DIRECTIONS

24 PEOPLE OF THE CRT CONFERENCE

32 ABNS: WHAT ARE THE PITFALLS AND LANDMINES?

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MATTHEW J. AGNEW, ESQ.

Agnew is an attorney with the Health Care Group of Brown & Fortunato, P.C., a law firm based in Amarillo, Texas. Agnew represents home medical equipment companies, pharmacies and other health care providers throughout the United States. He earned his B.A. from Wichita State University and his law degree from the University of Kansas School of Law. Agnew is licensed to practice law in Texas. SEE PAGE 32

CLAUDIA AMORTEGUI

Amortegui has her Masters of Business Administration and more than 20 years experience in the durable medical equipment, prosthetics/orthotics and supplies industry. Her experience comes from having worked on all sides of the industry, including 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 vs. standard durable medical equipment. This rare combination of industry experience 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. SEE PAGE 64

ALEXANDRA (ALEX) BENNEWITH

Bennewith is vice president of government relations for United Spinal Association. Bennewith advocates for legislation and regulations regarding disability and health policy at both the federal and state level. She works closely with a range of stakeholders in the durable medical equipment and supplies, prescription drug, public health and disability communities. She graduated from Brandeis University and received her Master of Public Administration from American University. SEE PAGE 54

ELIZABETH COLE, MSPT, ATP

Cole has been involved in many aspects of the provision of assistive technology, including clinical practice as a physical therapist, coordination of a seating and wheelchair clinic, seating and mobility product sales, instruction and education in seating, wheeled mobility and assistive technology, as well as reimbursement consulting for more than 30 years. She has lectured extensively at domestic and international conferences, trade shows and universities, and has been published in national industry journals. Cole is a member and past board member for RESNA, a member of the Clinician Task Force and a Friend of NRRTS. SEE PAGE 56

SUSAN JOHNSON

Johnson is the director of education, finance and information technology for Columbia Medical. She has a bachelor's degree in business administration from California State University in Pomona, with a concentration in accounting. She oversees the company's financial and operational reporting systems. Johnson has been in the DME industry for 14 years. In her role at Columbia Medical, she is involved in providing educational programs and reviewing instructional and marketing materials related to Columbia Medical's product line. SEE PAGE 22

DON OLSON, DPT, ATP

Olson is director of physical therapy at the Life Skills and Transition Center in Grafton, N.D. He has 29 years of experience working with persons with intellectual and developmental disabilities of all ages. SEE PAGE 40

MIKE OSBORN, ATP, CRTS®

Osborn is president of NRRTS. Osborn has been a NRRTS Registrant since 2000 and is part owner of Alliance Rehab and Medical Equipment in Ozark, MO. SEE PAGE 14

KYLIE PORTER

Porter is a consumer advocate who attended the National CRT conference in that capacity. SEE PAGE 16

JESSICA PRESPERIN PEDERSEN, MBA, OTR/L, ATP/SMS

Pedersen has more than 30 years of experience as a clinician working in a variety of settings. She has taught courses specific to wheelchair seating in the college classroom and throughout the United States, Canada and Europe. Pedersen has published extensively and is working on research to provide evidence-based findings to substantiate what she has been doing clinically. Pedersen has been involved in the Clinical Task Force for the Coalition to Modernize Medicare Coverage of Mobility Products since 2003 and advocates statewide and nationally with people with disabilities. She and Jill Sparacio co-developed the mandatory wheelchair and seating evaluation form presently used in the state of Illinois for anyone receiving Medicaid funding. Pedersen was one of the founding members of NRRTS, serving as its first secretary. She lives in Franklin Park, Ill., with her husband and two sons. SEE PAGE 44

JB RADABAUGH, CTRS, ATP/SMS, RRTS®

Radabaugh is a NRRTS Registrant who works for Home Health Depot in Broadview, Ill. SEE PAGE 28

ANDREA VAN HOOK

Van Hook is the communications and marketing manager at RESNA. She has more than 18 years experience working on successful, award-winning campaigns that promote equal access to health care, education and employment of diverse populations, including people with disabilities. SEE PAGE 60

JENN WOLFF, OT

Wolff is vice president of Community Initiatives for UsersFirst, a program of United Spinal Association. Wolff is an occupational therapist and wheelchair user from Waverly, IA. SEE PAGE 54

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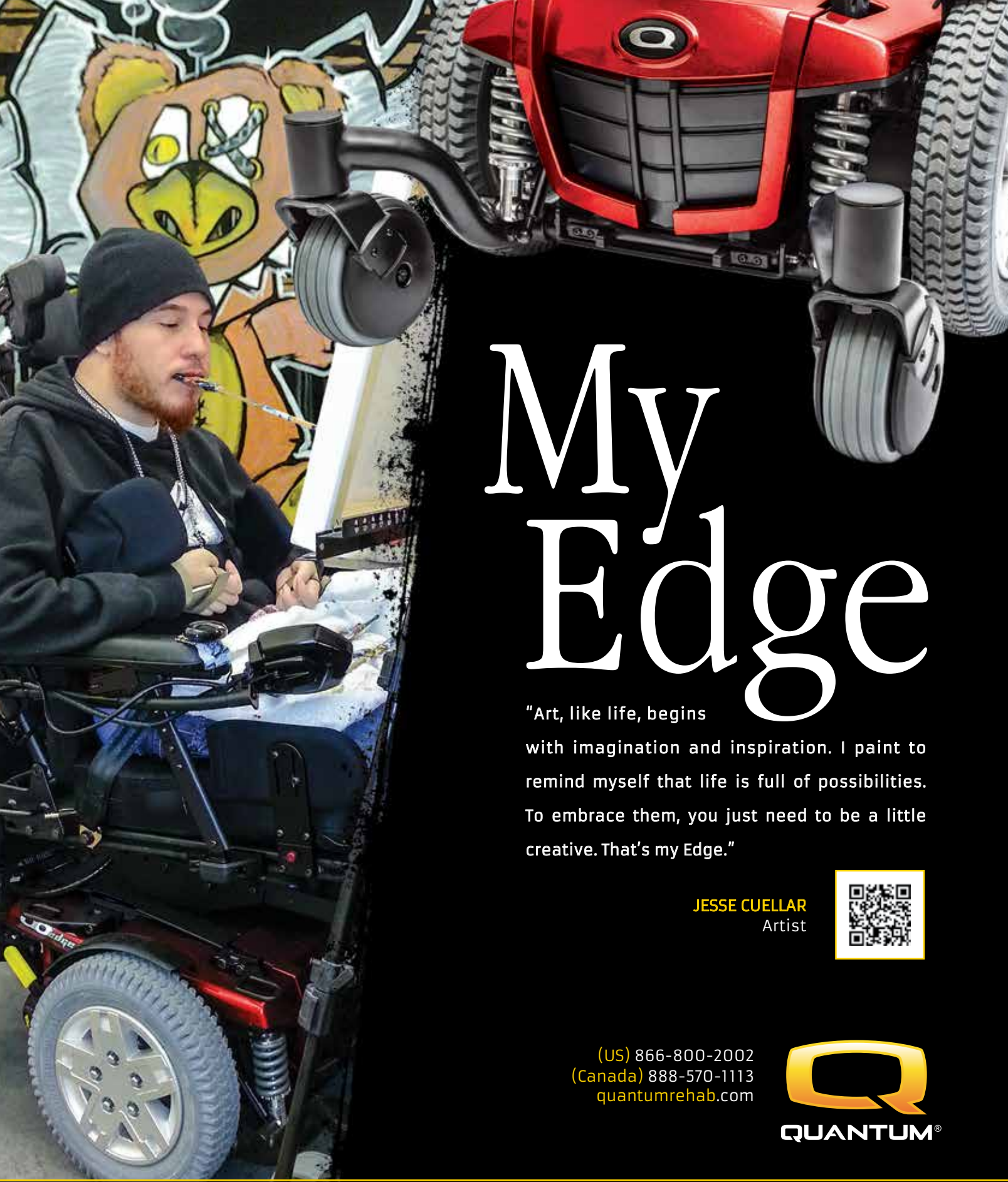

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TUESDAY, JUNE 17, 2014
5:00PM TO 7:00PM PACIFIC

Business Practices

Shaping the Future of CRT and the Professional RTS

WEESIE WALKER, ATP, SMS

THURSDAY, JUNE 19, 2014
5:00PM TO 7:00PM EASTERN

Restraints and Wheelchair Seating and Positioning

BARB CRANE, PH.D., PT, ATP/SMS, MEMBER OF CTF

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TUESDAY, JULY 15, 2014
5:00PM TO 7:00PM PACIFIC

Dealing with Difficult Clients and the Tools You Need to be Successful!

JILL SPARACIO, OTR/L, ATP/SMS, ABDA, MEMBER OF CTF

WEDNESDAY, JULY 16, 2014
9:00AM TO 11:00AM CENTRAL

Positioning out of the Box

Kinesio® Taping in Seating

KATHERINE L. CLARK, MOT, OTR/L,
ERIN M. POPE, PT, MPT

THURSDAY, JULY 17, 2014
5:00PM TO 7:00PM EASTERN

Advanced Power Mobility

Emerging Technologies

LISA ROTELLI

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TUESDAY, AUGUST 19, 2014
5:00PM TO 7:00PM PACIFIC

Posture and How it Develops

Standing and Sitting Considerations for the Young Child

SHARON SUTHERLAND [PRATT], PT

THURSDAY, AUGUST 21, 2014
5:00PM TO 7:00PM EASTERN

Power Mobility Options

For Clients with Muscle Weakness

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

TUESDAY, SEPTEMBER 16, 2014
5:00PM TO 7:00PM PACIFIC

Self-Advocacy

Where to Start and, by the way, I Don't Have Time!

GERRY DICKERSON, ATP, CRTS®, MEMBER OF CTF

WEDNESDAY, SEPTEMBER 17, 2014
9:00AM TO 11:00AM CENTRAL

Dynamic Seating

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

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THURSDAY, SEPTEMBER 18, 2014
5:00PM TO 7:00PM EASTERN

"Traffic School"

Tips for Creating a Power Mobility Training Program

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

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TUESDAY, OCTOBER 7, 2014
5:00PM TO 7:00PM PACIFIC

Pediatric Power Mobility

Earlier Intervention

AMY MORGAN, PT, ATP

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THURSDAY, OCTOBER 9, 2014
5:00PM TO 7:00PM EASTERN

The Relationship of Vision, Posture and Mobility

Implications for seating and mobility for neurologically involved clients

TERESA PLUMMER, PHD, OTR, ATP, CEAS, CAPS

TUESDAY, NOVEMBER 11, 2014
5:00PM TO 7:00PM PACIFIC

Back it Up!

Basics of Back Supports

BRENLEE MOGUL-ROTMAN, OT REG.[ONT.], ATP/SMS

WEDNESDAY, NOVEMBER 12, 2014
9:00AM TO 11:00AM CENTRAL

Complex Rehab Mobility

Medicare Reimbursement Requirements and Documentation Strategies

ELIZABETH COLE, MSPT, ATP, MEMBER OF CTF

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THURSDAY, NOVEMBER 13, 2014
5:00PM TO 7:00PM EASTERN

Choosing the Best Therapeutic Support Surface

LINDA NORTON, OT REG.[ONT], MSCCH

TUESDAY, DECEMBER 16, 2014
5:00PM TO 7:00PM PACIFIC

WHO Training Materials

An Overview and Usage Suggestions

JAMIE NOON

THURSDAY, DECEMBER 18, 2014
5:00PM TO 7:00PM EASTERN

It's More Than Just Physical

Considering All the Needs of Complex Clients in Seating and Mobility

TAMARA KITTELSON-ALDRED, MS, OTR/L, ATP/SMS, MEMBER OF CTF

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WOW!

WRITTEN BY: MIKE OSBORN, ATP, CRTS®

Looking back over our week in Washington, D.C., the word that comes to mind is "WOW!" What an amazing week. I've made the journey to Washington, D.C., every year for the National CRT Leadership and Advocacy Conference, but this year was – for me – the best so far. According to Weesie Walker, executive director of NRRTS, and Don Clayback, executive director of NCART, it was a record-setting year. Attendance for the three days was up almost 20 percent from a year ago. The two days of Leadership and Advocacy sessions saw 200 individuals in attendance. I looked around the meeting room at one point, and all aspects of our industry were represented – providers from all over the country, manufacturers, clinicians and consumers. It was that moment I realized how far we had come with the conference, our industry and our efforts toward a separate category for Complex Rehab Technology (CRT).

The Leadership and Advocacy days were filled with a variety of topics that kept me taking notes the entire time. It may have been the most informative two days I have spent in a conference setting. It was topped off by an unforgettable day on Capitol Hill. There were 245 hill visits this year. This is more than any other year. Some visits were to say 'Thank You' to those legislators who have already signed on in support of the CRT bill. However, most were to gain additional support and co-sponsors for the legislation. I can only speak for myself but, it was a great day. Finn Bullers joined a group from Missouri and took time to visit with Sen. McCaskill. It was a moment talked about throughout the Missouri contingent all day long. Bullers was able to share his personal message of how important his wheelchair access is to him and his daily journey. By the time the short meeting was over the senator was on board and handing out high fives. It is important to include that only a few days later McCaskill signed on to S-948 as a co-sponsor. This is only one highlight of a week filled with them. The final evening was filled with similar musings during the closing reception as the microphone was passed around the room, so everyone could share their stories. Again, it was a great week in Washington, D.C.

Follow-up is key, and continuing to build on what has been gained is important.

Thank you to all of those who made the trip. Thank you to those of you who took the time to make the phone calls or send emails to your legislators. But please realize we are not there yet. Follow-up is key, and continuing to build on what has been gained is important.

On behalf of NRRTS and the board I would like to thank our staff, Weesie Walker, Amy Odom and Amy Stripling as well as the NCART staff, Don Clayback and Mickae Lee, for their hard work and long hours put in preparing for this event and the time spent working during the conference.

Make plans to attend the National CRT in 2015. Dates will be announced soon.

CONTACT THE AUTHOR
Mike may be reached at mosborn@alliancerehabmed.com.

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CLASS ACT:

Wyoming family's advocacy efforts are making positive impact

WRITTEN BY: DANETTE BAKER

From their living room windows in the Porter's Southeast Wyo., farmhouse, they can see Colorado and Nebraska.

Like the frontiersmen who settled Wyoming, life for Kylie Porter, one of four siblings, has been a battle of the elements since she was born prematurely 19 years ago. Kylie and her twin sister, Eylisch, were two quintuplets who survived birth after being delivered at 28 weeks. Chele Mecomber Porter, their mother, said Kylie was intubated in the delivery room, but when the medical team took her to the NICU they determined she was too sick to live and turned their attention to her sister. As a result, Kylie has periventricular leukmalicia, meaning the centers of both hemispheres of her brain suffered a lack of oxygen and parts of them died, leaving her a spastic quadriplegic.

Kylie dressed up as an ice cream vendor

"It's like having a satellite dish on your home that does not work properly. The satellite in space and the television work, but the signal has to travel through the damaged dish on the house and scrambles the data," said Chele, explaining Kylie's disability.

Kylie was fitted for her first wheelchair at age 2, which first gave her the opportunity to experience the world in three dimensions. Before that she could not move on her own. At age 5, she moved into her first power chair. She alternates between a head array and a joy stick to maneuver her chair. Kylie also has limited verbal abilities and uses augmentative and alternative communication technology to communicate. "But her cognitive capacity is equal to that of her twin sister," said her mother. "She utilizes a tilt-in-space seating system to accommodate the low tone in her trunk region."

> And Kylie has a way of giving that voice a face whether she speaks or just smiles.

Kylie has a bubbly personality that draws attention. "Partly from her mother's German stubbornness and her dad's Irish humor," Chele said. "She wants to do more than sit in a chair and suck down assistance."

That's the message the Porters took to Washington, D.C., in April. This was not their first trip to Capitol Hill, or their first as advocates. Two years ago, Kylie was invited to speak to the Department of Education and her congressional representatives for the reauthorization of the assistive technology act. Additionally, the Wyoming Governors Council for Disabilities has an annual advocacy day during the state legislative session, which Chele and Kylie attend to advocate for disability services in Wyoming.

(CONTINUED ON PAGE 18)

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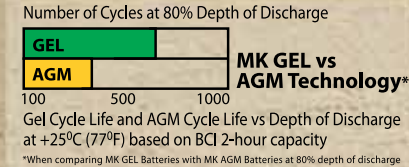

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CLASS ACT...
(CONTINUED FROM PAGE 16)

"It's important for them to understand the challenges for services for those of us living in the rural areas, which most of Wyoming is," Chele said. There are limited resources in Wyoming and the Porters travel to Colorado to get specialized services for medical and complex rehab technologies (CRT).

In fact, the Porters have followed one particular individual, Bert Lindholm, ATP, – who now works with NuMotion – since Kylie was 2. Lindholm invited the Porters to the National CRT Conference as consumer representatives.

"Kylie and I do a lot of advocacy work in Wyoming and Colorado, but I didn't really know much about the CRT bills until we got to Washington, D.C. But we think Bert walks on water, so if he felt like it was important for us to be there to represent Wyoming, then we wanted to be there," said Chele.

While at the National CRT Conference, Chele said visiting their Wyoming representative Cynthia Lummis was like visiting an old friend. "I rodeoed with her sister growing up. When we walked in, Kylie didn't have to say anything; she was ready to co-sign the CRT bill. Then we talked about things at home.

"Visiting with some of the other representatives and senators was interesting. Wyoming is a small state; I'm very active politically, and people in Wyoming know Kylie's message: I wouldn't be here if it was not important; we fight for important issues."

Douglas Porter, Kylie's dad, made an interesting observation while at the National CRT Conference, his wife said. Seeing the consumers and how they use CRT is great, but the senators and representatives may only see one or two


PICTURE 1


PICTURE 2


PICTURE 3

PICTURE 1 - *Kylie as Molly Brown* | **PICTURE 2** - *PopoAgie and Kylie* | **PICTURE 3** - *Shoni & Kylie*

people. If they were they were able to see 30 at a time, each one using very different chairs and seating systems, the impact would be even greater.

Back home after the National CRT Conference, the Porters continued with their advocacy for CRT. Just a couple of weeks later, Chele and Kylie did a public service announcement for Wyoming Institute for Disabilities, WIND.

"I explained how, without complex rehab technology, Kylie would have no access to the world. She couldn't communicate with her friends, she could not communicate at school, and she could not move herself. I'm not sure those responsible for making decisions about what Medicaid covers gets how important that is.

"Without complex rehab technology, Kylie would not be contributing to society; she would be a drain on it."

Instead, Kylie is going to college at Laramie County Community College to prepare for a career as a casting director. She participates in life just like her twin. She also volunteers at the Cheyenne Civic Center and the Community Theatres.

Kylie's speech therapist, who shares a love of community theater, introduced her to the theatrical world. In 2011, she was able to meet and spend time with the national touring company for CATS. "They took her under their wing and still involve her in their lives," Chele said. "She has a friend who performs in The Phantom of the Opera on Broadway."

Kylie's mom is involved in her daughter's life on a much greater scale since recent funding cuts in Wyoming forced her mother to quit her teaching job in September and become Kylie's service provider because they can no longer afford one. Kylie needs care 24/7, so mom goes to her classes with her, as well as to her volunteer activities.

"She can't do anything on her own; she couldn't even get out of the house on her own if it was on fire," said Chele.

Since the Porters live in the country and must travel at least 30 miles to access even a grocery

(CONTINUED ON PAGE 20)

CLASS ACT...
(CONTINUED FROM PAGE 19)


PICTURE 1

store, transportation has been an important issue. For several years, they relied on a 1991 van to transport Kylie. They had to transfer her manually from her wheelchair to the van, placing her in a toddler car seat and ramp the wheelchair into the van. "Kylie requires a CRT toileting chair as well, so when traveling, we would have to change her on the bathroom floors," Chele said.

Two years ago, advocacy allowed Kylie to acquire a new Sprinter van, which has wheelchair lockdowns and automatic lift so she can remain in her chair during travel. It also has an area for the CRT toileting system to travel with her. Kylie wrote a speech and presented it to a foundation in Wyoming. Her story, told to a panel which included six women, was compelling, said her mother. "She was very honest with them about how gross it was to have to lay on a public bathroom floor for toileting and how scared she felt about being dropped during transfer. Kylie is the only person who has received a grant for the full amount of a vehicle," Chele said.

The family now faces another hurdle in getting the automatic lift fixed, a common breakdown in vans used for transporting people who use wheelchairs. Now, instead of a two-minute process to get Kylie in the van, it takes about 10 minutes because of having to manually maneuver the lift up and down. "If I could still work, we could afford the $1,500 repair bill," said Chele. "But because of the cuts, Kylie's personal care comes first.


PICTURE 2

"It is frustrating because so often the decisions being made in regard to funding just don't make sense when you are in the trenches."

And so, Chele and Kylie continue with their advocacy efforts.

"Part of the reason," Chele said, "is because I understand the gift we have in Kylie. Parents who have children with special needs are often handed a 2-pound baby and told, 'You will be in the medical world for the rest of your life.' They are terrified, first of all, that their child

PICTURE 1 - *Kylie dressed as a washing machine*
PICTURE 2 - *Kylie dressed up for her part in Joseph and the coat of many colors*

is not even going to live. And then they are thrown into this world of others making the decisions about whether your child can have a piece of equipment and services or not. Many just don't have the energy to fight.

"I was just obnoxious enough to join that world and say, 'Listen. You are going to hear me.'

"And Kylie has a way of giving that voice a face whether she speaks or just smiles."

CONTACT

The Porter family may be reached at rokoranch@gmail.com.

SAFE AT HOME AND ON THE GO

Johnson's multiple roles with Columbia Medical instrumental in company's success

INTERVIEW BY: DANETTE BAKER

Columbia Medical is well-known as a leader in its product category, and Susan Johnson has played an integral role in situating the company as the premier provider of bathroom and transportation safety products. She also made significant contributions to the industry in terms of transportation and patient advocacy.

DIRECTIONS recently had the opportunity to visit with Johnson about her work in the industry and her multiple roles in accounting, information technology, sales and marketing for Columbia Medical.

How did you become interested in the medical equipment industry?

My educational background is in accounting and information technology. I was an accounting/computer consultant, and Convaid Inc. was one my clients for several years. In 2000, I was hired as the company's assistant controller and then became director of information technology. As part of the IT role I worked on website development and became very familiar with the product line. About six months after I joined the company, the sales and marketing manager left, and I was asked to serve in the interim as they recruited for the position. During that time, the product line and industry became my passion, and I assumed the sales and marketing manager role. I covered the entire U.S. and Canada territories, along with two other salespersons, visiting every state except Alaska and several Canadian provinces. I made industry friends all across North America.

What keeps you working in the industry?

I'm so empowered by the families and the way they live with the issues they face. After you get involved and realize the problems many of them have and then you see how they manage to find solutions – that's empowering. I also like working with the therapists and presenting new ideas for products that will allow a client to take care of simple daily activities such as toileting and bathing.

Also, the fact that we have a lot of web visitors who search for us by name tells me we are definitely known in our product category. There's a lot of pride in that.

What are some of the most significant milestones in your career?

For about two years, beginning in 2001, I represented Convaid in the pediatric wheelchair coding task force, which was the stroller company at that time. I was creating a unique category code for their pediatric stroller product line, because at the time there were not enough codes for the product differentials in pediatric manual wheelchairs. Working with NCART and AAHomeCare enabled me to meet and work with the industry leaders and learn about the industry and reimbursement from those with firsthand experience with Centers for Medicare and Medicaid Services (CMS) and the Statistical Analysis Durable Medical Equipment Regional Carrier, now the Pricing, Data Analysis and Coding contractors, which performs the coding verifications for CMS.

Second, I have overcome a tremendous fear of public speaking – well, sort of. After learning as much as I could about

I'm so empowered by the families and the way they live with the issues they face.

wheelchair transportation safety and participating on the RESNA COWHAT (Committee on Wheelchairs and Transportation), I developed an educational program to share wheelchair transportation safety (WC19) information with transportation providers, therapists and rehab specialists all over the U.S. and Canada. Columbia Medical continues to sponsor this educational program, and I still participate. We write the standards and make updates for transportation, testing and labeling of wheelchairs used as seats in motor vehicles. The RESNA group involves all stakeholders – wheelchair manufacturers, transportation specialists, therapists, etc.

> After you get involved and realize the problems many of them have and then you see how they manage to find solutions - that's empowering.

I also participated in the writing of RESNA's Position on Wheelchairs Used as Seats in Motor Vehicles. This involved working with therapists and transportation safety experts. Getting the paper published required a tremendous amount of work and patience by the team, but we got it done. In 2008, we had evidence-based research supporting reimbursement on the transit options on wheelchairs.

Third, would have to be my becoming certified as a child passenger safety technician. Upon joining Columbia Medical's team, it became my new mission to enhance their leadership in the special needs car seat market through expansion of knowledge in the area of car seat safety and getting to know the experts in this field. We now have three regional sales managers who are also child passenger safety technicians who can share their knowledge and contribute their skills to community car seat safety events. We have expanded our educational program to include special needs car seats. This has contributed to the success of our very popular Spirit APS car seat.

And my participation in CELA and accompanying a family with two children with disabilities to speak to our representatives was another milestone. The legislative process was a huge lesson for me in learning what it takes to gain support for a bill, as well as understanding the obstacles families must overcome in dealing with disabilities and getting the equipment they need in their daily living. The education and experience from these "fly-ins" have been invaluable in my career, and it's critical for the legislators to put a face to an issue. It helps them realize this is not about the suppliers or manufacturers' profitability. Oh, and tomorrow, I'll be participating in the call-in day, talking to legislators about the bills in progress for the complex rehab category. Those who can't go to Washington can still make their voices heard by calling their representatives.

Who has been instrumental in these accomplishments?

The owner of Convaid Inc., Merv Watkins, encouraged me early in my career to learn all I could and "dive into the industry with both feet."

Gary Werschmidt, the CEO of Columbia Medical, supports the continuation of my learning about the industry, seating and mobility, car seat and bathroom safety, regulatory issues and whatever becomes important for us to explore. He encourages my participation at conferences and on committees and expects me to help keep our company abreast of changes in the industry, funding and regulatory issues.

Wonderful therapists, such as Ginny Paleg and Delia Freney have shared their knowledge of seating and positioning with me to make me better understand the clinical aspects of our product lines. And my colleague, Keith Wright, Columbia Medical's global sales and marketing director, constantly challenges me for more "business intelligence" reports to help in growing our business.

You have three very different roles with Columbia, all very vital to the success of the company. How do you balance your responsibilities?

I don't really balance the roles; I take things as they happen and "blend" them.

Actually, my roles are not clearly separated. They often overlap. My interest in the "numbers" in accounting relates to my interest in IT, which relates to developing new analysis or metrics so we can work "smarter." My interest in IT is related to my interest in the website, which links to sales and marketing. That interest in sales and marketing is related to my interest in product development and clinical aspects of the product line, which leads to my interest in "education," which, in addition to seminars and educational programs, includes reviewing marketing materials, instructions for use, sell sheets, etc.

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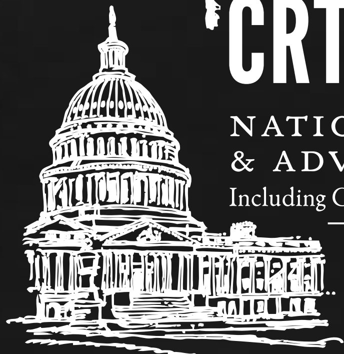
People of the CRT CONFERENCE



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(CONTINUED FROM PAGE 23)

I guess the most valuable and also the favorite part of my job is when I am in the clinic with families, therapists and rehab specialists during an evaluation, trying to "problem solve" an equipment need and helping determine what might work best and then following through to find out it actually has helped them in their daily lives. That passion shared by the entire Columbia Medical team in the field, is one key to our success.

What's new on the horizon for the company?

Anyone who has flown on an airplane has seen our airline boarding wheelchairs waiting on the gate ramp, and many have used our "strollers" that are accessories to our car seats. Columbia Medical has now expanded its mobility line to include a new CG Tilt wheelchair, the Innova. We plan to further expand this mobility line of products.

We continuously improve on our existing bathroom safety and transportation safety offerings and are working on new product development in these areas, too.

> I would love to turn back the clock to when clinicians could worry about treating their clients and rehab specialists could recommend equipment based on what is best for their clients without so much concern for reimbursement.

What changes would you like to see in the industry as a whole?

It seems that including the service component in the reimbursement of products has exacerbated the funding problems as budgets have tightened because the service cost is not transparent. I would like to see the industry figure out a way to quantify the service component so as to allow it to be reimbursed separately, perhaps similar to the way other industries have done it, such as in time units or flat rates. The value added by the rehab specialist should be recognized. But then, of course, the challenge will be to get the service compensated.

Another thing, often when I go in a clinic, three of five therapists are working at their computers, and two are working with the kids. Something is wrong with that picture. I would love to turn back the clock to when clinicians could worry about treating their clients and rehab specialists could recommend equipment based on what is best for their clients without so much concern for reimbursement. We will never go back to the past, but it is still my wish.

While many have tried to reduce the paperwork burden for all by creating templates for evaluations and letters of medical necessity, the ideas have not been embraced by the payers, mostly due to fear of fraud and abuse. I would like to see us continue lobbying for ideas to streamline the reimbursement processes, which include controls to minimize fraud and abuse.

What are the future challenges for Columbia Medical and the industry?

Funding, funding, funding. It seems that as soon as one challenge is either overcome or absorbed, one is waiting right behind it. Our challenge is to continually develop new products and improve existing products while maintaining cost efficiency so they will be accessible to the families who need them, and to support the rest of the rehab team who provide the services to do it right. Sometimes that means compromising on our wish list and facing the reality of reimbursement constraints.

What other roles do you have in the medical equipment/complex rehab industries (boards, association memberships, etc.)?

I'm a Friend of NRRTS, a member of TXRPC and have been a member of the Committee on Wheelchairs and Transportation for eight years.

What does a typical work day/week look like for you?

I never have a typical work day/week. Aside from about 15 percent to 20 percent travel, I mostly work from my home office. Los Angeles freeway traffic is brutal and means wasted hours in a day. I go into the office at least one day per week for meetings with the management team. IT work and much of the financial and sales reporting is done "after hours" and on weekends. My day always starts by checking the server backups, going through emails, then perhaps I might review a new brochure or work on a regulatory submission, answer a phone call from a therapist or dealer about a car seat installation, give technical support to a field salesperson with laptop problems, do a product in-service or a product

development review in a clinic, review financial information or send out reports. It is never "9 to 5." Our systems need to be up and running for our team around the country not only during the week, but on the weekend, as all are dependent on the system to keep up with their work.

I would say every day of my work is unique and an adventure in learning and problem solving.

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What's life outside of the 9 to 5 like for Susan Johnson?

I have been happily married for 38 years. My husband is a computer security specialist. We have three adult children. Two finished their undergraduate degrees, but continued their education. One of my daughters is married and finishing her PA program in May. My other daughter, who has almost finished her mathematics degree, also works as a bartender. My son – the youngest – lives in Germany, is learning the language and will start his MBA program there in the fall. I have no grandchildren yet. I enjoy spending time with my 86-year-old mother who has dementia and lives near me. I have lived in Southern California since I was 2 (almost a native) and love to go to the beach. My hobbies are kayaking, stand-up-paddling, fishing, and computer programming – and lately I have been tinkering with writing Android apps. Next, I want a 3D printer to play with; I am a bit of a geek.

> I would like to see us continue lobbying for ideas to streamline the reimbursement processes, which include controls to minimize fraud and abuse.

A HEART FOR THE CHILDREN:

Radabaugh finds fulfillment in helping youngest patients

WRITTEN BY: JULIE BARNETT

Jim "J.B." Radabaugh begins his days long before the sun comes up, and doesn't stop until 14-or-so hours later. And that's just how he likes it.

Radabaugh, CTRS, ATP/SMS, RRTS®, is a certified therapeutic recreation therapist who is working full time as a complex rehab mobility specialist with Home Health Depot in Indianapolis, Ind.

He graduated from Indiana University with a bachelor's degree in recreational therapy, then moved to Chicago to pursue a career in that area. But he found his calling was in a different direction.

"I had been around seating and wheeled mobility my whole life," he said. In fact, both of his parents, his sister and his wife are occupational therapists. "As a recreation therapist (RT), I'm the black sheep of the family, but my experience in that discipline allowed me to see how I could combine two of my passions into one practice area," he said. As it turns out, Radabaugh found he was spending much of his time as an RT modifying, fixing and fitting his patient's wheelchairs so that they could fully participate in the activities he had planned for them.

> My heart is with the children, for sure.

Radabaugh's first introduction to seated mobility came in high school, when he shadowed a local Indianapolis company. He noticed the positive impact it had on individuals with disabilities and took a job in their repair department. Later, it would become his career, beginning with a position at Apria Healthcare in Chicago, and now, with Home Health Depot. Radabaugh has been an ATP for about five years and passed his SMS certification this past year.

When asked about his day-to-day activities, he said, "the alarm goes off at 4:15 a.m., and I end the day around 7 [p.m.], but I love every minute in between." While the job includes a lot of traveling, the best part is meeting new people, playing with 'my kids' as I assess the technology solutions to meet their identified needs and making a difference in their daily lives," he said. "My heart is with the children, for sure."

Along with the joys come the challenges, and Radabaugh said the last year and a half has been a real eye-opener, particularly in light of the ever-changing funding situation in the Medicare, Medicaid and managed care programs. "One of my biggest concerns is that all insurance providers have tightened their reimbursement belts and increased the scrutiny on what they will cover for their beneficiaries – including people with disabilities," he said. "This leads to significant uncertainty and compromises our ability to ensure continued access to appropriate assistive devices for our complex rehab clients, including children. It is imperative that these individuals be able to get what they need from qualified providers now and in the future."

He continued, "I recognize that health care dollars are short, and payers have to demand accountability, but my fear is that funding will turn into the fast food model of provision where all we will be able to provide will be the same mass-produced products, just with a different brand name. The people I see in a typical day need customized products and services that are offered in financially responsible ways from qualified providers."

Another challenge Radabaugh noted was the changing documentation

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requirements. "For Medicare increased scrutiny, a largely subjective review of the patient's medical record and payer incentives to 'find fault' with required documentation has resulted in receipt of Additional Documentation Requests (ADRs) and payment reviews which take an enormous amount of time and capital for complex rehab providers to manage in order to be paid for the services already rendered for our customers," he said. Radabaugh said he much prefers the prior approval process used by state Medicaid programs and non-government payers.

> Knowing that I have a part in changing someone's life for the better is much more gratifying than a paycheck, and it is what keeps me going in the pursuit of separate recognition for complex rehab.

From Radabaugh's perspective the industry has changed in many other ways over the years as well. "The players are nearly all the same, but there are so many more products to chose from, the research is beginning to support what we do and the educational opportunities are much greater than they were when I was first exposed to this industry," he said. "At a time when we should be enjoying some of the fruits of the industry's labors we continue to struggle to provide, and our customers continue to struggle to receive what they need.

"Many of my clients have to rely on the decisions of third-party payers that do not necessarily keep up with the latest trends," he said. "We know how beneficial the provision of the right equipment is on their long-term health, yet it is a real financial challenge for them to maintain, repair or modify the equipment provided by their insurance company once they receive it in order to reap the full benefits of its use. Add to that the increased out-of-pocket expenses they incur for , under-funded and non-covered items that are also necessary for safe, independent mobility in their homes and communities and I often have to remind myself that we are moving in the right direction," he stated.

"I want to stress that as CRT providers we need to make sure our clients and their caregivers and families of the complex rehab community know they have the strongest voice in directing positive change to ensure access to complex rehab technologies continues," he said. "Until the end-users stand up and fight for what they need, the funding struggles that negatively impact them, and ultimately us, will continue. As an industry, we have made great strides in increasing awareness, changing policies, and fighting to separate complex rehab from traditional DME (durable medical equipment). However, without beneficiaries advocating for what they need legislators, regulators and other decision makers are not inclined to see this as anything other than businesses just protecting their income, and not what we are actually fighting for – access to quality complex rehab technologies from qualified CRT providers for our most vulnerable clients."

According to Radabaugh, at the end of a long day, the satisfaction of helping patients makes it all worthwhile. "There are so many exciting things about my job – like seeing a child in a power chair for the first time, or watching someone who suffered a stroke gain mobility they haven't had in years because I put in the extra effort to do it right," he said. "Knowing that I have a part in changing someone's life for the better is much more gratifying than a paycheck, and it is what keeps me going in the pursuit of separate recognition for complex rehab."

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ABNS: WHAT ARE THE PITFALLS AND LANDMINES?

WRITTEN BY: MATTHEW AGNEW

The Centers for Medicare and Medicaid Services (CMS) requires Medicare health care providers and suppliers to provide Medicare beneficiaries with an Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, if the provider thinks Medicare probably (or certainly) will not pay for the items or services because they are not medically necessary. A provider that fails to deliver an ABN when required may not bill the beneficiary for the noncovered items or services. The requirement to provide an ABN to a Medicare beneficiary is limited to certain Medicare Part B services (outpatient only) and Medicare Part A items and services (limited to hospice services, home health agencies, and Religious Nonmedical Healthcare Institutions only). However, providers are not required to provide Medicare beneficiaries an ABN for items or services Medicare never covers. On its face, the ABN is a simple tool to provide Medicare beneficiaries with notice of noncoverage. Below the surface, proper utilization of the ABN form can be difficult and improper utilization of the ABN form can result in thousands of dollars of nonbillable medical costs. This article will furnish providers with guidance to prevent some of the common ABN pitfalls and landmines, and help providers ensure proper liability is established prior to the provision of items or services to Medicare beneficiaries.

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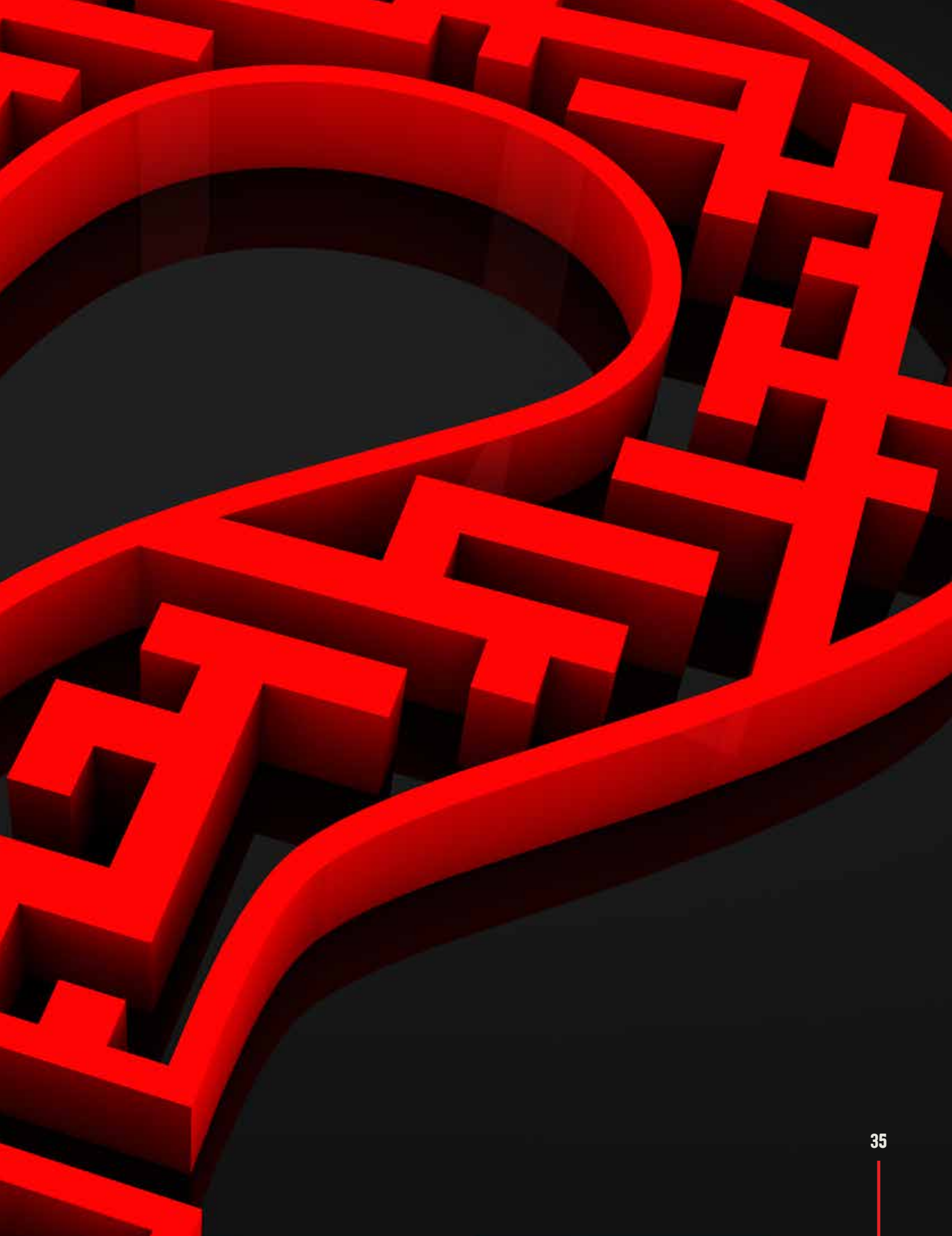

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When should an ABN be issued?

An ABN should be issued when: (1) the provider believes Medicare may not pay for an item or service; (2) Medicare usually covers the item or service; and (3) Medicare may not consider the item or service reasonable and necessary for this particular patient in this particular circumstance.[1] CMS has established additional requirements for durable medical equipment (DME) suppliers. DME suppliers are required to issue an ABN before providing a Medicare beneficiary with items or services if: (1) the provider violated the prohibition against unsolicited telephone contacts; (2) the supplier has not met the supplier number requirements; (3) the supplier is a noncontract supplier providing an item listed in a competitive bidding area; or (4) Medicare requires an advance coverage determination.[2] In a competitive bidding area, a DME supplier that is not a contract supplier must issue an ABN to a Medicare beneficiary if the supplier is offering an item or service that is provided under the Medicare Competitive Bidding Program.

CMS prohibits the use of ABNs on a routine basis and requires providers to maintain proper evidence supporting the issuance of each ABN. There are a few exceptions to the routine basis requirement, such as the provision of experimental items or services, services that are always denied for medical necessity, or items and services with frequency limitations for coverage (e.g., contacts and glasses). A provider's issuance of an ABN can be voluntary or mandatory. A voluntary ABN may, and should, be used by cautious practitioners in situations in which CMS may deny services, such as for services furnished by a supplier for an immediate member of his or her household, personal comfort items and supportive devices for the feet. CMS makes it mandatory to issue an ABN when the provider expects Medicare to deny payment for an item or service because it is not reasonable and necessary under Medicare program standards.[3] ABNs may not be used under duress (in compelling or coercive circumstances); therefore, CMS recommends providers not issue an ABN to a Medicare beneficiary with immediate health issues.

A provider's requirement to issue an ABN is triggered by three different events: initiations, reductions and terminations. At initiation of treatment, a provider may determine Medicare may not cover an item or service because the item or service is not reasonable and necessary, and the provider must issue an ABN to the Medicare beneficiary prior to the receipt of noncovered care. A reduction in care (when a component of care decreases) typically occurs because the care is no longer considered medically reasonable and necessary. In these instances, a provider must always issue an ABN if the Medicare beneficiary wants to continue to receive services that are no longer medically reasonable and necessary. Similarly, a provider must issue an ABN if a Medicare beneficiary wishes to continue to receive care after the provider has terminated services that are no longer medically reasonable and necessary. An ABN must be issued on CMS's ABN form, Form CMS-R-131, or on a form meeting CMS's requirements. It is highly recommended providers utilize CMS's form when issuing an ABN to a Medicare beneficiary.[4]

When is an ABN effectively issued?

To determine if an ABN is effectively issued, CMS has set forth several standards and requirements. CMS considers an ABN effectively issued when the notice is: (1) issued to and comprehended by the Medicare beneficiary or the beneficiary's representative; (2) completed on the approved, standardized CMS ABN form with all required blanks completed; (3) provided far enough in advance to the beneficiary to allow it to consider available options; (4) fully explained and all questions about the ABN are answered; and (5) signed and dated by the beneficiary or the beneficiary's representative after he or she selected one option box on the ABN.[5] CMS encourages, but does not require, providers to issue an ABN in person. If an in-person issuance is not possible, then CMS permits the issuance of an ABN by email, mail or secured fax machine, if done in accordance with HIPAA policies and procedures.[6] Notice by telephone is not considered sufficient unless the content of the telephone contact can be verified and is not disputed by the beneficiary. Telephone contact must be followed immediately by either a hand-delivered, mailed, emailed or faxed notice.

How does a provider properly fill out Blanks D, E, and F on the ABN form?

To complete the ABN form, a provider must pay particular attention to Blanks D, E, and F.

Blank D

Blank D requires providers to list the specific items or services the provider

believes will not be covered by Medicare. CMS encourages providers to use one of the following descriptors in Blank D: item, service, laboratory test, test, procedure, care, or equipment.[7] For expected partial denials, the provider is required to list the excess components of item or service for which denial is expected. Similarly, a provider must also list the specific components of any upgrades that may be, are expected to be, or will be denied. If an item or service that is offered — but expected to be denied — is repetitive or continuous, then the provider must specify the frequency or duration of the item or service to be provided on ABN form. When a provider reduces services, Blank D must specify with enough additional information to put the Medicare beneficiary on notice of the nature of the reduction. For example, "wound care supplies decreased from weekly to monthly" is sufficient, but "wound care supplies decreased" is insufficient.

Blank E: Reason Medicare May Not Pay

Blank E requires providers to explain in "beneficiary-friendly" language the reason the provider believes the item or service will not be covered by Medicare. A valid and effective ABN requires the provider to supply at least one reason for noncoverage. CMS has provided the following commonly used reasons for noncoverage: Medicare does not pay for the test for this particular condition, Medicare does not pay for this test as often as patient requests (denied as too frequent), and Medicare does not pay for experimental or research use tests.

Blank F: Estimated Costs

In order for Medicare beneficiaries to receive all information and make an informed decision, Blank F requires providers to disclose to beneficiaries an estimated cost for the item or service Medicare is not likely to cover. In making an estimate, providers must make a good faith effort to determine a reasonable estimate for the items or services listed. Generally, CMS expects the provider's estimate to fall within the greater of $100 or 25 percent of the actual cost.

What record retention requirements does CMS place on ABN forms?

CMS requires providers to retain all ABN forms for five years from the date of service, but only if state law has not established requirements for medical record retention. If a beneficiary declines care, refuses to choose an option, or refuses to sign the ABN, the provider must retain (either in hard or electronic format) a record of the ABN. If a Medicare beneficiary signs the ABN and thereafter changes his or her mind, then the Medicare beneficiary must annotate the ABN to reflect a clear indication of his or her decisions. The provider or the beneficiary may annotate the ABN, but the beneficiary must sign, date and return a copy of the ABN to the provider for its records.

When can a provider collect funds from a Medicare beneficiary for an item or service, and when must it return those funds?

Once a Medicare beneficiary signs an ABN, the provider is entitled to immediately collect payment for the items or services prior to providing them. If CMS denies payment for the item or service, the provider retains the funds. However, if CMS pays all or part of the claim, or if CMS finds the issuance of the provider's ABN ineffective, then the provider must refund beneficiary the proper amount in a timely manner. CMS has determined a "timely manner" to mean within 30 days after receipt of CMS's Remittance Advice or within 15 days if an appeal is brought by the provider and funds are still due to the beneficiary at the conclusion of the appeal. If a provider fails to issue a mandatory ABN or if it issues a defective ABN, then the provider is liable for the costs of the items and/or services, and the provider is not permitted to collect or retain funds from the beneficiary. CMS's "Advanced Beneficiary Notice of Noncoverage" guidance booklet provides claim reporting modifiers for filing Medicare claims associated with an ABN.[8] Detailed information and instructions on filing claims with ABNs are located in the Medicare Claims Processing Manual, Chapter 30.[9]

(CONTINUED ON PAGE 36)

A provider's requirement to issue an ABN is triggered by three different events: initiations, reductions and terminations.

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What are the common issues DME suppliers must address with ABN forms?

Two of the situations in which DME suppliers face ABN difficulties are: (1) the physician has failed to provide enough documentation to substantiate reasonable medical necessity; and (2) a provider supplies a Medicare beneficiary with a DME rental and Medicare subsequently terminates coverage for the item or service. When a physician fails to provide enough documentation to substantiate reasonable medical necessity, then it is incumbent upon a DME supplier to get the Medicare beneficiary to sign and execute CMS's ABN form. Failure to receive an executed ABN form places the supplier's likelihood for Medicare approval at risk when a physician fails to substantiate reasonable medical necessity. To prevent this error from occurring, DME suppliers must review physician documentation closely to determine if the physician has established and provided adequate justification to demonstrate reasonable medical necessity. If a DME supplier believes the documentation provided by the physician is insufficient, then it should require the client to execute an ABN form as a precautionary measure.

Rentals also present complications for DME suppliers. Often, a Medicare beneficiary is entitled to a rental device due to reasonable medical necessity but the rental is initially limited by CMS or CMS determines that the beneficiary's underutilization of the medical device results in a determination that the device is not medically necessary (e.g., CPAP machines that are initially limited to a 12 week period). Nevertheless, CMS termination of services triggers the requirement for the Medicare beneficiary to execute an ABN if the beneficiary elects to keep a rental after Medicare coverage for the rental has been terminated. Frequently, Medicare beneficiaries decline to voluntarily execute an ABN that makes them liable for the costs associated with the rental equipment. In these instances, it is incumbent upon a DME supplier to issue a letter to the beneficiary explaining that these services have been terminated and informing the beneficiary that it can return the device or incur personal responsibilities for the cost of the device if it is not returned. This letter should be accompanied with an ABN form with a request that the beneficiary sign the form. As always, a copy of this documentation should be retained if the DME supplier desires to collect any rental costs from the beneficiary.

Providers should ensure that their regulatory compliance officer and any staff members issuing ABNs fully understand CMS's requirements and general guidance regarding ABNs.

Conclusion

Providers often struggle with ABNs due to their highly technical requirements, but these struggles can be generally addressed by making a few simple internal changes. Providers should ensure that their regulatory compliance officer and any staff members issuing ABNs fully understand CMS's requirements and general guidance regarding ABNs. This article and the reference links herein should provide a solid foundation for any staff member to follow when filling out ABNs. Furthermore, maintaining adequate documentation to establish the need for a Medicare beneficiary to fill out an ABN is important. Maintaining proper documentation helps establish that the provider is not requiring all patients to sign ABNs as a condition of service and is instead providing all beneficiaries in need of an ABN proper and adequate notice of noncoverage for a particular item or service. Finally, providers should strive to provide good faith adequate notice of the cost of service to ensure the ABN is effective. This requires providers to work diligently in determining an adequate and accurate estimate for the cost of service. Generally, Medicare beneficiaries are not required to pay for services in excess of CMS's "$100 or 25 percent cost of service" estimate requirement.

If CMS denies a claim and a provider has not completed an effective ABN, then the provider is not automatically disqualified from seeking to recoup

those costs from a Medicare beneficiary. In 2011, the Fifth Circuit Court of Appeals concluded that written notice is not required to rebut the presumption that a patient did not receive proper notice, which entitled the provider the opportunity to demonstrate that the client received advanced oral notice of Medicare's noncoverage of the service provided.[10] Therefore, in some circumstances, oral notice meeting CMS requirements for disclosure, coupled with the Medicare beneficiary's understanding of the disclosure and informed consent to initiate or continue care, can be considered sufficient to establish a Medicare beneficiary's liability for the costs of items or services. For legal advice consistent with your particular circumstances, please consult an attorney who specializes in the area of health care regulation.

This material is provided for informational purposes only and is not legal advice. You should contact your own counsel to obtain legal advice with respect to any specific issue.

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1. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN) (November 2013) https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf.

2. Id.

3. 42 U.S.C.A. § 1395pp(a)(1) (West 2014).

4. CMS's ABN form and ABN form instructions may be downloaded here: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABNFormInstructions.zip.

5. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN) (November 2013) https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf.

6. For more information on issuing ABNs off site, see DEPARTMENT OF HEALTH AND HUMAN SERVICES, ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN) (November 2013) https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf.

7. CMS states that "Items/Services" is a common and sufficient descriptor most of the time.

8. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN) (November 2013) https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf.

9. THE CENTERS FOR MEDICARE & MEDICAID SERVICES, MEDICARE CLAIMS PROCESSING MANUAL (April 2014) http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf.

10. See Mississippi Care Ctr. of Morton, L.L.C. v. Sebelius, 449 F. App'x 341 (5th Cir. 2011) (finding that a nursing home operator was not required to show written notice to a beneficiary or its representative to meet the burden of persuasion that the beneficiary or representative received advance notice of Medicare's noncoverage; however, in this case, the operator was unable to overcome the burden of persuasion).

IT'S A VERY BUSY TIME FOR CRT ADVOCACY

WRITTEN BY: DON CLAYBACK

We've all heard the saying "idle hands do the devil's work." Well, a great many Complex Rehab Technology (CRT) stakeholders have been staying very busy and keeping that devil at bay. Hey, that's another good reason to keep advocating for CRT.

Here's a review of all that's been going on.

National CRT Conference

The week of April 28th was a great week for CRT. That week featured the second annual NCART/NRRTS National CRT Leadership and Advocacy Conference held in Washington, D.C.

The conference brought 200 dedicated CRT stakeholders together in one place for education, networking and advocacy. Attendees included providers, manufacturers, consumers, clinicians and other advocates all with one mission in mind: protecting and promoting access to CRT and the needed supporting services.

Attendance for the three-day event was up almost 20 percent from last year, which was very encouraging and much appreciated. It was a great cross section of people interested in CRT. Organizations in attendance included the United Spinal Association, the ITEM Coalition, the National MS Society, RESNA, the Clinician Task Force, and the University of Pittsburgh.

The great news is everyone's hard work really paid off!

The Leadership Day provided a forum for excellent business speakers and dialogue. Topics included: the direction and needs of the industry, using social media, the augmentative communication market, the home accessibility business, handling audits and appeals, managing a repair center, and the details of running a seating clinic. It finished with an old-fashion town hall meeting.

The Advocacy Day featured a variety of "outside the industry" speakers sharing information on: national health care policy trends impacting CRT, the latest legislative and regulatory matters, state funding sources, and Medicaid advocacy activities. All topics were CRT focused and the information was current and useful. We ended with a congressional orientation and review for the next day.

The Capitol Hill Day was all about gaining co-sponsors for the "Ensuring Access to Quality Complex Rehabilitation Technology Act" (HR-942/S-948). The day included 245 visits to congressional offices. Another record! The teams making these visits included 25 people who use wheelchairs. They were able to deliver their personal message directly to Congress and truly describe what CRT is all about. And what a great job they all did!

Special thanks to the organizations and individuals who participated in the National CRT Congressional Call-In Day on April 29. The calls made in advance of the Hill visits helped lay the groundwork for many of the congressional conversations and reinforced the request for support of the CRT legislation. Many offices commented they had received calls from the home district.

The great news is everyone's hard work really paid off! As of this writing we've added 20 House co-sponsors and three Senate co-sponsors. That's 23 new Congressional supporters. We now stand at 128 House members signed on to HR-942 and 14 Senate members signed on to S-948.

In addition, we know many attendees are continuing to follow up with certain offices. We expect to see more co-sponsors coming on board in the

weeks ahead. Remember, you can see the current list of who has signed on by state and access tools to pursue your members of Congress at http://www.access2crt.org.

A successful event like this does not happen without a lot of support.

Thanks to the conference sponsors who provided financial support for consumer attendance and made the conference program possible. If you are a provider, please remember them when you make your purchasing decisions. Thanks also go out to all the speakers who did an excellent job sharing their knowledge and advice.

Most importantly, thanks to all the attendees, especially consumer attendees, who traveled great distances to carry the CRT message to their Members of Congress. The commitment and participation from everyone was amazing and provided a solid foundation for the whole conference.

We're already discussing plans for 2015. If you weren't able to be with us this year, we want to see you next year!

State CRT Recognition Progress

While we're working hard on getting CRT legislation passed on the federal level, work and progress is also taking place at the state level. Last year we saw a CRT recognition legislation passed in the state of Washington, which went into effect this year. As we head toward the middle of 2014, we have some additional bills to report on.

In the state of Colorado, HB-1211 was passed in April and will be signed into law by the governor May 22. The bill goes into effect January 1, 2015. This was a great effort involving CAMES (the Colorado state association), consumers, clinicians, and providers. CRT providers Rich Salm of Numotion and Patrick Mahnke of USA Mobility were key leaders in this initiative.

In the state of Connecticut, legislation was passed May 8 and is awaiting the governor's signature as of this writing. The CRT recognition and standards were part of a larger bill that requires the Department of Social Services to report back to the legislature by Jan. 1, 2015, on the expected impact of implementing the CRT provisions. We expect that report to be positive and that the bill will go into effect later in 2015. Passage was achieved through the efforts of a Connecticut CRT Coalition led by Frank Biondello of Numotion and Ed Curley of Hudson Seating & Mobility.

In the state of New York, CRT legislation S-7252 has been introduced effective Jan. 1, 2015, once passed. This effort is being led by Doug Westerdahl of Monroe Wheelchair and NYMEP (the New York state association). A New York CRT Coalition is being formed to help move this legislation to passage.

National CRT Awareness Week

Be sure you have the week of August 18 marked on your calendar as National CRT Awareness Week. This will be our second annual campaign, and we are making plans to make this year's event much bigger than last year's. We will be providing CRT stakeholders suggestion and tools to spread the CRT message on both federal and state issues.

Start talking within your own organizations on what you can be doing within your community to raise awareness of what CRT is and the benefits it provides. Stay tuned for more details.

Recognition is Increasing, but

At a dinner on the eve of the National CRT Conference, Rep. Jim Sensenbrenner , R-Wis., (one of our sponsors) provided a congressional update and commented on our legislative progress to date. He stated he was happy with the increase in co-sponsors and noted our legislative challenge is that we really have two tasks at hand. We need to first educate members about what CRT is and then move to actually advocate for passage of the bill.

This is a good observation and one that underscores the importance of increasing CRT awareness whenever and wherever we can. Thanks to everyone's collective efforts as outlined above we are making progress in that area. Let's keep that up as we have many more to educate!

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RESTRAINTS: ACHIEVING SUCCESSFUL SEATING OUTCOMES WHILE ADDRESSING RESTRAINT CONCERNS

WRITTEN BY: DON OLSON, DPT, ATP

At some point during clinical practice, most seating and mobility practitioners will experience situations in which the application of a postural support device (PSD) is called into question as being a physical restraint. Service providers sensitive to regulatory compliance issues surrounding the use of restraints sometimes challenge products intended to provide greater freedom of mobility, lessen the risk of sitting complications, and reduce the development of orthopedic asymmetries. The concerns of these providers are understandable in light of a tightly regulated service environment. This can be a complicated issue as guidelines between regulating agencies can be conflicting, vague and easily over-generalized ***(Lange, 2011)***.

To address this issue, as well as provide clinical guidance to seating professionals in the field, a number of interested clinical professionals recently worked to develop and disseminate a position paper entitled, "RESNA Position on the Application of Wheelchairs, Seating Systems and Secondary Supports for Positioning vs. Restraint." The authors of the paper possess extensive experience in long-term care facilities, schools, institutions and hospitals, and recognize this as a relevant concern among practitioners who are working to provide appropriate positioning equipment to their clients. The intent was to assist practitioners in decision-making and justification by clarifying the concepts of positioning and restraint. It details current regulatory definitions and applies them to the process of providing products intended to enhance function and reduce complications. This article is adapted from the RESNA paper and provides a snapshot of the critical aspects of the restraint versus positioning discussion. The complete position paper can be found on the RESNA website (http://resna.org/resources/position_papers.dot).

As a professional group, we are wise to be out in front of these concerns and ready to thoughtfully and knowledgeably join conversations with rule-making entities.

The goal in any setting where restraint issues are of concern is for practitioners to work cooperatively with providers to ensure client needs are met in a way which acknowledges the complex issues surrounding external and internal restraint policies, rules and regulations. As with any regulatory issue, changing definitions, interpretative guidelines, and rulings are not uncommon. As a professional group, we are wise to be out in front of these concerns and ready to thoughtfully and knowledgeably join conversations with rule-making entities.

One of the interesting aspects related to the understanding of restraint might be the definition of the word itself, which is "an act or the quality of holding back, limiting, or controlling something." ***(Encarta Dictionary: English-North America)***. Additionally, a restraining entity (or device) is defined as "something that controls or limits somebody or something." While this accepted definition of the word itself is fairly straightforward, there are numerous regulations and policies that define a restraint and subsequently limit the use of these devices in many settings. The definition of a restraint can vary depending on the context or setting: community versus institutional, hospital versus long-term care, pediatric versus adult, and so forth. In contrast, a "support" is defined as "a foundation or prop" ***(Merriam-Webster Dictionary)***. This definition varies greatly in intent from the classical definition of "restraint" It is important to note that although a practitioner may have an appropriate therapeutic or functional justification for the application of a postural support, he or she may find the support satisfies the definition of a restraint in the specific environment where it is being applied, and may be regulated as such.

Practitioners almost universally refer to PSDs as "supports" rather than "restraints," despite the fact that many of the components we use may meet the classical definition of "restraint." Supports, as we know, are used to

achieve a very specific position or posture of a body part in addition to minimizing migration in a specific direction. Restraints, on the other hand, refer to devices used to limit harmful motion during vehicular transportation, or a device used to prevent harm to oneself or others in carefully controlled settings. The Food and Drug Administration and the Centers for Medicare and Medicaid Services also make definitional references to restraints pertaining to medical procedures or orthopedically prescribed devices. Interestingly, the language contained in these references either implicitly or explicitly exempts orthopedically prescribed devices and PSD's from regulatory consideration as a restraint.

The most oft-cited regulation regarding the use of restraints in facilities comes from the Omnibus Budget Reconciliation Act of 1987 (OBRA). OBRA regulations state: "Restraints may only be imposed, 1) to ensure the physical safety of the resident or other residents, and 2) only upon written order of a physician that specifies the duration and circumstances under which restraints are to be used." OBRA regulations apply to facilities receiving federal funding, although other settings may adopt these regulations, interpret them, and add to them. If a wheelchair or seating component is intentionally used as a restraint, documentation must clearly state why a secondary support (a support used in addition to primary supports, specifically seat and backrest surfaces) is being used as a restraint and documentation must be signed by a physician. Many settings add their own interpretation to current regulations. In this case, it is critical for the practitioner to be familiar with the original federal definitions and regulations. Documentation may need to address setting-specific requirements. RESNA's position paper provides much more detailed and exact language from regulatory citations for the interested reader.

To complete the exciting discussion on definitions and regulations regarding restraints and supports, we should include as relevant terminology restraint as it is used in motor vehicle transportation. Restraints in a motor vehicle, or "occupant restraints," are used to minimize the risk of serious injuries during normal and emergency driving maneuvers, as well as in motor vehicle crashes. It is important for practitioners and consumers to understand the differences between occupant restraints and postural supports in this environment as they become critical when a person using a wheelchair for mobility and postural support also uses this equipment for transportation in a personal or public vehicle. For more information on this subject please refer to the RESNA Position on Wheelchairs Used as Seats in Motor Vehicles ***(Buning, 2012)***.

As we enter into discussion of specific supports that may be misinterpreted as restraints in some settings, it is helpful to distinguish between primary postural supports and secondary postural supports (***Presperin Pedersen & Lange, 2001)***. Primary supports can be thought of as the "bare minimum" of postural supports, without them the person would likely fall out of the wheelchair or other mobility device and sustain injury – that is, seat and backrest surfaces, as well as foot supports. There is little controversy that primary supports are not physical restraints, as they have the beneficial effect of maintaining an individual upright and supported in sitting. Secondary supports are typically those used to help maintain a very specific posture or position of a certain body part or area, such as a person's upper torso, extremities or head, while the basic seated position is maintained by the primary supports. Indications for the use of secondary supports is well-documented in the literature ***(Presperin Pedersen & Lange 2001, Zollars 2010),*** but we can summarize these as: 1) minimizing the risk of body postures that impair safety or health, such as skin breakdown, pain, and orthopedic complications; 2) stabilization to allow increase function; and/or 3) accommodation of fixed asymmetrical postures necessary for optimal health ***(Hsieh, 2011, Clark 2004, Zollars 2010)***. All secondary postural support devices are actually intended to block or limit movement – either movement that is a result of the force of gravity (postural collapse), or active movement (voluntary or involuntary). These components have the potential to be identified as physical restraints in some settings. The number and type of secondary support components will vary widely depending on the voluntary and involuntary movement characteristics of the person using them. Individuals with a significant lack of voluntary control will require a very different body support system than a person with voluntary, functional movement. Through the use of established and sound evaluation processes, practitioners and suppliers work to minimize the use of secondary supports, both to lessen costs and to limit the equipment load on users and caregivers. The fact that fewer secondary supports lead to more rational discussion of restraint versus support in some settings is certainly an added benefit.

(CONTINUED ON PAGE 42)

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To minimize the use of secondary supports as much as possible, the evaluation process should always include a discussion of therapeutic interventions that could positively impact an individual's seated position ***(Zollars, 2010)***. I frequently encounter individuals who appear to be profoundly limited in basic motor skills such as head and trunk control. However, during the physical assessment we discover the person may actually have motor skills that have diminished over time from disuse or from limited opportunities for practice. The discussion of seating intervention may lead to recommendations for activities to promote the use of these skills in out-of-chair settings. For example, we might assist in the design of sitting, standing or other gross motor activities, not only to promote health, wellness, interaction and cognitive alertness, but also to reduce dependence on secondary wheelchair postural supports. Other interventions might include, but are not limited to, contracture management, muscle strengthening, tone management, and pain management. Intervention can also be provided to address behavioral issues or sensory seeking by a team enhanced by clinicians who have experience and training in these areas ***(Rappl, 2000)***.

When recommending seating interventions, the decision-making process should include consideration of the least restrictive secondary support devices that still meet the individual's needs. Trial with the recommended seating system may help to determine if the level of intervention is adequate for postural support, stability, and function while minimizing restriction of movement ***(Presperin Pedersen & Lange, 2001)***. An example of this is the use of tilt-in-space as a postural intervention. Tilt/recline technology is a major advancement in management of individuals with complex positioning needs and an appropriate intervention in many clinical situations ***(Dicianno, 2009)***. However, with careful selection of primary support surfaces along with strategically placed secondary supports, some individuals may function well in a fixed orientation, reducing costs and the associated equipment load on the user and caregivers. For more information on the clinical indications for tilt and recline seating systems, please refer to the RESNA Position on the Application of Tilt, Recline and Elevating Legrests for Wheelchairs – as tilt and recline strategies can be misapplied and therefore interpreted as physical restraints in some settings.

The authors of the position paper identified some circumstances that may call into question the provision of seating and mobility equipment not specifically intended for postural support. There are situations in which special seating is employed in settings where the goal of the product is to provide proprioceptive input, or to help a child understand boundaries and facilitate modulation in a therapeutic environment – not to restrain the individual. Seating and mobility bases are also sometimes used in the community with ambulatory individuals who lack judgment and may otherwise stray from their caregivers, possibly into a dangerous situation ***(Yonkman, 2013)***. In both of these scenarios, although the goal of the seating system is not primarily postural control, it still may have clinical and safety goals.

There are situations when the intentional use of secondary support components as a restraint could be clinically indicated for safety reasons, either to minimize the risk of falls or to limit self-abusive behaviors ***(Pierz, 2013)***. In these cases, the use of the component does not meet any of the three clinical indicators outlined above. A very common scenario is a person with cognitive impairment who is at risk for serious injury if they were to attempt to stand from their wheelchair unassisted ***(Chaves, 2007)***. Due to cognitive impairment, this client may not remember or understand that they are unable to stand without falling. In these cases an anterior pelvic support could be indicated for fall prevention, however, the concern arises for some individuals who are able to independently release the belt closure mechanism. Prior to 2007, this was of great concern as OBRA regulations were specific that if a device could not be released independently, it was considered a restraint. Since the operational definition of restraint does not now include this criteria, we are able to better assess the seriousness, and consequences of, an individual's fall risk in order to recommend strategies that may involve devices such as closures only a caregiver can operate. These strategies are not to be taken lightly as there could be a tendency for over utilization as a convenience for staff, or a substitute for less restrictive approaches. In the setting in which I practice, the use of a restraining secondary support is thoroughly vetted by a multidisciplinary specialty team that includes the individual and guardian. Alternative approaches (alarms, signaling devices, asking for assistance) are considered, however if the consequences of a fall may be catastrophic, the team will usually recommend a pelvic belt with

> Seating and mobility practitioners should be viewed as a resource people who not only support the health and well-being of individuals, but also as partners in regulatory compliance.

modified closure be implemented concurrent with other therapeutic strategies designed to lessen the person's fall risk.

In conclusion, for seating and mobility practitioners to be effective in environments where restraint guidelines can be misinterpreted, particular attention must be paid to documenting the clinical indications, as well as risks and benefits for each seating intervention provided. Practitioners would be prudent to include exact language from existing regulations that exempt mechanical postural supports from consideration as physical restraints. Finally, it is important to communicate the beneficial effects of postural supports which distinguish them from physical restraints that are used only in the most regulated circumstances. Seating and mobility practitioners should be viewed as a resource people who not only support the health and well-being of individuals, but also as partners in regulatory compliance.

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WHEELCHAIR RESTRAINT REDUCTION:

How Seating Professionals Can Meet Federal Mandates While Providing Appropriate Intervention

WRITTEN BY: JESSICA PRESPERIN PEDERSEN, MBA, OTR/L, ATP/SMS

What are Wheelchair Restraints and Why the Need for Regulation?

What do you think of when you hear the word restraint for wheelchairs? I think of the device pictured on this gentleman who looks like he is tied to the wheelchair ***(see Picture 1).*** In essence, he is. This restraint is a diaper shaped piece of webbing which is placed between the person's legs with a portion in front of the person's stomach and the other half behind his buttocks. The straps are tied to the wheelchair. The purpose of this restraint is to keep him from getting out of the wheelchair. These restraints were prominent in the '60s and '70s and used to prevent the person from wandering away or falling. Although the intent may have been good, the result was anything but. Besides the degradation of being tied to the wheelchair in such a way, many individuals became agitated, hurt themselves, and some even died in the process of trying to get out. Documented problems attributed to the use of restraints include chronic constipation, incontinence, pressure sores, emotional problems, isolation and loss of ability to walk or perform other activities ***(Atlanta Legal Aid Society).***

One of the major manufacturers of these devices is the Posey Company. Just as Kleenex became synonymous for a tissue, Posey became synonymous for this type of restraint. In fact, it was not unusual for a long-term care staff member to call out for someone to get a "Posey" or that someone needed to be "Posied" in their wheelchair. What was once given to any individual who was unruly or cognitively impaired in an effort to prevent unwanted behavior, these devices are now the last resort for patient safety when using a wheelchair. The Posey Company exists today and continues to make similar pelvic restraints, however, they are advocates for restraint reduction, make hundreds of other products which encourage independent movement, and offer courses in restraint reduction and safety in nursing homes ***(see Picture 2) (Posey).***

Restraining individuals either physically or chemically (by drugging them into sedation) was a common method of keeping someone with dementia safely in a wheelchair or bed in the past. It is now very much agreed upon that such practices took away a person's dignity and rights. The Omnibus Budget Reconciliation Act (OBRA) mandate was passed by President Reagan in 1987. It recognized the detrimental effects of physical and chemical restraints and focused on increasing quality of life and practicing restraint reduction. Each state has state survey guidelines for long-term care. One aspect of the survey is to ascertain that there is a restraint reduction plan in place and that each person using any type of restraint has a physician order and consent from the individual or guardian who is regularly monitored.

Restraints for wheelchairs include any form of strapping such as pelvic belts, anterior trunk supports, ankle and foot straps, and arm cuffs. Restraints also include anything that would impede someone from getting out of their wheelchair, such as trays or arm positioners, wedge or anti-thrust cushions, medial thigh supports, tilt or recliner wheelchairs, or anything that would prevent or impede voluntary movement up and out of the wheelchair. Even if the intended use of the device is not restraint, these interventions may still be considered restraints under certain regulations.

Complex Seating: Compliance with Regulations

As non-ambulatory individuals living in long-term care facilities began to receive complex seating

What was once given to any individual who was unruly or cognitively impaired in an effort to prevent unwanted behavior, these devices are now the last resort for patient safety when using a wheelchair.

systems and wheelchairs, concern about meeting the restraint reduction mandates grew. While most seating practitioners would not consider the equipment they recommend a restraint, the parameters of the OBRA mandate may include these devices.

The restraint reduction practice in long-term care or residential facilities is primarily for individuals with dementia who can walk, however, it is also considered for non-ambulatory wheelchair users, keeping in mind that all individuals should have the least restrictive device available to meet his or her needs.

Kathleen D. Weissberg is an occupational therapist with extensive experience working in long-term care facilities. She provides continuing education to long-term care practitioners throughout the country about restraint reduction and its benefits while following federal regulations. Weissberg states that the individual living in a long-term care or residential facility has the "right to be free from any physical or chemical restraint imposed for the purposes of discipline or convenience and not required to treat the person's medical symptoms" *(Weissberg)*.

Most administrators will acknowledge that Complex Rehab Technology is most likely recommended due to medical reasons rather than as a restraint. In some cases, a diagnosis and statement that the equipment is necessary for medical reasons is enough documentation. Other administrators will refer to the restraint reduction compliance regulation as a necessary avenue to assure that the physician,

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resident and legal representatives are in agreement with the recommendations, and therefore follow the documentation requirements of anyone living in the facility. While reduction of the complex rehab seating equipment considered a restraint may not be a goal, agreement between all parties to use the equipment is mandatory.

According to Weissberg, the following must be documented:

1. If the individual using the device wants the device.
2. All the risks and benefits of the equipment.
3. The therapeutic intervention to enable or promote functional independence.
4. The reason why the particular device is the least restrictive for this particular person.
5. The restraint or supportive device needs to be justified in the care plan.

The following is an example of a situation requiring compliance to restraint regulations. John Jones is a 65-year-old male with spastic quadriplegia resulting from cerebral palsy. He is using a power wheelchair with a power tilt that is operated through a right handed joystick. His seating system consists of a molded seat cushion, molded back support and headrest. A pelvic belt is attached to the seat rail at an 85 degree angle superior to his thighs in front of his pelvis. Jones is unable to release the belt independently. However, it stabilizes him in the wheelchair, preventing him from sliding forward or thrusting outward during functional activities with his UEs. It is the least restrictive device because without it, he would not be able to maintain his

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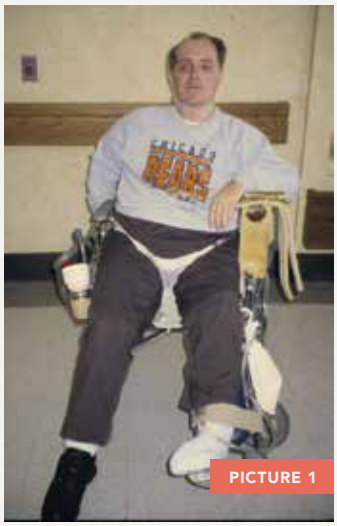
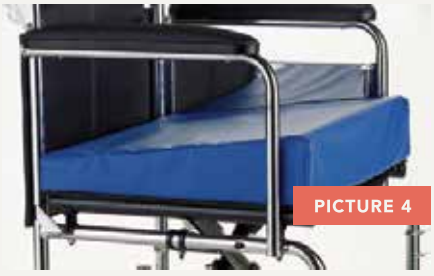

PICTURE 1


PICTURE 2


PICTURE 3


PICTURE 4


PICTURE 5


PICTURE 6


PICTURE 7

PICTURE 1. *1995 use of restraint. Person living in long term care center requiring seating intervention.*
PICTURE 2. *2014 Posey Breezeline Pelvic Holder.*
PICTURE 3. *Posey Soft strap. This strap is softer then a webbing strap and the individual may be able to release it more easily, however, placement might allow the pelvis to slide forward into a posterior pelvic tilt. Note there is no cushion on the wheelchair, which is not recommended by seating professionals.*
PICTURE 4. *When issuing a wedge cushion to prevent a ambulatory person with dementia from getting out of the chair, an evaluation should be performed to assure that the person has the hamstring range for this decreased seat to back angle.*
PICTURE 5. *Skil Reclining back with webbing strap as attachment. This allows for a more open seat to back angle, however, the uprights of the chair may interfere with UE function or rub against the shoulders.*
PICTURES 6 & 7. *The Posey self- releasing hugger or lap hugger for wheelchair desk arms are provided to discourage individuals from getting out of the wheelchair.*
PICTURE 8. *Invacare Geri chair.*


PICTURE 8

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(CONTINUED FROM PAGE 46)

functional posture in the wheelchair. John is his own guardian and his sister is power of attorney, if Jones should need one. Jones wants to use the pelvic belt whenever he is in the wheelchair. Jones, his sister and his physician agree it is beneficial to have the pelvic belt and sign an agreement form every quarter as is required by the state. Jones prefers to be in the wheelchair when he is out of bed due to the opportunity for independent mobility. He changes position through the seat functions on his wheelchair and does this as needed throughout the day.

Weissberg also states that even if a wheelchair and seating system is appropriate, there has to be some off time to allow freedom of movement or a change in position. The only alternative might be resting in bed, but if other sitting or standing opportunities are available and safe, it is strongly recommended that the person be allowed to change position. This parallels recommendations by Complex Rehab Technology professionals and seating literature stating that alternative positioning opportunities are recommended. Mandatory regulation assures the person has opportunity to change positions as is practical.

Restraint regulations might also provide justification for higher end products that would allow the person to remove the perceived barrier. For instance, a hinged desk style arm support for someone with hemiplegia may allow the person to independently flip up the support to get it out of the way during a transfer. Easy to release pelvic belt buckles might be recommended to allow the person to independently remove a belt. Removable or flip-up armrests might be recommended to allow a person to transfer more easily.

Administrators in long-term care settings, as well as state surveyors, are becoming more aware of individuals living in residential facilities who use complex rehabilitation equipment. It is the seating professional who must continue to educate administrators, nurses, therapists, direct care staff, and surveyors about the beneficial use of the equipment while fulfilling the documentation and regulatory requirements concerning products which might be considered restraints. The justification for an open seat to back angle, superior thigh belt, medial thigh support, or tilt wheelchair should be provided in a way anyone can understand. Pictures of the wheelchair seating system in use can be very helpful.

The Seating Professional's Role in Restraint Reduction for the Elderly person with Dementia Who Ambulates - An Opinion

I have had the opportunity to see what type of products are used as restraints or as part of the restraint reduction program for people living in long-term care facilities who ambulate and have dementia. Often times, the products are purchased by administrators who have little or no involvement with a seating professional. Some of the products are therefore being used without considering physical and functional abilities. Therapists working in long-term care facilities may not see wheelchair seating as their role, especially for individuals who can ambulate. I am hoping this is beginning to change and see the role of seating professionals as educators and mentors to those serving this population. As the experts in wheelchair seating who dedicate ourselves to learning about new products and sharing evidence and experience in seating intervention, I feel we need to help people working in long term care facilities.

Demonstrating the need for a proper evaluation with measurements of range limitations allows the participants to understand why equipment needs to be customized for the user and why one solution may not work for someone else.

Certain products are intentionally used as restraints and are designed to fit within restraint regulations. Unfortunately, these products can have a negative impact on posture.

The only alternative might be resting in bed, but if other sitting or standing opportunities are available and safe, it is strongly recommended that the person be allowed to change position.

Belts or strapping - Belts or strapping can be easily removed by the individual. While this may provide independence in removing the strap, the placement is often questionable. Many times strapping or belts are in the abdominal region (with potential to cause soft tissue injury) or at an angle that allows the person to slide forward into a posterior tilt or under the strap ***(see Picture 3).***

Wedge seat cushions - A wedge style cushion is a common alternative to a pelvic/hip belt and is designed to prevent someone from getting out of a wheelchair. Seating professionals may find the angle promoted by a wedge of this size a little extreme. Before using a wedge cushion, it is essential to determine if the person has adequate range of motion. If the person has tight hamstrings, a wedge is contraindicated and could lead to a posterior pelvic tilt. Many aging individuals tend to have tight hamstrings, often addressed by increasing the seat-to-back angle rather than decreasing it the way a wedge does ***(see Picture 4).***

Recliner back - When an individual does need a greater than 90 degree seat-to-back angle, rather than opening the seat-to-back angle on the frame or using a reclining wheelchair, a foam and vinyl back may be attached to the back canes with webbing which opens the seat to back angle. This is typically a cost saving measure, rather than an attempt to circumvent restraint regulations. The back may provide enough of a seat-to-back angle opening to accommodate the person's needs (i.e. fixed kyphosis). However, the client may not fit between the back canes ***(see Picture 5).***

Elevating leg rests - Elevating leg rests have been used to keep someone

(CONTINUED ON PAGE 50)

WHEELCHAIR RESTRAINT REDUCTION: ...
(CONTINUED FROM PAGE 49)

in the wheelchair, rather than accommodate postural needs or range limitations. These can be removed or swung to the side on a regular basis to allow for freedom of movement and to allow the client to get out of the chair while supervised. A common problem with using elevating leg rests, as we know, is that the person may have tight hamstrings, limiting the available range of motion at the knees.

> "The residents in geri-recliners are the dorks of the nursing home."
>
> Eleanor Barbera, Ph.D.

Trays – The foam style tray is very popular as a method to keep someone from getting out of the wheelchair, avoiding use of strapping. It is designed to release when squeezed ***(see Pictures 6 and 7)***. This obviously does not impact posture with the exception of supporting the arms.

Geri chairs - In a 2011 article, Eleanor Barbera, Ph.D., states, "The residents in geri-recliners are the dorks of the nursing home." The geri chair is still commonly used to provide seating in long-term care facilities and is difficult to get out of. It is hard to understand how these can be seen as comfortable or accommodating to a person's body. Geri chairs are often difficult to maneuver, take up extra room in the elevator (thus reducing the chance of being transported to activities), and make it virtually impossible for residents to go out on pass with their families to enjoy a meal at home or in a restaurant if another mobility base is not available. Additionally, people tend to assume residents in geri-recliners aren't "with it." The seating professional would note that the vinyl covered foam is often hard and unforgiving. The seat depth is usually very long, causing the person

(CONTINUED ON PAGE 52)

INVEST IN THE FUTURE OF CRT

If you're with a company that provides or manufactures Complex Rehab Technology (CRT) you know coverage and payment challenges continue to mount at the federal, state, and private payer levels. It's a real battle out there.

To protect the interests of your customers and your business, we invite you to invest in the future of CRT by joining the National Coalition for Assistive and Rehab Technology. NCART works with policy makers, legislators and others to establish and maintain appropriate coverage and funding in order to protect and improve access. But NCART needs additional companies to join the fight.

We're asking you to join other committed CRT providers and manufacturers in supporting efforts to protect access to CRT by becoming an NCART member. Companies can submit an online membership application by going to the NCART website at www.ncart.us and visiting the Membership area.

For questions or additional information contact Don Clayback, NCART Executive Director, at 716-839-9728 or dclayback@ncart.us. Thanks for your support!

www.ncart.us

JOIN TODAY!

NCART was established to provide the leading advocacy voice on CRT issues. Our mission is to ensure individuals with significant disabilities and chronic medical conditions have adequate access to needed CRT products and services.

The resources and activities of NCART are focused on three primary priorities:

-- Securing a Separate Benefit Category (H.R. 942 and S. 948) to provide formal recognition of the specialized nature of CRT and improve coverage policies and safeguards.

-- Addressing Medicaid CRT problems by providing strategic advice and advocacy on CRT coverage and funding issues.

-- Building relations with Consumer and Clinician organizations through joint advocacy among all CRT stakeholders.

NCART brings together dedicated CRT providers and manufacturers to make a positive difference. Join NCART today to fight for CRT so people in your community can access the specialized equipment and services they require and depend on.

WHEELCHAIR RESTRAINT REDUCTION: ...
(CONTINUED FROM PAGE 50)

to be pulled into a posterior pelvic tilt. The knee angle is never less than 90 degrees, often pulling on tight hamstrings. Obviously, there is no opportunity for self-propulsion ***(see Picture 8).***

My question is often, "how about providing the people who are ambulatory but may fall or wander when not supervised an opportunity to sit in a wheelchair and propel themselves?" This doesn't seem to be an option in any of the solutions to restraint reduction I read. It would seem that rather than frustrate someone who may need to move, providing a means of safe self-propulsion rather than a geri chair might be one solution.

This article is not meant to justify complex seating intervention, as it is expected the seating specialist is aware of the benefits of optimal seating. Several articles and books are available for someone wanting to learn more about seating intervention and its benefits. This article is meant to explain that the OBRA mandate was meant to recognize the rights of individuals living in long-term care facilities and provide for freedom of choice while maintaining safety. While we advocate for the most optimal form of seating intervention, federal regulations and mandates must be followed in applicable settings. Documentation and education is critical to ensure complex seating is allowed in long-term care facilities while providing the individual using the equipment the opportunity to use the least restrictive seating to meet their needs and alternative positions outside of the wheelchair. The article also touches upon devices being recommended in nursing homes to prevent individuals from falling when supervision is not consistently

available. Proper use of these devices may be overlooked due to lack of education and understanding of seating principles. As seating professionals we can reach out to people working and living in these facilities to ensure optimal interventions.

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PROGRESS

WRITTEN BY: JENN WOLFF AND ALEX BENNEWITH

My first advocacy trip to Washington, D.C., was with you – the suppliers, manufacturers, clinicians and other advocates – in 2010. It was life-changing. For the first time in my life, I felt like I could help encourage change. It was empowering – addicting almost. The "high" of being around people who were all fighting for the same thing, of being around other motivated people, of being around people who cared about the end-user getting the right equipment was energizing. As I think back today and remember that trip, it is very gratifying to see the progress Complex Rehab Technology (CRT, HR-942/S-948) has made.

In 2010, our government had just been through an enormous debate on health care, more specifically the Affordable Care Act or "Obamacare." Our legislators were tired of hearing about anything related to health care issues even if those policies did not make any sense. None of my state legislators were aware of CRT and what was happening to many wheelchair users.

All parts of this system are working together for better assessment, service, equipment and better reimbursement so suppliers and manufacturers can stay in business.

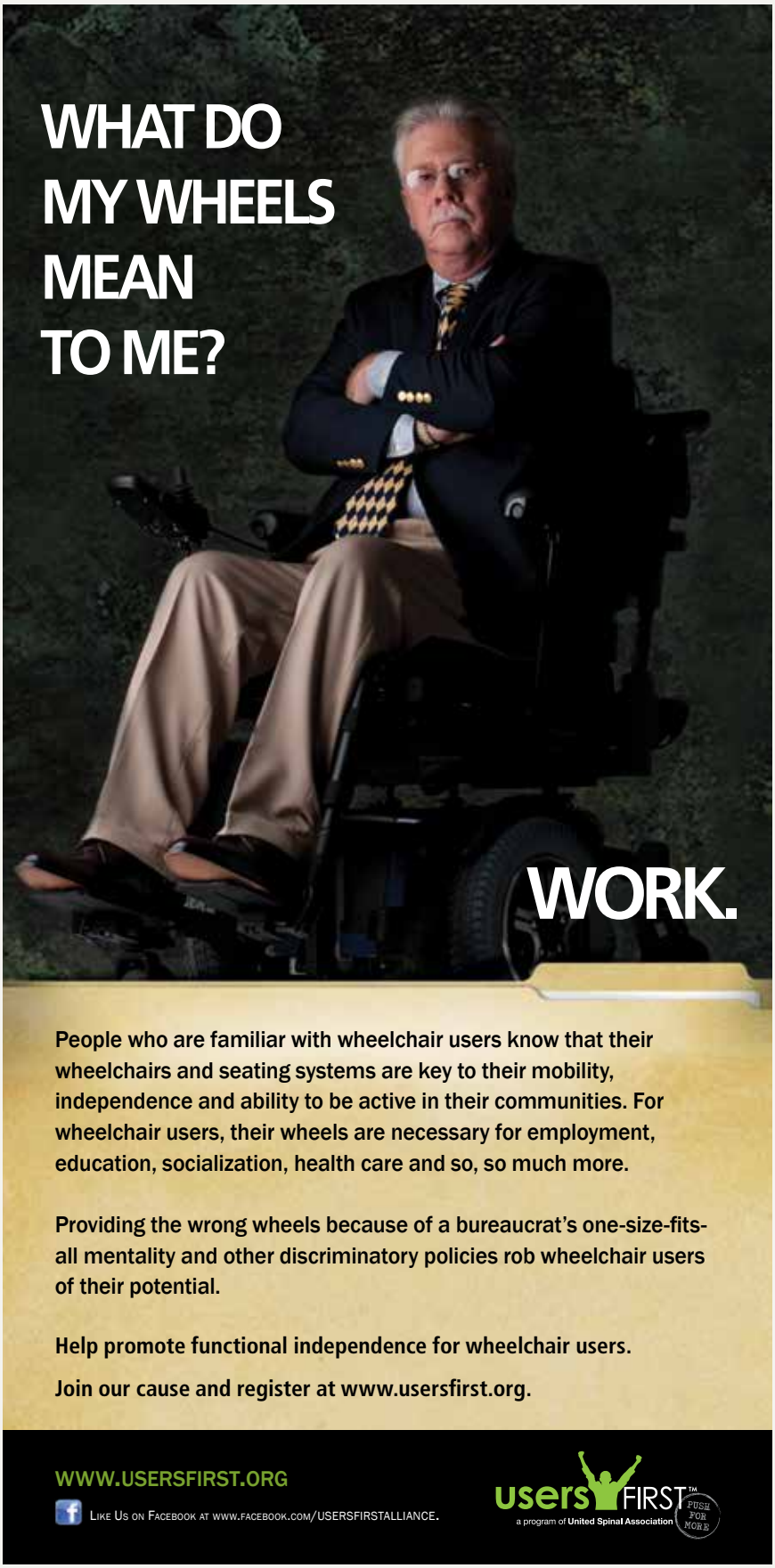
Through the next several years, some of the advocates stayed the same. Some changed, but the message became stronger. Congressional health legislative aides began to remember us and understand some of the complexities surrounding CRT – like getting an unadjustable K4 wheelchair due to "in the home" instead of a K5, because, of course, all wheelchair users stay home all the time, right?

I was able to attend a few Abilities Expos with UsersFirst, which only riled me up more. I heard the horror stories people had to struggle through just to get the piece of equipment that allows them to live the lives they choose, instead of being stuck at home or worse, in an institution. So many wheelchair users were glad to know a group like UsersFirst existed and that they were not alone in this fight.

This year, we seem to have turned a corner. The team approach is working. The trade associations, suppliers and manufacturers alike are looking beyond the financial bottom line and want to see their clients/consumers thrive. Clinicians who understand the evaluation process and documentation, but still cannot get their patients the equipment they should have, and advocates whose passion and dedication can drive system change for themselves and others. All parts of this system are working together for better assessment, service, equipment and better reimbursement so suppliers and manufacturers can stay in business.

The progress made from 2010 to now is tangible. At this year's NCART/NRRTS CRT conference, all of my Iowa legislators knew exactly what we were talking about and five out of six are in support of CRT. For the first time, there was talk about which bill it could get attached to or "who else do I need to talk to?" We are now truly getting somewhere. At press time, we now stand at 128 representatives signed on to HR-942 and 14 senators on S-948. Go team!

UsersFirst works to get the grassroots community involved and empowered to join the fight. Visit our website at http://www.usersfirst.org to view the stories we are hearing – both good



and bad. Continue to share UsersFirst information with your members, clients and consumers and we will continue to make our voices heard to generate positive change. Join me, Jenn Wolff. Join us. Join the movement at http://www.usersfirst.org/forms/join.html. You'll find me and UsersFirst at United Spinal's Roll on Capitol Hill policy and advocacy conference in Washington, D.C., June 22-25.

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CLINICIAN TASK FORCE: DEEP DIVE INTO DEFENSIBLE DOCUMENTATION

WRITTEN BY: ELIZABETH COLE, MSPT, ATP

Clinical documentation has come under rigorous scrutiny with stricter standards and more stringent coverage criteria. The "old way" of writing is no longer acceptable, including use of broad statements, parroting policy verbiage, using "cookie cutter" language, and/or just dazzling with the brilliance of technical "lingo." New expectations demand clear and concise information, a clinical picture specific to the individual and most of all objective, quantitative exam results to support what is being prescribed. Justification can no longer be based on subjective professional judgment or patient report. To clearly spell out the rationale, the dots must be connected between the evaluation results and the recommendations.

The members of the Clinician Task Force recognize that although it is the therapists and physicians who provide the clinical documentation, it is the suppliers who bear a financial burden if it is insufficient. We are therefore dedicated to helping to ensure clinical (and supplier) documentation is complete and sufficient to meet funding requirements. Through ongoing education and training via NRRTS webinars, publications, and in person training, we hope to raise the skill level so suppliers can provide equipment with the knowledge that the documentation will hold up in an audit. To this end Laura Cohen, PhD, PT, ATP/SMS, and I developed the content that follows in this article after encountering the same issues over and over again in reviews of clinical documentation for wheeled mobility and seating equipment claims. We hope it is useful information for clinicians to utilize and for suppliers to pass on to their referrals.

Basic "DOs" and "DON'Ts"

There are several basic "dos" for any document submitted for reimbursement. Although some of these may seem obvious, they unfortunately are often overlooked. First, every evaluation form or letter of medical necessity (LMN) should contain a title to indicate what type of report it is. That is, it should clearly show whether it was generated by the physician, the therapist or the supplier. For example, an evaluation from a physical or occupational therapist could be titled "Clinical Seating and Mobility Evaluation," while the documentation from a supplier could be titled "Technological Evaluation." The patient's name should be at the top of every page and each page should be numbered (i.e., pg 1 of 5). The date of the exam should be clearly indicated (it is amazing how often this is not obvious or not there).

The evaluator should sign and date the document with either an electronic or a handwritten signature. If others sign in concurrence, there should be a statement to indicate their agreement followed by their signatures and not just their signatures alone. All signatures should be dated and the person's name should be legibly printed above or below. In the case of an illegible signature, a separate signature attestation could also be included.

If the document itself is handwritten, it must be "readable" with little effort from the reviewer, both as far as legibility and organization. Areas for comments should be large enough and spaced sufficiently to allow the required writing to be legible. Use of a lot of unfamiliar abbreviations and clinical "lingo" should be avoided.

Evaluation Forms

Clinical documentation may consist of an evaluation form or an LMN or both. Which one is used may depend in part on the requirements of the specific funding source (FYI, Medicare does not specify or require one versus the other). Although both have pros and cons, a thorough evaluation form is often much better than an LMN. Because the LMN is a narrative, it runs the risk of leaving out important information from the examination, especially critical objective exam results.

A good evaluation form should include much of the information that

would be found on any initial evaluation for any patient, as described in the sections that follow.

Interview and History

The interview should contain the primary and secondary diagnoses and complaints, history of the condition(s), prognosis, recent changes, surgical history/plans, height and weight. There should also be a brief description of the person's "social history and status," such as caregiver assistance, type of home, mode of transportation, environments of typical use, daily activities and activity level. Finally, a list of the individual's and/or caregiver's goals should be provided. Remember, the document must "paint a picture" for the reviewer who has never seen this person and knows nothing about him/her.

There should also be a sufficient description of the individual's current equipment and any additional equipment at home; i.e., cane, walker, manual wheelchair, power wheelchair or scooter. Information regarding the funding source, manufacturer, model, age and seat dimensions of the wheelchair, the seat cushion and the back support should be included, as well as any pertinent features or options. Most importantly, the documentation must provide the specific reason as to why the current equipment is no longer appropriate (it is amazing how often this is missing as well).

Finally, a review of systems should identify impairments in bowel and bladder function, endurance, hearing, vision, communication, cognition and cardiopulmonary function. Documentation of pain should include the specific location, severity and triggers. Information on skin integrity must be provided, especially for skin protection cushions, therapeutic support surfaces or tilt or recline systems. This includes the location, stage and cause of past and/or current breakdown (with ICD-9 codes), a list of risk factors, the location and extent of impaired sensation, as well as a description of the method, frequency and effectiveness of weight shifts.

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CLINICAL TASK FORCE: DEEP DIVE INTO...
(CONTINUED FROM PAGE 57)

Physical and Functional Exam

The physical and functional exams should be as thorough as that for any initial evaluation. This should include an assessment of UE and LE motor coordination as well as the type, triggers and location of any abnormal muscle tone. The assessment of muscle strength should be as detailed as needed. In some cases, it might be sufficient to say something like "right UE 3/5, left UE 5/5, right LE 2/5, left LE 4/5, while other cases might require identifying the strength of specific muscle groups (i.e. right shoulder 3/5, elbow 4/5 and wrist 4/5). Still, in other cases, specific muscles should be tested (i.e., in the case of SCI). In all cases, the results should be quantitative and all four extremities should be addressed in some way. Similarly, any limitations in ROM should be described by specific joint angle measurements.

A postural assessment is a must. Again, it is surprising how often this is inadequately addressed. The specific posture of the pelvis, trunk, LEs and neck in sitting should be described, abnormalities and limitations in the pelvis, trunk and lower extremities should be documented and postures should be identified as fixed or flexible. Static and dynamic sitting balance should be described, as well as the location, amount and type of support required to achieve optimal posture. Remember, the seating recommendations must relate back to these results.

Justification for any device must rule out lower cost alternatives for mobility. As appropriate, there should be an assessment of the person's ability to ambulate (with and without any device), propel an manual wheelchair and operate a scooter and power wheelchair, as appropriate. Objective exam data to demonstrate limitations must be documented. This might include distance covered, time required for the distance, gait or stroke pattern, method of propulsion and so forth. The specific limiting factors should be identified and quantified. These could include pain, cardiopulmonary compromise, fatigue, instability, risk of falls and so forth. Quantitative data, such as "before" and "after" measurements of O2 sat, HR, BP, RR, and/or pain, along with the time needed to "recover" are excellent ways to document adverse effects. This is probably one of the most poorly covered areas in supporting documentation of the therapists (and the physicians).

The evaluation form must have appropriate objective exam results to demonstrate that trials with mobility equipment were actually performed. Equally as important is ample space in each section for comments that will explain the effects of any limitations for that individual, demonstrate that coverage criteria are met and support the final recommendations. These comments must be specific for that person. Again, it should be clear as to which information came from a subjective patient report versus actual examination, testing or observation.

Assessment and Plan

The assessment is the product of analyzing the exam results, determining what equipment parameters are needed to achieve seating and mobility goals and documenting the rationale for their medical necessity. Generic equipment features should be matched to the physical and functional problems observed during the exam. In other words, for each limitation or issue, it is important to identify what the equipment needs to provide or do in order to correct, accommodate, facilitate or ameliorate the problem. It should also be clear why lower coded alternatives are not sufficient. The plan should identify what is appropriate to achieve the goals, including further therapeutic treatment, additional equipment trials, and/or a recommendation to order equipment

More and more funding sources are looking for objective, quantitative exam results. A subjective report from a patient regarding a limitation or a negative result with a particular type of equipment in the past does not ensure this is still currently relevant or true. Similarly, just because a patient arrives at a clinic using a certain

> They are looking for evidence that the individual meets the coverage criteria for the specific device recommended and that the device is medically necessary.

type of device, this does not guarantee he or she qualified for it when it was issued and/or qualifies for it now. Clinicians must evaluate for themselves and write their own documentation based on their own observations. Unfortunately, the most common reason for claim denials is that the medical records failed to clearly establish medical necessity for the device and failed to rule out lower cost alternatives.

Red Flags for the Reviewer

There are certain "red flags" that might cause a reviewer to pause, including:

- Inconsistency between documents, such as when the therapist's information conflicts with the physician's or the supplier's documentation.
- Verbiage in the LMN that is not supported by, contradicts, or is completely new from, what is on the evaluation form.
- Generic lingo and "cookie cutter" verbiage that does not completely apply to that person and appears to have been merely chosen from a generic list of justifications.
- Broad statements and generalizations with no objective exam results for support.
- A big leap from current equipment to requested equipment with little explanation/rationale.
- Descriptions and/or rationale that are inconsistent with photos.
- Redundant, duplicative, excessive and/or medically unnecessary items.

What Is The Reviewer Looking For?

To recap, the reviewers are looking for a description of the seating and mobility limitation and how it specifically affects the individual's ability to carry out all required activities in all typical environments. They want objective test results that demonstrate the physical/ functional limitations and support the need for the recommended items. This includes specific test results that were actually observed and measured, and not just vague statements. They want specific justifications for the base and any feature or option and these justifications must relate back to specific evaluation results. They are looking for evidence that the individual meets the coverage criteria for the specific device recommended and that the device is medically necessary. There must be evidence that all lower alternatives have been sufficiently ruled out. And finally, there must be a description as to how the recommended device will meet the needs and solve the daily limitations of the individual and why the recommended device(s) is the most appropriate and cost effective solution. The results should be presented in an organized, recognizable and understandable manner. Do not expect the reviewer to dissect the information or go on a "treasure hunt" in search of the necessary information. If it is not obvious, and clear, they will most likely miss it.

When writing documentation it is critical to consider that the reviewers have never seen the individual and are relying solely on the documentation before them to make a decision. Although they may have a clinical background, they may know very little about wheelchairs and seating. Even if they do have clinical experience, they are typically not permitted to use their own judgment or clinical inference. A great exercise is for a clinician (or supplier) to put himself/herself in the reviewer's seat. Based on the documentation, would there be enough information to approve the recommendations without ever having seen the patient?

In closing, a paradigm shift is needed in clinical documentation practices. Clinicians can no longer perform the evaluation and merely provide their clinical judgment. They must clearly document what they have done and provide objective evidence to support the recommendations. They must write with a reviewer's "eye" and continually self-assess their documentation. If you would like an example of a clinical evaluation form for seating and wheeled mobility to use and/or pass on, please go to http://rehabtechconsultants.com/resources.html.

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TEN FACTS ABOUT THE SMS CERTIFICATION

WRITTEN BY: ANDREA VAN HOOK

FACT #1: It's an advanced certification for seating and mobility professionals who provide direct client service.

Unlike the ATP certification, which is designed to establish a base level of knowledge among all assistive technology professionals, the SMS recognizes and identifies rehabilitation professionals with advanced clinical knowledge, expertise and skills in seating and mobility.

FACT #2: The SMS is a growing certification.

RESNA launched the Seating and Mobility Specialist exam in 2009 due to community input expressing a need for an advanced certification in this area. There are now 122 SMS-certified individuals currently active in the United States and Canada, and the number continues to grow every month.

FACT #3: If you've been working in direct client service doing advanced seating and mobility for at least three years, you're probably eligible.

There are three requirements:

- Hold an ATP certification in good standing.
- Have at least 1,000 hours of direct, in-person, consumer service delivery experience in seating and mobility at any time during career. (These hours can be the same hours used to establish eligibility for the ATP.)
- Demonstrate initiative in two of the seven professional service categories within the past five years. The professional service categories are: continuing education (CRTS® designation from NRRTS can fulfill this category), presentations/formal instruction, mentoring/supervision, client service delivery (examples provided on the website), advocacy, leadership, and publication.

Some employers have started encouraging their staff to obtain their SMS.

FACT #4: You do need to study for the exam.

The exam focuses specifically on seating, mobility and positioning. There are 165 questions and it includes photographs and videos. Questions cover performing an assessment; funding resources, coverage, and payment; implementing an intervention; outcomes assessment and follow-up; and professional behavior. Studying is recommended, and some companies, like The MED Group, offer SMS exam prep courses. Check the RESNA website for resources.

FACT # 5: The SMS certification is not required … yet.

Right now there is no regulation or requirement for professionals to obtain the SMS certification. This may change in the future. Some employers have started encouraging their staff to obtain their SMS. If the legislation establishing a separate benefit category for Complex Rehab Technology (CRT) in Medicare is passed, it would require practitioners to have an "ATP plus." There's discussion within the industry that the SMS certification could be the "ATP plus," but that is not yet established.

FACT #6: Certificate holders are required to uphold RESNA's Code of Ethics and Standards of Practice.

As a condition to be able to use the SMS designation professionally, certificate holders are required to abide by these standards and ethics. This requirement ensures consumers are receiving high quality, unbiased advice that supports their goals for themselves.

FACT #7: Compliance with the standards and ethics is enforced.

RESNA's Professional Standards Board (PSB) monitors and maintains compliance with the Code of Ethics and Standards of Practice. The complaints policy, available on the RESNA website, outlines the process whereby the PSB can take action to protect the integrity of the certification process, up to and including revocation of the credentials. These actions can include reporting to legitimately-interested entities, such as state licensing authorities, accrediting bodies, federal and state Medicare/ Medicaid reimbursement authorities and other payers, and employers. It can also include revoking or suspending certification; probation; and asking for acts or behaviors to be immediately corrected.

FACT #8: Once certified, the same continuing education courses can count towards maintaining both the ATP and the SMS certifications.

There is a common misperception that if you have both certifications, you then have double the continuing education requirements in order to maintain your certifications. The same continuing education requirement applies to both. There's nothing extra required to maintain the SMS.

(CONTINUED ON PAGE 62)

TEN FACTS ABOUT THE SMS CERTIFICATION
(CONTINUED FROM PAGE 61)

FACT #9: It doesn't cost "double" to be an ATP/SMS.

Once you receive your SMS certification, your ATP and SMS certifications are coupled together, so you renew both at the same time and pay only an additional $50.

FACT #10: SMS certificate holders report increased job opportunities, greater job satisfaction, and higher standing among their colleagues with the certification.

Since the SMS is not required, those who decide to achieve their certification tend to do it out of a sense of professional pride. Anecdotally, these SMS certificate holders report they are being considered for better job opportunities, have greater job satisfaction, and enjoy a higher professional standing. For example, Alice-Marie Laverdiere, ATP/SMS, found her certifications very helpful as she began building a career in international circles. "I recently have been involved in global issues in wheelchair service provision with United Cerebral Palsy Wheels for Humanity and with the World Health Organization that I believe would not have happened for me without the ATP and SMS certifications," she said.

Check the RESNA website at www.resna.org for information on application and testing periods.

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UPGRADE... IS THIS A BAD WORD?

WRITTEN BY: CLAUDIA AMORTEGUI

It seems every which way we turn as a provider, our biggest fear is an audit. They seem to be coming at us from all sides and unfortunately have us all on pins and needles. I have seen this fear has now made many providers antsy about looking at anything that does not fit in the perfect "funding box." As providers stay within this box, they are missing on potential revenue, and more importantly the end-users are not being offered opportunities for even better products.

In the past year or so, I have heard people say upgrades are not allowed. What bothers me most is this seems to be an all-inclusive statement. Let it be known that upgrades are still allowed in certain situations. Whether you are a provider, referral or even an end-user, you need to know the specific funding situation for each individual order.

Rather than simply educate end-users on all product possibilities – from options to full bases – some providers seem to skip over this information assuming such items would never get funded. I get it. Margins have shrunk, and times are tough for many. This practice is not done in spite of the end-users, but in protection of your business.

As an industry, many of us need to take a step back and look at the full picture when it comes to upgrades. The first and most important rule of any upgrade is that it must be the client's choice. An upgrade is their option, and not something they can be forced into. Think about it in the simple, everyday world. If you are buying a car, a good salesperson would tell you about every additional option you can choose. In most cases, you will not select all of them, but you know what is available and the salesperson is not limiting you on what you are buying. When it comes to wheelchairs, they allow many people to live their everyday lives; therefore they also need to know all their options.

Let's break down the basics for key funding areas:

- Medicaid – Many people feel that as a provider you can never collect cash from a Medicaid patient. "Never" is not actually the case. There are instances where you are able to collect cash from a Medicaid client. For many states, this is for items they deem non-covered or items they deny for specific reasons. As a provider, you need to know the rules for your state programs. Another option for some Medicaid clients is that family, friends or a community may want to provide an item as a gift. This is more common after the initial wheelchair is received, and they are looking to add a specific option.

Some Medicaid programs will use an Advance Beneficiary Notice or some other type of waiver. If not, I would be certain to obtain something that shows the client's agreement in wanting the specific item. When it comes down to it, you must do the research to provide an upgrade for a Medicaid client. Be smart – know the details before you say, "Yes" to the upgrade.

- Medicare – Around the time manual wheelchair bases in the K0009 code category were "reclassified" by the PDAC, there was a rumor going around that upgrades could no longer be provided to Medicare clients. This is untrue. Upgrades are still allowed by Medicare, they just have to be correctly done. In these cases, an

If you are buying a car, a good salesperson would tell you about every additional option you can choose.

ABN is key and required in most situations. When looking at upgrades, providers do need to know what is considered an upgrade. In Medicare's world they point to an "excess component" – an item or feature that is in addition to, or is more extensive than the item which is reasonable and necessary under Medicare's coverage criteria.

Just like you may not know their insurance nightmares, we cannot expect them to know the nuances with upgrades.

As a provider, you need to know what meets this upgrade definition, what is considered included in the base (if billing with the initial wheelchair order), and how to properly execute the upgrade. Keep in mind that some upgrades will be done after the initial chair order. In some cases, clients may even choose to purchase a "back-up" item such as a full wheelchair base or specific parts such as a second set of wheels and tires. Medicare does not deem back-up equipment as medically necessary, but it would still be their choice to purchase these items. An ABN in this scenario is not required, but I always recommend one.

• Private Insurances – When it comes to private insurance, you are looking at a full mixture of policies. In most cases, using Medicare regulations as the foundation is not a bad idea, but many private funding sources will be more open to certain payments. If prior authorization is an option, it will be your best way of knowing up-front as to what will be paid and what could be considered an upgrade. Again, many of these funding sources will also use an ABN or waiver type form.

Ultimately, providers should not ignore or turn their backs on upgrades. By all means, always let your clients know what will be funded by their insurance, but also be sure to educate them on other possibilities. Put yourself in their shoes, and then top it off by pretending you were never in this industry. I am sure you would want to know about all the items that could make you more functional and your overall life easier. Have the conversation with them and feed them the knowledge. Let them make the choice and by no means should you give the upgrades away.

Providers must also realize they need to help educate their referrals on this subject. Just like you may not know their insurance nightmares, we cannot expect them to know the nuances with upgrades. Again, just have the conversation. Hopefully, you will know the client's funding prior to the seating assessment. This will allow you to talk with the referral about the specific coverage requirements and/or limitations. You can then work as a team to provide the client with the education regarding product and funding.

For any type of upgrade, it is strongly recommended to obtain, at minimum, a portion of the payment up-front prior to ordering, and of course the completed and signed ABN/waiver. As much as upgrades are for the end-users, providers need to be certain they are protected as well.

When it comes down to it, upgrades are a benefit to end users, referrals, and providers. End users have the right to choose something to help improve their everyday lives. Referrals should see their patients functionality improve (i.e. outside in their community), and providers will see a nudge in their bottom line while providing what their clients want.

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Congratulations to the newest NRRTS Registrants. MARCH 18, 2014 THROUGH MAY 21, 2014.

Russell Roggenkamp, ATP, RRTS®
Grace Healthcare
1120 Broad Ave
Gulfport, MS 39501
Telephone: 228-863-3331
Fax: 228-248-4414
Registration Date: 4/11/2014

Donald Wrye, RRTS®
1st America Home Medical Equipment, L.P.
212 Northside Dr
Valdosta, GA 31602
Telephone: 229-242-3060 x.7022
Fax: 229-242-9914
Registration Date: 3/25/2014

Brent Manning, ATP, RRTS®
MacPherson's Medical Supply
2325 S 77 Sunshine Strip Ste B
Harlingen, TX 78550
Telephone: 956-412-9100
Fax: 956-412-9105
Registration Date: 5/21/2014

new CRTS®

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 listed are from MARCH 18, 2014 THROUGH MAY 21, 2014.

Rusty Horne, ATP, CRTS®
Numotion
Middleburg, FL

Jay Lujan, ATP, CRTS®
Numotion
El Paso, TX

Eric Newell, ATP, CRTS®
American Seating and Mobility
Portland, OR

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 March 18 through May 21, 2014. For an up-to-date verification on Registrants, visit **www.nrrts.org**, updated daily.

Jason Oravec, ATP, Springfield, OR
Tim C. Regan, ATP, Tucson, AZ

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