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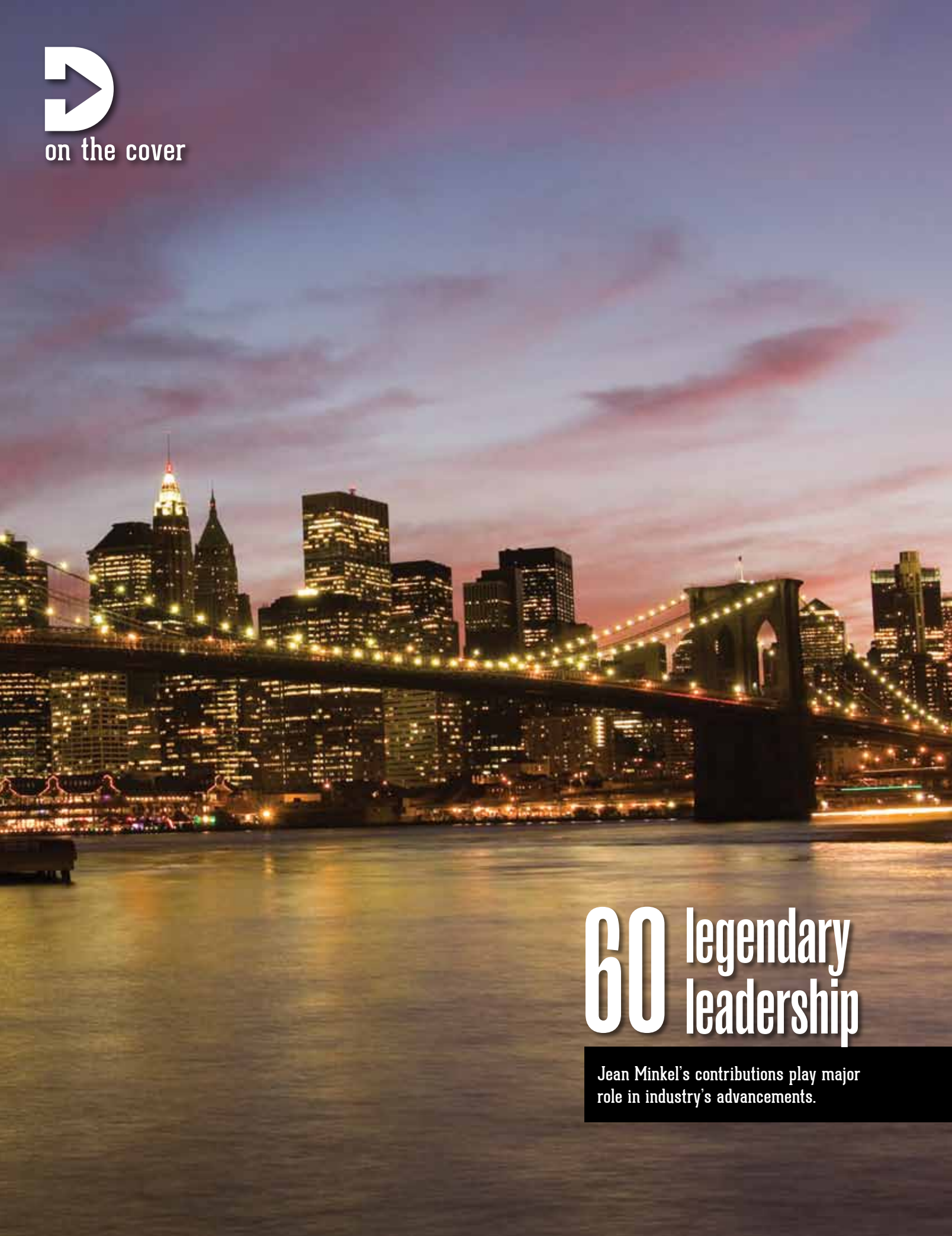

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ALEXANDRA (ALEX) BENNEWITH

Bennewith is vice president of Government Relations for United Spinal Association. She advocates for legislation and regulations regarding disability and health policy at the federal and state level and works closely with a range of stakeholders in the durable medical equipment and supplies, prescription drug, public health, and disability communities. Bennewith graduated from Brandeis University and received her Master of Public Administration from American University. SEE PAGE 56.

DON CLAYBACK

Clayback is executive director of the National Coalition for Assistive and Rehab Technology (NCART). Clayback has more than 23 years of experience in the Complex Rehab Technology and Home Medical Equipment industry as a provider, consultant and advocate. He is actively involved in industry issues and a frequent speaker at state and national conferences. SEE PAGE 38.

LAURA COHEN, PHD, PT, ATP

Cohen is the principal for Rehabilitation & Technology Consultants in Arlington, VA. She is the executive director of the Clinician Task Force (CTF), a national group of seating and mobility clinicians working to influence Medicare and Medicaid coding, coverage, and payment policies for complex rehab and assistive technology devices. The CTF provides clinically relevant information about seating and wheeled mobility device assessment and decision making to policy makers to ensure appropriate access for individuals with disabilities. SEE PAGE 52.

ANN EUBANK, LMSW, OTR/L, ATP

Eubank is vice president of Community Initiatives for UsersFirst, a program of United Spinal Association. SEE PAGE 56.

DENISE FLETCHER-LEARD, ESQ.

Fletcher-Leard is an attorney with the Health Care Group at Brown & Fortunato, P.C., a law firm based in Amarillo, Texas. She represents pharmacies, infusion companies, home medical equipment companies, and other health care providers throughout the United States and Puerto Rico. Fletcher-Leard is board-certified in health law by the Texas Board of Legal Specialization. SEE PAGE 22.

MICHELE GUNN, ATP, CRTS®

Gunn is president of NRRTS. She works for Browning's Health Care in Orlando, Fla., and has been a NRRTS Registrant since 1996. SEE PAGE 14.

SUSAN JOHNSON TAYLOR

Johnson Taylor is an occupational therapist in the Wheelchair and Seating Clinic at the Rehab Institute of Chicago. She has been involved with evaluation and provision of seating and wheelchair technology for more than 30 years. SEE PAGE 42.

JEFF KERSEY, ATP, RRTS®

Kersey is a new NRRTS Registrant. SEE PAGE 32.

SHERRI MARKS, RRTS®

Marks is a new NRRTS Registrant. SEE PAGE 32.

ROBERT (JOE) MCKNIGHT, ATP, SMS, RRTS®

McKnight is a new NRRTS Registrant. SEE PAGE 32.

JEAN L. MINKEL, PT, ATP

Minkel is a physical therapist and master clinician well-recognized for her work in assistive technology. She is currently the senior vice president for Rehabilitation Services for Independence Care System, a nonprofit, Medicaid long-term care program in New York City. Minkel is also an independent consultant who provides educational and consulting service to all members of the AT team – consumers, therapists, suppliers, manufacturers and payers. SEE PAGE 60.

JOHN MORGAN

Morgan is a national sales and business development manager, Eastern region, for Freedom Designs and PinDot. SEE PAGE 28.

STEPHANIE TANGUAY

Tanguay is an occupational therapist and is currently the Clinical Education Specialist for Motion Concepts. Tanguay has many years of hands on experience in the clinical setting as well as a rehabilitation technology supplier. SEE PAGE 48.

CHRISTINE WOODELL

Woodell is a consumer advocate who attended CELA 2013 in that capacity. SEE PAGE 16.

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SEPTEMBER 17, 2013 | 5-7PM PST

Dependent Mobility Bases (aka Strollers)

ANGIE KIGER, M.ED, CTRS, ATP

When a parent or caregiver hears the word "stroller" the first things to come to his or her mind might be: normal, acceptable, and/or easy to transport. However, when a clinician or ATP hears the same word, he or she is likely to think: poor posture, not age appropriate, and/or limited function. Trying to find the happy medium for everyone involved (especially the end-user), can be difficult. In this two-hour webinar, we will explore the options of different stroller styles available on the market today, discuss clinical indicators for a stroller versus a wheelchair, and review essential points to remember when seeking funding.

SEPTEMBER 18, 2013 | 9-11AM CST

Transfers: Getting From One Surface to Another - Products and Strategies

KAREN MURPHY, OTR/L

This webinar will teach you about a variety of lift systems to either make transfers easier for the caregiver or to allow individuals to transfer themselves independently. Transfers to/from the bed and in/out of the bathtub will be emphasized. You will learn what the clinical indicators are for using a floor-based, wall-mounted, or ceiling-mounted system.

SEPTEMBER 19, 2013 | 5-7PM EST

Seating Considerations for Clients with ALS

JAY DOHERTY, OTR, ATP/SMS

A client with ALS is going through constant functional changes in their life. For most who have ALS, their independence seems to be slipping away. Proper seating and positioning is extremely important for good functional outcomes especially as the individual changes. As part of a seating team, we must all think about each one of the client's needs now and in the future. This two-hour webinar will provide attendees with a look at the seating and positioning needs of the client who has ALS and how seating and power positioning can be utilized to allow continued independence with mobility within their different environments.

OCTOBER 22, 2013 | 5-7PM PST

Power Wheelchairs: Interfacing Other AT

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

A wide variety of assistive technology devices can be interfaced to power wheelchairs with complex rehab electronics. Interfacing streamlines access methods, so that one access method can control more than one device, including speech generating devices, computers and electronic aids to daily living. For persons with limited access, interfacing can greatly increase independent control. This course will systematically explore how and when to interface assistive technology. This webinar will also include learning how to control other features through the drive control, such as power seating, infrared transmission and mouse emulation.

OCTOBER 24, 2013 | 5-7PM EST

Seating Considerations for Clients With Muscle Weakness

SHARON PRATT, PT

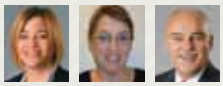
Sitting is indeed a lot of work. My job, I believe, is to take the work out of sitting for my clients … Imagine now – sitting with muscle weakness. The workload just went up. What tools or strategies do we have to firstly identify the challenges of sitting and then understand the additional complexity caused by muscle weakness? What kind of seating "Band-Aids" do we see frequently used to address some of the presenting symptoms with this population. What could we do differently if we understood the cause of the presenting postures and sitting behaviors'? This webinar will attempt to take us on this journey of exploring these possibilities.

NOVEMBER 12, 2013 | 5-7PM PST

Wheelchair Standing: Clinical Benefits and Funding

MAGDALENA LOVE, OTR

This webinar will help clinicians and providers better understand the indications for wheelchair standers. In addition to the physiological benefits of weight bearing (standing), the increase in functional performance that standing provides makes it a desirable feature on a wheelchair base. This session will look at the research supporting standing wheelchairs and will discuss how to use this research to support a consumer's need for a standing wheelchair. Several successful case studies of people using standing wheelchairs (both manual and power) will also be shared.



NOVEMBER 13, 2013 | 9-11AM CST

Respiratory Implications of Positioning

LOIS BROWN, PT, ATP/SMS, JILL SPARACIO, OTR/L, ATP/SMS AND BOB MESSENGER, RRT

When fitting patients for a seating system close attention is paid to posture and pressure distribution. However, little consideration is given to the impact on respiratory function. This presentation will focus on objective measures that can be used during the wheelchair assessment to determine the effect that seating and positioning intervention has on the consumer's respiratory function. Specifically, the effects of the consumer's diagnosis, the type and orientation of the support surfaces, as well as the use of ancillary supports will be discussed in regards to respiratory function. A review of the research will be shared to establish evidence-based practice.

2013 NRRTS WEBINARS

NOVEMBER 14, 2013 | 5-7PM EST

Pediatric Power Mobility: Research Links to Developmental Skills

GINNY PALEG, DSCPT, MPT, PT

Children and young adults with severe gross motor dysfunction can present with postural deformities, movement disorders and medical conditions that make seating and positioning quite challenging. Clinicians need to know the latest research, interventions, and available equipment to obtain the best possible outcomes for their patients. This information will be conveyed using a melding of evidenced-based best practices, real-life clinical cases and a bit of humor and sarcasm.

DECEMBER 17, 2013 | 5-7PM PST

Putting Outcome Measures Data to Work

KEVIN PHILLIPS, ATP/SMS

So you have data, now what? Data on outcome measures is only useful if you put it to work. This webinar will explore how data can improve your practice (product recommendations, follow-up, etc.), consumer education, funding approvals and marketing. The presentation will include results of a Seating Outcome Measure survey more than a two-year period, as well as practical applications based on those results.

DECEMBER 19, 2013 | 5-7PM EST

Mat Exam

SHARON PRATT, PT

Have you ever wondered after the fact why our outcomes in seating and mobility are not as good as we hoped for? Have you ever been challenged with really understanding why our clients sit the way they do or why the seating system that we spent so much time prescribing is just not doing what we thought it would do for our client? The purpose of this session is to go back and review the hands-on assessment process. Participants will leave with a clear understanding of what we need to look for relative to the sitting world as well as how to translate the findings in the language of sitting and load bearing surfaces. Attend prepared to "think" hands on.

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I AM NOT A BAD PERSON

WRITTEN BY: MICHELE GUNN, ATP, CRTS®

So why do I have to apologize on a daily basis for policies I did not write or conceive? In my head I picture the evil genius who came up with the face-to-face rule as Dr. Evil from the Austin Powers movies – no hair, smart gray suit and his little finger up to the side of his mouth with a sinister laugh, "Hee hee hee, let's see how they figure this one out!" This evil genius is also an over-achiever as it seems every time we do think we have it figured out, there is a new clarification handed down to make sure we don't.

How did dates in sequence that are said to make sure doctors complete paperwork in a timely manner turn into reasons to deny prior authorizations and then claims? What happened to looking at the medical necessity of the person in need of the equipment – the 23-year post-SCI quadriplegic who is stuck in bed without the use of his chair? Does the fact that the physician's orders were signed on the same day or not on the same day make a difference in his paralysis? I am sure I am not the only one who has to send my unhappy clients back for additional face-to-face appointments because the physicians are unable to complete the paperwork as requested. This is sold under the guise that this process will reduce fraud and get beneficiaries their equipment quickly. For too long we have tried to understand the position of the policy-maker and said there must be a rational reason for these policies that do not include our demise. Is anyone out there thinking differently these days?

For too long we have tried to understand the position of the policy maker and said there must be a rational reason for these policies that do not include our demise. Is anyone out there thinking differently these days?

One day several years ago, I was paged for a call from a doctor of a clinic I had attended. I thought how great it was she was taking time out of her busy day to talk to me personally. When I picked up the line I was found she had taken the time just to tell me how unreasonable I was being over the documents requested. Of course you know what followed, "No one else asks for this. So-and-so company sends a form over, and I just sign it." The call ended with my invite to not return to the clinic because I was following the rules set forth for me by someone else. Talk about damned if you do and damned if you don't. If I follow these rules, I incur the wrath of my clients and referral sources. If I don't, my company could end up with chains on the front door.

I also love the in-the-home rule. It is a personal favorite that is guaranteed to get you yelled at a few times a week. It is made even more frustrating when you learn that it is a misinterpretation of the definition used to describe the difference between the A and B benefit. We all end up with some clients who are like family. Recently, I had to take a meeting with one of these clients who was disappointed with her one-year-old chair. It was a group 3 that was not performing as her previous group 4 chair did. She had rolled the front tire off the caster rim a few times in her van and traveling outdoors. With a great group 3 chair, there is no arguing that it would not do what her other chair could. Even though we had gone through the process when she got the chair we had to relive that what she wanted was not a covered benefit or even available at the time we made our decision. During these discussions, when your client is looking at you like you are some kind of nut, you have to wonder if the evil genius is rolling on the floor with laughter. Here you are, stuck defending a policy you do not believe in just because you followed the rules when you sold the chair.

We were able to come up with a suitable solution for the caster problem with this client. Many others are not so lucky and end up with nothing if they ambulate well enough to be considered

Here you are, stuck defending a policy you do not believe in just because you followed the rules when you sold the chair.

> Though it is tough when taking fire, always keep in mind that this is not personal - it is survival. The strong and ethical will persevere. We are not failing our clients - the system is.

"functional" in the home, or with chairs that do not meet their needs for the conditions they encounter in their outdoor environments. So, damned if you do and damned if you don't will continue to be our way of life until we convince someone these policies must change. H.R. 942 and S-948 will accomplish this goal which is why we are fighting so hard with our industry partners for their success. Please join the fight. We are the only ones who can tell these stories and explain to people the value of providing Complex Rehab Technology correctly.

By the way, that doctor has been sending us referrals again. Though it is tough when taking fire, always keep in mind that this is not personal – it is survival. The strong and ethical will persevere. We are not failing our clients – the system is. So, on those days when it seems as if you are not able to please anyone, feel free to borrow the following: I am not a bad person; apparently I just do bad things.

CONTACT THE AUTHOR
Michele may be reached at mgunn@brownings.net or 407.650.9585

THE LETTER

That Changed Christine's Life

WRITTEN BY: RANDY CHRISTIAN

It rolled over the small West Texas town like the powerful spring thunderstorms that were always welcomed, yet often feared by folks who lived and died financially at the whim of Mother Nature. The consequences of those spring storms are as unpredictable as the roll of the dice in a Las Vegas casino.

Sometimes the dark clouds bring gentle soaking rains to the rough, dry land creating an oasis for man and beast. Other times, its deafening thunder followed by fierce lighting strikes quickly set the prairie ablaze faster than old wooden matches and a half-pint of kerosene. It was difficult for the hardy folks of San Angelo, Texas, to fathom a vicious, invisible storm could cause more devastation than the legendary West Texas "thunder boomers," and that it would soon strike their close-knit town, but it did in the summer of 1949.

The storm of '49 rolled over San Angelo and struck its more vulnerable citizens – children – again and again with a virus called poliomyelitis, better known as polio. Terror, confusion and panic struck deep in the hearts and minds of all its citizens. The fear of being in the same room with someone who might be carrying the polio virus caused gathering places all across the city to lock their doors. Movie theaters, churches and swimming pools were void of humans. Those diagnosed with polio were immediately quarantined into hurriedly organized polio wards in the local hospital. Many children died, but more were crippled for life. San Angelo, will never forget the summer of 1949.

Woodell has successfully battled polio's bullet that forced her to navigate the world on crutches and now in a power chair. She has not only bravely embraced her lifelong disability, but also has used her experience as a military wife, mother and now grandmother, to advocate for the disabled everywhere she goes.

Christine Woodell was born in 1950. Four years later she was diagnosed with polio – one month before her mother, a physician, was scheduled to administer a newly developed polio vaccine to children in a small Michigan community not far from Woodell's hometown. Ironically, many years later Woodell's son was stationed at Goodfellow Air Force Base in San Angelo. She was not aware of the polio epidemic in San Angelo until then.

Woodell has successfully battled polio's bullet that forced her to navigate the world on crutches and now in a power chair. She has not only bravely embraced her lifelong disability, but also has used her experience as a military wife, mother and now grandmother, to advocate for the disabled everywhere she goes.

Woodell's life as a disabled child began in earnest when she entered school sporting leg braces and crutches. It was in the '50s and little to no accommodations were provided for children who were not able-bodied. Restrooms, stairs and especially classroom desks were not designed to accommodate someone in a wheelchair or a kid with leg braces and crutches like Woodell's. Many kids, like Woodell, were often plopped into what were called "special ed" classes.

"My mother just sashayed into that school and said that I couldn't sit down in a desk with my braces. She said, 'So what are we gonna do? Let's get a table that'll work.' It was just a given that I was going to attend class with the regular kids," Woodell said.

Woodell's energetic and vivacious personality was certainly a plus when it came to calming the concerns of teachers and

(CONTINUED ON PAGE 18)

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THE LETTER *(CONTINUED FROM PAGE 16)*

administrators. It also helped to win lifelong friends she made in school who she dearly cherishes, even today. Chances are her charming manner has influenced a few Mississippi "knuckle heads" along the way, too.

Most all of her friends have stuck by her side through "thick and thin" and always included her in activities associated with growing-up, but with one exception.

"I didn't learn until later in life that my friends didn't include me in what I'd call 'questionable activities.' Whether they did that because they thought my mother would kill them, or for some other reason, I don't know," Woodell says.

When pressed about the meaning of "questionable activities" the fact that Woodell was a "child of the '60s" comes into play. No one invited her to sample mind-

"I didn't learn till later in life that my friends didn't include me in what I'd call 'questionable activities.' Whether they did that because they thought my mother would kill them, or for some other reason, I don't know," Woodell says.

altering cannabis, other staples of the hippie generation or iced cold beer. One college friend did take it upon herself to bring Woodell's Mayberry-like life to a screeching halt. It all started when she discovered Woodell had never been drunk. So, bright and early on a Saturday morning the two-college students purchased a fifth of whiskey and found a park convenient to campus. Woodell commenced to drink until she was drunk. Thank goodness Woodell's friend was there primarily as a designated driver and documentarian.

Of course, as Woodell's inebriation began to take flight her ability to navigate on her crutches began to falter. Her friend thought it was hilarious. Woodell enjoyed laughing at herself, too. With her youthful "booze baptism" successfully completed, thanks to her dear friend, one has to believe that it sent a message to other friends saying, "Woodell is just like us, except for the leg braces and crutches." Miraculously, Woodell's life has taken her to a place where she continues to help abled-bodied people better understand that disabled folks are just like them.

Woodell met her husband when they were in the seventh grade. It was a romance that wasn't embraced by her mother, but still flourished into marriage that has lasted more than 35 years. As a career U.S. Air Force guy, his job has taken them and their family to several wonderful locations in the states and overseas. Of course, that meant Woodell was in charge of coordinating the moves to and from and then back again to Mississippi. It was hard work; her leg braces and crutches made moving extremely grueling, but the love for her family and privilege to be a stay-at-home mom was all the motivation she needed to turn every new Air Force location into a delightful home.

With her kids grown and well on their way to successful lives, Woodell decided it was time to try her luck at getting a job. Even though she had a bachelor's degree in history with a minor in psychology, and tons of experience working as a volunteer for a variety of charities, especially the March of Dimes, the "not hiring" sign kept smacking her in the face.

"I think one of the most depressing things a person can do is look for work. It's hard for anyone to do. I was either over-qualified or I was under-qualified or I didn't have enough life experience. One company asked me what type of birth control I used. The low point in my job seeking experience was when I received a call on Saturday morning that woke me up to tell me that I was turned down for a job that I had not applied for. I thought, 'How much worse can it get?' " Woodell said.

After crashing into the job-hunting wall Woodell decided to visit the state's vocational rehabilitation agency and ask for help. It was the same agency that years earlier had helped her go to college. Her visit led to another dead end, but just as she was about to leave a sliver of hope revealed itself.

"They said it was too bad I wasn't here three weeks ago. Someone was here looking to hire someone for an independent living program. I said, 'What's that?' I had never even heard of it."

The more she learned about the job the more it seemed to be a perfect fit. Woodell's entire life was a textbook filled with real life examples as to how someone with a disability could live a more active, independent, rewarding life. Luckily,

(CONTINUED ON PAGE 20)

"I think one of the most depressing things a person can do is look for work. It's hard for anyone to do. I was either over-qualified or I was under-qualified or I didn't have enough life experience. One company asked me what type of birth control I used. The low point in my job seeking experience was when I received a call on Saturday morning that woke me up to tell me that I was turned down for a job that I had not applied for. I thought, 'How much worse can it get?'" Woodell said.

THE LETTER *(CONTINUED FROM PAGE 19)*

the position had not been filled. She immediately applied. The state personnel board immediately rejected her. Why? She didn't have enough life or work experience. Woodell would not be denied. She knew that as a person who had lived with polio all her life — yet had successfully raised three children was an Air Force wife who had packed-up and moved her family to numerous locations, had earned her college degree, had worked tirelessly for charitable organizations, and had endured restrooms, sidewalk, doorways, hotel rooms and other unfriendly environments for the disabled — she was the perfect candidate for the job.

On the verge of desperation Woodell decided to write a letter to her U.S. senator, Trent Lott. She shared her life's story with him, as well as her goals and ambitions. She mailed her letter with little hope of a response. The trials and triumphs she chronicled in her letter did make it to the senator's desk. It also spawned a response in the form of a one-sentence letter from the senator to the Mississippi State Personnel Board. Soon after, Woodell received a phone call telling her that her application was being reconsidered. She was now eligible for the job of independent living consultant. She was officially hired in 1998 when the independent living program opened an office in Long Beach, Miss. In the five years Woodell worked in the Long Beach office, she was named Vocational Employee of the Year and received the Governor's Award for Outstanding Employed Person with a Disability. Some might think this is the end of Christine Woodell's story, but it is just the beginning.

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Today, as an independent consultant, she provides training, technical assistance and site survey assistance to further the understanding and compliance of the American with Disabilities Act and the Fair Housing Act. She shares her personal experience and professional training with a myriad of local, state and federal organizations and their employees throughout Mississippi. It is an effective concoction that opens the eyes of abled-bodied individuals to the seemingly simple daily tasks that can be monumentally challenging for the disabled.

Woodell loves her job, not because of the many awards and accolades she has received, but because she has truly made a difference in the lives of thousands of people just like her.

Many more people with disabilities now have a fairer shot at getting a job, owning a home, renting an apartment and accessing "disabled-friendly" public restrooms. Fire, police and other public servants now feel more comfortable when encountering someone with a physical as well as mental disability because of Woodell's boundless enthusiasm. Compassion, instead of misconception, now leads the way in communities all across Mississippi thanks to Woodell.

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"People with disabilities are just like everyone else ... Understand that people with disabilities have capabilities and can be a valuable asset in their work place. They simply want to have the full American experience and live the American Dream."

She admits our country has made great strides toward providing access and fairness to the disabled over the last 30 years, but is quick to point out that there remains a long way to go. Fortunately, Woodell does not lack tenacity and has absolutely no intention of retiring. When asked what she would like America to know about the disabled she said the following:

"People with disabilities are just like everyone else. There are a few 'bad apples' in the basket, but most people with disabilities just want equal opportunities and fair access. Understand that people with disabilities have capabilities and can be a valuable asset in their work place. They simply want to have the full American experience and live the American Dream."

Is that too much to ask for, America?

Ironically, Woodell's life has been similar to the thunderstorms that have rolled into places like San Angelo, Texas. Yes, there may be a little thunder and lighting when she rolls into towns across Mississippi, but a soft, gentle downpour of hope, faith and a future soaked in freedom and independence for the disabled seem to always follow. Woodell is and will always be a ray of sunshine for the state of Mississippi, too.

CONTACT
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YOU HAVE BEEN HIT. NOW WHAT?

Understanding the Appeals Process is the Key to Mitigating the Damage

WRITTEN BY: DENISE FLETCHER-LEARD, ESQ.

You've gotten the dreaded claim denial or, even worse, the overpayment demand letter for that post-pay audit and are looking at the appeal process. Overall, the process is pretty straightforward. However, there are several nuances a successful supplier must understand. For example, do you know how to stop offsets in the case of a post-payment demand letter or how to make sure the administrative law judge (ALJ) will consider all of the relevant information in making his decision? If a supplier understands the regulations, appeals will be easier to navigate and the supplier is more likely to be successful.

redetermination -first level of appeal

The first level of appeal is the redetermination level. A redetermination is an independent review of the claim by someone who wasn't involved in the initial review. It is an "on the record" review, so you will need to present your argument on paper. It is important that your appeal be organized and succinct. The reviewer has a limited amount of time to spend on each claim. A supplier must submit everything necessary to prove medical necessity but be careful about submitting documentation that isn't relevant, as it will distract the reviewer, making it harder for the reviewer to locate the relevant information. In addition to relevant documentation, a supplier should provide a summary of the medical necessity, noting specific documentation that supports medical necessity. If the supplier has a clinician on staff, it is recommended that the clinician be involved in writing the patient summary.

In addition to relevant documentation, a supplier should provide a summary of the medical necessity, noting specific documentation that supports medical necessity.

A supplier has 120 days from the date the initial determination is received to file a request for redetermination. CMS presumes the notice is received five days from the date of notice unless there is evidence to the contrary. All suppliers need to have some sort of tickler system in place to ensure a request is filed in a timely manner. If the request is not received timely, it will not be heard and the overpayment demand will stand. A supplier should calendar the deadline to be 120 days from the date of the letter. This will create a little bit of a grace period in the case of a last minute appeal.

It is strongly suggested that a supplier not wait until the last minute to file an appeal. This is even more important in the case of a post-payment demand if the supplier wants to avoid recoupment. Filing of the appeal will stop the DME MAC from recouping through the second level of appeal or the reconsideration decision. However, to stop recoupment, a redetermination request should be filed within 30 days or offsets will begin taking place on the 41st day. If a request is filed between days 30 and 120 once the request is processed, offsets will cease, but any amounts already collected will not be returned.

The request for redetermination must be in writing and filed with the DME MAC. CMS states the preferred method for filing a request for redetermination is on a standard CMS form (Form CMS-20027), but other written requests will be accepted if they contain accurate information for all of the following:

- The beneficiary's name;
- The Medicare health insurance claim number;
- Specific item(s) and/or service(s) and the applicable date(s) of service;
- The name and signature of the supplier or the supplier's representative; and

If even one required element is missing, the appeal will be dismissed.

The redetermination is an independent, critical examination of a claim by contractor personnel who was not involved in the initial determination. The reviewer must obtain and review all available, relevant information needed to make

a determination. Such information must be included in the case file and the case file must be made available for inspection by an appellant (i.e., the supplier who is appealing) or party upon request.

The redetermination decision must be mailed to the supplier within 60 days of the date the DME MAC received the request for redetermination. This 60-day period is extended by 14 days each time the supplier submits additional evidence after filing the request for redetermination, even if the evidence is submitted at the request of the reviewer.

The DME MAC may dismiss a request for redetermination for a number of reasons, including, if:

- The supplier gives written notice withdrawing the request for redetermination;
- The party requesting the redetermination is not a proper party or is not entitled to a redetermination;
- The request for redetermination was not timely filed and the contractor did not find good cause for such failure;
- The request for redetermination was submitted by a representative, but the representative has not been properly appointed; or
- The redetermination request was not valid (i.e., did not have the required elements).

A supplier may appeal a dismissal of a redetermination to the qualified independent contractor (QIC) by filing a request for reconsideration by the QIC within 60 days of the dismissal. A supplier may also request the contractor vacate its dismissal within six months of the date of mailing of the dismissal notice if the supplier can show good and sufficient cause.

The QIC reconsideration consists of an independent review. Like the redetermination review, a reconsideration review is based solely on the written record. QICs must follow national coverage determinations, CMS rulings, and applicable laws and regulations.

reconsideration – second level of appeal

If a supplier disagrees with the redetermination decision, he or she has 180 days from the date the supplier received the redetermination decision to file a request for reconsideration. The QIC reconsideration consists of an independent review. Like the redetermination review, a reconsideration review is based solely on the written record. QICs must follow national coverage determinations, CMS rulings, and applicable laws and regulations.

The request for reconsideration must be received by the QIC within the 180-day period. Again, if the request is even one day late, it will not be considered and the overpayment demand will stand. To stay recoupment, a request for reconsideration should be filed within 60 days of the date of the redetermination decision. Recoupment is allowed by statute while an ALJ decision is pending. If the overpayment demand is large and the supplier cannot pay it in full when the reconsideration decision is issued, the supplier should take steps to make payment arrangements with the DME MAC while it is awaiting the reconsideration decision. Information on making payment arrangements are usually provided with the redetermination and reconsideration decisions.

The request for reconsideration must be in writing and filed with the QIC. The request may be on a standard CMS form (CMS-20033), the form included with the redetermination decision, or another writing (e.g., a letter). If the request is made in a letter, the letter must contain all of the following:

- Beneficiary's name;

(CONTINUED ON PAGE 24)

NOW WHAT *(CONTINUED FROM PAGE 23)*

Beneficiary's Medicare health insurance claim number;

The specific service and item and date of service for which reconsideration is requested;

The name and signature of the party making the request or the party's representative; and

The name of the contractor who made the redetermination.

Also, the supplier should explain why it disagrees with the initial determination and redetermination and present any additional evidence and arguments of fact or law.

When the QIC receives a request for reconsideration, it will request the case file from the DME MAC. It is very important to know that evidence not submitted to the QIC will not be considered at an ALJ hearing or further appeal unless good cause is shown as to why the evidence was not previously provided. Therefore, all relevant information proving the supplier's case should be submitted to the QIC. Every level of review is what is considered a de novo review, meaning it's a new and independent review of the claim. So, even if a specific requirement was not questioned at a lower level, you should provide all information that supports the medical necessity of the claim. You never know what will catch the eye of the reviewer.

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Within 60 days of receiving a request for reconsideration, the QIC must:

Issue a written decision; or

Provide the supplier with a statement advising that it is unable to complete its review within the 60-day time frame and provide reasons why it could not complete the review during that time frame in accordance with the rule.

If a supplier files a timely request for reconsideration to the QIC and the QIC has not made a decision within the 60-day period, then the supplier may send a written request to the QIC to escalate the appeal to the ALJ. Within five days of receiving a request for escalation, the QIC must either issue the reconsideration decision and notify all of the parties of its decision or acknowledge the escalation notice in writing and forward the case file to the ALJ hearing office.

alj hearing – third level of appeal

A supplier who disagrees with the QIC's reconsideration decision may request an ALJ hearing. This is the first time a supplier actually gets to talk to an individual and present its case on the claim. The supplier must file a written request for an ALJ hearing within 60 days after receipt of the QIC's reconsideration decision. The supplier must also send a copy of the request to all other parties.

To qualify for an ALJ appeal, the amount in controversy must be greater than or equal to $120. The request must be made in writing and include all of the following:

The name, address and Medicare health insurance claim number of the beneficiary whose claim is being appealed;

The name and address of the appellant, when the appellant is not the beneficiary;

The name and address of the designated representative, if any;

The document control number assigned to the appeal by the QIC, if any;

The dates of service;

The reasons the appellant disagrees with the QIC's reconsideration or other determination being appealed; and

A statement of any additional evidence to be submitted and the date it will be submitted.

The ALJ may conduct an oral hearing by video-teleconferencing, if such technology is available, or by telephone (which is often the

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NOW WHAT *(CONTINUED FROM PAGE 24)*

case) if the request for hearing shows that a telephone hearing may be more convenient for one or more parties. An in-person hearing will be conducted if video-teleconferencing technology is not available or other special or extraordinary circumstances exist.

The ALJ sends a notice of hearing. The notice will contain a proposed time and place of hearing, and require all parties to reply to the notice by (1) acknowledging whether they plan to attend the hearing at the time and place proposed in the notice of hearing or (2) objecting to the proposed time or place of the hearing.

Any evidence that was not submitted prior to the issuance of the QIC's reconsideration decision must be accompanied by a statement explaining why the evidence was not previously submitted. The ALJ will examine the new evidence and determine whether the supplier had good cause for submitting the evidence for the first time at the ALJ level. If good cause does not exist, the ALJ will exclude the evidence from the proceeding and will not consider the evidence in reaching his or her decision.

The ALJ is supposed to issue a decision, dismissal or remand no later than 90 days after the date the request for hearing was received. The deadline is extended to 180 days if the appeal was escalated from the QIC level. Unfortunately, the ALJs are very busy these days and, often are not meeting these deadlines. When the ALJ's office calls to schedule the hearing, it will ask the supplier to sign a waiver of timely hearing. While this seems against the notions of fair play, generally, it is in the supplier's best interest to give the ALJ the full time needed in order to make a full and complete decision.

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review by the medicare appeals council (MAC) – final administrative appeal

A supplier dissatisfied with an ALJ decision may file a written request for a MAC review within 60 days after receiving the ALJ decision (or dismissal). The final level of administrative appeal is a review by the MAC. The MAC may also decide on its own to review an ALJ decision or dismissal. CMS may also refer a case to the MAC for the MAC to consider reviewing it on its own within 60 days of the ALJ decision. A supplier may file objections to CMS's referral to the MAC within 20 days of the referral notice.

For most cases, suppliers should pursue all appeals at least though the ALJ level. A determination of medical necessity can be very subjective and different reviewers may see the documentation more favorable and allow the claim. Whether or not to pursue a MAC appeal should be decided based on the facts of the claim at issue, and not all claims are appropriate for appeal at this level.

A request for MAC review must be filed in writing to the MAC and be made either on a standard form or other writing. Such other writing must include the following to be accepted:

- Beneficiary's name;
- Medicare health insurance claim number;
- The specific service(s) or item(s) for which the review is requested;
- The specific date(s) of service;
- The date of the ALJ's decision or dismissal order, if any;
- If the party is requesting escalation from the ALJ to the MAC, the hearing office in which the appellant's request for hearing is pending;
- The name and signature of the party or the representative of the party;
- Any other information CMS may decide.

The request for MAC review must identify the parts of the ALJ decision with which the appellant disagrees and explain why it disagrees with the ALJ decision. The MAC will limit its review to those exceptions raised by the request for review, unless the appellant is an unrepresented beneficiary. The MAC will give, upon request, a reasonable opportunity to file briefs or other written statements about the facts and law relevant to the case. The MAC will only consider

the evidence contained in the ALJ's record, unless the ALJ decision contained new issues the parties did not have a chance to address. If the MAC determines that additional evidence is needed to resolve the issues in the case and the hearing record indicates that the previous decision-makers (QIC, ALJ, etc.) have not attempted to obtain the evidence, the MAC may remand the case to an ALJ to obtain the evidence and issue a new decision.

If new evidence related to issues previously considered by the QIC is submitted to the MAC by a supplier, the MAC must determine if the supplier had good cause for submitting it for the first time at the MAC level. If not, the MAC will exclude the evidence. When the MAC excludes evidence, it must give notice thereof to all parties. The MAC may, either on its own or upon request, issue a subpoena for evidence that is material to an issue at the hearing, but may not issue such subpoena to CMS or its contractors. The MAC generally decides a case from the record. However, the MAC may grant a party's request to present oral arguments if it decides that the case raises an important question of law, policy or fact that cannot be readily decided based on written submissions alone. If the MAC decides on its own that oral argument is necessary, it will give the parties notice of the time and place for oral argument at least 10 days prior to the scheduled date.

judicial review

A supplier may request court review of the MAC decision by filing a complaint (i.e., lawsuit) with the U.S. District Court. The complaint must be filed within 60 days after the date the supplier receives notice of the MAC's decision. To qualify for judicial review, the amount in controversy must be greater than or equal to $1,220. This is typically a very expensive process and few cases are actually filed in federal court for this reason.

conclusion

The appeals process can be daunting. The best defense to any audit is doing a good job of reviewing medical necessity documentation at the time equipment is dispensed. This is the easiest time to get additional information from the ordering physician. If the documentation isn't perfect, the supplier can also choose not to place the equipment, which is better than having to refund Medicare and being out the cost of goods. If a supplier must go through the appeal process, the supplier should know its rights, pay careful attention to deadlines, and be organized. Appeals are a routine part of doing business with Medicare these days. Be prepared and have policy and procedures in place so, when you have been hit, you know exactly what steps to take to mitigate the damage.

The MAC will only consider the evidence contained in the ALJ's record, unless the ALJ decision contained new issues the parties did not have a chance to address. If the MAC determines that additional evidence is needed to resolve the issues in the case and the hearing record indicates that the previous decision-makers [QIC, ALJ, etc.] have not attempted to obtain the evidence, the MAC may remand the case to an ALJ to obtain the evidence and issue a new decision.

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WORKING ALL ANGLES

Long-time industry leader utilizes experience, political interests to ensure successful future

INTERVIEW BY: DANETTE BAKER

John Morgan will tell you he has the best of both worlds working for Freedom Designs. In his position as a national sales and business development manager, Morgan gets the opportunity to interact with distributors and therapists in the field and impact bottom-dollar numbers, which satisfies his self-described sales-driven personality. But more importantly, Morgan keeps a pulse on the Complex Rehab Technology industry and has worked diligently to ensure it remains viable. His political interests locally in his hometown of Oxford, Miss., recently served as a springboard to acquire a co-sponsor for a senate of version of H.R. 942.

DIRECTIONS recently had the opportunity to visit with Morgan about his work in the industry:

How did you become interested in the medical equipment industry?

In 1989, I was working in Memphis, Tenn., as headhunter for a durable medical equipment company. They came to me to fill RTS position, which was before the CRTS® or ATP certifications, for their office in Nashville. During that search, I realized I just wasn't satisfied in the work I was doing as a headhunter. So when the company had an opening in the Memphis office, I applied. In the late '80s and early '90s, if you were in the DME industry, Memphis was the place to be because it was home to the International Seating Symposium before the ISS moved to the University of Pittsburgh. After about five years, I had an opportunity to move to Mobile, Ala., and open a branch for National Seating and Mobility. I enjoyed my time in Mobile with them, but, in April 1996, an opportunity came to move back to my hometown of Oxford, Miss., and be a sales representative for Freedom Designs. From there, I've worked my way up to my current position as a national sales manager.

I've had an interest in the medical field since I worked for an orthopedic surgeon in college. I loved working in sales and putting people in devices and chairs they didn't have before and seeing the freedom on their faces and the relief on the parents' faces to have the equipment for their children. But I've always been more sales driven. Now, I've got the best of both worlds because I still get to see the results of what we do, but I also get to sell and drive numbers.

With your work history, I'm sure you have experienced the highs and lows of the industry? What has kept you going?

I'm often told one of most frustrating things about what we do is trying, in a social setting, to explain our occupation. Very few people understand the whole process of evaluation and prescriptions. Most people have never really thought about how someone who needs a wheelchair gets one. I think there is a great misconception that they just go to the store and buy one. I was fortunate to come into the industry when funding was great and kids and adults alike could more easily get the type of equipment they needed. There is more of a challenge now because of the funding issues, but I still love this industry. I love the fact that it's small yet powerful,

I loved working in sales and putting people in devices and chairs they didn't have before and seeing the freedom on their faces and the relief on the parents' faces to have the equipment for their children. But I've always been more sales driven. Now, I've got the best of both worlds because I still get to see the results of what we do, but I also get to sell and drive numbers.

because there are so many who have been around for a number of years. I also love that I'm seeing more and more new faces as others find, despite the challenges, this is an industry they want to be a part of as well.

You mentioned the impact of helping people. Has there ever been a client that made a significant impact on you?

I could tell you story after story, but there is one that immediately comes to mind. There was a child who had hydrocephaly that I worked with about 20 years ago when I was covering the Jackson, Miss., territory. His head was extremely large, and we had to construct a molded system for protection. His mother worked so hard to get him the right type of equipment. She would come and talk with us and then work with him. We could see how much progress he was making and what an impact we had every time we saw him. After I had moved away from Jackson, I learned that he had died. That made such an impact because being right there in the same community with the family I had really gotten to know them and what they were going through, and I saw how we impacted lives.

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

Ric and Kay Taylor gave me the opportunity to begin working in this industry, and then Mike Ballard with National Seating & Mobility opened my eyes to what was going on in durable medical equipment around the country through attending the symposium and traveling. Of course, Ginny Malaco offered this incredible opportunity at Freedom Designs. Those are just some of the people who gave me the chance and moved my career forward. I'm also extremely honored to have been elected to the Oxford City Council. That is something that has really meant a lot to me – not only for the people here to elect me over a four-term incumbent in a citywide race, but also because of my family's heritage in Oxford politics. I grew up here, and my grandfather was involved politically as was my father, so I was deeply interested in the future of our town, which is one of fastest growing small towns in the South. I knew this would be a challenge – to have the support and blessing from Freedom Designs to serve my community really meant a lot. When I went to Bob Gardner, general manager for Freedom Designs, and told him what I wanted to do, he not only supported my bid for office, but also said he believed that Freedom Designs and its parent company, Invacare, would be proud to have someone from their team involved in local issues.

Freedom Designs, as a whole, has made some significant contributions to the industry. Your website indicates the company designed and manufactured the first folding tilt-in-space wheelchair. What other areas of the industry has the company taken a lead in?

Technically, that's right. I had been with the company about two years when we bought Scott Designs, a wheelchair company that had a chair where only the seating system tilted. Ginny Malaco, who owned Freedom, bought the design and with our engineers designed the first tilt-in-space wheelchair with a folding frame.

I've always stressed the quality of our products, and maintaining that has not always been easy, especially in the type of funding environments we have now. But we do have a really good folding tilt-in-space wheelchair that we've been able to bundle with a really high quality seating system. We can provide that on one invoice, which is something not a lot of seating manufacturers can do.

We also have some of the most knowledgeable and experienced distributors and sales representatives in the industry. For example, our direct sales rep with the least amount of history with Freedom is about nine years. One of the reps in southern California and one in Texas have been with the company for more than 20 years.

As Freedom Designs and the CRT industry move forward, what are some of the challenges?

Our greatest challenge is funding, and I say that because making a quality product is, and always has been, our number one goal. As funding continues to be cut, our challenge becomes not only how to continue doing that, but also introducing new products. As a manual wheelchair and custom-seating manufacturer, you have to come out with something new every couple of years to stay competitive. In the "old days," the design team would approach this with the mindset of how can we improve the design and function of a wheelchair. Today, they also have to consider what code the new design fits into and the allowables to determine the viability of the design. It all stems from having to factor in how much we can get for a chair. That's really an obstacle to innovation and, ultimately, the consumer can be the loser. That's why funding is not only a big issue for us, but for the entire industry and why we need and must get a separate benefit category for Complex Rehab Technology.

(CONTINUED ON PAGE 30)

WORKING ALL ANGLES *(CONTINUED FROM PAGE 29)*

How, then, does Freedom Designs meet this challenge?

We are working on new chairs and seating systems as we speak, keeping in mind the reimbursement challenges. We also are growing internationally, which is always challenging for a small company. We have distributors internationally. I will go and work in their respective countries and also attend trade shows, such as REHA in Dusseldorf. Also, we are growing in South America and Latin America. It's frustrating, but our European market is growing so much because the Euro is kicking the dollar's ass. The good thing is that American products are well made and the Europeans like that and like to buy them when they can afford to.

What changes would you like to see in the industry?

Obviously, to get the separate benefit category for CRT passed. Right now we are kind of just making it work; but sooner or later we have to get our own category. So, that is the number one priority. Other changes? All of the acquisitions going on right now in the rehab industry make it hard to navigate, but we are not the first industry to metamorphosize like this. I hate to say that I don't like seeing all of them because that is capitalism, and we live in a great country. Sometimes it's painful to see the small mom-and-pop branches that just can't make it anymore because of the atmosphere and the ever-changing funding environment. At the same time, it's encouraging to see providers who have worked hard and built up a business to a sizable amount and then be rewarded by selling their interest to one of the larger companies. Some people call it "cashing in" but I like to think of it as getting their reward for hard work.

Sometimes it's painful to see the small mom-and-pop branches that just can't make it anymore because of the atmosphere and the ever-changing funding environment. At the same time, it's encouraging to see providers who have worked hard and built up a business to a sizable amount and then be rewarded by selling their interest to one of the larger companies.

As for us as a manufacturer, it helps to have a good relationship with the larger companies so that when that acquisition takes place, we are already juxtaposed with both the previous and new larger company.

You were instrumental in getting Sen. Thad Cochran, R-Miss., to co-sponsor a Senate version of the House bill for a separate benefit category for CRT. What other support roles do you have in the medical equipment/complex rehab industries (boards, association memberships, etc.) and why do contribute your time and energy to "volunteer" endeavors?

I have followed our quest for a separate benefit category and was pleased that I could have a part in getting the Senate to adopt a version of the bill. My interest in politics played some role. Mississippi is a relatively small state and because of my interest in politics, I knew Senators Cochran and Roger Wicker, R-Miss., and Rep. Alan Nunnelee, R-Miss. I've also been to CELA three times and met with them in their offices on the Hill. Until this year, I really had not pushed the envelope for them to sign on. To be honest, before I just didn't think we had a chance, and I didn't want to use the political capital I had until the odds were better.

To get Sen. Cochran to be the lead Republican sponsor was huge. There is so much going on in Washington that we really needed a bi-partisan bill. I've been working with Cara Bachenheimer to get more of the legislators to co-sponsor. There is a big push to contact them between sessions in August while they are back in their hometowns. We have to get those in the industry to somehow understand that just one email or one phone call or one visit during CELA just isn't enough. If you continue to contact them, it's not a hard sell because what we are after is such a noble cause. I'm extremely proud that, with the help of a local physical therapist, Allison Fracchia, we have all four Mississippi representatives signed on. Right now, of the only three senators who have signed onto S-948, two are from Mississippi as well.

Other than that, I definitely like to give back and volunteer, especially on issues where I think I can make a difference. That really was what led me to run for the council position. I felt like we had a board that was stale and not thinking outside the box.

Through Freedom Designs, we also support industry causes through various partnerships. We are a Charter Corporate Friend of NRRTS, and we are involved in activities to advance the industry such as CELA as well as in the various expos and trade shows.

Between your work responsibilities and political interests, I'm guessing your calendar fills up fast. What does a work day/week look like for you?

Well, it all depends on if I'm traveling. If so, I will be out working with sales reps whether they are calling on distributors or therapists. I really like getting to do in-services with the therapists at therapy units. I don't get to do that as often as I did 10 to 12 years ago. Now, funding drives so much of the product selections. Years ago, the therapists would look at a product and decide if that was what they wanted to use. Today, the therapist still has to sign off, but now it's more about what can get funded.

When I'm not traveling, I might be at my home office or Freedom's home office in Simi Valley, where I'll set up conference calls or maybe a video conference call. Otherwise, I may be attending various trade shows, such as ISS or Medtrade. I still like to get in the car and travel around the southeast to my old territory, to drive out and meet with the suppliers. That's where you really learn about what's getting approved or denied. I also enjoy being in a clinic when a chair is being delivered. There is nothing better than to see a child put in a new chair. Years ago, it was special, but once I had kids, I realized just how much more important it was for that child, and the parents, to have access to the equipment.

What's life outside of the 9 to 5 like for John Morgan?

I'm lucky to have three healthy children and a wonderful wife. Working in this industry has truly given me a perspective I didn't appreciate as much until my own children were born. The parents we work with are amazing.

My children – all boys – are very active. My oldest is on the high school tennis team and the youngest plays on a travelling baseball team. Our middle son is huge into outdoors and will be receiving his Eagle Scout badge soon. They keep my wife and me going constantly. With my politics here in town, there is always some type of duty there. I also enjoy the outdoors. I like to hunt and fish locally, and I'm an avid gardener and a beekeeper.

CONTACT
John may be reached at JMorgan@thehelixxgroup.com.

JOHN MORGAN, LEFT, WITH MISSISSIPPI GOV. PHIL BRYANT AND REP. ALAN NUNNELEE AT AN OLE MISS FOOTBALL GAME.

CLASS OF 2013:

New registrants hope to expand knowledge, support industry

WRITTEN BY: JULIE BARNETT

Robert J. (Joe) McKnight, an assistive technology professional (ATP), seating mobility specialist (SMS) and recent NRRTS registrant, has been in the health care industry since 1977, but sometime around 1995 McKnight realized that there was a specific group of patients falling through the cracks.

"I trained at St. Mary's Hospital and Deaconess Hospital School of Nursing in Evansville, Ind. I started as an EMT, firefighter and paramedic and have worked in the homecare industry since 1977," McKnight said. "I've worked with rehab patients since I was old enough to turn a wrench, but really began to intensely focus on seating and positioning about 1995-96 when we sold our homecare business and I moved to central Nevada and no one wanted to take care of these patients."

McKnight has served on the Region D Advisory Committee (DAC) since its inception. The nonprofit, volunteer organization is comprised of home medical equipment providers, state and national associations, manufacturer supporters, and industry consultants and covers 17 states. He also has served on the Rehab and Respiratory and Rehab A-teams nearly from the start. He currently is vice president of business development for Aero Mobility Inc. in Anaheim, Calif.

McKnight says he expects NRRTS will be instrumental in standardizing the business side of the equation.

"As we move to a separate rehab benefit, it will develop a new category of personnel (ATPs) and a curriculum and a path to licensure similar, I should think, to PTs, OTs, RNs and other professions," he said. "We need NRRTS to represent, defend and standardize the supplier side (of the business). NRRTS needs to work very closely with the DACs and RESNA and NCART to provide a united front.

"Of all of these groups, NRRTS has the most convoluted and difficult job," he continued. "I expect that NRRTS will define their role as the registry of suppliers. RESNA has the people, NRRTS needs to be the 'registry of suppliers' and work with the accreditation agencies (Joint Commission, Accreditation Commission for Health Care, Community Health Accreditation Program, Board of Certification, etc.) to create the supplier wing. We need to make sure that suppliers have sufficient staff in billing, tech, delivery, customer service and care delivery to actually deliver a complex rehab product to our patients."

continuing education

New registrant Jeff Kersey, ATP, RRTS®, says he looks forward to opportunities to expand his knowledge.

(CONTINUED ON PAGE 36)

Of all of these groups, NRRTS has the most convoluted and difficult job," he continued. "I expect that NRRTS will define their role as the registry of suppliers. RESNA has the people, NRRTS needs to be the 'registry of suppliers' and work with the accreditation agencies [Joint Commission, Accreditation Commission for Health Care, Community Health Accreditation Program, Board of Certification, etc.] to create the supplier wing. We need to make sure that suppliers have sufficient staff in billing, tech, delivery, customer service and care delivery to actually deliver a complex rehab product to our patients."

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CLASS OF 2013
(CONTINUED FROM PAGE 32)

"I do expect NRRTS to be a source of industry information and continuing education as I plan to continue to grow as a rehab professional," Kersey said.

Kersey, who works with Rehab Medical in Atlanta, Ga., describes himself as a 49-year-old, happily married father of 12 (yes, 12) and a grandfather of two and one-half. "I have a blended family of biological and adopted children, some with special needs," he said.

His day-to-day consists of serving on a team that assists clients in determining appropriate mobility and seating products. "I work closely with the client and his/her doctor, physical therapist or occupational therapist and caregivers in an all- inclusive approach to assessment. I follow through with delivery and final fittings to assure a good outcome and that goals that are achievable are met," he said. "I also complete full home assessments for accessibility and make recommendations for safety and modification. We, as a company, have a follow-up process internally to check the outcome measures and client satisfaction ratings independently of the location to ensure satisfaction as well."

"I do expect NRRTS to be a source of industry information and continuing education as I plan to continue to grow as a rehab professional," Kersey said.

Kersey says he has worn many hats through the years since beginning his career in 1984 as a service technician. He also has been a MED Group Gold certified technician since 1999 and has managed both a MED Group certified repair center and a National Mobility Equipment Dealer's Association Quality Assurance Program auto mobility shop, while doing rehab work on and off as needed during that time as well.

"I get great pleasure out of helping people gain or regain their mobility and independence," Kersey said.

Sherri Marks, also a recent NRRTS Registrant, hopes to gain continuing education opportunities, as well. "I'm hoping to increase my knowledge on new things in the market. And I want to give back to the rehab field," she said.

Marks has worked for the durable medical equipment company Mobility Unlimited Inc., based in Allentown, Penn., for the past eight and one-half years and has been in the industry since 1984.

"I function as a rehab specialist, I measure for power chairs, figure out what assistive technology patients need," she said. "Therapists call and ask me for advice, what assistive equipment, such as walking frames or shower chairs, is available for their patients."

Marks, an ATP and certified occupational therapy assistant, said she joined NRRTS after being encouraged by a mentor. "One of my co-workers, who has since retired, was a Registrant and really encouraged me to get involved," she said.

Kersey said his reasons for joining include the influence membership brings. "I joined for many reasons, one being that there is a certain amount of clout associated with being registered and then certified," he said. "Referral sources like to have professionals they can count on to do things right for their clients. Also, in the state of Georgia rehab providers must be registered as well as being an ATP to provide to primary Medicaid beneficiaries."

"We have a couple of bills in Congress [H.R. 942 and S-948] that need support. They need it financially. They need it emotionally and energetically," he said. "It takes a license in most states to administer a haircut. It should take at least some sort of legislation and regulation to give someone a complex wheelchair or other rehab equipment that costs thousands of dollars."

McKnight says he hopes to leverage his membership to support legislation currently before Congress. "We have a couple of bills in Congress (H.R. 942 and S-948) that need support. They need it financially. They need it emotionally and energetically," he said. "It takes a license in most states to administer a haircut. It should take at least some sort of legislation and regulation to give someone a complex wheelchair or other rehab equipment that costs thousands of dollars."

In describing how long he's been in the industry, McKnight emphasized the speed at which things change.

"I would like to think I have been doing this since 1977, but in reality, I have been doing this since Friday morning. At the end of Monday, I will have been doing this since Monday morning. We are changing so fast and our patients are so ill and the laws are so complex that I make it up on the fly," he said. "Manufacturers give us new products on the fly from stereo lithograph machines and computer numerical control (CNC) machines and electrical engineering computer solutions we could only dream of just a few years ago. I guess I've been in rehab for about 20 minutes. I know this because that's how long it takes on average to call a rep, a colleague or a therapist, or a doctor to dream up a solution for a patient.

"I think I know a bit about human form and function and that helps," McKnight continued. "I study human gait, seating, disease processes and how other animals address themselves. In the end, I think I'm in this industry for about 30 minutes. Maybe that's not correct, I could be exaggerating."

CONTACT

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Sherri may be reached at sherri@mobilityunlimitedinc.com.

SUCCESSFUL CONGRESSIONAL BRIEFING

and Other SBC News

WRITTEN BY: DON CLAYBACK

It's summer time and while the living ain't necessarily easy, at least it's productive. Work continues on our quest to secure a Separate Benefit Category for Complex Rehabilitation Technology (CRT) within the Medicare program through passage of the "Ensuring Access To Quality Complex Rehabilitation Technology Act."

As of this writing, we have 61 representatives signed on to H.R. 942 and three senators signed on to S-948. That's good progress, but continued work is needed. Here's an update on some key happenings.

CRT congressional briefing

We had a very successful congressional briefing on CRT and our Separate Benefit Category legislation in Washington on July 15. The briefing was entitled "Enabling Independence for People with Disabilities: the Importance of Complex Rehab Technology" and was co-hosted by the Bipartisan Disabilities Caucus and the offices of Rep. Joe Crowley and Rep. Jim Sensenbrenner. There were approximately 100 people in attendance with 71 congressional offices represented (57 House offices and 14 Senate offices).

As of this writing, we have 61 representatives signed on to H.R. 942 and three senators signed on to S-948. That's good progress, but continued work is needed.

The one hour program opened with a welcome from Todd Adams, Rep. Jim Langevin's legislative director, introducing the topic on behalf of the Bipartisan Disabilities Caucus. I followed by providing an overview of CRT covering what it is, who uses it, the benefits, how it's provided, and the access challenges that exist.

Paul Tobin, president of United Spinal Association, then reviewed the important role CRT plays in the lives of people with disabilities, including how it assists in maximizing function and independence, how it reduces health care costs, and how it enables people to fully access their communities and engage in education, employment and other activities of living. Adam Lloyd, a college professor from Maryland (who uses a power wheelchair and chin control), then told his personal story and how important CRT has been in the aspects of his life: his education, his employment, his quality of life, and the management of his health care.

We had a very successful congressional briefing on CRT and our Separate Benefit Category legislation in Washington on July 15. The briefing was entitled "Enabling Independence for People with Disabilities: the Importance of Complex Rehab Technology" and was co-hosted by the Bipartisan Disabilities Caucus and the offices of Representative Joe Crowley and Representative Jim Sensenbrenner.

Paul and I then reviewed the key aspects of H.R. 942/S-948 and fielded a variety of questions. The attendees were very attentive, and we had a

> Your connection can take many forms with the objective being CRT stakeholders "touch" their member of Congress that week and ask for support of the CRT bills. If you can't connect that week, then make the contact sometime during the month.

solid 15 minutes of questions and answers. To wrap up, Nicole Cohen, Rep. Crowley's legislative assistant, and Kara Webster, Rep. Sensenbrenner's legislative assistant, spoke on the need for additional co-sponsors and encouraged attendees to talk to their bosses about becoming a co-sponsor to the CRT legislation.

Of the 71 Congressional offices in attendance, only 17 had signed on to H.R. 942 or S-948 to date. That meant there are 54 member offices that now know more about CRT and can be asked to become co-sponsors to our legislation. While the forum provided a great CRT educational opportunity, the related follow-up is underway so we can secure additional Congressional support.

(CONTINUED ON PAGE 40)

SUCCESSFUL CONGRESSIONAL BRIEFING *(CONTINUED FROM PAGE 39)*

national CRT week starts august 19th

When Congress goes home for their August recess, it's a great time to connect with members in their home districts. To help emphasize this opportunity, we have officially declared August 19 to 23 National CRT Week. With your members back home for the whole month, you can get their attention on our CRT bills in-person. No need to travel to Washington.

Your connection can take many forms with the objective being CRT stakeholders "touch" their member of Congress that week and ask for support of the CRT bills. If you can't connect that week, then make the contact sometime during the month.

A home run is to have them visit your store or facility. This is a fairly easy event to hold, and we are happy to provide personal assistance with the planning, structure and materials needed to ensure an effective visit. The most difficult part is to get on the member's schedule. Please contact me or Simon Margolis directly and we can offer you specific guidance and suggestions. To obtain an overview of the structure of a visit, access the Microsoft® PowerPoint® presentation entitled "Hosting a Visit at Your Business" in the educational area of the NCART website at *http://www.ncart.us.*

If you can't do a visit at your location, there are plenty of other ways to connect: you can visit them at their office; you can attend a local fundraiser; you can attend a community event at which they will be in attendance. Get creative and partner with other CRT stakeholders in your community. Make it fun!

While they likely will not commit on the spot, you can push for their support and find out who in their office you can follow up with for further discussion. Hand them a copy of the H.R. 942/S-948 Information Pack that contains all the primary information. You can download it at **http://www.access2crt.org.** That way you are leaving them with the specifics they can review and respond to.

While legislators likely will not commit on the spot, you can push for their support and find out who in their office you can follow up with for further discussion. Hand them a copy of the H.R. 942/S-948 Information Pack that contains all the primary information. You can download it at *http://www.access2crt.org.* That way you are leaving them with the specifics they can review and respond to.

From a big picture perspective, we need to secure enough support and resolve any questions or issues so when a larger piece of Medicare legislation is brought to the floors for a vote our small bill can be attached to it.

2013 legislative roadway

When Congress returns in September, the next four months promise to be full and hectic given all the pressing national issues they will be dealing with. We will continue to promote our legislation with members and with the staff on the committees of jurisdiction. From a big picture perspective, we need to secure enough support and resolve any questions or issues so when a larger piece of Medicare legislation is brought to the floors for a vote our small bill can be attached to it. While it's difficult to predict, one certainty is that Congress will need to vote on legislation to address the scheduled Medicare physician fee schedule cuts (known as "the doc fix") prior to January 1. This will likely occur in December and may be the opportunity for us to attach our bill to something bigger. There is a lot that needs to happen between now and then.

Ongoing Assignment for CRT Stakeholders

As we've said, it's all about getting as many members of Congress to sign on to H.R. 942 and S-948. So, after reading this update, go to *http://www.access2crt.org* and see if all your representatives have signed on yet. If yes, please send them a thank you email. If not, put on your sales cap, get the member's health care legislative assistant on the phone, and work to get them on board.

To sign on as a co-sponsor, all a member's office has to do is email or call one of the following:

House Bill H.R. 942: Contact either Nicole Cohen in Representative Crowley's office at *nicole.cohen@mail.house.gov* or 5-3965 or Kara Webster in Representative Sensenbrenner's office at *kara.webster@mail.house.gov* or 5-5101.

Senate Bill S-948: Contact either Veronica Duron in Senator Schumer's office at *veronica_duron@schumer.senate.gov* or 202-224-6542 or Sarah Stone in Senator Cochran's office at *sarah_stone@cochran.senate.gov* or 202-224-5054.

Remember, you can access additional CRT advocacy tools and information at *http://www.access2crt.org*. Keep us posted on your progress and let us know if we can be of assistance. Thanks for the continued advocacy!

Visit *http://www.ncart.us* for more information

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SEATING AND MOBILITY CONSIDERATIONS

for the Bariatric Client

WRITTEN BY: SUSAN JOHNSON TAYLOR, OTR/L

Most health care and related professionals have become familiar with the term "bariatric" during the last 10 years or so. In a 2004 report, the Organization for Economic Cooperation and Development cited the United States as leading all developed countries with 64.5 percent of its population considered overweight. Those numbers continue to increase with morbidly obese and extreme morbidly obese patients placing a demand on hospitals for surgical intervention and treatment.

Rehabilitation professionals are challenged to prescribe functional seating and mobility for many consumers who are obese. Finding appropriate equipment to meet the requirements of bariatric rehab clients can be challenging, although there are more commercially available cushions, back supports, manual and powered mobility devices available today than ever before.

As with any other seating and mobility intervention, the first step toward appropriate equipment is to complete a thorough evaluation. This should start with the subjective interview, including goals of the client.

As with any other seating and mobility intervention, the first step toward appropriate equipment is to complete a thorough evaluation. This should start with the subjective interview, including goals of the client. Where and how do they need to function? Which activities of daily living and functional skills are important for them to perform? A weight history and accurate weight need to be obtained. Has the client been steadily increasing or decreasing in weight? Is surgery planned? It can be difficult to obtain the weight of an obese client. Hospitals often have platform scales (like the ones used to weigh wheelchairs) or bed scales. Some professionals in the field have used one scale under each foot and added the two together. Aside from ensuring the client falls within the weight limit of the equipment, the team must also know what the combined weight of the client and the equipment is for accessibility and transport. Issues such as accessibility and transportation are magnified because of the weights, widths and lengths of bariatric equipment.

The mat evaluation is the next vital component to the prescription process. Depending on the client's ability to maintain a seated posture, this may require two or three people to safely and accurately complete. The client needs to be supported in sitting. As with any other mat evaluation, the client needs to be measured on a firm planar surface. This will assure the most accurate dimensions. Soft surfaces can accommodate and compress tissue, providing inaccurate measurements. In a clinical setting, a height adjustable therapy mat or table is ideal. The height adjustment allows upper leg support on the table surface while the feet can be in contact with the floor and allows a safer sit-to-stand transfer.

Clinicians and suppliers who are experienced in evaluation and prescription for seating and mobility are familiar with the typical body measurements that are taken. Some additional measurements are necessary with the bariatric client. *(See Figure 1 on next page.)*

Excessive adipose tissue in the gluteal region can prevent obese consumers from sitting with adequate spinal support, which can contribute to incidence of back pain for this population. Additionally, failure to accommodate this usually results in the client essentially sitting in a reclined position with complaints of constantly "sliding down" in their seats. Two key measures relate to this: overall depth from the posterior aspect of the calf to the most distal part of the gluteal region, as noted in Figure 1, and measurement from the evaluation support surface to the top of the gluteal tissue. This can assist in determining the height at which

(CONTINUED ON PAGE 45)

ADDITIONAL MEASUREMENTS FOR BARIATRIC CLIENTS

Current weight:_____ Weight history:_____

_____

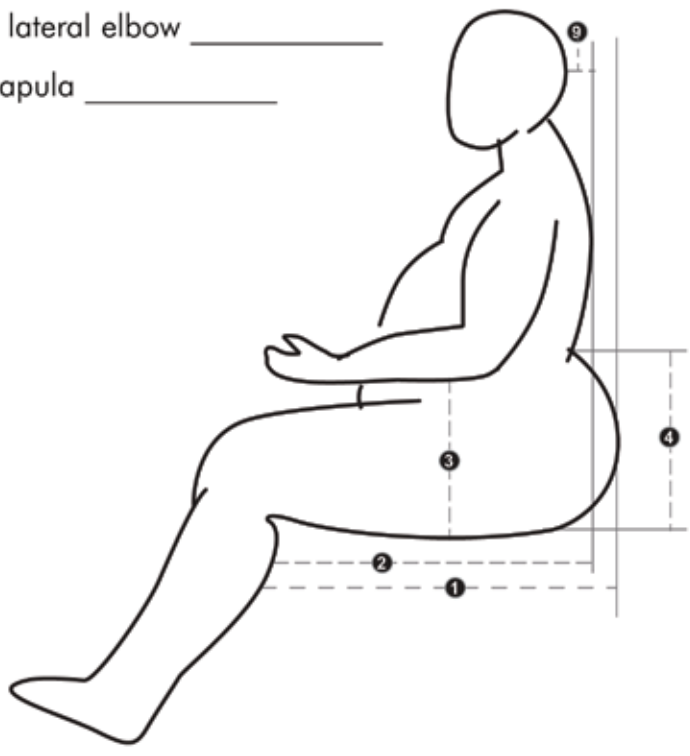
_____

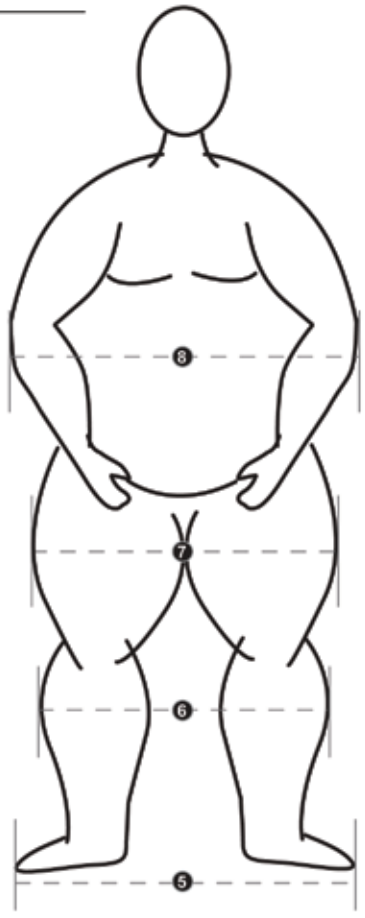
_____

_____

_____

1. Back of knee/calf to back of buttocks (seat pan depth) _____
2. Back of knee/calf to thoracic-lumber trunk (for seat depth) _____
3. Seat pan to under forearm (armrest height) _____
4. Seat pan to top of gluteal tissue (lower aspect of back support height) _____
5. Width at toes (lateral aspect) _____
6. Width from lateral calf to lateral calf (at widest aspect) _____
7. Overall hip width _____
8. Lateral elbow to lateral elbow _____
9. Back of head scapula _____





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SEATING AND MOBILITY CONSIDERATIONS
(CONTINUED FROM PAGE 42)

a back support surface is mounted, allowing some of the redundant tissue to stay below the back support and posterior of the back canes while supporting the client's mid -trunk.

The "geometry" of the client must be noted to ensure functional interface between the client and their seating and mobility. Several different bariatric body types have been noted by Michael Dionne in his book "Among Giants: Courageous Stories of Those Who Are Obese and Those Who Serve Them." Each of these body shapes distributes weight differently and creates very different shapes. These include abdominal obesity (described as the apple shape) and gluteal/femoral obesity (described as the pear shape).

Abdominal obesity has the primary excessive weight distribution in the belly area. This anterior weight distribution can lead to more anterior instability of the wheelchair. The other complication for patients with abdominal obesity is the effect this type of weight distribution has on their seated posture. The mass of adipose tissue can prevent the consumer from sitting completely upright. Evaluation of the clients' tolerance for upright sitting is very important. This often leads to seating and mobility products that have adjustment in the seat-to-back angle. Some consumers' hip flexion may be limited and/or their abdominal tissue may exert pressure on their femurs forcing their upper legs into a more abducted posture. This in turn can make the use of footrests on a wheelchair very difficult. The lateral aspect of the knees or lower legs may be in constant pressure against the footrest hangers.

Clients with gluteal/femoral obesity carry most of their adipose tissue below their waist and above their knees. Dionne further differentiates these patients into "pear adduction" and "pear abduction" types. This results from distribution of adipose tissue that is either more medially or laterally distributed. Excessive medial femoral tissue will prevent the femurs from achieving a neutral alignment in sitting. In addition, it can result in pressure at the lateral knees or calves on footrest hangers. Excessive lateral femoral tissue can require larger seat widths for accommodation, a necessity that can have a negative consequence for footrest and armrest position as well as access to the rear wheels for those who want to propel a manual wheelchair. With either of these scenarios, it is important to note where the client's feet need to be supported.

Most clients are concerned with how their bodies' overall width will fit into the narrowest chair possible. During the mat evaluation, the team must discuss with the client how much of the client's width could be compressible to fit into a more narrow overall width without impacting skin integrity.

Most clients are concerned with how their bodies' overall width will fit into the narrowest chair possible. During the mat evaluation, the team must discuss with the client how much of the client's width could be compressible to fit into a more narrow overall width without impacting skin integrity.

Bariatric consumers who require wheeled mobility devices benefit from equipment that is adjustable according to their physical and functional needs, just like any other person who utilizes a wheelchair. Maximizing the function and performance of any manual or power wheelchair requires the distribution of the client's weight relative to the chair's drive wheels (power) or propulsion wheels (manual). The geometry created by the bariatric consumer's weight distribution will impact the wheelchair's overall performance. While the bariatric chair can be considerably heavier than other chairs, it is still possible to have efficient propulsion.

Many manual chairs have a non-adjustable rear axle integrated with the rear frame and back post component of the chair. Obese consumers whose excessive adipose tissue in the posterior gluteal area and/or the posterior trunk can struggle with propulsion of a manual wheelchair due to their anterior position away from the rear wheels (see picture in Rehab

(CONTINUED ON PAGE 47)

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SEATING AND MOBILITY CONSIDERATIONS
(CONTINUED FROM PAGE 45)

Case Study). This rear wheel position also lends to less weight being placed over the rear wheel and too much on the front casters, which leads to poor mobility and a great deal of instability of the chair. There are some manual wheelchairs designed with the needs of bariatric consumers in mind. Adjustable rear wheel placement as well as placement of the casters further forward can accommodate the forward center of gravity of the bariatric client, thus providing better mobility and anterior stability for the client.

This same weight distribution issue is a factor with power wheelchairs. It is important to consider the client's weight distribution in relation to the drive wheels as well as the length of the wheelbase for anterior stability. The more weight over the drive wheels as opposed to the smaller turning wheels, the better the chair will perform for the client. Short wheelbases with suspension stabilizers in the front can compress with excessive anterior weight loads, pitching the system forward – especially when driving down inclines.

Prescribing appropriate mobility bases for bariatric consumers is not simply a matter of getting the width right. Taking the time to carefully evaluate and measure the client and problem solve some of the challenging aspects can assure more successful outcomes and greater consumer satisfaction.

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Compiled by Susan Johnson Taylor from information created by Stephanie Tanguay, OTR, ATP.

BARIATRIC POSITIONING

WRITTEN BY: STEPHANIE TANGUAY, OTR/L, ATP

Bariatric consumers face many challenges for assisted mobility and seating. Too often the goal may be to find a wheelchair (manual or power) that simply has an adequate weight capacity. As consumer weights exceed 300 lbs., there are greater considerations and possible complications in the prescription process.

seat depth challenges: lymphedema

One of the secondary risks of long-term morbid obesity is the potential for severe lymphedema to develop. As the consumer's mobility becomes more restricted and they spend greater amounts of time in a seated position, the lymphatic system may be occluded in the groin region. Lower extremity lymphedema can impact the functional seat depth and anterior cushion shape and length as the shape and size of the lower extremit(ies) changes and increases. Additional complications such as cellulitis or lipoma pose additional challenges.

Figure 1 shows a lipoma mass that was eventually surgically removed accounting for a decrease in weight of approximately 80 lbs. Before surgical removal, this area required support from the seating system itself and impacted both seat width as well as seat depth. *Figure 2* shows the same consumer seven years later in a manual wheelchair with a 20" seat depth, which the seating team determined was 3" too deep. As the seat depth was too long, the front edge was in contact with the posterior aspect of her lower legs. Contact with the right leg constantly irritated the old surgical site where the lipoma was removed. She also presented with chronic recurrent cellulitis, a common infection of the skin and subcutaneous tissues. Lymphedema predisposes to recurrent episodes of cellulitis.

Figures 4 and 5 show anterior and lateral views of a newer manual wheelchair (30" wide x 18" deep), which was provided in 2012. This seat depth is 2" shorter than the previous wheelchair and, with new adjustable back upholstery, the seat depth is more appropriate in comparison to the stretched back upholstery of the previous mobility device. This prevents contact with the posterior lower legs. This consumer is very independent. A home evaluation determined a mixture of ambulation and manual wheelchair use that fully met her in-the-home needs. As she partially propels using her lower extremities, the seat-to-floor height accommodates this. In addition, she demonstrated the ability to manage the heavy-duty wheelchair up three to four steps to get into her apartment independently.

seat depth challenges: posterior pelvic tissue

Excessive posterior pelvic tissue distribution (or posterior gluteal adipose tissue) is often difficult to measure and accommodate. This

(CONTINUED ON PAGE 51)

FIGURE 1: LIPOMA MASS

FIGURE 2: SEAT DEPTH TOO LONG

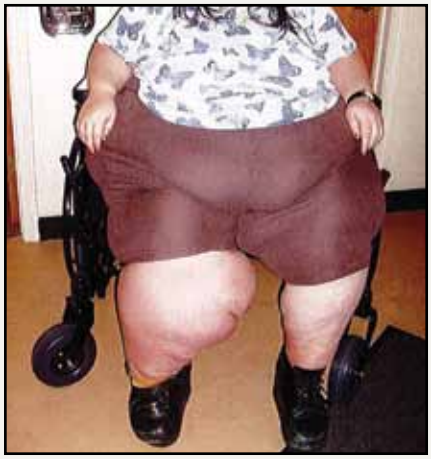

FIGURE 3: NEW WHEELCHAIR, FRONT

permobil

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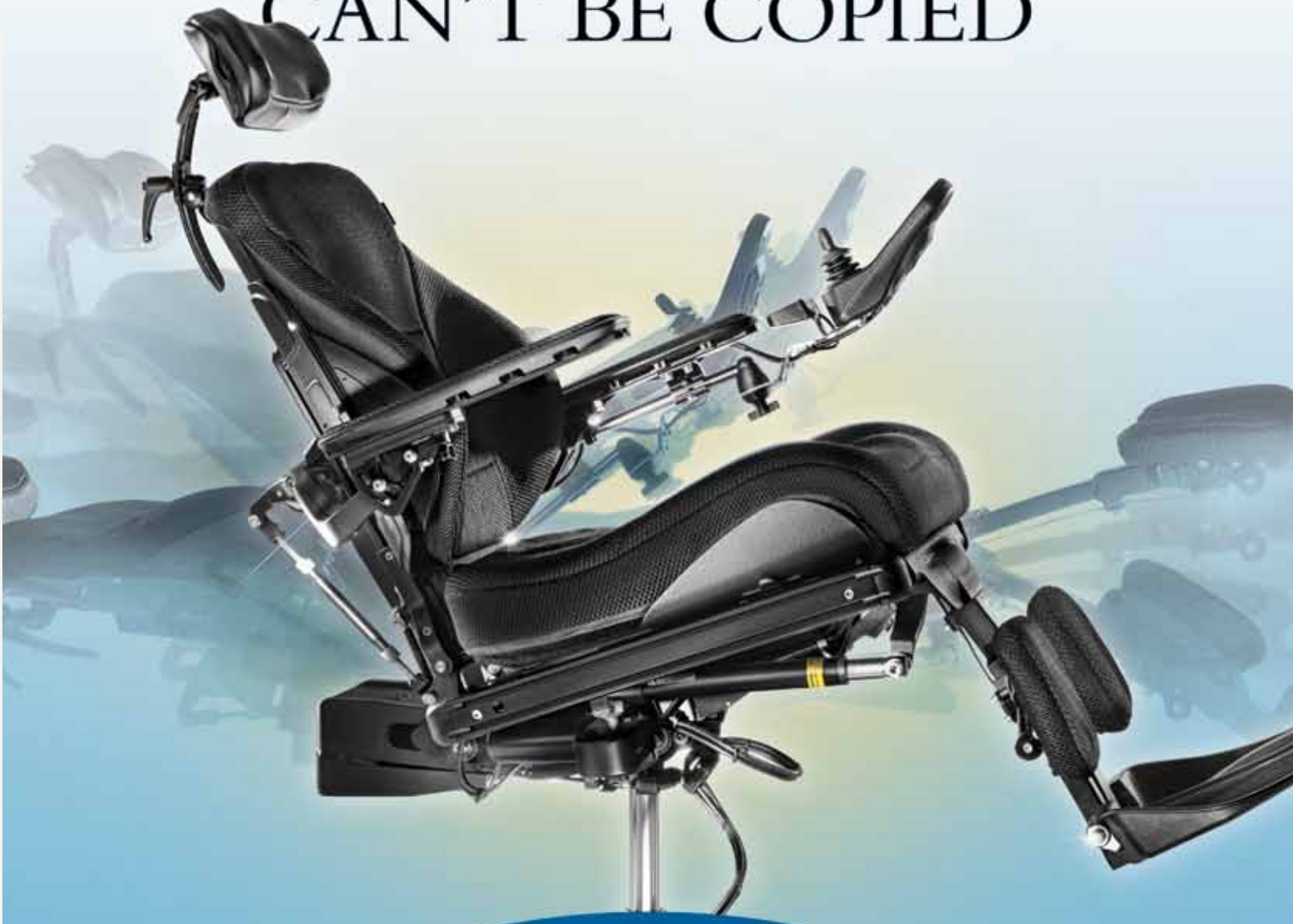

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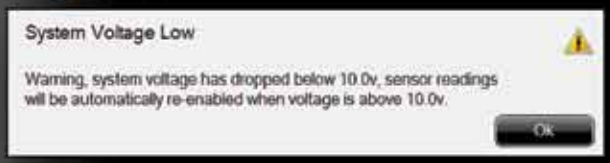

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In order to improve lower extremity contact to the floor, footrests and seat cushions are often abandoned by the consumer. This can result in extremely high areas of pressure, particularly at the front edge of the seat surface. It is important to note signs of high pressure, as circulation can be compromised in this population.

FIGURE 4: NEW WHEELCHAIR, SIDE

FIGURE 5: REAR WHEEL PLACEMENT

SEATING AND MOBILITY CONSIDERATIONS
(CONTINUED FROM PAGE 48)

frequently results in inappropriately long seat depths, a discrepancy that can cause contact and pressure in the popliteal region. In addition, failure to accommodate the unique posterior shape created by this tissue results in poor support of the trunk often causing a reclined posture. As with any person sitting in a system that is too deep, this lack of posterior pelvic and trunk support can cause chronic back pain.

seating and impact on mobility

Seat-to-Floor Height: Very often, consumers with excessive morbid obesity utilize manual wheelchairs and attempt to propel them with combinations of upper extremity and lower extremity motility. In order to improve lower extremity contact to the floor, footrests and seat cushions are often abandoned by the consumer. This can result in extremely high areas of pressure, particularly at the front edge of the seat surface. It is important to note signs of high pressure, as circulation can be compromised in this population. For mobility devices with fabric or sling seat materials, watch for stretching and tearing over time. Some wheelchairs have reinforced seat materials as standard, or perhaps as additional, charge options. If a consumer is using their lower extremities for manual wheelchair propulsion, ideally the seat-to-floor height, including a cushion, must reflect this.

Endurance: The consumer's ability to perform propulsion and sustain mobility is frequently limited by poor endurance related to obesity and co-morbidities. Compromised respiratory function is a common secondary complication for this population. Watch for labored breathing with mild exertion. These consumers are very often independent with standing transfers and may be able to ambulate somewhat within their household. However, power mobility may be required for longer distances.

Rear Wheel Placement: Consumers who need to rely on their arms may not have appropriate access to the rear wheels for propulsion, depending on the options available for their weight and their body shape (see Figure 5). Excessive posterior pelvic tissue pushes the consumer forward of the rear wheels, impacting self-propulsion and overloading the front casters. The wheelchair frame must include the necessary adjustments to move the rear wheel in a more optimal position for self-propulsion and center of gravity.

Searching for seat support surfaces and back supports that are size and weight appropriate can be difficult. If the consumer requires increased postural support, it may be impossible to find off-the-shelf seating solutions. Although many more heavy duty options are available today, the wider the equipment must be and the higher the weight capacity required, the fewer options are available.

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The author would like to acknowledge assistance from Kim Davis, MSPT, ATP.

A MEANINGFUL ACCOMPLISHMENT

The American Physical Therapy Association Adopts Policy on Access to Durable Medical Equipment

WRITTEN BY: LAURA COHEN PT, PHD, ATP/SMS

The American Physical Therapy Association (APTA) recently adopted a policy on access to durable medical equipment (DME). This is a meaningful accomplishment and one that required the Clinician Task Force to be involved in the APTA's House of Delegates. This policy now instructs staff and the BOD to take action and advocate on issues related to DME, which includes Complex Rehab Technology (CRT).

The past several months have been busy with APTA activities and progress on issues related to CRT and DME. This update focuses on Clinician Task Force activities with the APTA.

APTA house of delegates adopts policy on access to durable medical equipment

The process of passing a motion within the APTA House of Delegates is a long, curvy road. There are more than 400 delegates representing APTA State Chapters and Sections. The House of Delegates meets annually for three successive days each spring, during which time nominated delegates make decisions on issues that may have far-reaching implications for the association and for the profession of physical therapy. Business of the House of Delegates follows parliamentary procedure and is conducted through the introduction of delegate-proposed motions, which may amend APTA's bylaws, direct a course of action, articulate an association attitude on the physical therapy needs of the public or the needs of members, or describe a goal the association wishes to achieve.

The amended statement reads: Resolved, that the American Physical Therapy Association supports a patient's/client's access to high-quality durable medical equipment and services by advocating for choice, access, quality, cost-effectiveness, and adequate funding to allow patients/clients to live active and productive lives in their homes and communities.

This year, a motion about durable medical equipment was introduced by the Arizona delegation. After months of education, outreach and politicking by task force members and colleagues the Arizona motion was amended and replaced with broader more inclusive advocacy language. In the last eight minutes of the 2013 House of Delegates, the DME motion was passed. The amended statement reads:

Resolved, that the American Physical Therapy Association supports a patient's/client's access to high-quality durable medical equipment and services by advocating for choice, access, quality, cost-effectiveness, and adequate funding to allow patients/clients to live active and productive lives in their homes and communities.

This is a positive outcome. This motion instructs staff and the board to take action and advocate on issues related to DME.

APTA payment policy & advocacy committee (PPAC) appoints a workgroup to develop guidance related to DME and CRT issues

Once the formal 2013 House of Delegates minutes are approved and finalized in September, the board will discuss the direction of work according to the motions passed by the House. The PPAC is in the process of convening a work group about DME/CRT to develop guidelines for implementing the adopted motion. Once work begins, the subgroup plans to engage a task force member content expert to assist with this policy topic.

APTA BOD adds CRT and DME to the legislative and regulatory policy priorities

Due to the attention and chatter that occurred before and during

(CONTINUED ON PAGE 55)

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A MEANINGFUL ACCOMPLISHMENT *(CONTINUED FROM PAGE 52)*

the House of Delegates, thanks to the members of the task force, the APTA Board, PPAC, and House of Delegates heard a lot about DME and CRT issues. As a result the board and PPAC have taken notice and moved CRT/DME to the legislative and regulatory priorities list for the organization. This is a first and noteworthy progress!

public comment period for revisions to the guide to APTA practice ends

The task force has worked for more than three years to incorporate assistive technology (AT) practice specific to seating and wheeled mobility and CRT into "The Guide to PT Practice" July 1, 2013, the final public comment period for this project ended.

If you question why this is important, "The Guide to PT Practice" defines professional practice. As an official document of the organization, it is used to define the content and requirements for Accredited Physical Therapy and Physical Therapy Assistant academic programs to ensure the next generation of new professionals will have seating and wheeled mobility training in entry level programs. Inclusion of AT and CRT in the guide will define professional practice so that practicing therapists can self-recognize when they are practicing within their scope of expertise or when further development is needed in this content area. Incorporation of AT and CRT into "The Guide to PT Practice" is an important step toward ensuring that physical therapists have the requisite knowledge and skills to fulfill our role and responsibilities on the CRT team.

in closing

The Clinician Task Force continues to work diligently to keep our professional clinical organizations informed of policies and legislation that negatively impact consumer access to medically necessary and appropriate DMEPOS and CRT. Keeping our associations up-to-date and abreast of how regulatory and legislative changes are impacting clinical practice and the individuals we serve is necessary if we are to mobilize the clinical community to participate in issues related to CRT and DME.

Task force members regularly communicate with voluntary leadership and staff of our professional organizations, including: the American Physical Therapy Association (85,000 members), the American Occupational Therapy Association (40,000 members), the American Academy of Physical Medicine and Rehabilitation (8,000 members) and the Association of Academic Physiatrists (1,200 members).

This is a challenging time for all of us who work in the CRT industry. We need to periodically step back and pause to admire our progress. We believe that our effort to educate and support our professional organizations is valuable to the CRT industry to garner support of the clinical communities on CRT issues and to help build capacity of the work force to ensure there are enough skilled and knowledgeable clinicians to meet the public need. The Clinician Task Force is thankful to our donors who continue to support our work and enable us to make steady progress!

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WHEELCHAIR USERS SPEAK OUT

United Spinal Association's Annual Roll on Capitol Hill

WRITTEN BY: ANN EUBANK AND ALEX BENNEWITH

As a grassrooter, some days can bring frustration trying to connect with and mobilize like-minded people (a tribe if you will). Grassroots works best, or at all, when the tribe directs itself attending to and acting on issues relevant to their own lives. Leadership within a tribe includes facilitation and organizing, the focus is on the organic and authentic collective voice of the wheelchair user. Grassroots is bottom-up and sideways messaging, not top-down; there is an absence of an entitled leader. As a disability organization, run by people with disabilities, the affinity we share with our members and other disability organizations is fostered by connecting with our hearts and our minds. We share our time and our lives as we roll towards the common goal of equal rights and access for people with disabilities.

In June 2013, we pushed up Capitol Hill at our second annual Roll on Capitol Hill, our trust and respect for one another, along with our shared frustration of the inequalities experienced by all, galvanized our community to a new level of strength and capacity. Eighty members of United Spinal Association [including National Spinal Cord Association, UsersFirst and VetsFirst], representing 30 states, including the District of Columbia, came together to speak directly with our elected officials.

In June 2013, we pushed up Capitol Hill at our second annual Roll on Capitol Hill, our trust and respect for one another, along with our shared frustration of the inequalities experienced by all, galvanized our community to a new level of strength and capacity. Eighty members of United Spinal Association (including National Spinal Cord Association, UsersFirst and VetsFirst), representing 30 states, including the District of Columbia, came together to speak directly with our elected officials. At the end of the day, we completed 200 visits. This event, without a doubt, was very successful and empowering for all.

H.R. 942/S-948, Ensuring Access to Quality Complex Rehabilitation Technology Act of 2013 was one of our key issues. Aware of the personal ramifications, attendees were primed and eager to share their

Another major issue addressed at this year's Roll on Capitol Hill was to support H.R. 1717, Medicare DMEPOS Market Pricing Program Act of 2013 which preserves access to medical equipment, supplies and related services. H.R. 1717 makes improvements to the current bidding program by establishing an independent pricing mechanism: setting binding bids from participating suppliers; creating smaller bidding areas; and, allowing any willing supplier to enter a bidding area at a set price for that area. This makes sense for consumers to ensure improved access to quality equipment, service and supplies.

PAUL TOBIN, SEN. JOHN MCCAIN AND TERRY MOKLEY

SEN. JOHN MCCAIN

experiences with their representatives. How does not passing H.R. 942 impact me? "Without the wheelchair and options that meet my medical needs and allow me to live my life, what good are all the existing disability policies passed by Congress? Curb cuts and accessible buses are wonderful, but of no good to me if I don't have the right equipment to utilize them."

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(CONTINUED ON PAGE 58)

WHEELCHAIR USERS SPEAK OUT *(CONTINUED FROM PAGE 57)*

Currently, Medicare accepts the lowest bid for medical equipment, supplies and service, which results in the cheapest equipment and supplies and worst service. Representatives' offices were eager for UsersFirst/United Spinal Association to share consumer data with them and hear in-personal stories. They stated they value the authentic voice of the consumer. We were there to tell them the bidding program and rigid insurance guidelines are limiting consumer access to preferred products and service.

As a consumer organization, we link civil rights and equality issues to equipment and service access issues, it makes for a compelling and comprehensive presentation.

We recognize the impressive accomplishments of attending 200 Hill visits, the presence of Sen. John McCain, R-Ariz., at our reception along with other representatives, staffers and a personal letter from Bob Dole read aloud. We also recognize we are exponentially stronger because of our resilience and commitment to make positive change for people with disabilities. With every phone call, email and personal connection, our message becomes viral, touching and mobilizing many.

We understand there are essential elements (steps of success) that have helped build our momentum. We are part of an historic disability organization, United Spinal Association, which is committed to continuing to build and sustain a strong grassroots effort along with guidance and support from a nationally-based policy department.

UsersFirst is part of the grassroots effort embracing all people who use wheelchairs and people who care that all Americans have the right to move freely in their communities. We are a peer-to-peer organization managed by people with disabilities providing "on-the-ground" services along with advocacy. We are a service organization and an advocacy organization. We build and sustain community. With this amazing community we are united and mobilized.

We also recognize that support from our sponsors allows us to grow our programs and outreach strengthening our presence locally and in D.C.

The passion generated from the D.C. trip will further fuel our efforts to continue developing chapters and support groups, increase communication throughout our programs, create education materials to foster membership, and follow up on every meeting and every conversation to strengthen our relationships with our representatives' federal offices and their offices back in our home towns.

From here we continue to serve our members and advocate for policies, (federal, state and private), that enhance the lives of our members. We are strong, connected, educated and mobilized.

We are a peer-to-peer organization managed by people with disabilities providing "on-the-ground" services along with advocacy. We are a service organization and an advocacy organization. We build and sustain community. With this amazing community we are united and mobilized.

ROLL ON CAPITOL HILL

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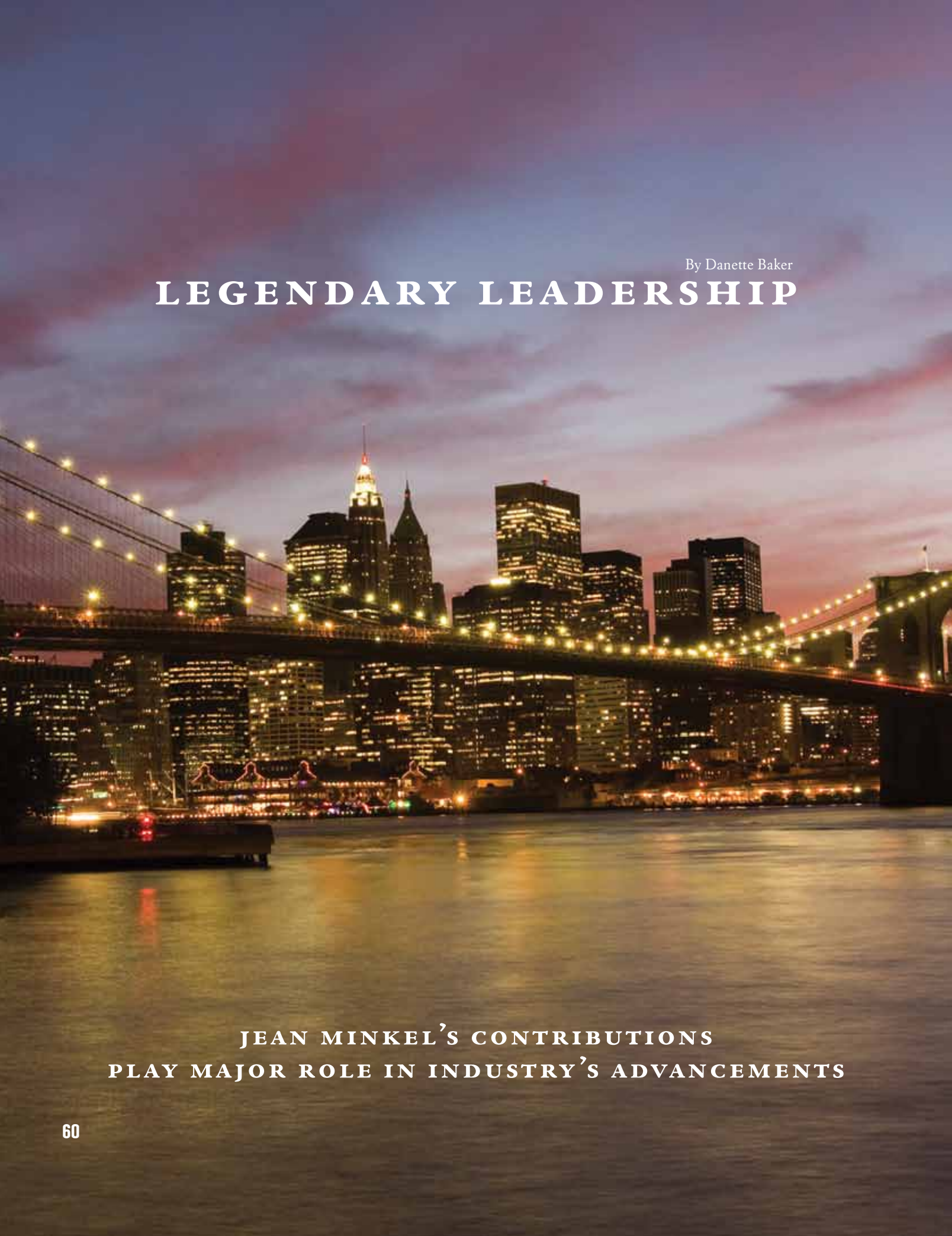

By Danette Baker

LEGENDARY LEADERSHIP

JEAN MINKEL'S CONTRIBUTIONS PLAY MAJOR ROLE IN INDUSTRY'S ADVANCEMENTS

Jean Minkel, PT, ATP, was crossing the street at the corner of 135th Street and Amsterdam Avenue in New York City when she heard a familiar voice call out and noticed a young man coming toward her. It took her a few minutes to realize that two years before, this was the young man confined to the lobby of his North Manhattan apartment building. Leaving the building was not so much a problem, but the uphill climb back home for a wheelchair user made the effort almost futile. As a result, the young man spent his days inside the apartment building, often alone.

Until he met Minkel.

Minkel is a physical therapist and clinician well-recognized for her work in assistive technology. For 17 years, she has managed a consulting company in New York that supports members of the assistive technology team, including consumers, therapists, suppliers, manufacturers and payers. The last 11 years, she also has worked for a company that provides seating and mobility services for adults with physical disabilities, allowing them to live independently in their own homes in New York City.

Relying on traditional fee-for-service funding, the young man would never have qualified for the power wheelchair, but then again, Minkel has never been one to settle for the status quo.

One of the first Christmases after she began her physical therapy career (almost 30 years ago), Minkel asked her father for a socket wrench set. Minkel was a therapist at Boston's Mass Hospital School, a residential educational facility for children with multiple disabilities, where all but one of the 21 students used wheelchairs. "I had always had a mechanical inclination, so for me it was just natural to pick up a tool and do the small repairs to their chairs," she said. "I wanted to make sure they had the best means possible to succeed."

About this time, the world of durable medical equipment and complex rehab technology began to emerge. At the hospital school, Minkel was introduced through literature to the pioneering work of Adrienne Bergan, whom Minkel calls a "true legend" in the field. "Having access to her work was exciting, because it gave me new tools for the kids I was working with," Minkel said.

Within a couple of years, she had the chance to succeed Bergan at Blythedale Children's Hospital, a clinical environment that embraced assistive technology as a part of the therapist's repertoire. "They also were excited to have a therapist that cared about the shop in the basement," Minkel quipped.

One of the true breakthroughs in her career, however, was becoming involved with RESNA; there, Minkel said she "found a professional home."

Through RESNA, Minkel met Martin Ferguson-Pell, with whom she founded the Center for Rehab Technology at Helen Hayes Hospital, located just outside of New York City. Leading the seating and mobility unit for the center presented Minkel the opportunity she had worked a lifetime for — to fully integrate technology and mobility. During the next eight years, Minkel discovered, through work with RESNA and at the center, a passion for helping people with disabilities integrate back into the community, as well as a community of professional colleagues who shared her passion.

From her colleagues, Minkel learned more about spinal cord injuries, augmented communication devices and the importance of function as well as alignment in seating systems.

"The patients were also incredible teachers," Minkel said. "They taught me a lot about life from the 'chair perspective.' "

One of the center's missions was to provide educational opportunities and generate research questions while delivering services. An example of fulfilling this mission was Minkel's development and testing of the interface pressure mapping system, a technology not previously available. She also discovered she had an innate ability to communicate with the end user and the engineer, a trait that has served her well and advanced the industry. Minkel recalls working with Martin IE on development of the wheelchair stander, when the question arose regarding the technology's "dynamic stability of manual wheelchair."

"There was a group therapist looking like 'what are they talking about,' and I just said, 'That means how easy it is to pop into the wheelie position.'

"In the profession, there is a vocabulary that, if you don't know, makes it hard to communicate effectively. I understood both the mechanics behind the equipment as well as the clinical aspects so I often was the translator."

Then came the days of health care reform and managed care. The therapy and services offered at Helen Hayes was labor intensive, and reimbursement was meager, Minkel said. In 1995, she left Helen Hayes and began Minkel Consulting to provide educational and consulting services to members of the assistive technology team. Her first contract was with RESNA to develop a C. Gerald program. In an article published on Stanford University's website, Minkel said, "Throughout the process, Gerry imparted his wisdom, integrity and total commitment to the high standards of 'Quality Assurance,' which had a huge impact on my practice."

Minkel's involvement with RESNA has been long-standing. Today, she is a member of the ANSI/RESNA Wheelchair Standards Committee and serves as the organization's representative to the

Program Advisory and Oversight Committee on Competitive Acquisition for Durable Medical and Supplies.

"I have worked with Jeanie in both professional and volunteer settings, and truly consider her a pioneer and leader in the field of assistive technology. She has consistently supported certification in her roles as educator, mentor, friend and entrepreneur," said Carmen DiGiovine, PhD, ATP/SMS, RET and member of the RESNA Professional Standards Board. "She is the consummate leader by action and words."

A result of Minkel's work with RESNA led to a consulting contract with Johnson and Johnson to bring the IBOT™ to the market. Minkel, along with Peter Axelson and Rory Cooper, were instrumental in the development of the new technology, which involved a gyroscope-type balancing device that allowed the user to maneuver across multiple terrains and even climb stairs.

"It was like the Fred Astaire of wheelchairs," she said. "In my mind, it was and still is the absolutely best breakthrough ever in technology."

The dance through FDA regulations was anything but smooth. In 1999, about the time the IBOT™ was making its debut, there was a huge pendulum swing in reimbursement for power wheelchairs, Minkel said. The FDA initially categorized the IBOT™ as a Class 2 power chair. It could climb up and down stairs so it had to have a higher safety rating, making it fundamentally different that a standing chair, which was a real victory, Minkel said. However, when Johnson and Johnson went to the Centers for Medicare and Medicaid (CMS) to get a unique medical device code, CMS set reimbursement as that for a standard power wheelchair. "The funding would never match the cost of manufacturing this new technology so it has never been introduced to the market," Minkel said.

Despite the set back for the industry, the opportunity to take the product before the FDA opened the door for Minkel to advance services to those with disabilities. She discovered the work being done by Independence Care System and joined as its senior vice president for Rehabilitation Services – a move that brought her work full circle.

"I am taking everything I learned as a rehab professional and in evaluation support to know the type of equipment needed. From my early days, when I was a therapist, I recognized interdisciplinary work was far more gratifying –'we' can do more than 'me.' Now, though ICS, I get to place the equipment in homes and work with people to help them achieve and enjoy independent living."

Which is what she did for the young man in Manhattan, and he crossed the street that day to thank her. "He said, 'Thanks to you I'm out enjoying this summer day!' and then he went back to his group of friends," Minkel recalled.

ICS allowed Minkel to rent a power wheelchair for him to use on a trial basis. Within the first few days, she said, the young man reported he had ventured beyond the walls of his apartment for the first time in years to do his own shopping and was socializing with friends.

"He is a different person now," Minkel said. "That would have never happened if the social worker had not been willing to think outside of the box and ask if we could do something different to help him."

A subscriber to Stephen Covey's seven habits of highly effective people, Minkel said his 'abundance versus scarcity mentality' really resonates. "If we truly embrace the success and struggles of all, together we will move ahead further and faster."

Minkel credits Rick Surpin, founder of ICS, with a concept that she says can be replicated nationwide to address the needs of those with physical disabilities. According to information on the ICS website, Surpin established two companies prior to ICS — Cooperative Home Care Associates in South Bronx, an employee-owned home health company, and PHI, a national policy organization that works to improve the lives of people who need home or residential care.

ICS CLINIC

"Rick came from the home care world and then increasing got called from those with disabilities," Minkel said. "He has a wonderful way of asking the questions that others don't ask like how can a system such as CMS designed to meet the needs of the elderly also meet the needs of those with disabilities."

ICS grew out of a Medicaid demonstration project working on a semi-capitated model of managed care that was approved by the New York state legislature, Minkel explained. In 2001, the company was granted certification of insurance and has been meeting the needs of young adults in city ever since, she added.

The young man Minkel spoke about is a different person because ICS was able to offer him a trial power wheelchair, and then provide him with his own. "We absolutely made a significant difference in his life and that is one of the best outcomes to measure."

Yet, Minkel is not content. The model ICS uses, she said, is one that can be replicated in communities across the country to potentially keep those with disabilities out of hospitals.

"I'm in position with ICS to move this incredibly successful model in long-term care to a fully integrated system. I have a chance to see if we can have an impact on hospitalization when a person with a disability is provided with appropriate long-term care – home care equipment and transportation — and connected with a primary care giver who understands disabilities.

"For me, this presents a very exciting opportunity on a personal level. CMS competitive bidding has created an incubator in the health care arena that is counter active to everything we've worked for over the last 30 years, which is why we need a separate category for reimbursement.

"I hope that, by working for that, means I can in the next five years, have as much of an impact in functionality as I have had in credentialing."

CONTACT

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The MEDGROUP — Connecting Partners, *Delivering Results*™
MK Powered
NSM National Seating & Mobility
permobil
Snug Seat — nothing compares to a smile!
Sunrise Medical
the ROHO group — shape fitting technology
U.S. REHAB

cfons

AEL Adaptive Engineering Lab
Bodypoint
Columbia Medical — Solutions for Daily Living
Convaid — Advanced Seating & Mobility
EasyStand
FMS Frank Mobility Systems, Inc.
Hudson Seating & Mobility — Providing Technology for Independence
Innovation In Motion
Metalcraft
Motion Concepts
nu motion — Mobility starts here.
ottobock
Prairie Seating Corporation — Custom Contoured Cushions
Prime Engineering
PRM — The Power of Precision
Quantum Rehab — Life Beyond Limits®
Aspen Seating
Ride
rifton — Products for life from people who care.™
Stealth Products
The Comfort Company
Therafin Corporation
Thomashilfen North America
Ti
Varilite

afons

Children's
GAMES — Georgia Association of Medical Equipment Services
Midwest Association for Medical Equipment Services
NCART
NEMED
RESNA
Texas
users FIRST
UCP Wheels for Humanity