DIRECTIONS

34 UNDERSTANDING DIFFICULT CLIENTS AND CAREGIVERS: problems & solutions

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CLAUDIA AMORTEGUI

Amortegui has her Masters of Business Administration and more than 20 years experience in the durable medical equipment, prosthetics/orthotics and supplies industry. Her experience comes from having worked on all sides of the industry, including Medicare contractor, supplier, manufacturer and consultant. For many of these years, Amortegui has focused on the rehabilitation side of the industry. Her work has allowed her to understand the different nuances of complex rehab versus standard durable medical equipment. SEE PAGE 56

ALEXANDRA (ALEX) BENNEWITH

Bennewith is vice president of government relations for United Spinal Association. Bennewith advocates for legislation and regulations regarding disability and health policy at both the federal and state level. She works closely with a range of stakeholders in the durable medical equipment and supplies, prescription drug, public health and disability communities. She graduated from Brandeis University and received her Master of Public Administration from American University. SEE PAGE 46

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 32

LAURA COHEN, PHD, PT, ATP/SMS

Cohen is the Principal for Rehabilitation and 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 48

BARBARA CRUME, PT, ATP

Crume earned her bachelor's in Physical Therapy from the Medical University of South Carolina in 1982, became Pediatric NDT Certified in 1988 and RESNA Certified as an Assistive Technology Professional in 1997. Crume has 30 years of experience providing evaluations, fittings and training for clients of all ages and all diagnoses to obtain manual and power wheelchairs with custom seating. She works closely with a variety of suppliers and consults with manufacturers on product development. SEE PAGE 48

TODD DINNER

Dinner is President of PRM, a custom seating manufacturer in North East Pennsylvania. SEE PAGE 20

CINDY DUFF, PT, ATP

Duff has practiced PT for over 25 years at Denver Health, a level one trauma, safety net hospital. She performs seating and mobility evaluations on the inpatient critical care, acute, and rehabilitation units and is a member of the assessment team in the outpatient Wheelchair Clinic. SEE PAGE 38

JOE ENTWISLE

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

LAURA MCALILEY, ATP/SMS, CRTS®

McAliley is a NRRTS Registrant who works for Integrity Medical in Savannah, Ga. SEE PAGE 26

MIKE OSBORN, ATP, CRTS®

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

LISA K. SMITH, ESQ.

Smith is an attorney with the Health Care Group at Brown & Fortunato, P.C., a law firm based in Amarillo, Texas. Smith represents pharmacies, home medical equipment companies, hospitals and other health care providers throughout the United States. She earned her bachelor's degree from Stephen F. Austin State University and her law degree from the University of Texas School of Law. Smith is Board Certified in Health Law by the Texas Board of Legal Specialization. **SEE PAGE 30**

JILL SPARACIO

Sparacio is an occupational therapist in private practice in the Chicago area with more than 30 years of experience. A graduate of Western Michigan University, she currently provides consultation to individuals with complex medical fragility and intellectual disabilities. In addition, she consults with rehab technology suppliers and equipment manufacturers, providing clinical support and education. She is actively involved in funding issues at the state and federal levels and is currently serving on the executive board of the Clinician Task Force. She teaches seating and mobility courses extensively throughout North America and internationally. **SEE PAGE 34**

ANDREA VAN HOOK

Van Hook is the communications and marketing manager at RESNA. She has more than 18 years experience working on successful, award-winning campaigns that promote equal access to health care, education and employment of diverse populations, including people with disabilities. **SEE PAGE 52**

JENN WOLFF, OT

Wolff is vice president of Community Initiatives for UsersFirst, a program of United Spinal Association. Wolff is an occupational therapist and wheelchair user from Waverly, Iowa. **SEE PAGE 46**

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TUESDAY, AUGUST 19, 2014
8:00PM TO 10:00PM EASTERN

Posture and How it Develops

Standing and Sitting Considerations for the Young Child

SHARON SUTHERLAND [PRATT], PT

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

Power Mobility Options

For Clients with Muscle Weakness

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

2014 NRRTS WEBINARS

TUESDAY, SEPTEMBER 16, 2014
8:00PM TO 10:00PM EASTERN

Self-Advocacy

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

GERRY DICKERSON, ATP, CRTS®, MEMBER OF CTF

WEDNESDAY, SEPTEMBER 17, 2014
10:00AM TO 12:00PM EASTERN

Dynamic Seating

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

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THURSDAY, SEPTEMBER 18, 2014
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"Traffic School"

Tips for Creating a Power Mobility Training Program

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

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TUESDAY, OCTOBER 7, 2014
8:00PM TO 10:00PM EASTERN

Pediatric Power Mobility

Earlier Intervention

AMY MORGAN, PT, ATP

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

The Relationship of Vision, Posture and Mobility

Implications for seating and mobility for neurologically involved clients

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

TUESDAY, NOVEMBER 11, 2014
8:00PM TO 10:00PM EASTERN

Back it Up!

Basics of Back Supports

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

WEDNESDAY, NOVEMBER 12, 2014
10:00AM TO 12:00PM EASTERN

Complex Rehab Mobility

Medicare Reimbursement Requirements and Documentation Strategies

ELIZABETH COLE, MSPT, ATP, MEMBER OF CTF

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

Choosing the Best Therapeutic Support Surface

LINDA NORTON, OT REG.[ONT], MSCCH

TUESDAY, DECEMBER 16, 2014
8:00PM TO 10:00PM EASTERN

WHO Training Materials

An Overview and Usage Suggestions

JAMIE NOON

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

It's More Than Just Physical

Considering All the Needs of Complex Clients in Seating and Mobility

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

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STAYING FOCUSED ON WHO YOU ARE AND WHAT YOU DO

WRITTEN BY: MIKE OSBORN, ATP, CRTS®

Like many of you, I get a lot of windshield time through the week. It seems like the last few weeks I've had more than normal, but it has given me time to think about what we do as complex rehab providers, our role and the direction of our industry.

We hear it said all the time that change is good. I agree, change is good. However, sometimes I get caught up in the change and the effects it has rather than the big picture or the here and now. It's been discussed over and over that our industry is changing. We, as complex rehab providers, even joke about how we can't approach our jobs the same way we used to because of the change. The reimbursement cuts have been difficult for everyone. The pre-pay audits, post-pay audits, complex reviews, approvals received from insurance companies to only find out the code was a non-covered code all along, and the list goes on with funding obstacles. The documentation requirements that have changed in order to get items funded continue to be an issue, even for those of us who understand the process. It appears at times it isn't about medical necessity any longer, but about whether a page is date-stamped correctly or not. Don't even get me started on warranty work in our industry. The obstacles continue to come up on a regular basis. However, the need for the services we provide as a CRTS® stays the same. NRRTS, NCART and many in our industry have worked hard for several years now to establish a Separate Benefit for Complex Rehab, and this year we have had some major movement in a positive direction. The Separate Benefit will impact many of the issues we are facing as an industry and as complex rehab providers. However, we know this will take time and even the Separate Benefit will bring about some change. How do we weather the storm?

The skill set we possess is not easily obtained.

I have to admit as an owner and a CRTS®, I sometimes ask myself that question. How do we keep doing what we do? There are even days I wonder why. This year I have been fortunate enough to be reminded why over and over again. I had the opportunity to interact with other NRRTS Registrants earlier this year and hear the passion they have for what they do and the individuals they serve. On a regular basis I am reminded of what a unique breed of professionals we are. The skill set we possess is not easily obtained and, to be honest, I'm not sure where else we could use such a skill set and be emotionally rewarded the way we are. NRRTS Registrants seem to be driven by the desire to serve and compassion for others. Unfortunately, we are in a time when the desire to serve doesn't always allow us to provide the services the way we would like to, but we keep pushing to provide the best outcomes we can within the guidelines we are given.

There will continue to be obstacles in our road to provide those outcomes. The Separate Benefit will move us closer to an environment that will help us reach a higher quality of outcome. Through all the changes we face and will face, what makes us unique, "uncommon," is who we are and what we do. I am proud to be part of an industry that puts itself out there everyday for the betterment of what we do rather than what we receive in return. I am excited to be part of an organization like NRRTS that encourages its Registrants to remain uncommon and helps provide the tools needed to continue pushing forward knowing that you do make a difference.

CONTACT THE AUTHOR
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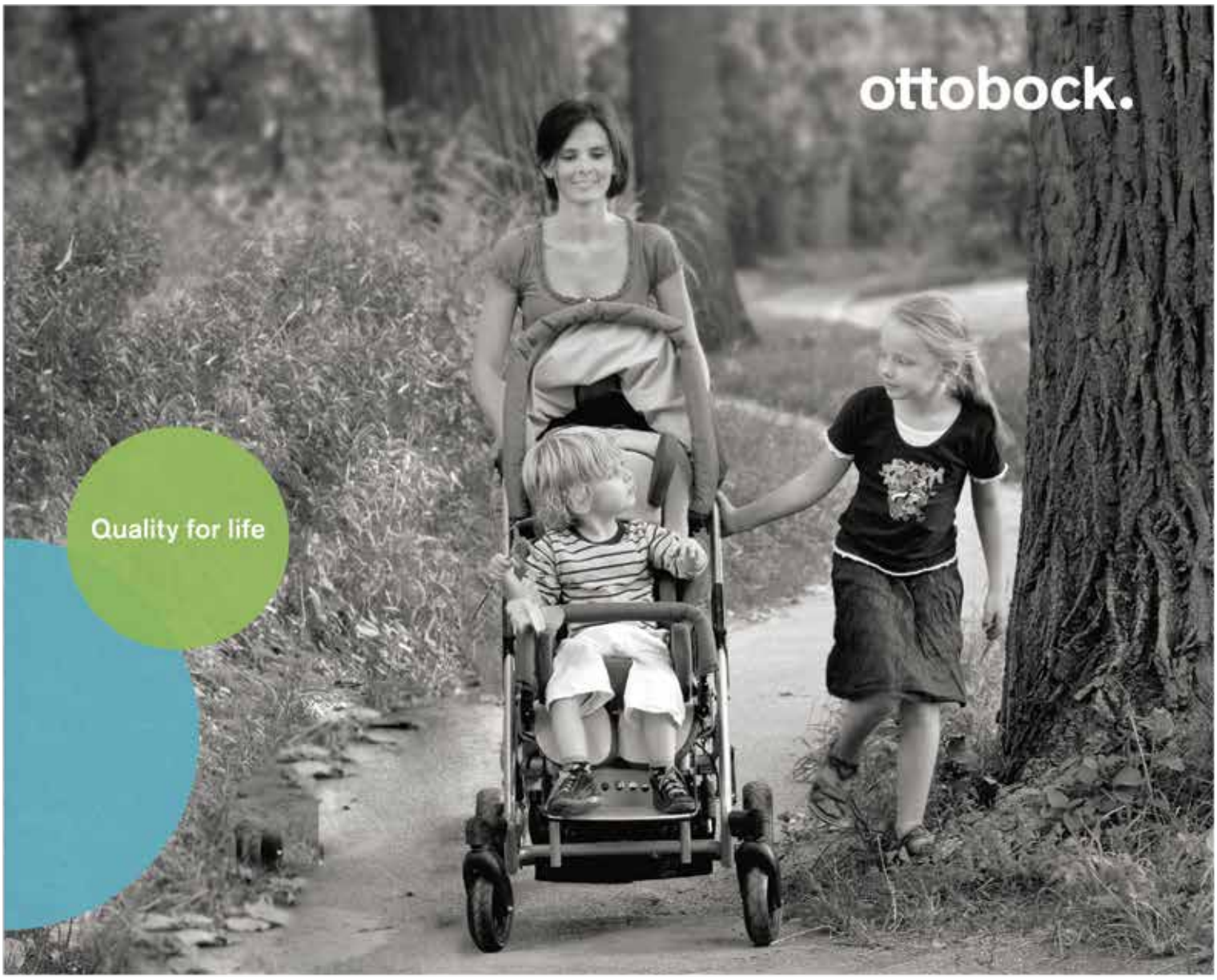
mosborn@alliancerehabmed.com.



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ENTWISLE FINDS MOTIVATION IN ADVOCATING FOR OTHERS

WRITTEN BY: JULIE BARNETT

Joe Entwisle's genuine passion for helping others is evident, whether it's counseling peers, analyzing and improving the policies that impact those with disabilities, or simply sharing his optimistic and oftentimes humorous outlook on life

Entwisle serves as a senior policy analyst at Health and Disability Advocates based in Chicago, working to promote income security, enhance work opportunities, and improve health care access and services for populations living at the margins of economic and health care security. Entwisle is uniquely privy to the insight his position brings. At age 16, he sustained a spinal injury during wrestling practice that damaged his C4 and C5 vertebrae, leaving him paralyzed from the shoulders down.

"I got into the policy and advocacy side of things, because it's interesting work, and I learned pretty early on that no one's going to figure it out for you," he said.

Entwisle, who recently turned 42, decided early on that he wasn't going to let his injury sideline him. "I wanted to graduate with my class, go to school like planned, so I graduated and then completed my undergraduate degree and graduate school," he said.

He worked as a peer counselor while earning a master's degree in rehabilitative psychology and became interested in the policy side of the health care safety net, particularly as it interacts with employment. "I got really interested in benefits planning, which is necessary when you require long-term care and work," he said. "At that time, no matter how good your insurance was you eventually end up on Medicaid after hitting your cap on services. Medicaid required you to be low income and have a significant disability. I started as a counselor before they had a lot of those programs, such as Work Incentive Planning Assistance and realized it was really an opportunity of moving individuals toward self-sustainability."

Entwisle has worked extensively on the Medicaid buy-in program, instituted a number of grants and worked on policies around transportation, health care and employment, just to name a few. His current position as a senior policy analyst focuses on programming, the Affordable Care Act incentive options and looking at how federal policy rolls to state programs and partnerships with businesses and others. "I'm fortunate to have rich experience understanding federal policy, how it rolls to state, to county and to individuals, particularly individuals with disabilities," he said.

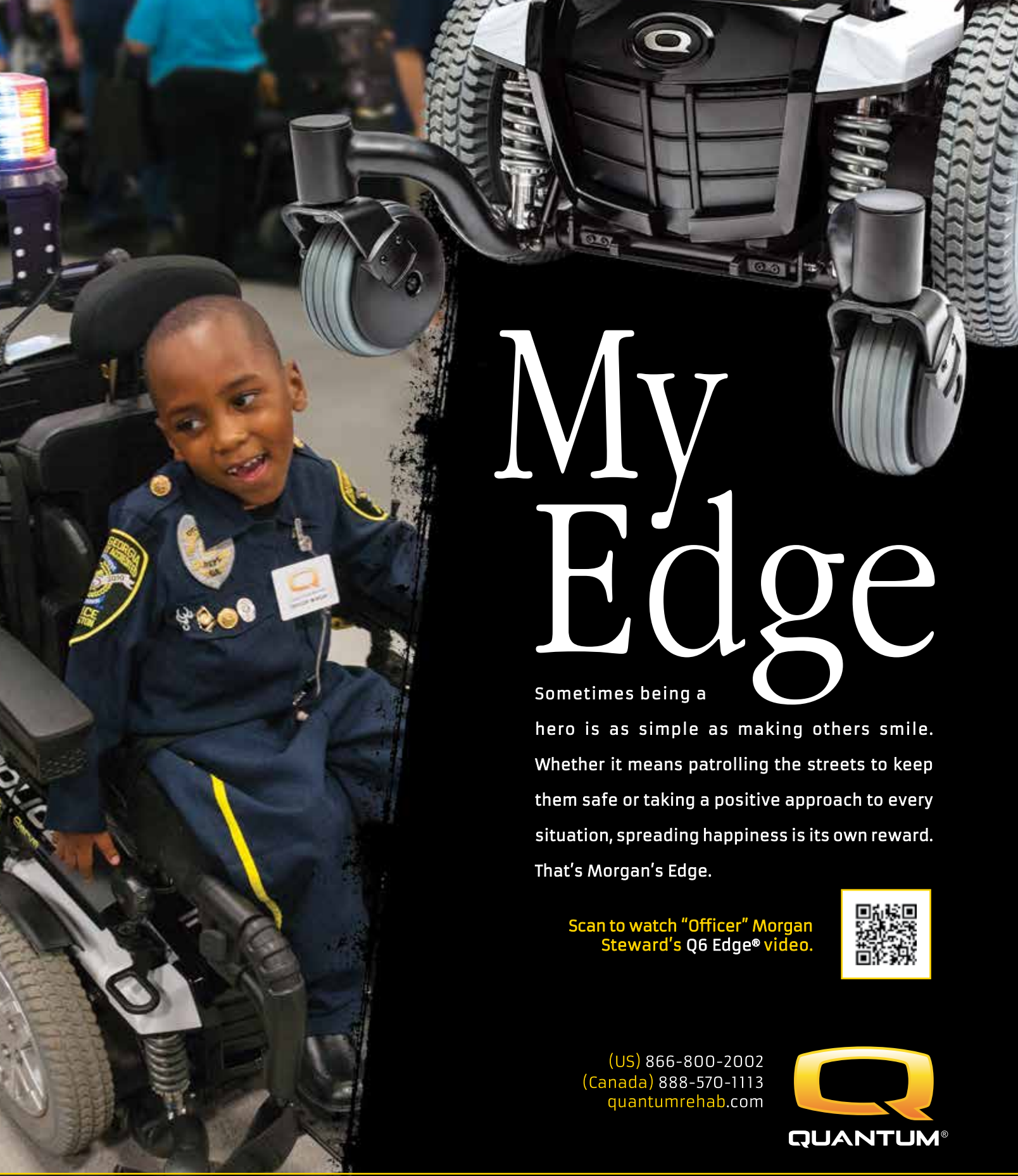
> "Technology has advanced; if we can work together across the board politically, we can provide a much more effective system for individuals at a better cost."

"Most of it is policy analysis, how health care and employment policy impact individuals," he continued. "We're looking at innovative options, examples or models to redesign how we do things to create a more responsive safety net for individuals with disabilities and individuals with a low-income backgrounds – one that works smarter, not harder.

"This is a broad spectrum of what we do. We cover a pretty broad target."

He believes there's always room for improvement in policy. "With health care, transportation, employment and education, there's lots of opportunity to be more coordinated, seamless," he said. "We silo how we fund and do things."

(CONTINUED ON PAGE 18)



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ENTWISLE FINDS MOTIVATION…
(CONTINUED FROM PAGE 16)

A project he's working on now in Wisconsin is looking at a broader cross-county system of funding – seamless braided funding – particularly in the area of rural transportation. "There's a lot of redundancy in the way we do things. We're in a time in which we need to think differently," he said. "Technology has advanced; if we can work together across the board politically, we can provide a much more effective system for individuals at a better cost."

This project aims to improve access to employment, transportation and community living. In rural areas, Entwisle said, there are few options and no access to jobs or the community primarily because of lack of transportation. There are project models in Colorado, Maryland and Washington for cross-county transportation. "Partnering with county and state funding to supply a public approach to transportation (including non-emergency medical transportation) will reduce cost and expand access," he said. "You may have someone who had a doctor's appointment and is locked into one county whose hospital is on the opposite side of the border, neglecting the hospital five miles away across the bordering county. Now we can look at cross-county models, access for employers to find employees, employees to reach work, university education, whatever they need. It serves aging, disability and non-disabled individuals, too."

In looking to the future, Entwisle has his eye on ever-changing technology and the possibilities it holds. "One of the things I'm really interested in is how things like Google cars will impact transportation," he said. "I'm fascinated, encouraged and excited for it. I'm very familiar with transportation and the barriers that exist; Google cars would be a tremendous option. Yet I think about the mass increase in transportation, how it plays out cost-wise, roads, the environment, etc. and see unfortunate unintended consequences of technology that need planned out in advance."

Entwisle's high hopes for technology and his advocacy for others keep him motivated.

"A stark reality for me early on was that my life wasn't like a lot of people's," he said. "I have always had an amazing family, incredible friends, and a fortuitous life, but I would frequently see folks who didn't have that. A lot of people with disabilities don't see good models of what's possible. Were my life different I might be in the same shoes. It fuels the fire."

Indeed, Entwisle's seen many of those possibilities realized and includes his loving and supportive family and friends among his biggest blessings. "I've gone hang gliding, water skiing, snow skiing, I've traveled all over the country," he said. "Work's never been a problem for me as there is a sea of opportunities available. It's important to have an appreciation of all you have and realize not everyone has that.

"My disability hasn't impaired my life or anything I want to do, and for that I have nothing but gratitude."

CONTACT
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jentwisle@hdadvocates.org.

TECHNOLOGY TRUMP

PRM president believes technological influences key to advancing industry

INTERVIEW BY: DANETTE BAKER

From his first introduction as a college student, Todd Dinner was drawn to the durable medical equipment industry. After less than a decade working for others, he stepped out on his own to start PRM Inc., a custom wheelchair seating manufacturer in North East Pennsylvania. As president of this still relatively small company, Dinner remains involved with all aspects – product development, marketing, sales and customer support. Seeing the impact their products make for the end user, however, makes Dinner thankful he said yes to that very first job offer.

DIRECTIONS recently had the opportunity to visit with Dinner about his work in the industry.

How did you become interested in the medical equipment industry?

I went to a small community college for marketing and business management in Kitchener, Ontario, Canada, about an hour west of Toronto. CPSC, Canadian Posturing and Seating Company, came to campus, and I applied for a marketing job with them and ended up getting hired. That was my first introduction to the industry, which was in the mid- to late-80s. After a couple of years, Invacare acquired CPSC, and they moved me to the U.S. Invacare took the products from CPSC, as well as some of their own and further developed them into what became the Avanti seating line, propelling Invacare into the wheelchair seating market.

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

My entry into the market was very significant. Invacare's acquisition of CPSC put that business on the map. Invacare also became a player in the seating market while I worked for them. I moved around in the marketing department, but was one of the team members who revolutionized the power tilt and recline wheelchairs. At the time, most tilt and recline chairs had a long wheelbase and just pivoted where the seat and back met shifting the center of gravity rearward. We developed the first weight shifting power tilt where the tilt and recline chair shifted forward as it tilted. Now, all tilt and recline chairs shift as they tilt.

More recently, with PRM (Precision Rehab Manufacturing), we have the first stereo vision camera digitizer for seating systems. The technology uses a digital video camera to capture the seat and back image – with 6,000 data points on the seat and 6,000 on the back – these points are needed to manufacture a custom seat for the client. For the end user, this technology provides accuracy within a quarter of inch. I developed this technology based on a concept used for medical measuring, primarily for surgeries. Soon, we will be introducing the second version of the software. To my knowledge, no other manufacturer is using this type of technology. I'm proud of what this provides for both the end user and the supplier – an improved contour and shape in seating in a product that has superior fit and finish too.

Who has been instrumental in those accomplishments?

In my professional career, there have been two people who really impacted my career and the direction I've taken that led to owning my own company. Both are icons in the industry. Hymie Pogir, was vice president at Invacare; I worked for him almost my entire career

We developed the first weight shifting power tilt where the tilt and recline chair shifted forward as it tilted.

at Invacare. He definitely helped me and sculpted me to run my own business. Hymie is a rehab guy and really knows that market.

When I first moved to the U.S., I worked for Allen Siekman; he taught me so much about seating. I still keep in touch with both Hymie and Allen.

It's a matter of developing a product at the right price. I'm a huge believer in embracing technology. In fact, our entire operation is paperless.

What are the future challenges for PRM Inc. and the industry as a whole?

With all the pressure on funding and reduction of funding dollars, it's a challenge to develop products that funding people are willing to pay for while not compromising the quality of the product. In my 13 years with PRM, we've never raised prices. Our costs go up, but I know that if we increase prices it will come out of my customers' margins. We'll have to continue to design products at the right price.

What's on the horizon for PRM Inc.?

We have an off-the-shelf cushion line, the Contoured-Fit cushions, so we are going to develop that line further. We want to sell more products to the same people, so that's why we are evolving our product line. It's a matter of developing a product at the right price. I'm a huge believer in embracing technology. In fact, our entire operation is paperless. We do everything electronically. That makes things more efficient, and that's what we try to do as a manufacturer so we can produce products that are accurate and get them quickly to the customers.

What areas in the industry has PRM Inc. taken a lead in?

Digitizing is the biggest one. It's one thing to have technology, but it has to be user-friendly. The Insight Digitizing system is easy to use. You can be competent in 10 to 15 minutes after we show you how to use it.

What changes would you like to see in the industry?

I think there has to be more done in regard to outcome-based findings. There is such a focus on acquisition cost, but little if any information on replacement, complications and client satisfaction. I don't know the answer to how you measure client satisfaction, but if there was some way to determine how well a product met the client's needs and how satisfied they were, I think that would greatly help the industry because it would justify why one product cost a little more than another and how dealers are taking the time to do things correctly.

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

I'm a friend of NRRTS, and we contribute to NCART. We are trying to do what we can to help get the politicians on our industry's side. I truly believe durable medical equipment is the answer to keeping people in their homes and reducing the overall health care costs. Again, it comes back to outcomes. It is very expensive to have someone in a hospital versus in their home where they want to be anyway.

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

My time varies because I wear so many hats. I run a production facility and do product development, as well as sales, so I also travel to see customers. There really is no work week that is typical for me. But I really am having fun, and I get to see how our products affect people on both sides of the fence. I like working with the end users and customers teaching them how to use our products. I like the product development side too, because I get to be involved with development and sales, which allows me the opportunity to then see the faces of our customers as we show them the new product. There are not many jobs you can do that greatly impact the lives of people. That is extremely powerful.

I also like the combination of owning my own company. It really gives you the whole picture of what we are doing to impact lives. In marketing, you don't get the interaction with the end user. You are primarily working just with the

(CONTINUED ON PAGE 23)

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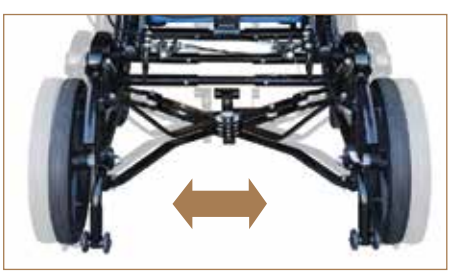
- Seat width: 14", 16", 18"



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TECHNOLOGY TRUMP
(CONTINUED FROM PAGE 21)

supplier and the engineering staff. Now I get to see an evolution of those who work for our company as well. Some of my people were on food stamps when they started and now they have homes and families.

> For one mom, we gave her the ability to take her young daughter outside and calmed her fear that her daughter would be injured because of her constant movements. We created a molded seating system that was padded all around that would protect her in the chair.

What's life outside of the 9 to 5 like for Todd Dinner?

My time outside of work focuses on my family. My wife and I have four children, ages 16, 15, 13 and 8. The two oldest are boys, and the younger two are girls. They all are very active, and it's very important to me to be involved in their lives. Last night, I was golfing with my son and later today I'm going to dry land training with my youngest daughter. She plays on a travel hockey team, as do the boys. They also play golf in the summer and our oldest daughter is into cheerleading.

My wife and I basically are taxi drivers, but we love it.

What has kept you in industry?

I really enjoy and like what I'm doing, and when you like something you want to do it. I feel like I really understand my customers and think development of products really helps them serve the end user.

(CONTINUED ON PAGE 25)

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Josh Anderson

TiLite VP of Product & Brand Management

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TECHNOLOGY TRUMP
(CONTINUED FROM PAGE 23)

For example, there was a gentleman in the Philadelphia area who was in his early 30s. He lived with his mom. He had never really been positioned in his chair, so we weren't sure if he could sit and for how long with custom seating. We molded a seat and back for him and he did so well they moved him into a power chair. Once he got the hang of driving his chair, he eventually moved to a group home.

For one mom, we gave her the ability to take her young daughter outside and calmed her fear that her daughter would be injured because of her constant movements. We created a molded seating system that was padded all around that would protect her in the chair. The mom had tears of joy when we delivered it.

And we created a mold for a young man in Pittsburgh, who has cerebral palsy and as a result is hard on his equipment. They struggled with the durability of his seating until they got to us. Now we see them every couple of years. They keep coming back because we positively impact their life.

I enjoy seeing these outcomes. I think I got pretty lucky in finding this industry.

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AFTER 25 YEARS,
McAliley still amazed by clients, colleagues, technology

WRITTEN BY: JULIE BARNETT

Some experiences just stick with us, becoming a part of who we are and why we continue to do what we do. Laura McAliley remembers smiling all the way back to her work truck after watching a 5-year-old take herself across the stage for kindergarten graduation.

"I can still see the huge grin on her face as she used a fairly rudimentary head array system on a pink chair," McAliley said. "There is rarely a day that goes by that I don't think at least once, 'What a great job!'

"That has held true as I worked for a Mom and Pop business [her own mom], a regional provider, a national provider and a manufacturer before coming back to what I love the most – seeing clients and figuring out a solution," she said.

McAliley, ATP/SMS, CRTS®, is a Rehabilitation Technology Supplier for Integrity Medical in Savannah, Georgia. Her day-to-day activities include a healthy mix of seeing clients at seating clinics or at their homes to evaluate their need for equipment to help them continue to live in their homes, problem-solving to get the equipment to address exactly what those needs are, and fitting the equipment to get the best outcome.

"I can still see the huge grin on her face as she used a fairly rudimentary head array system on a pink chair."

"Along the way, I work with therapists and physicians to decide if a complex rehab wheelchair or other device will help their clients manage their mobility in their homes and out in the community," she said. "The equipment has become much easier than when I first began; all of the manufacturers have stepped up to the plate to make ordering and fitting a smoother task than ever."

When asked about other significant career milestones, McAliley says a few specifically come to mind, the first being her mother guiding her into her career. "The first was letting my mom talk me into trying this 'rehab' thing for one year and the promise that if I didn't like it, she would not broach the subject again," she said. "Corollary: Mom is always right. That was 25 years ago, and I am amazed by my clients, therapists and technology every single day."

Another milestone was going to Pin Dot school to learn how to do custom-molded seating. "I remember looking at the little concrete torsos and thinking 'Wow, there are so many of them,' " she said. "Michael Silverman, all the Pin Dot professionals, Cathy Bazata, Kerry Jones – we were learning with some of the gifted pioneers in our industry; we just didn't know that yet."

She says getting to take the first exam for the credential ATS was another key moment, again among "giants."

"I remember being so geeked out because people I was sitting with were soon-to-be not only experts in the field, but also leaders who never stopped thinking about the clients and how we could impact the lives of not only the patients, but their families and caregivers, too," she said. "It was awesome to know that there were other folks who did this job with great love and care.

"If I have my timeline correct, NRRTS started in August 1993; I was so thrilled to have a chance to raise the bar for complex rehab providers that I joined NRRTS in October 1993," she said. "I got to go to Pin Dot, LaBac, Sunrise Medical, Jay, Roho, Signature 2000, Invacare, Permobil, ASL, Matrix Seating, Creative Rehab, Freedom Designs

(CONTINUED ON PAGE 29)

INVEST IN THE FUTURE OF CRT

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

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

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

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

www.ncart.us

JOIN TODAY!

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

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

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

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

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

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

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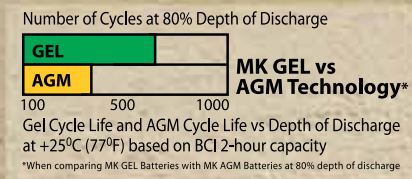

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AFTER 25 YEARS
(CONTINUED FROM PAGE 26)

and many, many other schools that not only taught us the right way to do the equipment, but were awesome preparation for the ATS – and then later – the SMS credential."

Like many of her peers, she believes funding is the biggest challenge the industry currently faces.

"It concerns me that with the cuts on reimbursement, we will 'dumb down' the products that clients need, become cookie cutter providers and lose that spark of creativity that is the difference between the good, the bad and the ugly," she said. "We have to educate not only our customers, but our funding sources as well. If only we could get everyone in the same room to talk about how what we do every day is a cost-savings center in the realm of public health.

> "We have to become a partner in the funding arena – most importantly, we have to engage our clients in our battle."

She continued, "Not once in my career has anyone ever said, 'I would much rather be in a nursing home than in my home.' Never. We have to get this message to people all along the spectrum. The math is not hard – when an investment of $10,000 is made on a piece of equipment, we are gaining at least $90,000 per year in most states simply by not putting the client in a nursing home.

"We have to become a partner in the funding arena – most importantly, we have to engage our clients in our battle."

Indeed, McAliley is happy to lead that charge by calling and writing her congressman and representatives at least once a month, and passing out information on Medicare and how they can help.

In spite of her busy schedule of helping and advocating for her clients, she finds time to enjoy being near the beach and Tybee Island, along with a little reading, golf and teaching taekwondo lessons.

"Between the work I love in a place that's like a perpetual vacation, I squeeze the good out of every day."

CONTACT

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LEGAL ISSUES TO CONSIDER WHEN OFFERING PRICE DISCOUNTS

WRITTEN BY: LISA K. SMITH, ESQ.

A Medicare supplier is prohibited from charging Medicare substantially in excess of the company's usual charges, unless there is good cause. This provision must be considered when a supplier wants to offer discounted prices to cash customers or accept discounted fees under contracts with third-party payors that are well below Medicare DMEPOS fee schedule amounts.

The relevant section of the Medicare statute, which is codified at 42 U.S.C. § 1320a-7(b)(6)(A), provides as follows:

> The Secretary may exclude the following individuals and entities from participation in any Federal health care program (as defined in section 1320a–7b (f) of this title): …
>
> Any individual or entity that the Secretary determines—
>
> (A) has submitted or caused to be submitted bills or requests for payment … under subchapter XVIII of this chapter or a State health care program containing charges … for items or services furnished substantially in excess of such individual's or entity's usual charges … for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs.

A Medicare supplier that violates this prohibition is subject to exclusion from federal health care programs.

The term "affiliated entity" was defined as "any entity that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the provider."

The key terms "substantially in excess" and "usual charges" are not defined in the statute. The current regulations issued under the statute, codified at 42 C.F.R. § 1001.701, simply repeat the language of the law, without providing any guidance about the meaning of "substantially in excess" or "usual charges." The Office of Inspector General (OIG) has provided guidance through OIG advisory opinions and a guidance letter regarding the meaning of these terms on several occasions, but that guidance has been inconsistent.

In 1997, the OIG proposed amendments to the regulations. The proposed regulations would have provided that Medicare charges could not be substantially higher than the supplier's charges to any other customer or payor. However, this proposal was heavily criticized and was withdrawn. In a 1998 advisory opinion, the OIG said charging cash-and-carry customers 21 percent to 32 percent less than Medicare would violate the statute, and suggested a "useful benchmark" was to compare the profit margins on a cash sale and a Medicare sale. The statute would not be violated if the profit margin on a Medicare sale was less than or equal to the margin on the cash sale. In another advisory opinion the following year, dealing with laboratory services, the OIG said the test was whether "the charge to Medicare or Medicaid substantially exceeds the amount the laboratory most frequently charges or has contractually agreed to accept from non-Federal payors." In 2000, the OIG's chief counsel issued a guidance letter stating the law could be violated if "a provider's charge to Medicare is substantially in excess of its median non-Medicare/Medicaid charge."

The OIG's most recent attempt to clarify the meaning of the statute came in 2003, when the agency issued a new set of proposed regulations (68 Fed. Reg. 53939 (Sept. 15, 2003)). In the proposed rules, a provider's "usual charge" is defined as the average or the median[1] of the provider's charges for the same item or service during

the previous year, excluding charges for services provided to uninsured patients free of charge or at a substantially reduced rate; charges under capitated contracts; charges under fee-for-service managed care contracts where the provider is at risk for more than 10 percent of its compensation; and charges to Medicare, Medicaid and other federal health care programs, except TriCare. In other words, the "usual charge" would be the average or median of (i) charges to cash purchasers, (ii) negotiated rates under commercial indemnity and non-risk commercial managed care contracts, (iii) out-of-network payments from commercial payors, and (iv) charges under TriCare contracts.

It is also important to note the proposed rules specifically addressed the issue of a separate legal entity being formed to handle the non-Medicare business. The proposed rule required the charges of "any affiliated entities providing substantially the same items or services in the same or substantially the same markets" be included when calculating the usual charge of a provider. The term "affiliated entity" was defined as "any entity that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the provider."

Under the proposed regulations, a DMEPOS supplier's charge to Medicare would be considered "substantially in excess" of its usual charges if the fee schedule amount for an item (or the submitted charge, if the submitted charge was less than the fee schedule amount) was more than 120 percent of the supplier's usual charge. Stated another way, the supplier would be considered to be in violation of the statute if its "usual charge" for an item was less than 83 percent of the Medicare fee schedule amount (i.e., in excess of a 17 percent discount from the Medicare fee schedule). The statute provides an exception for "good cause," which could allow a supplier's usual charges to be less than 83 percent of the Medicare fee schedule if the supplier can prove unusual circumstances requiring additional time, effort or expense, or increased costs of serving Medicare beneficiaries. In June 2007, CMS withdrew the proposed rule. (72 FR 33430, 33432 (June 18, 2007))

Based on the above discussion, while there is no definitive guidance on when a supplier's charge to Medicare will be viewed as "substantially in excess" of its "usual charge," we believe it is unlikely the OIG will take action against a supplier whose charges to "cash and carry" customers, including those of affiliated entities, do not exceed a 17 percent discount off the Medicare fee schedule. If the supplier's cash charges exceed a 17 percent discount off the Medicare fee schedule, then the supplier should have documentation showing that such a discount is justified by the cost savings in not having to bill and collect from Medicare.

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Reference:

1. In the preamble to the proposed regulations, the OIG said that it had not decided whether the average or the median charge was the better measure of the "usual charge."

THINGS DON'T SLOW DOWN IN THE SUMMER

WRITTEN BY: DON CLAYBACK

While kids everywhere are enjoying their summer vacation, there's a lot going on that impacts Complex Rehab Technology (CRT) stakeholders. Here's a review of current topics you should be aware of.

CRT Federal Legislation Progress

The "Ensuring Access to Quality Complex Rehabilitation Technology Act" (H.R. 942/S-948) continues to move forward in Congress.

As of this writing we stand at 146 House members signed on to H.R. 942 and 18 Senate members signed on to S-948. We have added 17 new House co-sponsors and four new Senate co-sponsors since the last column at the end of May. That's 21 new congressional CRT converts!

The collective work of individuals and groups across the country continues to pay off. Polite persistence wins – with emphasis on persistence. Great job and thanks to everyone who brought us to where we are today.

Great job and thanks to everyone who brought us to where we are today.

If you're reading this column, the key question is, "Are your three congressional members signed on?" You can see the current list of co-sponsors by state and access other advocacy information and tools at www.access2crt.org.

We continue to work closely with our congressional champions Sens. Charles E. Schumer, D-N.Y., and Thad Cochran, R-Miss. and Reps. Joseph Crowley, D-N.Y., and Jim Sensenbrenner, R-Wis. We will be looking for an opportunity to have our bill included in the next Medicare-related legislation Congress considers, which could occur post-election.

It's hard to make solid predictions, but one thing is certain. The more co-sponsors we get, the closer we are to getting our bill passed. As we move through the rest of this year, Congress is heading to their August recess and September through November will be election focused. It's an opportune time to get the attention of your members.

National CRT Awareness Week in August

Speaking of passing our CRT legislation, National CRT Awareness Week starts Aug. 18. As members of Congress will be home for their August recess, it's the perfect time for CRT stakeholders to connect with their representatives on a local level and secure additional support for our bill.

With your members back in town for the whole month you can get to them in person. There's no need to travel to Washington! We need CRT stakeholders to touch their members that week and ask for support of CRT bills H.R. 942 and S-948. You can't beat a face-to-face connection. If you can't connect that week, then make the contact sometime during the month.

Special Thanks to the United Spinal Association

The United Spinal Association held their third annual "Roll on Capitol Hill" conference in Washington, D.C, at the end of June. They had 120 attendees and the CRT legislation was one of the primary topics.

The conference included a panel discussion on H.R. 942/S-948 presented by Alex Bennewith, vice president of government relations; Jenn Wolff, director of UsersFirst; and yours truly. The session was a great opportunity to review CRT issues and needed solutions with all the attendees. On Tuesday, attendees

made more than 200 visits to the offices of Congress, including the CRT legislation in their discussions. Thanks to United Spinal for their continued support!

CMS Proposed Rule on Competitive Bidding Pricing and Bundling

On July 2, CMS issued Proposed Rule CMS 1614-P. This proposes a variety of significant changes impacting access and payment relating to the end-stage renal disease benefit and the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) benefit. CMS is seeking comments from the public.

The DMEPOS aspects described in the Fact Sheet are: (a) This rule proposes methodologies to implement the use of information from the DMEPOS Competitive Bidding Program (CBP) to adjust the fee schedule amounts for DME in areas where CBPs are not implemented; and (b) This rule proposes a limited phase-in of bundled monthly payment amounts for the equipment, supplies, accessories and any necessary maintenance and repairs for enteral nutrition, oxygen and oxygen equipment, standard manual wheelchairs, standard power wheelchairs, hospital beds, continuous positive airway pressure devices and respiratory assist devices furnished under the CBP in place of capped rental policies.

There is a great deal of details to review (359 pages with 47 charts and exhibits) although much of it does not relate directly to DME. The proposed changes include some that would have significant negative implications to access and payment of DME in general, including wheelchairs, accessories, and related repairs. The final changes would be published in a Final Rule and would impact DME access and payment starting Jan. 1, 2016.

Public comments are being solicited with a deadline of Sept. 2, 2014. While CRT items are not included in the proposal, there are very dangerous concepts proposed that must be addressed. CRT stakeholders need to be engaged in the comment process and related follow up. NCART will be providing further analysis and guidance and will be working with other CRT stakeholder groups and our Congressional champions during the comment period and beyond.

Updated CRT Websites

As the challenges to CRT access continue, NCART wants to equip CRT stakeholders with professional, effective, and easy-to-use information and tools. This is especially important given that CRT education/awareness is the critical first step to successful CRT advocacy. With that in mind, NCART has unveiled new and improved NCART and Access2CRT websites.

The NCART website contains a wide variety of information that can be helpful to both NCART members and other CRT stakeholders. The Access2CRT website is specifically designed as a "non-denominational" site for all CRT stakeholders focused solely on CRT access issues and advocacy.

The sites have been completely redesigned to enhance the communication of CRT news and to better promote CRT education and advocacy on both federal and state levels. The improvements include: easier to navigate layouts; reporting of CRT issues segregated under federal and state headings; ability to conduct and track specific CRT advocacy campaigns (emails, calls, etc.) targeting federal and/or state government officials; updated CRT educational materials and advocacy tools (downloadable at no charge); and the ability to locate qualified CRT suppliers by state (with links to company websites).

We hope these updated sites will help all CRT stakeholders stay current on access issues and be more effective in CRT education and advocacy. We will be continually adding to the content on each site as we move forward. Check them out at http://www.ncart.us and http://www.access2crt.org and share the links with others who have an interest in protecting access to CRT.

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UNDERSTANDING DIFFICULT CLIENTS AND CAREGIVERS: problems & solutions

JILL SPARACIO, OTR/L, ATP/SMS, ABDA

"I DON'T HAVE TIME TO DO PRESSURE RELIEFS."

"BUT MA'AM, THIS SEAT CUSHION IS GOOD ENOUGH FOR YOUR DAUGHTER."

"I WON'T GIVE UP ON MY DREAM FOR MY SON TO DRIVE A POWER WHEELCHAIR!"

"I AM NOT GOING TO PAY FOR LABOR FOR THE NEW PARTS... IT CAN'T TAKE THAT MUCH TIME!"

We deal with difficult people in all aspects of our lives. Away from work, we are able to remove ourselves and limit interaction with those we find difficult. In our professional life, this becomes more difficult since we are unable to pick and choose which clients to work with. What we often overlook is that others may perceive us as the difficult ones.

When thinking of difficult clients, the term "non-compliant" often comes up. Compliance is simply the act of changing one's behavior under the direction or request of someone. An individual is expected to do something simply because someone asks them. Compliance differs from obedience as obedience implies the request is being made by an authority figure. A consumer who willingly performs pressure reliefs like clockwork is viewed as compliant. Clients are asked to comply with treatment plans, use of new equipment, and suggestions made to improve their situation. When not done, they are often referred to as non-compliant. In the world of seating and wheeled mobility, these individuals can be perceived as "difficult" when their lack of compliance interferes with the ability of a therapist or provider to complete his or her job successfully. Moreover, their perceived difficult nature becomes a frustration to all parties involved.

INTERPERSONAL EVENT

Interaction with another can be referred to as an interpersonal event. When you consider the seating and mobility evaluation is accomplished through a multi-disciplinary approach, the number of interpersonal events increases drastically. The opportunity for "difficulty" is multiplied. Although we can control our own emotions and interactions, we cannot control how the other team members and the consumer are going to interpret or react to our interaction. A by-product of interpersonal events is conflict. Conflict can begin as tension, a misunderstanding or a disagreement. It can escalate into an emotionally fueled interpersonal event that is destructive to both parties. Once that occurs, effective communication is lost unless someone pulls back and re-evaluates the situation.

Many factors are involved in dealing with difficult clients. These range from cultural and educational issues to mental health issues that interfere with interpersonal skills. Another factor includes consumers' acceptance of their disabilities. If they have an accurate awareness of their disabilities, they will be more open to the use of equipment for assistance. Unrealistic expectations of ability or potential for recovery make the process more difficult. Once a difficult situation is encountered, the professional needs to step back and attempt to identify the factors that are causing the difficulty. Current behaviors of all involved need to be evaluated and modified. Clinical interaction can be described as a "dance:" there are two partners who work cooperatively, however one needs to lead while the other follows.

As a clinician or supplier, the role of educator has to be assumed. All aspects of the evaluation and delivery process need to include the provision of education to the consumer. Since the consumer and caregivers are unfamiliar with possible options, education needs to occur to allow them to make informed choices. The clinician needs to be aware of learning styles and possible roadblocks that might interfere with the learning process. An awareness of different learning styles is vital, helping those in the teaching role to present information in the most effective manner for the consumer. Be aware that one's ability to learn is also related to their cognitive function and ability to process the information.

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LEARNING STYLES

In terms of learning styles, most are aware of visual, auditory and kinesthetic learning styles. To take it one step further, consider four styles of learning: sequential, global, active and reflective. Sequential learners prefer a step-by-step process, not varying from a sequenced, chronological pattern. These are the individuals who assemble an item following written directions, going from step one to two, etc. They have a difficult time varying from the anticipated course. Global learners tend to look at the big picture, maybe following some directions; however, they are able to see the end result and usually able to work to gain it. Active learners learn by doing. They appreciate the opportunity to problem solve and discuss all possible options before initiating the task. Reflective learners tend to over-think a task, looking at all options and pondering what the best solution would be. From early interaction with consumers, their learning style can be identified. Tapping into the proper learning style can facilitate education and communication, helping to avoid potential difficulties.

Learning styles can also be generational. Younger individuals might prefer the use of technology while older consumers prefer face-to-face interaction. Older individuals tend to believe what they are told while younger consumers may want to know their options, allowing them to make an informed decision.

Other causes of "difficult" interaction can result from cultural issues, caregiver issues and environmental issues. If any of these issues are ignored, a difficult situation can arise and interfere with the process.

TYPES OF DIFFICULT CLIENTS

To effectively deal with difficult clients, a full understanding of the typical characteristics of difficult clients need to be identified. According to Debra Beaulieu, there are four typical groups: dependent clingers, entitled demanders, manipulative help-rejecting complainers and the self-destructive denier.

- Dependent clingers tend to be very appreciative for everything the professional does for them, verbally praising and thanking them for every little detail. As a result, the professional often offers to go beyond what is necessary, which further exaggerates their dependency. Soon, the client starts calling and asking for additional favors and requests. As the "clinger" becomes needier, the interaction with the professional can take a turn for the worse. The professional needs to reassure while creating and enforcing definite boundaries.

- Entitled demanders are the individuals who tell the professional how to do his or her job. From their perspective, they want to take aggressive control even though they are probably feeling helpless and powerless. Gentle encouragement to "work together" is helpful, often bringing the client back to cooperation instead of demanding.

- Manipulative help-rejecting complainers are the clients who find fault with every solution offered. The recommendations of the professional are never good enough even though the client continues to come back with future issues. At times, this group can be aggressive and blaming, taking on little responsibility for themselves. To help this group, all options need to be discussed and the consumer encouraged to take an active role and ownership in the final decision.

- Self-destructive deniers participate in behaviors that are self-destructive. They hide their feelings of hopelessness through their overt destructive behaviors with an "I don't care" attitude. Oftentimes there can be an undiagnosed depression or anxiety. If the behaviors are significant enough, referral to a mental health professional may be needed.

WHAT DOESN'T HELP

With all types of difficult clients, there are some basic "don'ts." Although they seem obvious, they get lost in the emotional responses that can go hand in hand with difficult interactions. These include:

1. Don't tell the client he/she is wrong. A sympathetic nervous system response can occur resulting in a fight or flight response, putting the individual in a mode of self-protection and no longer open to learning.

2. Don't argue with the client. Arguing leads to poor communication, either through yelling or the "quiet treatment." Arguing can lead to the communication of truly honest thoughts; however the delivery is usually not effective. Once an argument escalates, it can lead to a release of emotions that can result in improved communication.

3. Don't speak with an authoritative tone as if you have to prove the client wrong. Use of a confident tone is good. Use of an authoritative tone can bring the individual back to an event in his or her life that can stir up unpleasant memories. As the professional, you do not know what that person has endured previously.

4. Don't say things like "we could never do that." This infers superiority. It is belittling and insulting, completely shutting down effective interaction.

5. Don't be afraid to apologize – it is not an admission of fault, merely a means to explain, terminate an argument or start over. An apology opens the gate for improved communication.

WHAT DOES HELP

Communication skills are vital in all interpersonal events. Effective communication on the part of the professional is imperative to set boundaries and provide education while also alleviating stress and anxiety. The provision of education is imperative for so many reasons. Requests of actions with an understandable purpose are more apt to be honored. Education needs to include information regarding the client's condition, potential problems and potential solutions.

When communicating with clients, the choice of words can make or break a therapeutic interaction. For example, telling a mother that her daughter's new seat cushion is "good enough" may trigger an emotional response from the mother, hearing that the therapist is settling for mediocrity. Listening to the client's words while also observing body language can give cues as to how the interaction might be interpreted.

There are many other solutions that need to be considered when dealing with difficult consumers. According to Renee Taylor, Ph.D., the best advice is "everything starts by stopping." If a difficult situation arises, stop what you are doing and identify why the difficulty occurred. Nothing will be gained from continued interaction unless one of the parties changes. It is the professional's responsibility to maintain open communication and be the "professional" one.

Other solutions and advice are simple:

- Shut up and listen.
- Set boundaries up front.
- Stay cool and calm.
- Validate and empathize; don't sympathize.
- Remember that their behavior makes sense to them.
- Use the phrase "I can't agree with you more."
- Ask the question "What do you really want?"
- Don't react and take their bait.
- Adjust your mindset.
- Listen actively and be neutral.
- Swap shoes.

And finally, ***keep it simple.***

In summary, differences of opinions and lack of education can lead to difficult interaction. These differences can be as simple as a color choice or as complex as when the client or caregiver has unrealistic expectations either of themselves or the equipment. The role of the professional is to provide clarification through education, helping to set reasonable expectations and goals. For example, a young man with cerebral palsy who has experienced difficulty with the use of a head array for control of a power mobility system no longer shows interest in working on that skill. His mother, however, verbalizes during the trial, "I won't give up on my dream for him to drive a power chair." The mother is not open to hearing that her son does not have the ability or desire. Instead, she becomes "difficult" as she is unwilling to pursue other mobility options. Education and separation of her goals from her son's goals needs to be encouraged.

Most importantly, when a situation is developing, the professional needs to modify his or her behavior in order to remedy the situation. Modification of actions needs to occur from all parties, however, you can only modify your own behavior. And always remember – everything starts by stopping.

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DIPLOMACY AND ADVIL:

DEALING WITH DIFFICULT CLIENTS

WRITTEN BY: CINDY DUFF, PT, ATP

We all know that great feeling when the equipment and services we provide result in a successful outcome. The client and family goals of improved function, more independence in mobility, and/or increased comfort are achieved. There is nothing more professionally satisfying than knowing you have made a difference in someone's life. But what happens when the client, despite your best efforts, is not happy with the outcome? Headaches ensue. And the art of diplomacy begins.

In the wheelchair clinic at Denver Health, clients are assessed by a team including a physiatrist, a physical therapist and a supplier representative. Less than 30 percent of our referrals need complex rehab technology. The remaining 70 percent of our clients are seeking basic mobility devices, ranging from a four-wheeled walker to "consumer" power. It often feels like the interventions performed with this population do not require extensive clinical skills. It is easy to get lulled into complacency with assessments and recommendations. However, this complacency can result in being blind-sided when a particular situation becomes difficult. The following case study illustrates what can happen when a seemingly basic assessment turns into a customer service challenge.

Mr. G is a 71-year-old man with diagnoses of chronic back and leg pain due to multijoint osteoarthritis, diabetes with peripheral neuropathy, and obesity. He was referred to the wheelchair clinic by his primary care physician. During the initial visit, Mr. G reported he had a cane, but no other assistive devices or ambulatory aids. He was independent in stand pivot transfers, but his ambulation was limited by increased pain in his back and legs after walking more than 100 feet. He reported frequent falls while walking at home and in the community, up to two or three times per month. He attributed the falls to his legs "buckling." Mr. G reported he lived alone in an apartment with one step to enter. On evaluation, Mr. G presented with generally age-appropriate strength in both arms and legs, but poor grip strength bilaterally. Joint crepitus was noted in both shoulders, hands and knees.

The team agreed Mr. G would benefit from increased support in ambulation to prevent falls and decrease joint pain. A four-wheeled walker was recommended, but Mr. G adamantly refused, stating he had tried using a friend's four-wheeled walker and that "it didn't do anything for me." Barriers to using a manual wheelchair included his poor grip strength and excessive body weight (260 pounds). Next, power mobility was discussed, including the pros and cons of a scooter versus a mid-wheel drive power wheelchair. Mr. G again became adamant, insisting he wanted a scooter. The team then discussed the remaining barrier – the one step to enter his apartment. Mr. G said he could get the step ramped. I provided my contact number and asked that he call me when the ramp was in place. (Subjectively, less than half of our clients follow up with this request.) Mr. G was enrolled in Medicaid Choice, a Medicaid program managed by Denver Health. Through this program, Mr. G had been assigned a Complex Case Manager, Brian Chicon, to help manage his compliance with medications and follow-up appointments. Chicon very quickly became an integral part of the process to help Mr. G obtain the recommended equipment.

Three months after his initial clinic visit, Mr. G called me to report that he had had a ramp installed. I scheduled a home evaluation visit with myself and the supplier, Brendan Warner, ATP with Numotion. On arrival at his apartment, we noted the "ramp" was a large piece of plywood. I advised

> We discussed the possibility that a mid-wheel drive power wheelchair would be easier to maneuver. His response was as expected - "Nope, I want a scooter and that's what I'm getting."

Mr. G that the plywood was not what we recommended. He insisted "it's my business whether it's good enough or not." The interior space in his apartment was insufficient to allow use of the scooter inside. We reviewed the need to be able to use the power mobility device within the apartment to help decrease his falls at home. We discussed the possibility that a mid-wheel drive power wheelchair would be easier to maneuver. His response was as expected – "Nope, I want a scooter and that's what I'm getting."

Two months later (five months after the initial clinic visit), Warner reported that a three-wheeled scooter had been delivered to Mr. G, but at a different address. It appeared that Mr. G was now living at a friend's house. The house was wheelchair accessible with both a ramped entrance and enough interior space to maneuver the scooter. Warner reported Mr. G was very pleased with the new scooter. At this point, it seemed this episode was completed. Although the time from assessment to delivery was longer than usual, the outcomes of accessible housing; safe, independent patient mobility; and good customer satisfaction were achieved. Or so I thought.

Three months after Mr. G received his scooter, his Complex Case Manager called me. Chicon reported that Mr. G was very upset, because the scooter was not what he wanted, and he had already tipped the scooter in the middle of a busy street on multiple occasions. I told Chicon that we had discussed the option of a scooter versus a power wheelchair several times with Mr. G, and he insisted on a scooter. Because he had received the scooter several

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months before, we would be unable to exchange it. Chicon offered to explain this situation to Mr. G. Several days later, Chicon called to say that Mr. G agreed that he had wanted a scooter but was not given the opportunity to try the scooter first. Chicon said his exact words were, "You wouldn't buy a horse without first looking at his teeth, would ya?" We both chuckled at this response but, in reality, a customer service issue and a potential client safety concern were now at hand. Because Mr. G had been somewhat obstinate in our previous visits, it was clear that even greater diplomacy would be needed to handle this situation moving forward.

Warner and I visited Mr. G at his home and discussed his concerns. He said the scooter was too small and didn't "have enough wheels on the ground" to keep it from tipping over ***(See photograph 1).*** I had no idea if we would be able to provide a different device at this point, but to smooth things over I offered to bring him a clinic demo power wheelchair to try. Mr. G agreed. I brought the chair to his home and showed him how to drive the chair and charge the battery. We practiced crossing the street at the point where he had previously tipped the scooter. Mr. G expressed interest and willingness to try the chair for a week. However, the next day Chicon called me. Mr. G wanted me to, "Come pick up this thing. The wheel is falling off!" Alarmed, I drove to his house that afternoon. The plastic hubcap on the left drive wheel had come loose and rattled when the chair was moving. I acknowledged that the noise was annoying, but pointed out that the chair was otherwise safe to use ***(See Photograph 2).*** Mr. G adamantly refused to continue the trial.

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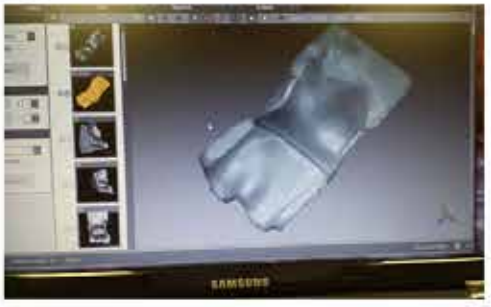

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Although I was extremely frustrated by Mr. G's resistance to work together to find a solution, I realized I needed to step back from objective problem-solving and try to figure out what was really going on. First, we needed to see eye-to-eye – literally. I wasn't going to get anywhere standing over him and saying, "What is it, exactly, that you want me to do here?" I asked Mr. G to pull up to a table on the patio next to his house. I sat in the chair next to him and started the conversation with an open statement: "Please tell me what you're thinking. What is frustrating you?" His story tumbled out. He was upset about his slowly declining health, his loss of function and independence, his inability to get his own wheelchair-accessible apartment, as well as the need to move in with friends and the subsequent loss of privacy. I sensed that Mr. G was experiencing an overall loss of control of his life. I realized that although it would require a lot of negotiating and pleading with Medicaid Choice and the wheelchair company, we could help with one little part by giving him the opportunity to try as many mobility devices as he wanted. To "look at the teeth before buying the horse," as it were. I offered to arrange a visit to the supplier showroom to look at other products. Mr. G didn't think he could get a ride there. I offered to bring different product catalogs to his home. He didn't think that would be helpful. After discussing his goals and "wants" in more detail, it appeared that Mr. G was seeking a four-wheeled scooter. I told him I would arrange to have a four-wheeled scooter brought out to his house to trial. Easy for me to say! I would have to depend entirely on the supplier for this demo equipment – and on the funding source to agree to pay for a different device.

When I contacted Warner and updated him on the situation, he expressed the same frustration I had experienced. But he generously agreed to obtain a demo scooter and to find out if his company would be willing to "eat the cost" of the original three-wheeled scooter. I then called Chicon and told him about the results of my visit with Mr. G and the next step in the plan. Like Warner, he also graciously offered to advocate for funding for a different scooter through Medicaid Choice. I also checked in with our clinic physician who was willing to sign off on "whatever you think will work best." I am lucky to work with such a great team!

PHOTO 1: BRENDAN WARNER WITH NUMOTION AND CINDY DISCUSS MR. G'S REQUEST TO RETURN THE 3-WHEELED SCOOTER

PHOTO 2: MR. G DOESN'T LIKE THE POWER WHEELCHAIR

PHOTO 3: MR. G RECEIVES HIS FOUR-WHEELED SCOOTER

With everyone on the same page, Warner and I scheduled another home visit and delivered the demo four-wheeled scooter ***(See Photograph 3).*** We again practiced driving the scooter across the busy intersection and advised Mr. G that this scooter, even with four wheels, could tip if he wasn't careful. After a one-week trial, Mr. G called to report he was very happy with the scooter and asked me to get one for him.

> I sensed that Mr. G was experiencing an overall loss of control of his life.

Thanks to each team member working as an advocate, the wheelchair company and the insurance company were willing partners in this situation. Numotion refunded Medicaid Choice the cost of the first, three-wheeled scooter. Because Mr. G had used the scooter for several months, Numotion could no longer provide it as new equipment and it became part of their demo stock. At the time of this episode, Medicaid Choice coverage policies classified four-wheeled scooters as a non-covered "luxury" item, but the insurance company made an exception in this case to ensure client safety and satisfaction. (This exception is no longer considered under the current coverage policies.) Although the Medicaid Choice allowable for a four-wheeled scooter was the same as a three-wheeled scooter, Numotion was willing to provide the higher-cost device under the same reimbursement as the first scooter.

Finally, one year after his initial clinic visit, Mr. G had the mobility device he wanted. I followed up with Mr. G with a phone call about three months after he received the new scooter. Other than complaints of back pain when he drove the scooter over bumpy sidewalks, he continued to be very happy with the scooter. Since then, he has contacted Numotion only to request repairs. Because Mr. G regained more independence in mobility, he was more compliant with attending medical appointments and following recommendations from his primary care physician. He therefore no longer needed a case manager to help him with these issues, and Chicon was able to discharge Mr. G from his case load after almost two years of management.

This situation did not require great clinical knowledge to resolve. I didn't consult others in the field, nor do a

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literature search for ideas. But I did gain invaluable experience in using diplomacy and emotional insight in resolving a difficult situation. I learned to sense when the client's perception of what we are recommending may not be what they have in mind and how product trials can clarify those perceptions. I learned that it is often better to sit and listen carefully than to throw solutions at a problem. I learned that even the simplest assessments can become complicated without much warning, and I learned the value of working with team members who place client safety and satisfaction above all else. These lessons can't be learned at a conference or by reading a technical journal. So, a final lesson: while a difficult situation can be headache-inducing, each one is invaluable to our professional growth.

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POSITIVE CHANGES

WRITTEN BY: ALEXANDRA BENNEWITH AND JENN WOLFF

Admit it. You need us, the wheelchair users, to help make positive changes in current policies. And yes, we need you, too.

The "permanent" wheelchair user profile is changing. No longer are we tolerating being in the back of the room or not being able to get into places in our communities. We are active, vibrant individuals who want to live, work and play just like everyone else. We don't want to be considered "inspirational" just because we get out in the world and do the same things others do instead of fading away at home or in an institution.

We have more access to information regarding our health care (about our own conditions and the equipment we use) which means we can better educate ourselves. This means we have higher expectations – from our health care professionals, from our equipment, and from those who provide service and repair. We can find out how things should be done by talking with our community online, researching the different styles of wheelchairs and features and expressing our individuality.

Wheelchair users must try to learn as much as they can about the equipment.

You need us to share how the current policies are unjust to the point of being unethical and discriminatory; they do not allow us to live our full lives in our communities, but only consider how we get around the four walls of our homes. You need us to share how a few pounds of extra weight can put more wear and tear on joints, how less adjustable wheelchairs are not ergonomic and can cause additional health care costs. When we have the "right" wheelchair, lightweight and individually fitted, we can actively participate in life, have a better chance at finding and keeping employment, have less depression, less risk of pressure sores, etc.

So this is our call for action: we need a true system change. The durable medical equipment community must be aware of the breadth of equipment, how to more effectively work with health care professionals, and how each piece can help or hinder individuals. Respect the user of the equipment and the right for them to choose. The health care professionals who write orders, provide medical necessity documentation and evaluate our equipment needs, must have the knowledge to properly recommend the "right" equipment. They also need to be able to efficiently document evidence of why the equipment assists in all aspects of life – not just tasks at home.

Wheelchair users must try to learn as much as they can about the equipment they use so they can ask questions and be a part of the decision-making team when choosing a mobility device, which is more than just picking a color. We all must work together to make this happen.

The health care professionals who write orders, provide medical necessity documentation and evaluate our equipment needs, must have the knowledge to properly recommend the "right" equipment.

With true system change, money will be saved, health care costs could be reduced and, yes, fraud would go down. So my challenge to you, wheelchair vendors, suppliers and fellow advocates – empower your consumers, educate them. Make them value you and your services, and you will create life-long customers. You are not only helping create the system change we all need, but also helping wheelchair users feel valued, empowered and inspired to do more than they ever expected of themselves. I know I feel that way. Visit us at http://www.UsersFirst.org.

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CLINICIAN TASK FORCE: TRENDS IN SEATING WHEELED MOBILITY SPECIALTY CLINICS

WRITTEN BY: LAURA COHEN PHD, PT, ATP/SMS AND BARBARA CRUME PT, ATP

The Complex Rehabilitation Technology (CRT) team approach is critical to the service delivery process. Physical therapists and occupational therapists play a vital role in the provision of clinical-related CRT services. Today many clients receive CRT clinical services at dedicated seating and wheeled mobility (SWM) clinics. These clinics are often located at major university medical centers, regional and local rehabilitation centers, dedicated model centers (e.g. model spinal cord injury or brain injury centers), or through specialty clinics (e.g. amyotrophic lateral sclerosis, muscular dystrophy, spina bifida, pediatric clinics).

SWM clinics have historically been viewed by their organizations as a service to the community to meet an unmet community need. They are not typically money makers for the organization and, in fact, commonly lose money or, if fortunate, break even. Today with the shrinking health care dollar and consolidation of health care systems we have seen several organizations that have prided themselves on their pioneering SWM clinics downsize or eliminate their clinics entirely.

Sustainability of the dedicated SWM clinic directly impacts supplier access to qualified clinicians. Industry-wide health care trends are negatively impacting the CRT team approach. Here we will review issues being faced by clinicians that suppliers and manufacturers should be aware of – including payment issues influencing SWM clinical practice, challenges of operating a SWM clinic and strategies to improve clinic efficiencies.

Trends Influencing the CRT Clinical Team

Faced with policies resulting in shrinking payment and margins, suppliers and clinicians are redesigning their services and service delivery practices to maintain solvency. Understanding the demands and challenges faced by SWM clinics is important, because ultimately these challenges impact consumer access to CRT clinical services such as the specialty evaluation, fitting and follow-up training.

Therapy Cap and Other Payment Regulations

Health care policies such as the Medicare Therapy Cap enacted by the Balanced Budget Act of 1997 placed annual spending limits on outpatient therapy services totaling $1,900 (USD) for physical therapy and speech language pathology services combined and a separate $1,900 (USD) cap for occupational therapy services. This means if a consumer is receiving traditional physical therapy, speech-language pathology or occupational therapy services they may quickly use their annual cap and not have access to seating and mobility clinic services for the required specialty evaluation until the next calendar year unless they are willing to pay out of pocket or have other resources. On March 31, 2014, Congress passed a twelve month patch avoiding a 24 percent payment cut caused by the sustainable growth rate (SGR) formula and temporarily extending the therapy exemptions process. A permanent solution is needed in order to stop a 10-year pattern of last minute extensions and short term. Legislation for permanent SGR reform and elimination of the Medicare therapy cap has been introduced. CRT stakeholders can offer support by understanding the impact of this legislation on clinical services and by supporting passage of HR 713 and S 367.

State Medicaid programs and private payers are also working to reduce costs. To accomplish this, many payers have implemented policies capping therapy services or limiting the number of visits covered. These policies vary by state or insurance plan. It is important to know the coverage benefit and limitations for your clients' plans. NCART offers links to Medicaid policies and fee schedules that are searchable by state at http://www.ncart.us/state-issues.

With the proliferation of CRT legislation working its way through

the legislative process in numerous states it is vital that the specialty therapy evaluation, assessment, fitting and training required as part of the CRT process, be recognized and covered in addition to any existing therapy or visit cap. Otherwise, consumers may be faced with waiting until a new calendar year before accessing the needed service.

Mergers and Acquisitions

With changes in health care and expansion of new models of care, many health care organizations are looking for ways to leverage resources and alliances. As a result, there is a climate of mergers and acquisitions occurring for hospital systems, outpatient facilities, home care organizations, skilled nursing facilities, etc. Non-profit organizations are being acquired and converted to for-profit organizations. The result is a shift in mission/purpose/priorities and elimination of services that are not profitable such as SWM clinics.

Redesigning Services to Align with Affordable Care Act and New Models of Care

As an outgrowth of the Affordable Care Act and innovative models of care there is an increasing move from "fee-for-service" (i.e. payment for each procedure or service) to "shared risk" (i.e. consolidated billing and capitated service agreements). Consolidated billing pays providers with bundled payments to cover care received (e.g. per patient per episode of care). Capitated service agreements are an increasingly popular payment method where providers are contracted a set amount for each enrolled person assigned to them whether or not that person seeks care.

Challenges to Building Work Force Capacity for CRT Clinical Services

Clinicians and physicians are not always interested in learning or able to retain the nuances of policy requirements if they have only an occasional or infrequent referral.

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CLINICAL TASK FORCE: TRENDS IN SEATING...
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Currently, there are very few clinicians working in acute hospital outpatient clinics, home health or assisted living who are familiar with the documentation requirements for durable medical equipment or CRT. There is a need to engage and educate clinicians beyond specialty SWM clinics to meet the public need for obtaining this equipment. Importantly, we all must help identify clinicians working in the community who are interested in developing their expertise in this area of practice to meet their patient's needs. A Clinician Task Force strategic priority is to advance the practice of CRT within the American Physical Therapy Association and American Occupational Therapy Association to ensure a qualified workforce to provide clinical services. Suppliers can assist in educating clinicians by teaming up with them and sharing information about the CRT process.

Low reimbursement and Medicare cap limits can be a disincentive to expand into this market, yet the services are billable and reimbursable. The paperwork may seem extensive due to the need to document medical necessity for two policies: the physician/PT/OT LCD PLUS the DME LCD requirements. Frequently facility documentation systems are fixed or rigid and do not support changes to eliminate redundancies. However, electronic health records (EHR) have the potential to improve clinical efficiency. The increasing capability of attaching Word document or PDF files into existing EHR systems allows clinicians to develop templates or utilize existing forms for this purpose and reduce redundancies. New electronic standards for medical documentation are under development to ensure the interoperability of electronic health record systems. These initiatives, when implemented, will enable secure transmission of electronic records for claims processing and review and have potential to streamline documentation processes.

Strategies to Support SWM Clinic Sustainability and Capacity

Clinicians currently working in SWM clinics are faced with doing more with less. Having access to data about the fiscal health of the clinic allows identification of areas to improve. Often, administrative support and prioritization is necessary to obtain access to this information. Awareness of the payer mix, contractual adjustments, payer limitations on number of visits and time allowed or units of service billable per visit may lead to changes in the amount of time scheduled per patient to maximize reimbursement. The use of support staff to obtain prior authorization for therapy, collect co-pay at the time of the visit and assist with appealing denials in a timely manner may increase reimbursement. To maintain high productivity, either support staff or the supplier may call patients to remind them of their appointments a day or two early, which will reduce the no show/cancellation rate. If someone does cancel, it is helpful to keep a list of those willing to move into a newly available appointment.

For clinicians currently working in an SWM clinic and for those just starting, reasonable payment for services requires that clinicians have access to adequate knowledge about the utilization of CPT codes and modifiers for use on the same day of service. They also must make sure the documentation clearly describes the skilled care provided and that it matches the codes billed specifying total treatment time provided.

The use of G-codes for Functional Limitation Reporting is challenging for those providing therapy services because Medicare automatically discharges an episode of care after 60 days of inactivity. Therefore, clinicians usually need to discharge the patient and report all three G-codes prior to the end of 60 days while awaiting funding approval for the wheelchair to avoid denial of payment. The patient can be readmitted for custom molding, fitting and training and a new set of G-codes reported.

Suppliers can also assist clinicians by providing information on the patient's current equipment model, size, age, condition and need for repair, as well as, information on their home environment and medical and/or functional needs they are aware of prior to the evaluation. Bringing

> The voice of many taking action will help ensure continued consumer access to CRT products and services, reasonable payment for services and solvency of the organizations that provide them.

equipment to the appointment set up and ready for assessment or fitting is extremely important to maintain efficiency.

In Closing

To ensure the sustainability of SWM clinics, it is imperative that there exists reasonable remuneration for services provided. As noted above, some payers limit total payment on one visit by restricting codes or time allowed. This practice frequently results in insufficient payment for the cost of services. In response, some clinicians have been successful in teaming with the CRT suppliers and working with the agency (Medicaid, private payer) to change the policy. Other times SWM clinics have had to alter their practices and conduct the SWM evaluation over a series of visits.

The CRT team approach is the foundation for our service delivery model. Individuals with CRT needs are increasingly losing access to CRT services and technologies. In this time of shrinking funding and consolidation, all stakeholders must work together to realize efficiencies. A united voice from clinician, supplier, consumer and manufacturer stakeholders has potential to influence coverage, coding and payment policies. The voice of many taking action will help ensure continued consumer access to CRT products and services, reasonable payment for services and solvency of the organizations that provide them.

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MEET THE PROFESSIONAL STANDARDS BOARD

WRITTEN BY: ANDREA VAN HOOK

Have you ever wondered who makes the policy decisions regarding the ATP and SMS certifications? RESNA's Professional Standards Board (PSB) provides oversight and guidance for the organization's certification programs. The PSB works closely with RESNA's board of directors to ensure the ATP and SMS certifications meet independent quality standards for recognizing the qualifications of assistive technology practitioners, and validate the knowledge required for safe and effective service to people with disabilities.

Among other tasks and responsibilities, the PSB is charged with setting the eligibility requirements and fees; designing and maintaining the exams; maintaining a registry of certificate holders; and serving as the final decision-making body for appeals and disciplinary action. For more information, visit http://www.resna.org/certification.

Mike Seidel, ATP, CRTS – Chair

Mike Seidel is a regional vice president with Numotion, and has been active in the promotion and advancement of the rehab technology supplier position for more than 20 years. He has been a RESNA-certified ATP since 1997 and a NRRTS Registrant since 1994. Seidel has served on the NRRTS board as treasurer and president and continues to work for the advancement of NRRTS Registrants.

Brenlee Mogul-Rotman, OT, ATP/SMS – First Vice Chair

Brenlee Mogul-Rotman is an occupational therapist who owns a private practice in the Toronto area. She has a special interest in seating and mobility and is involved with vendors and manufacturers in product development, clinical trials and product application. In addition to the PSB, Mogul-Rotman is a RESNA member and a member of the Ontario Society of Occupational Therapists.

Dan Cochrane, ATP – Second Vice Chair

Dan Chochrane is the district-wide assistive technology specialist/coordinator for Community Unit School District 200 in Wheaton and Warrenville near Chicago. He works with school teams and parents to implement and integrate assistive technology and accessible instructional materials for students with disabilities. He holds an Master of Arts in Special Education from National Louis University in Chicago and an Master of Science in Disability and Human Development from the University of Illinois at Chicago.

Carmen DiGiovine, PhD, ATP/SMS, RET

Carmen DiGiovine is a rehabilitation engineer and a clinical assistant professor in the Occupational Therapy Division-School of Health and Rehabilitation Sciences at The Ohio State University. He is also the program director for the Assistive Technology Center at The Ohio State University Wexner Medical Center. DiGiovine holds certifications for all three of RESNA's programs, and is the immediate past-chair of the PSB.

Leah Hagedorn, PhD

A consumer member of the PSB, Leah Hagedorn is associate professor of history at Tidewater Community College in Virginia. A scholar of American Jewish history, Hagedorn has also held positions as a lecturer at Princeton University and visiting assistant professor of history at Tulane University. Prior to joining TCC in 2004, she directed a public history project at the Center for the Study of Southern Culture at University of Mississippi.

Craig Kraft, ATP/SMS

Craig Kraft is the seating and mobility director for Shriners Hospital for Children in Tampa, Fla., where he specializes in seating and mobility for pediatrics. Kraft has extensive experience with custom molded and commercial seating for power and manual wheelchairs. He has served on the RESNA Professional Standards Board since 2009 and has been a member of RESNA since 2004.

Julie Piriano, PT, ATP/SMS

Julie Piriano is director of rehab industry affairs for Pride Mobility. She is a subject matter expert on legislative and regulatory issues that impact the complex rehab industry and is actively involved with the coverage, coding and standards work groups as part of the Complex Rehab Separate Benefit Initiative. Recently elected to RESNA's board of directors, she started her first term as a board member on Aug. 1.

Ian M. Rice, PhD, MSOT

A consumer member of the PSB, Ian Rice is assistant professor in the department of kinesiology and community health sciences at the University of Illinois, Urbana Champaign. His research interests include interventional and adaptive technologies to promote injury

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MEET THE PROFESSIONAL...
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prevention, physical activity, and full life participation in persons with mobility limitations. Rice is a two-time Paralympian in the sport of wheelchair racing, and has won numerous international track and road races, competed in more than 60 marathons, and has more than 15 years of experience playing quad rugby.

Emma Smith, OT, ATP/SMS

Emma Smith is the founder and director of Jump Start Occupational Therapy in Vancouver, British Columbia. She holds an Master of Science in Occupational Therapy from Dalhousie University, and has worked with adults and children in Nova Scotia, Ontario, and British Columbia. She is a RESNA member and a member of the Canadian Association of Occupational Therapists (CAOT).

Fred Tchang, BSE, ATP

Fred Tchang is director of assistive technology services at Advancing Opportunities in New Jersey, where he and his staff help consumers, employers and school districts with their assistive technology and accessibility needs. Tchang's formal training is in product design and rehabilitation engineering technology. In addition to RESNA, he is active in the New Jersey Coalition for the Advancement of Rehabilitation Technology, and the New Jersey Coalition for Inclusive Education.

Ann "Weesie" Walker, ATP/SMS

Weesie Walker is executive director of NRRTS. She is a retired NRRTS Registrant who opened the Atlanta office for National Seating and Mobility in 1992. Walker has presented at the International Seating Symposium, RESNA conference, National Seating and Mobility Symposium, Canadian Seating Symposium and the American Association of Occupational Therapists Conference.

ATP and SMS applications now accepted for fall exam dates

ATP and SMS applications are now being accepted until Aug. 31 for the fall exam period, which starts Oct. 1. After Aug. 31, applications with a late fee of $50 will be accepted until Sept. 15. The fall exam testing period is from Oct. 1 to Dec. 31.

Continuing education opportunities for certification renewal

In addition to NRRTS webinars, which are accepted for ATP and SMS certification renewal, RESNA accepts the following:

- RESNA webinars
- RESNA courses
- AT Journal Quizzes
- RESNA Catalyst Project WebEd
- ATIA webinars
- University-accredited assistive technology courses (such as University of Pittsburgh)
- IACET CEUs for assistive technology courses

If you have any questions as to whether a course, webinar or training will be accepted for your certification renewal, please contact Stacey Singleton or Eric Nepomuceno in the RESNA Certification Department at ssingleton@resna.org or enepomuceno@resna.org.

CONTACT THE AUTHOR
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HAVE YOU BEEN GETTING PAID THE RIGHT AMOUNT? IT'S TIME TO GET LOUD!

WRITTEN BY: CLAUDIA AMORTEGUI

When it comes to competitive bidding program, Complex Rehab Technology (CRT) providers are thankful for the carve-out. However, ever since round two started last July it has not been painless. To my surprise, this pain has not been heard as loudly as one would think.

If you service customers in round two competitive bid areas, have you noticed an increase in certain Medicare denials? Have you noticed if you have received the appropriate Medicare allowable on many of your billed options? If you haven't, you would either be a rarity amongst CRT providers across the country, or you need to dig deeper.

Most of you reading this article are ATPs and may think, "Why do I care about billing and reimbursement?" You need to care about this, as it's affecting your bottom line. As the margins continue to shrink, we all need to be aware and involved with all parts of this industry.

When round two of competitive bidding went into effect July 2013, providers were instructed to use a specific modifier to ensure certain HCPCs codes would be paid appropriately. For CRT this was necessary since several wheelchair base codes were not marked for competitive bidding, but many of the accessory codes were since they could be used on either a "standard" wheelchair base or a CRT base. The Medicare system needed to have a method to identify when it should require a contract bid supplier to provide a competitively bid HCPCs code versus when it was considered a part of the carve-out and excluded from the program. Lo and behold, the KY modifier was introduced to the CRT world. This sounds like it should be rather easy, right? Unfortunately, that has not been true.

As easy as the use of a modifier should be, a twist was added. Please don't ask me why, we just have to accept this fact. Medicare instructed providers to use the KY modifier on all wheelchair accessory codes that fall under the competitive bid program that are to be used on a CRT power wheelchair base not manual CRT (i.e. K0005 and E1161). This sounds like a tongue twister, and it is certainly a mind-bender for all – be sure that this is completely understood.

We also cannot forget that many years back we were given the KE modifier to make sure we did not receive a 9.5 percent cut in the allowable for all manual wheelchair options/accessories. This cut was only for options/accessories on power bases. Even with this modifier, there was a twist: it is only to be added on those HCPCs codes that could be used on either a power or manual base and only when being placed on a manual wheelchair base. With that in mind, you have to be sure someone is reading the official HCPC code description.

For this article, there is no point to go any deeper on billing and modifiers. Let's discuss what appears to not be happening by the Medicare system when it comes to the processing of your claims for CRT orders.

Most of you reading this article are ATPs and may think, "Why do I care about billing and reimbursement?" You need to care about this, as it's affecting your bottom line. As the margins continue to shrink, we all need to be aware and involved with all parts of this industry.

All four Medicare jurisdictions are not consistently recognizing that the HCPCs for wheelchair options and accessories billed for use on a CRT base are not part of competitive bidding – this has been happening since last July. Therefore, these billed line items are being outright denied if you are not a contract supplier for standard wheelchairs under competitive bidding, and/or you are being paid, but at the Competitive Bid Single Payment Amount, not the standard allowable.

So what do you do now? First, you need to know how this is affecting your claim payments. If you do find these payment errors, you need to speak up.

The tough part for providers is not being completely on top of payments. Claims that are being paid at the lower competitive bid rate are still being paid, so the errors can be missed. If your reimbursement team is only looking for full denials, the flags will not go up, but you will be cheating yourself of proper payments. As we all know, nobody can afford this on a large amount of orders – and in many cases, on any orders.

I know this is confusing, but I have to go back and ask. Are you being reimbursed correctly? If not, we all need to get loud as a group and demand this be corrected now. Also, we need to make sure all your old claims are adjusted appropriately.

For a while now, a few others and myself have been trying to get this issue resolved. CMS is aware of this problem, as is the Competitive Bidding Implementation Contractor (CBIC) and the DME MACs. The answer we consistently receive is that everyone is waiting for "instructions from CMS." This round of competitive bidding started over a year ago, and this problem was identified immediately, therefore the contractors have been waiting quite a while for these instructions at your expense. Keep in mind, if Medicare pays you incorrectly, this affects the secondary payers' reimbursement amount, including an individual's co-pay.

So what do you do now? First, you need to know how this is affecting your claim payments. If you do find these payment errors, you need to speak up. You can either contact CMS, the CBIC, and your DME MAC directly or you can let me know, and I will work with NRRTS to start compiling a list. We need to show Medicare the magnitude of this problem. If you do call your DME MAC (the ones who process your claims), you need to understand that in many cases they are just as confused with the modifier requirements. Many of their customer service staff does not understand these options, and accessories are exempt from the program when provided on the excluded HCPCs codes for CRT bases (make sure you know which ones those are). If you do reach a person who understands, they may try to correct the issue. However, this also may be beyond their control, as it does appear to be a system issue. Sometimes it works, sometimes it doesn't.

For all these reasons we need to get loud as a group. Just imagine, CMS is already talking about expanding the program, but this part does not even work after a full year. Take the time to look into your claim payments; look at each line and make sure it is correct. Let us know what you find – good and bad – and we will continue the fight. The power will be in the numbers. There is no reason this issue should not be fixed immediately.

CONTACT THE AUTHOR
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Fax: 215-956-5142
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USA Seating & Mobility
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Uvalde, TX 78801
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Toll Free: 877-591-2698
Fax: 830-591-2386
Registration Date: 6/2/2014

Michael Thompson, ATP, RRTS®
National Seating & Mobility, Inc.
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David St. Louis, ATP, CRTS®
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former NRRTS registrants

The NRRTS Board determined RRTS® and CRTS® should know who has maintained his/her registration in NRRTS, and who has not.

NAMES INCLUDED ARE FROM MAY 22 THROUGH JULY 22, 2014.

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

Michael Bird
Betty Boylston
John Burke
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