to … " If the documentation supports one of the qualifying coverage criteria, it should be sufficient during the Medicare review process.

At times, the clinical face-to-face notes (to be completed by a medical professional), are also viewed with parameters that may be a bit too strict. There have been numerous instances where I review the physician chart notes within a file and deem them sufficient to meet the face-to-face requirements. However, I will still see where the provider continued to request additional notes at least once, if not many more times. For some reason, there are some providers who feel the physician must write what I call "the perfect paragraph." They feel the physician is required to follow the Medicare algorithmic approach; meaning, they must rule out each lower level type of equipment directly in their chart notes. Everyone needs to remember that much of this information, if not all, will be in the specialty seating evaluation. In these cases, there does need to be certain information in the chart notes, but not necessarily each individual detail.

With all this talk of documentation, what about Medicare and its Advance Determination of Medicare Coverage (ADMC) or the Power Mobility Device Prior Authorization (PMD PA) programs? Had a wheelchair supplier asked me many years ago about using Medicare's ADMC program, I would have likely said it was a waste of time.

But my tune changed a while back. There are various reasons that changed my mind. The biggest reason is not necessarily the increase in audits, but more so the question of how differing Medicare contractors may view medical necessity. Medicare clearly states that an approved ADMC or PMD PA is not a guarantee of payment. However, obtaining an approval does protect you in the area of medical need – the hardest piece to prove. Therefore, if there ever was an audit, the provider has some sort of insurance on the specific claim.

Whether you are submitting a Complex Rehab Technology (CRT) manual wheelchair to ADMC or a power wheelchair to prior authorization, your documentation does need to be detailed. But again, more is not necessarily better. When it comes to CRT much of the basic coverage criteria is easily justified within the clinical documents. In my opinion, standard power mobility is likely the most difficult when it comes to face-to-face documentation. For these orders there are many borderline cases. Some clients may benefit from a standard power wheelchair but not truly meet the in-the-home medical necessity coverage criteria for Medicare. In the CRT world, where we need to be careful is in the details for many of the options.

First, clinicians cannot assume that Medicare knows their patients like they do; the reviewers only know the end users by what is written on the documentation. Clinicians also need to document more than what a specific option does. For example, many will document that a thru-drive control will allow the client to function their power seating option through the drive control versus a separate switch. This statement is true, but why does the specific individual medically need this option? What are the clinical reasons behind the need? For example, "The client may not have the ability to access a separate switch due to _____."

ADMC and PMD PA offer a sense of security to the providers, however everyone still needs to be aware of what the approvals actually mean. For ADMC, a provider will receive a decision for each item (base and options) submitted. For PMD PA requests, the provider will only receive a decision on the base and not the individual options. Per Medicare, under the PMD PA program, they will review the options necessary for the base to be coded as submitted. For example, if you are submitting an order for a Group 3, Multiple Power Option PWC (K0861) and Medicare approves the base, then you can also assume that Medicare reviewed the medical need of the power seating systems. Coverage of most other options for that order will not receive individual decisions and can be questioned for meeting coverage criteria during the initial claim review or post-payment audits. For both ADMC and PMD PA, Medicare specifically states that approvals are not a guarantee of payment, meaning the claim could deny for a reason other than medical need. This would normally be a technicality, such as a client not being discharged from a facility on time or dropping their Medicare coverage for some odd reason.

Simply put, documentation must be thorough, but it does not need to be overly excessive. Step back and ask yourself, if you did not know the client would the documentation support the medical need based on the insurance coverage criteria? Is there anything in the file that would cause questions by the insurer at the time of review or during any type of audit? And lastly, is the justification for each part found within the evaluation, which may include some additional free-form text at the end of the documentation?

CONTACT THE AUTHOR
Claudia may be reached at
INFO@ORIONREIMBURSEMENT.COM

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

MY DAY IN COURT

Written by: **WEESIE WALKER,** ATP/SMS

A few months ago, NRRTS was contacted by a Department of Justice attorney requesting information on an article published in DIRECTIONS in 2010. The topic was "Legal Guidelines for Sales and Marketing by HME Suppliers". Little did I know that this inquiry would lead to a subpoena to testify in federal court to certify the article for evidence.

I later learned the trial centered on a DME company paying kick-backs to a clinic that was providing knee braces and TENS units to patients. In most cases, this equipment was not needed by the patients. The DME company knew what the documentation should state. This activity went on for about four years. The prosecutors claimed it involved over $4 million! The defendant was found guilty on all counts.

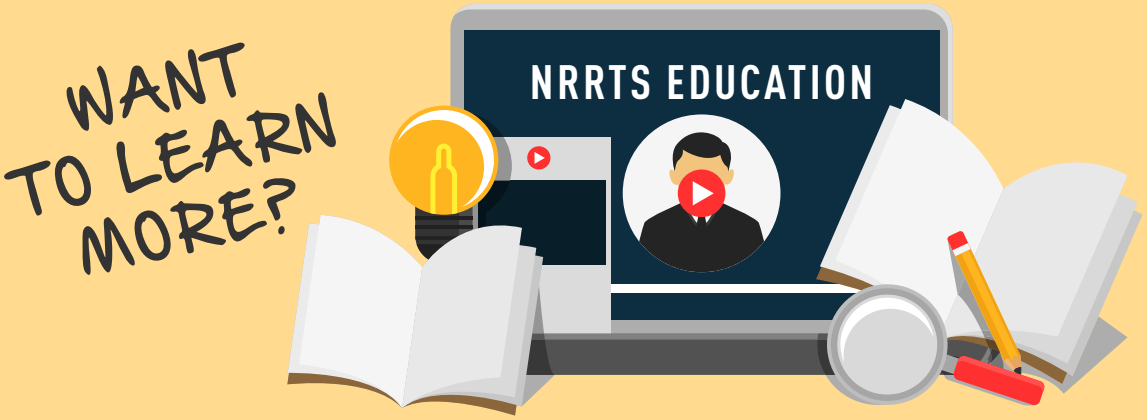
How does this happen? I wonder how much money is wasted through fraud and abuse. If there were a faster way to identify fraud and so decrease the financial impact to Medicare, beneficiaries might have more access to medically necessary services provided by competent, qualified suppliers.

In the end, most fraud is eventually discovered. But the damage has been done: to the Medicare beneficiaries who were provided unneeded equipment, to the financial resources that are many times never recovered and to legitimate suppliers who must overcome the "rotten apple" effect. With multiple agencies involved, the cost of prosecuting fraud is another drain on limited resources.

As the Center for Medicare and Medicaid services and Congress look at ways to cut health care costs, getting a jump on fraudulent billing looks like the first place to start.

CONTACT THE AUTHOR
Weesie may be reached at
WWALKER@NRRTS.ORG

Weesie Walker, ATP/SMS, is the executive director of NRRTS. She has more than 25 years of experience as a CRT supplier. She has served on the NRRTS board of directors and GAMES board of directors and the Professional Standards Board of RESNA. Throughout her career, she has worked to advocate for professional suppliers and the consumers they serve. She has presented at the Canadian Seating Symposium, RESNA Conference, AOTA Conference, Medtrade, ISS and the NSM Symposium. Walker is a NRRTS Fellow.



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Congratulations to the newest NRRTS Registrants. NAMES INCLUDED ARE FROM FEB 12 THROUGH APRIL 23, 2019.

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National Seating & Mobility, Inc.
200 Roxalana Business Park
Dunbar, WV 25064-2727
Telephone: 304-766-9317
Fax: 304-766-9336
Registration Date: 3/5/2019

Luis Amaro, RRTS®
National Seating & Mobility, Inc.
1335 NW 98th Ct Ste 1
Doral, FL 33172
Telephone: 305-262-3399
Fax: 305-262-3811
Registration Date: 3/25/2019

Doug Ambrusko, ATP, RRTS®
People First Mobility
2128 Elmwood Ave
Buffalo, NY 14207-1910
Telephone: 716-566-5000
Fax: 716-877-1371
Registration Date: 4/23/2019

Daryl Bullard, ATP, CRTS®
National Seating & Mobility, Inc.
7105A Avalanche Ave
Yakima, WA 98908-1381
Telephone: 509-424-0522
Fax: 509-598-3189
Registration Date: 4/23/2019

Brent P Fadler, ATP, CRTS®
Alliance Rehab and Medical Equipment
2205 Petrus Circle
Ozark, MO 65721
Telephone: 417-581-5747
Fax: 417-581-5762
Registration Date: 3/12/2019

David Glancy, ATP, CRTS®
SSM Health at Home
463 Hammersley Rd
Madison, WI 53711
Telephone: 608-276-3959
Fax: 608-246-7420
Registration Date: 2/19/2019

Justin Harris, ATP, RRTS®
Numotion
4301 Founder's Way, Ste A
Chattanooga, TN 37416
Telephone: 423-468-4872
Fax: 423-486-4874
Registration Date: 4/18/2019

Kevin Jones, MS, ATP, CRTS®
Travis Medical
2704 SW 44th St
Oklahoma City, OK 73119-3339
Telephone: 405-682-2222
Fax: 405-682-2226
Registration Date: 3/12/2019

Lucas Jones, RRTS®
National Seating & Mobility, Inc.
3936 NW Urbandale Dr
Urbandale, IA 50322-7922
Telephone: 515-270-1522
Fax: 515-270-4914
Registration Date: 4/10/2019

Giles Kaarto, ATP, RRTS®
Durable Medical Supply Inc.
720 Glyn St Ste D-1
Fayetteville, GA 30214
Telephone: 770-719-9998
Fax: 770-719-9970
Registration Date: 3/25/2019

John Lanier, ATP, CRTS®
Alliance Rehab and Medical Equipment
2205 Petrus Circle
Ozark, MO 65721
Telephone: 417-581-5747
Fax: 417-581-5762
Registration Date: 3/25/2019

Robert Lees, RRTS®
Trustcare Home Medical Equipment
8677 Telegraph Rd
Glenn Allan, VA 23060-4030
Telephone: 804-262-9001
Fax: 804-262-9004
Registration Date: 2/25/2019

Shad Lofgreen, RRTS®
Rehabilitation Equipment Professionals, Inc.
5130 Duke St, Ste 12
Alexandria, VA 22304-2955
Telephone: 703-370-2100 x.4022
Fax: 703-370-7985
Registration Date: 2/18/2019

Scott Lopez, OTR/L, ATP, CRTS®
Alliance Rehab and Medical Equipment
2205 Petrus Cir
Ozark, MO 65721
Telephone: 417-581-5747
Fax: 417-581-5762
Registration Date: 3/12/2019

Marc Martinez, RRTS®
Verio Healthcare
2060 Chicago Ave Ste A-1
Riverside, CA 92507
Telephone: 951-776-7285
Registration Date: 3/26/2019

Benjamin Paull, RRTS®
National Seating & Mobility, Inc.
320 Premier Court Ste 22
Franklin, TN 37067
Telephone: 401-524-3112
Registration Date: 4/10/2019

Charlotte Whitecavage-Welch, PTA, ATP, RRTS®
Browning's Pharmacy & Health Care
13000 West Colonial Dr
Orlando, FL 34787
Telephone: 321-288-3343
Registration Date: 2/21/2019

FORMER NRRTS REGISTRANTS

The NRRTS Board determined RRTS® and CRTS® should know who has maintained his/her registration in NRRTS, and who has not.
NAMES INCLUDED ARE FROM FEB 12 THROUGH APRIL 23, 2019.

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

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Burton B Barmore III, M.D., ATP, Augusta, GA
Michael Neil Coffman, ATP, Farmers Branch, TX
Caneta R. Hall, Huntsville, AL
Nancy Lezotte, ATP, Middleburg, FL
Jason A. Sharpe, ATP, Fayetteville, GA
David J. Simpson, ATP, South Burlington, VT
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Congratulations to NRRTS Registrants recently awarded the CRTS® credential. A CRTS® receives a lapel pin signifying CRTS® or Certified Rehabilitation Technology Supplier® status and guidelines about the correct use of the credential. NAMES INCLUDED ARE FROM FEB 12 THROUGH APRIL 23, 2019.

Jeremy Adkins, BS, ATP, CRTS®
National Seating & Mobility, Inc.
Dunbar, WV

Daryl Bullard, ATP, CRTS®
National Seating & Mobility, Inc.
Yakima, WA

Brent P Fadler, ATP, CRTS®
Alliance Rehab and Medical Equipment
Ozark, MO

Christopher Ford, ATP, CRTS®
Numotion
Norcross, GA

David Glancy, ATP, CRTS®
SSM Health at Home
Madison, WI

Kevin Jones, MS, ATP, CRTS®
Travis Medical
Oklahoma City, OK

John Lanier, ATP, CRTS®
Alliance Rehab and Medical Equipment
Ozark, MO

Scott Lopez, OTR/L, ATP, CRTS®
Alliance Rehab and Medical Equipment
Ozark, MO

Randy Schmitt, ATP, CRTS®
Alliance Rehab and Medical Equipment
Ozark, MO

RENEWED NRRTS REGISTRANTS

The following individuals renewed their registry with NRRTS between Feb 12 through April 23, 2019.

PLEASE NOTE **IF YOU RENEWED AFTER APRIL 23,** YOUR NAME WILL APPEAR IN A FUTURE ISSUE OF DIRECTIONS.
IF YOU RENEWED PRIOR TO FEB 12, YOUR NAME IS IN A PREVIOUS ISSUE OF DIRECTIONS.

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

Sarah Anderson, ATP, CRTS®
Amy Askelson, ATP, CRTS®
Jodi Baumgard, ATP, CRTS®
James Randall Blackwell, ATP, CRTS®
Reggio Blackwell, RRTS®
J. Gregg Blanchard, ATP, CRTS®
Christopher Boyd, ATP, CRTS®
Christopher E. Bridgeman, ATP, CRTS®
Orenthal Brown, RRTS®
Sue Bryant, ATP, CRTS®
Jorge Cabrera, RRTS®
William Cavender, ATP, CRTS®
Cyle Cook, ATP, CRTS®
Peter Eastman, RPTA, ATP/SMS, CRTS®
Michael A. Edney, ATP, CRTS®
Steven Edwards, ATP, CRTS®
Karl Thomas Eklund, ATP, CRTS®
Katherleen Fallon, ATP, CRTS®
E. Scott Filion, ATP, CRTS®
Gregory M. Fleming, ATP/SMS, CRTS®
Stephen A. Frangione, ATP, CRTS®
Joseph Matthew Garcia, RRTS®
Scott Grant, ATP, CRTS®
Johnothan Grimes, ATP, CRTS®
Richard Gross, RRTS®
Michele A. Gunn, ATP, CRTS®
Raoul K. Harlan, ATP, CRTS®
Moshe Dave Hartman, ATP, CRTS®
Chad E. Hayes, COF, ATP, CRTS®
Corey Hileman, ATP, CRTS®
Michael Hohler, ATP, CRTS®
Edward B. Homan, ATP, CRTS®
Justin Horn, ATP, CRTS®
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Blaine Hunt, ATP/SMS, CRTS®
Debbie Huston, ATP, CRTS®
Ryan Jewell, ATP, CRTS®
Joseph L. Kelley, ATP, CRTS®
Prak Kim, RRTS®
Jeffrey M. LaRosa, ATP, CRTS®
Jose Lopez, ATP, CRTS®
Jason S. Lovato, ATP, CRTS®
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Nathan Lyon, ATP, CRTS®
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Patrick R. Mazey, ATP, CRTS®
Jason Ray Miller, ATP, CRTS®
David T. Murray, ATP, CRTS®
Roxann Nasello, ATP, CRTS®
Dan Nederhood, ATP, CRTS®
Eric Newell, ATP, CRTS®
Valerie A. Pagan, ATP, CRTS®
James Parnell, ATP, CRTS®
Michael F. Peterlin, ATP, CRTS®
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Sergio Ribeiro, PTA, ATP, CRTS®
Omar Rozo, RRTS®
David D. Russell, ATP, CRTS®
Richard Samay, ATP, CRTS®
Christopher Savoie, ATP/SMS, CRTS®
Kurtis L. Schmidt, ATP, CRTS®
Timothy A. Schrag, ATP, CRTS®
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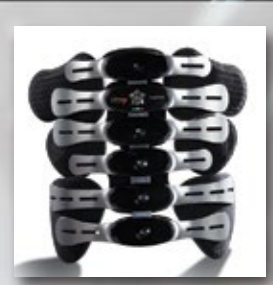

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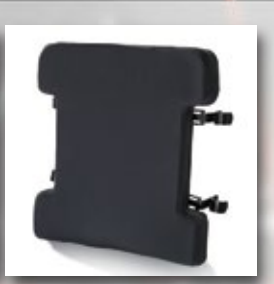

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