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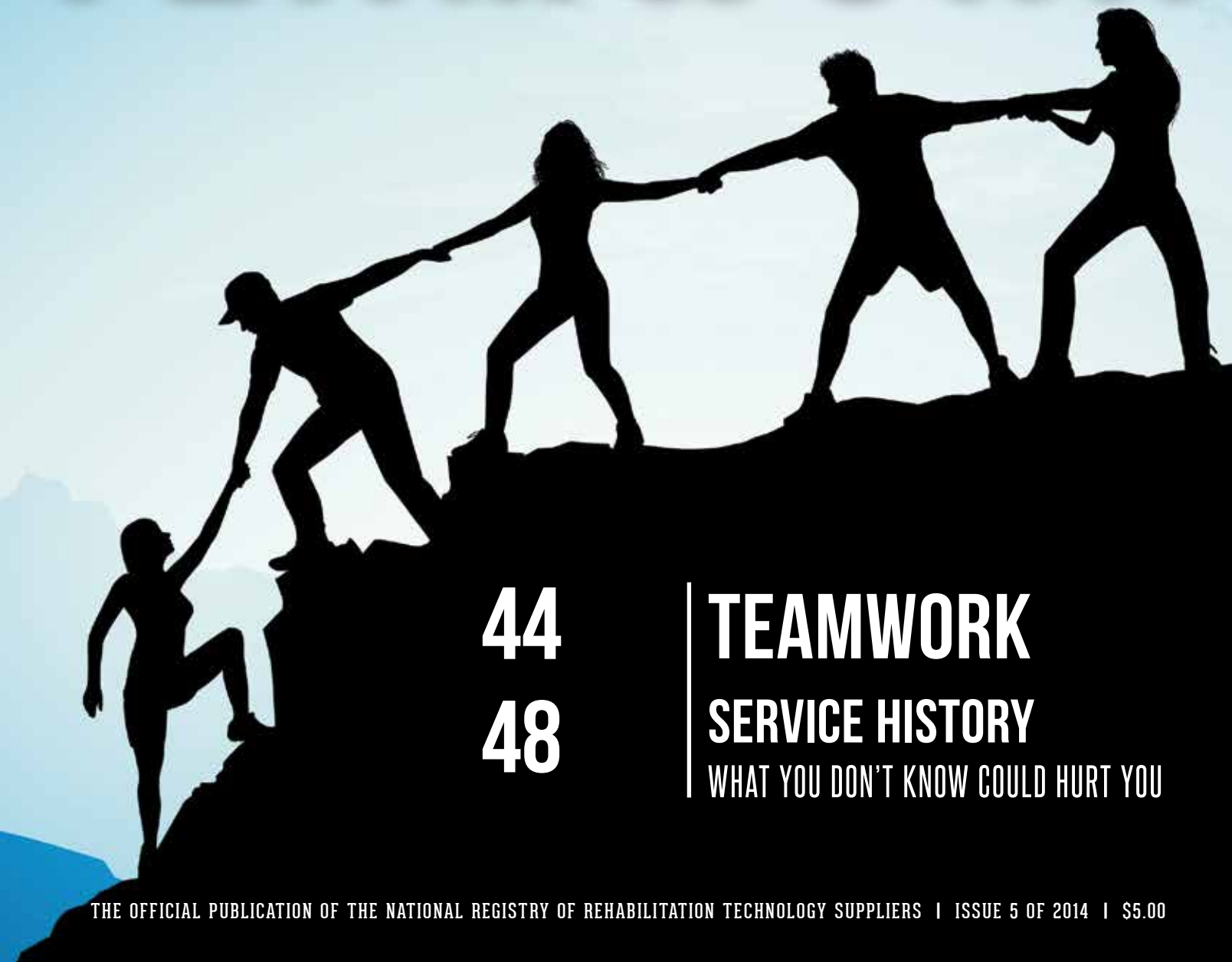

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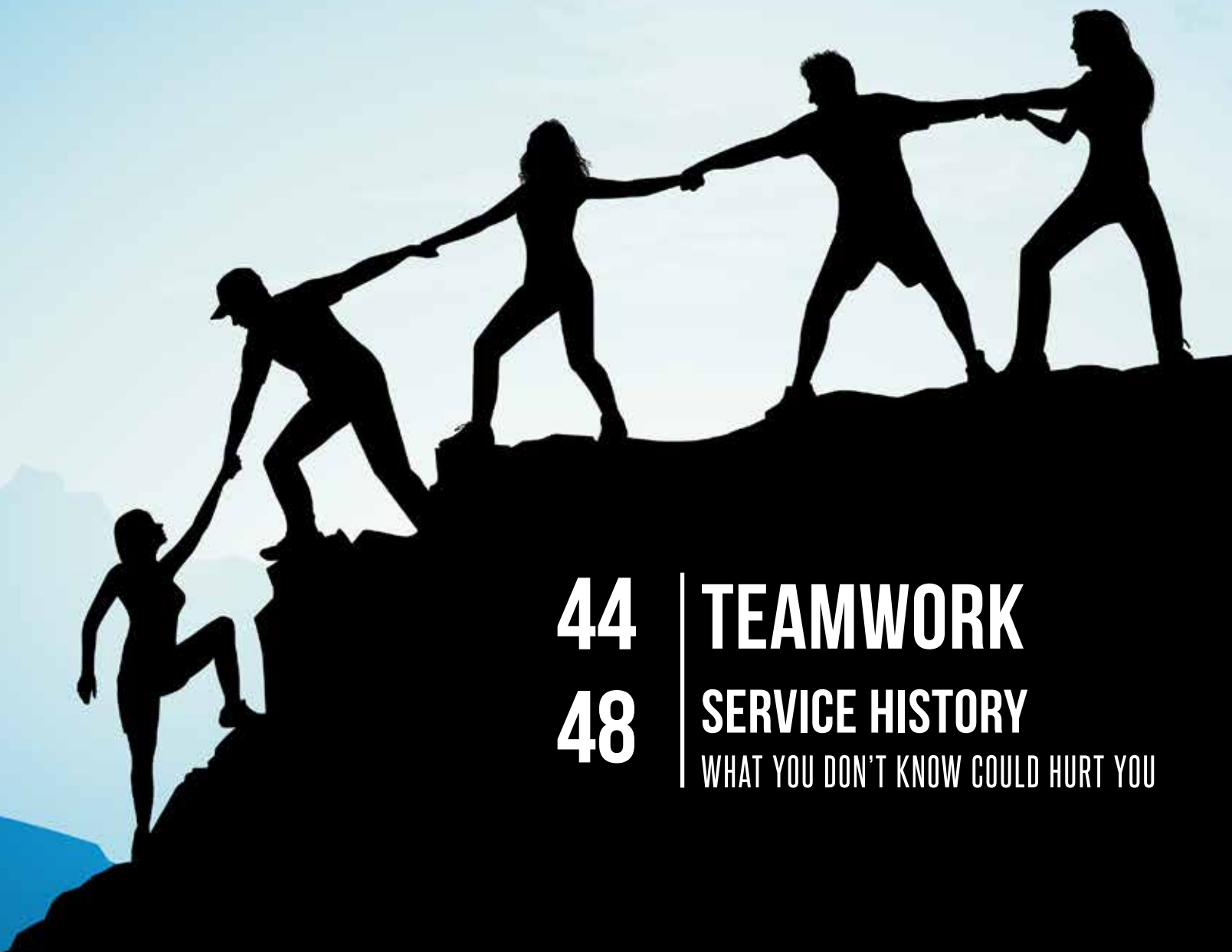

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CLAUDIA AMORTEGUI

Amortegui has her Masters of Business Administration and more than 20 years experience in the durable medical equipment, prosthetics/orthotics and supplies industries. 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 68

ROB BELLAIRE

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

ALEXANDRA (ALEX) BENNEWITH

Bennewith is vice president of government relations for United Spinal Association. Bennewith advocates for legislation and regulations regarding disability and health policy at the federal and state 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 58

KATHERINE CLARK, MOT, OTR/L

Clark is a lead therapist at the Perlman Center, part of the comprehensive Cerebral Palsy Program at Cincinnati Children's Hospital. The Perlman Center is a specialty center designed to address the complex therapy, developmental, assistive technology and care coordination needs of children, youth and adults with cerebral palsy and other complex conditions. SEE PAGE 40

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 industries as a provider, consultant and advocate. He is actively involved in industry issues and a frequent speaker at state and national conferences. SEE PAGE 38

ALLISON FRACCHIA, PT, ATP/SMS

Fracchia is the assistive technology clinic coordinator at Methodist Rehabilitation Center in Jackson, Miss. She has worked in the area of seating and mobility for 16 years. She serves as an Executive Board Member of the Clinician Task Force (CTF). The CTF is 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. SEE PAGE 60

DICK FULLER

Owner of Richard Fuller Consulting, Fuller has more than 30 years experience in the home medical equipment and complex rehab technology industries with an emphasis in powered wheelchair technology and service management. Fuller earned his bachelor's degree in Business Administration & Marketing from California State University, Northridge, and has completed post-graduate courses in service management at the University of Wisconsin, Madison. SEE PAGE 48

LUKE MOORE, ATP/SMS, CRTS®

Moore is a new at-large board member who works for Provider Plus in St. Louis, Mo. Moore has been a NRRTS Registrant since 2011. SEE PAGE 32

JILL MONGER

Monger focuses on mobility solutions for people of all ages with severe disabilities. She received her bachelor's degree in physical therapy from East Carolina University in 1984 and her master's in health professions education from the Medical University of South Carolina in 1998. She was certified in assistive technology from the Rehabilitation Engineering Society of North America in 1994 and currently serves on the boards of several organizations related to advocacy and independent living for people with physical disabilities. Monger is on the steering committee of the Clinician Task Force. **SEE PAGE 60**

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, Missouri. **SEE PAGE 44**

BRAD PETERSON

Peterson is vice president of sales and education for Motion Concepts. He received his bachelor's degree in sports medicine from Springfield College. **SEE PAGE 24**

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Pope is a lead therapist at the Perlman Center, part of the comprehensive Cerebral Palsy Program at Cincinnati Children's Hospital. The Perlman Center is a specialty center designed to address the complex therapy, developmental, assistive technology and care coordination needs of children, youth and adults with cerebral palsy and other complex conditions. **SEE PAGE 40**

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Skora is an attorney with the Health Care Group of Brown & Fortunato, P.C., a law firm based in Amarillo, Texas. Skora represents home medical equipment companies, pharmacies, and other health care providers throughout the United States. He earned his B.A. from Dartmouth College and his law degree from the University of Minnesota School of Law. Skora is licensed to practice law in Minnesota and is a member of the American Health Lawyers Association. SEE PAGE 36

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 64

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 58

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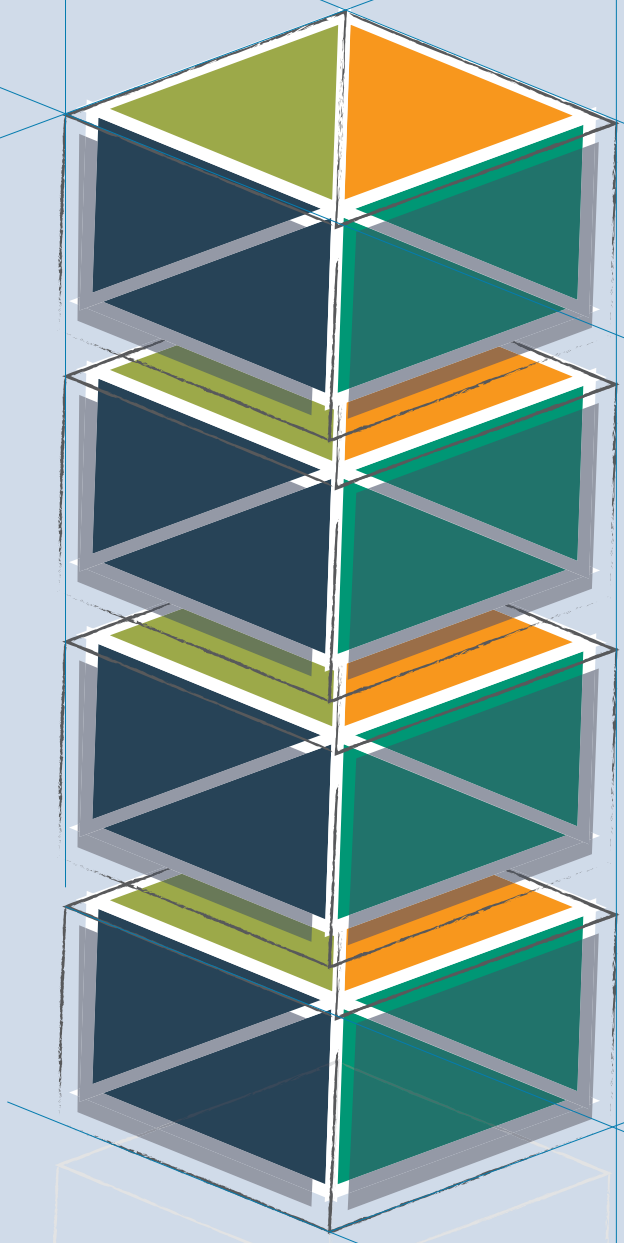

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LIFE WITH A 3-2 COUNT

Childhood cancer, including treatments put Rob Bellaire down early in the count, but he's not going to lose the game

WRITTEN BY: DANETTE BAKER

Bulls, Blackhawks, Bears, White Sox and Cubs – Robert Bellaire counts himself a diehard Chicago professional sports fan. He's attended the games live and follows his teams on television when they are televised. And like many a Cubs fan, he looked forward to his visit to Wrigley Field. Even if you are not a Cubs fan, those who truly love the game long to visit the baseball mecca and often never forget it when they do. Many describe it as heavenly – a place where nostalgia meets new age in the ivy walls and rooftop residencies.

ROB BELLAIRE

For Robert Bellaire, the experience was less than impressive. When he and his parents, Thomas and Rosemary Bellaire, visited Wrigley field three years ago, it took three innings and assistance from ballpark officials for the family to get to their seats. And then, the Bellaires said, they were asked to exit the stadium during the seventh inning stretch – all because the wheelchair lift was malfunctioning, and couldn't handle her son's 450-pound power wheelchair, said Rosemary.

"They can say they are wheelchair accessible, but I'm not so much a fan anymore," said 27-year-old Robert, known as Rob to family and friends. Instead, he's partial to Chicago's other baseball team, where he and campers participating in Children's Oncology Services Inc.'s One Step at a Time Summer Camps have much easier access to the White Sox stadium and have often gotten to watch the games from the skybox adjacent to Sox owner Jerry Reinsdorf's.

"Rob has had so many experiences like that at Wrigley Field where he would go to something and then find out there was some problem that prohibited him from being able to participate," said Rosemary, who is a retired CPA. "I remember when he went to a Super Bowl watch party at Elmhurst College with a group of friends while he was in school there only to discover the party was on the second floor, and the building's one and only elevator was not working.

"Somebody else would have pitched a fit, but Rob just rolls with the punches."

In 1992, at age 5, Rob was diagnosed with an inoperable brain stem tumor. Within three days of the Bellaires noticing their son's unfamiliar gait, Rob was diagnosed and was undergoing radiation treatments a week later.

During the next month, Rob's condition deteriorated rapidly as the tumor continued to grow, and the irradiated brain tissue became more and more irritated. Rosemary explained how Rob suffered hydrocephalus as a result, and required emergency surgery to put in a shunt to relieve the pressure. The next four weeks, Rob lay unconscious in the Pediatric Intensive Care Unit at Loyola University Medical Center before Thomas and Rosemary were able to take him home with a grim prognosis. The

(CONTINUED ON PAGE 16)

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LIFE WITH A 3-2 COUNT
(CONTINUED FROM PAGE 14)

doctors gave Rob no more than two months to live. At home, Rob remained unconscious, unable to swallow, eat, talk or control his body. His home-based care was entrusted to hospice, with around-the-clock nursing support.

But Rosemary had other plans for her son and the rest of the Bellaire family. When Rob was still in a semi-comatose state, she decided it was time to make the best of their situation and live, whatever time they were given with Rob, a life as normal as possible.

"I told Thomas and his sister, who happened to be staying with us for a few days, 'I'm going to take Rob with me today when I go to pick up John (Rob's younger brother) at preschool.

"They both looked at me like I was crazy.

> During his seventh grade year, Rob's mobility had declined to a point he was forced to begin using a power wheelchair while having only limited control over his arms and legs.

"I just thought we owed it to John, and all of us, to achieve as much normalcy as possible," Rosemary said. "He was only two when Rob got sick. So you know, I'm sure he felt the effects. We just thought it was not fair to him if everything was Rob, Rob, Rob."

Thomas agreed those first few years of Rob's illness were overwhelming, and his care was all-consuming. "Rosemary was right, we all needed some form of normalcy; it was, and is still sometimes, very hard to live in a high pressure medical world every second all day long."

Slowly, Rob fought back and by late fall, he was attending kindergarten and walking, albeit unsteadily.

THE ENTIRE SEABEES CAMP GROUP WITH ROB IN THE MIDDLE

"Do you remember the first day you went to school?" Rosemary asked Rob. "Your head was shaved. It was the Halloween party and your friend, T.J. Smith, came up to you and said, 'Nice buzz cut, Rob.' That kind of broke the ice. T.J. is now in medical school at Northwestern University, so his compassion and caring tendencies continue today."

"And my best friend, Alex, was there at my side the entire time," Rob added.

For kindergarten and first grade, Rob had around-the-clock nursing support and then continued to have a full-time aid throughout high school. That made the transition back to school a little more settling, said Rosemary. However, Rob fought constant medical challenges including physical, occupational and speech therapy; new medications; numerous medical appointments; surgeries and hospitalization. Slowly over the years, he developed severe dystonia, characterized by involuntary muscle movements and muscle tightness that resembles cerebral palsy. During his seventh grade year, Rob's mobility had declined to a point he was forced to begin using a power wheelchair while having only limited control over his arms and legs. Three years later, Rob suffered a six-month period of brain infections and shunt failures – 15 operations total – which almost cost him his life again.

His junior year in high school, Rob had a spinal fusion on his back, and since then his health has been stable, said Rosemary. But his dystonia and movement disorders have largely confined him to his power wheelchair. Rob also uses Dragon Dictation voice recognition software, but it doesn't always recognize his voice. Rob sometimes has difficulties because of short-term memory loss, primarily caused by the radiation.

"For all that he's been through, he is a very lighthearted, happy person," said John Bellaire, Rob's younger brother.

"One minute you look at him and keep seeing the nuances to the difficulties and realize it's hard for him to put his thoughts all together," said Thomas, a retired CPA.

And then in the next moment, Rob will be very sharp, added Rosemary. "He will come up with some great observations and reaffirm how bright he really is."

Despite all of the challenges from Rob's medical condition, Thomas and

(CONTINUED ON PAGE 18)

LIFE WITH A 3-2 COUNT
(CONTINUED FROM PAGE 17)

Rosemary were determined to make life as normal as possible for their sons, which included spending time with extended family – Thomas is originally from Sioux City, Iowa, and Rosemary grew up in Central Illinois – and taking summer vacations.

With no extended family in the Chicago area, many of their vacations and trips are tied to family events, such as weddings, graduation parties, etc.

"They did a very good job making things as normal as possible," John said. "One of the things that did always puzzle me growing up was that my parents would never let me bring anyone with us on family vacations. It was always just the four of us. Now in hindsight, I appreciate the quality uninterrupted time we had, especially because we were always so busy. My parents always worked. I had 80 million things going on at school, and Rob always had medical appointments.

"In so many cases, trauma, like what our family went through, can easily destroy a family, but I think my parents did a very good job making sure that didn't happen to us. In fact, we probably spent more time together than most families did and still do so even today.

"I try to come home at least one night a week to have dinner with the family and hang out, and often I'll come home a second night or come over the weekend. Around the holidays, I'll go spend a week at home."

John lives in Chicago's Lincoln Park and works as a CPA for EY (formerly Ernst & Young). His work is about a 45-minute commute from his parents' condominium in Clarendon Hills, a western Chicago suburb. The family moved 10 years ago from their home in Burr Ridge, Ill., into a wheelchair-accessible condominium custom-designed for Rob's needs.

One of Rob's greatest desires is to work again. Rob worked at his school, Hinsdale South High School, and also part time for a School District 205 committee and the Williams Syndrome Association, while in high school and as a college student at Elmhurst College. But with a declining economy and increasing physical limitations, finding appropriate work has been a challenge for Rob, his father said. Thinking back to Rob's years at Hinsdale South and the skills his son demonstrated in CAD and architectural design courses is perplexing because Thomas knows his son has the intellect, but his inability to use his arms and hands is a detriment. Thomas attended the two CAD classes with Rob and was his hands on the computer keyboard as Rob gave direction for the assignments.

"Even though he understands computer programs, he is slow with the mouse," Rosemary said. "We've tried a joystick mouse, the tracking on the forehead and knee and different size keyboards. The most persistent we've been is with voice recognition software. We've been through about 12 versions of Dragon Dictate, but Rob's voice changes as he's talking, which makes it challenging for the software.

ROB PLAYING MINIATURE GOLF AT SEABEES CAMP

> "I try to come home at least one night a week to have dinner with the family and hang out, and often I'll come home a second night or come over the weekend. Around the holidays, I'll go spend a week at home."

ROB USING THE STANDING FUNCTION ON HIS CHAIR

Sometimes it will handle it splendidly, and at other times it just puts garbage on the screen."

Rob spends a majority of his days on his computer and watching TV – sports, of course, is a high priority, said his mother. Depending on the season, the Bellaires will be cheering for the White Sox, Bears, Blackhawks and the Bulls. Rob also enjoys various programming on the Discovery channel, Animal Planet and CNBC. He also participates in various social outings through a special program sponsored by the local parks and recreation district, where he attends sporting events, goes to dinner and to movies, and participates in other civic and cultural events such as the DuPage County Fair, said Rosemary.

Rob is also a huge fan of country music, introduced to the genre when a college friend burned him a CD. The family often attends concerts and has seen shows by George Strait, Tim McGraw, Taylor Swift, Kenny Chesney, Keith Urban, Alan Jackson, Luke Bryan, and Lady Antebellum.

And there is an impressive trillion-dollar phantom stocks and securities portfolio Rob has assembled during the past 10 years, said Thomas, joking that he often asks his son for investment tips. "I had a piece of software that Rob began working with in 2004, and he's kept it up ever since and done very handsomely. His biggest success has been with AutoZone. He first invested when it was at $82 dollars and now it is up over $500."

"Too bad this isn't real money," said Rosemary.

Of course, all that takes a back seat to Rob's desire to make system changes that will positively impact those with disabilities. In 2003, then 16-year-old Rob was invited as part of the One Step at a Time Camp to speak before a House of Representatives subcommittee supporting additional research for childhood cancers. When the teens finished their presentation, they stood in unison and asked the subcommittee to pass the bill. "Then one-by-one, the committee members stood up and said, 'I support the bill,' until the entire first row was standing," said Thomas, who accompanied Rob on the trip.

For Rob, the meeting with Illinois Rep. Judy Biggert was most memorable. "While I was talking to Rep. Biggert, I broke into tears because one of my good friends died from osteosarcoma, which is a bone cancer," Rob said.

In April, Rob and his parents attended the National CRT Conference in Washington, D.C.. He was there to deliver a very similar message again to those representing him in Washington: pass HR-942/S-948.

"I rely on my chair to get around and plus I have osteoporosis so the standing feature on my chair is very important too," Rob told the senators and representatives he met with.

(CONTINUED ON PAGE 22)

LIFE WITH A 3-2 COUNT
(CONTINUED FROM PAGE 21)

GRADUATION FROM ELMHURST

TOM, ROSE, ROB, & JOHN (JUNE 2012)

The standing function of Rob's power wheelchair has become an even more important part of his efforts to counter his osteoporosis, Rosemary explained. However, it is a feature that is not covered by Medicare, so the Bellaires had to pay the difference. They have also had to battle funding for physical and occupational therapy services, which were covered through their private insurance until Rob went on Medicare. It took a lawsuit filed in Vermont for Medicare to cover limited visits to maintain physical function, Rosemary said. For Rob, the therapy has helped him regain and now maintain enough muscle strength that he can help in transfers and pulling himself up in bed. Since Medicare only covers a limited number of visits, the Bellaires pay for someone to come into the home to work with Rob on range of motion and strength.

Before heading to Capitol Hill, the Bellaires knew little-to-nothing about NCART, NRRTS, CELA or the Separate Benefit Category for Complex Rehab Technology, but had extensive experience in dealing with funding issues, both from a private insurance perspective and, more recently, as Rob transitioned onto Medicare, with federal and state funding.

"When ordering Rob's new customized power wheelchair, we felt like given his osteoporosis, we had no choice but to pay for the standing function, which Rob desperately needs so he can do weight-bearing to try and stop bone loss from osteoporosis," said Rosemary. "Medicare wouldn't pay for the standing feature and several other features, so we paid more than $9,000 out-of-pocket and then made do with other complex rehab technology items cobbled together from his old chairs, such as the knee block, a support that fits between feet and knees to aid in alignment. We are using the one from his old chair. I mean there are a lot of crazy things that sound like the decisions were made by someone sitting in an office that had probably never seen complex rehab technology.

> "He'll tell them how infuriating it is when they ignore him as the patient, and they work on 'doctor time,' which means when they tell you they will be right with you and it takes two hours before they see you."

"Fortunately, so far we have been able to pay for the functions Medicare does not cover. I know there are many other families who do not have the resources."

For Thomas, learning firsthand the importance of H.R. 942/S-948 was eye-opening. "I never really understood the problems until we got into the meeting and people started talking about what the law was and how problems got to be what they are right now. Understanding the background and intricacies really gives you the ability to address the problem more rationally."

Rosemary's takeaway was the impact of reality. "When you put a person who uses complex rehab technology in front of a staffer in a congressman's office, that is so much more powerful than just the supplier meeting with them and trying to convince them such legislation is needed."

While in Washington, the Bellaires met with Sens. Dick Durbin and Mark Kirk, as well as Rep. Rodney Davis, who represents the district in which Rosemary grew up.

"The first thing he (Kirk) said when he was introduced to Rob was, 'Boy your chair is a lot cooler than mine.' Kirk had a stroke last year so he uses a manual wheelchair sometimes. We got to chat for a minute and that is just so much more powerful than having a supplier try to convince these people. It puts the face with the issue."

Durbin had already signed on to support the bill, but Kirk was non-committal. Davis has since signed on, Rosemary said. After their meeting, the Bellaires met with a senior staffer in Kirk's office who seemed to understand the need and urgency of passing the bill, Rosemary said. "I think in the long run Sen. Kirk will support the bill."

Stepping up in the advocacy role was not a hard decision to make for Thomas or Rosemary. "We've been at this for more than 20 years and have seen the importance in the advancements," Thomas said.

Rob has easily followed in his parent's footsteps. He has been invited multiple times to speak to students at the Loyola University Medical School where he receives treatment. Rob talks from the patient perspective about what life on wheels looks like. "He'll tell them how infuriating it is when they ignore him as the patient, and they work on 'doctor time,' which means when they tell you they will be right with you and it takes two hours before they see you," said Thomas.

More recently, Rob has become a self-advocate, speaking out to both his parents and his medical team. His message: don't ignore me. I'm the patient.

"Rob was concerned or bothered that no one ever bothered to talk to him. Largely, they would just talk to Rosemary and me," Thomas said. "Rob helped us to realize we were sticking our noses too far into his business, so we have pulled back and let him do a lot of the talking at the medical appointments. He helped us realize this is his life and he wants to handle the conversations."

So, in spite of many obstacles and medical issues, Rob's wonderful personality, good sense of humor and determination continue to shine through, Rosemary said, "Many people have commented about what an inspiration he is."

CONTACT

The Bellaire family may be reached at rosemarybellaire@comcast.net.

LITTLE THINGS THAT MEAN A LOT

INTERVIEW BY: DANETTE BAKER

For Brad Peterson, innovation is more than an industry buzzword. It represents a personal and company commitment to bring innovative products to Motion Concepts' proven line of power positioning systems and seating and positioning products – and ultimately increase independence to the consumer.

DIRECTIONS recently had the opportunity to visit with Peterson, vice president of sales and education for Motion Concepts, about his 11 years with the company and his commitment to the industry:

How did you become interested in the industry?

I guess you could say I got into it right out of college, in a very nontraditional way. In 1991, I had my bachelor's degree in sports medicine from Springfield College and was working at Western Massachusetts State Hospital in Westfield, Mass. At Western Mass I was exposed to an entirely different patient population than the able bodied athletes I had worked with in college.

My goal always was to go back and pursue my master's degree in physical therapy. I had grandiose dreams of being the head athletic trainer and physical therapist for the Boston Celtics! However, after working with the residents in wheelchairs and using my hands to literally build things that created independence for people, I really liked what I was doing. Western Massachusetts Hospital is a Department of Public Health facility, and we had a large population of people with multiple sclerosis, amyotrophic lateral sclerosis, or ALS, and various neurological conditions requiring a lot of custom seating.

From there, my first real employment in the industry was as an independent sales representative. I was a sub-rep in New England and carried lines such as LaBac Kid Kart, Jay Medical and several of the more popular rehab lines before they were purchased by larger companies. It was a great experience for me, and I met many people, many good friends that I still work with today.

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

For about four years, I worked as provider in central Massachusetts for FW Access, a small, family owned provider. Working for FW Access allowed me to continue that one-on-one interaction with consumers that I enjoyed so much at Western Mass, while also enabling me to look at the industry from yet another point of view – that of a provider. I loved building, figuring out difficult solutions and seeing the tangible results of what I did. We were very small so I did all my own set-up, delivery, repair, evaluation etc. [It was] A great, fun time.

Another milestone in my career came when I was working for FW Access and heard about a position with Pride Mobility Products in their rehab division. Frankly, back in 1999, I didn't even know Pride had a rehab division. FW Access didn't do a lot of power chairs and my only experience with Pride was their seat lift chairs and scooters. I interviewed, was hired for the position, and the rest is history. That was a big milestone for me – taking that chance and moving my life from Boston

I loved building, figuring out difficult solutions and seeing the tangible results of what I did.

> We are very proud of our diverse relationships and try very hard, every day, to maintain a balance of independence and dedication to delivering on commitments to our parent company.

to Exeter, Penn. I worked with a lot of great people at Pride, and then Quantum Rehab. Scott Meuser, chairman and CEO of Pride, and Dan Meuser, who was president of sales at the time for Pride, gave me a wonderful opportunity to take my career to the next level, and I took advantage of the opportunity I was given. I was very fortunate to be in the right place at the right time and it was fun to watch Quantum grow.

The next big milestone came when I joined Motion Concepts in 2003. That allowed me to move back to New England and work for what I think is an incredibly innovative, very cutting edge company. In my days at Pride/Quantum I had always been very impressed with Motion Concepts, what they did and how they did it. We really grew together, Quantum and Motion, and when I had a chance to join the Motion team I jumped at it. I like that we are constantly evolving and I appreciate that. Even in challenging times, we continue to evolve and remain innovative.

Who has been instrumental in those accomplishments?

There have been quite a few over the years. I have been very fortunate to be surrounded by great people who were very generous with their knowledge and time.

Going back to the beginning it was Bob Bergquist. He was one of my professors at Springfield College, a mentor and the reason I worked at Western Massachusetts Hospital where he was a consulting physical therapist. He encouraged me to look beyond working with athletes and broadening my horizons. He worked very early on with wheelchair sports and was an incredibly generous and giving man. He passed away last year, and I wish I could have thanked him for helping me get my start.

While I was at Western Mass, I met some wonderful people. They kind of "infected" me with the rehab bug! They are the ones who I saw working, creating and I thought, 'This is pretty cool.' They kind of get to be like a therapist and prescribe equipment and they get to build wheelchairs. Those people were Bob Esser, who at the time worked for a company called Kustom Rehab, a custom seating fabricator. He now works for National Seating & Mobility in Albany, N.Y., and we remain close to this day. Another was John Zona, who still works as a provider in Worcester, Mass., for Lakeview Medical and is a past NRRTS president. Richie Samay, who worked for Burke Medical and now also works for National Seating & Mobility was another provider who taught me a lot. Lastly, the therapist I worked for, her name was Anne Kring. She taught me a ton about seating and positioning and how to respect and advocate for the consumer. They were all very instrumental in me learning.

When I moved on to Pride, Scott Meuser and Dan Meuser were the ones who kind of let me go and explore working for a manufacturer. They gave me the opportunity to work on a national level, travel, teach and meet so many wonderful people.

Of course there are the people I work with now at Motion Concepts: Ann Quigley, sales manager; Joe Bornbaum, president; and David Ciolfe, vice president of operations. They have been phenomenal to work with for the past 11 years. I can't say enough about what they do for our company and our industry and for the opportunities they have also given me.

What are the future challenges for Motion Concepts and the industry as a whole?

Motion Concepts is kind of a unique company within the industry because we are an Invacare-owned company. We are very independent day-to-day and enjoy strong relationships with some of Invacare's competitors. We don't currently manufacture our own mobility base, so we work with Invacare and other partners such as Quantum Rehab, Sunrise Medical and other various power base manufacturers. It has always been a bit more challenging for us as we must deliver products that stand on their own, while also positively complimenting a variety of different power bases and manufacturers. We are very proud of our diverse relationships and try very hard, every day,

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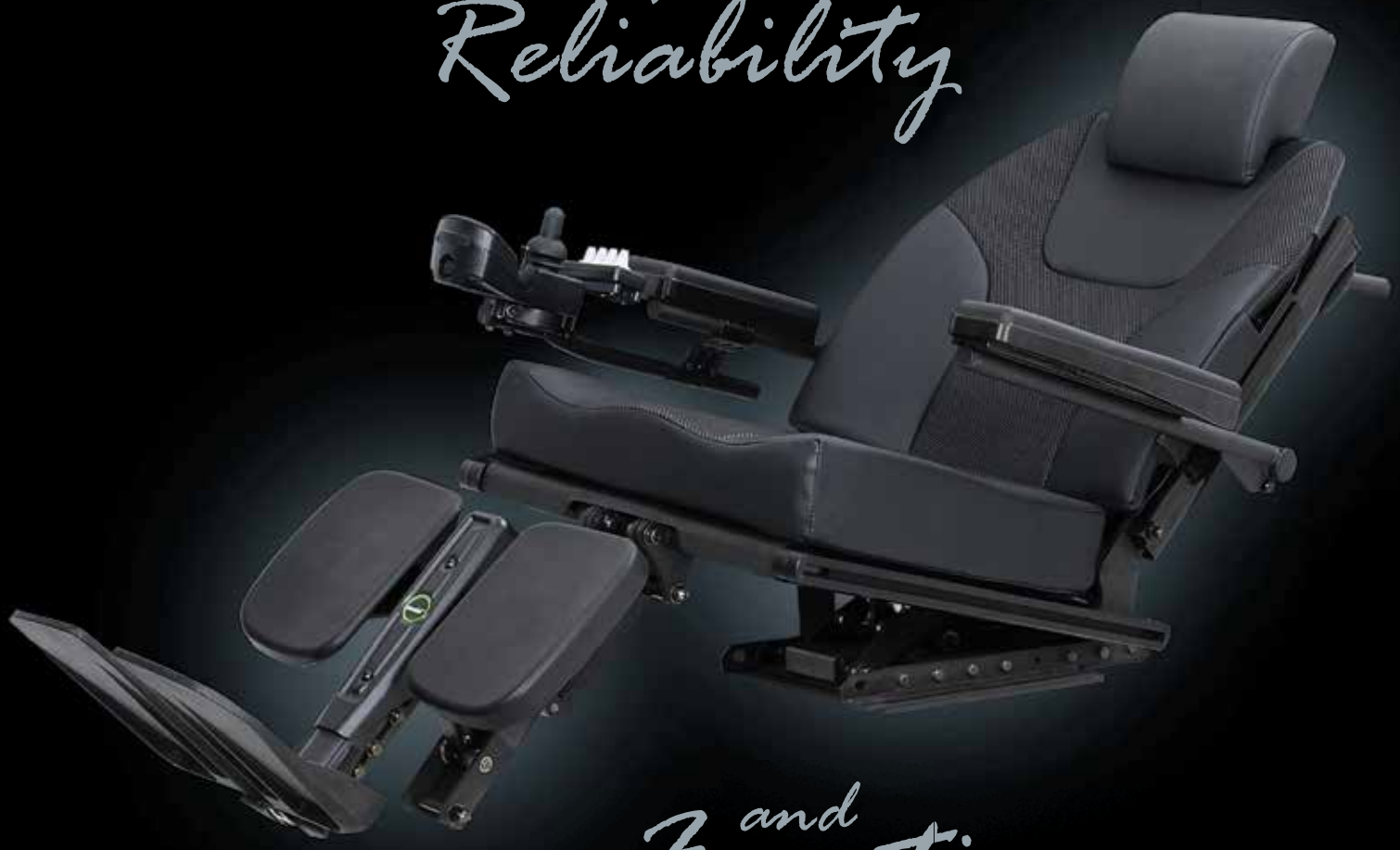

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LITTLE THINGS THAT MEAN ALOT
(CONTINUED FROM PAGE 25)

to maintain a balance of independence and dedication to delivering on commitments to our parent company.

Beyond that we face the same challenges as any manufacturer. Doing more with less, delivering innovative, modular, durable products to a marketplace that has seen funding decline and become more challenging. As funding changes and providers merge, we have continued to do what we do best: produce quality, innovative products that are more cost competitive. We have been successful in reducing costs without, in my mind, sacrificing quality or function. We can't sacrifice. As an industry, we owe it to our consumers to deliver the best possible products, as their needs and expectations have not changed, nor should they.

As funding changes and providers merge, we have continued to do what we do best: produce quality, innovative products that are more cost competitive. We have been successful in reducing costs without, in my mind, sacrificing quality or function.

What's on the horizon for Motion Concepts?

In the 11 years I've been with Motion Concepts, I have never been as excited as I am now. We have more new, innovative products than ever before. We are a solutions company, so we are continuing to design the next generation of power positioning systems such as our all new Ultra Low Maxx, power positioning accessories that compliment the Maxx, and our full line of Invacare Matrx seating and positioning products – from the MX 1 Back, which is our lightweight carbon fiber back to our Matrx PB elite deep backs and cushions – we have the most complete line of seating and positioning in the industry.

(CONTINUED ON PAGE 29)

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LITTLE THINGS THAT MEAN ALOT
(CONTINUED FROM PAGE 27)

I like to say we are a "little things" company. We are always thinking about the little things because it is the little things that make the biggest difference in how the ATP and clinicians provide function and independence to the consumer. So we have a lot of new products on the horizon. We are looking to maintain the function and innovation in our products while also addressing the looks of the systems and, while it is a necessary evil that we have to design with codes and allowables in mind, we're also thinking about ways to maximize function and independence outside traditional codes and allowables.

We also have a new bariatric power positioning system featuring a 40-degree posterior tilt with a 7-degree anterior tilt. This system offers very low seat-to-floor heights as well as incredibly low transfer heights all with a 600-pound weight capacity.

We will continue to innovate and lead in off-the-shelf seating and positioning products such as cushions and backs. The Invacare Matrx line continues to evolve and expand. We are very excited about the Invacare Matrx Libra cushion, which will be out very soon. Those who have seen it feel it is a game changer.

Finally, there is a project we have been working on for a while that will allow us to continue being innovative and deliver a much more integrated power positioning system than we have in the past. Stay tuned; we have a lot going on!

What areas in the industry has Motion Concepts taken a lead in?

There are a lot of companies doing some nice things with power positioning and seating and positioning, but I think

(CONTINUED ON PAGE 30)

LITTLE THINGS THAT MEAN ALOT
(CONTINUED FROM PAGE 29)

we are viewed as leaders and innovators in these lines because we specialize. All we focus on is the interface between the consumer and their power or manual mobility base. We create many unique modules and accessories such as Lateral Tilt, Horizontal Tilt, Low Seat to Floor Height Anterior tilts, Power Swing Away Chin Controls, etc., as well as a full line of seating and positioning products, and they all compliment our more standard systems. Because we specialize, we are able to innovate and develop in these sectors more than others. We manufacture our products with very comprehensive, long-lasting warranties and really stand behind what we sell. We don't want to sacrifice function or clinical outcomes just to provide something that fits neatly within a code. This is becoming more and more difficult, but our culture and stubborn dedication to this belief continues to serve us and our customers well.

What changes would you like to see in the industry?

(Chuckling) This kind of feels like a Miss America question, when asked what they would change if they had two wishes. The answer always is something like, "World peace and end hunger." I'd like to see CMS (Centers for Medicare and Medicaid Services) and the different payers finally recognize how different our industry is and fund us properly, so that consumers can obtain the equipment and independent mobility solutions they need and manufacturers can afford to truly innovate! So we can step way out of the box and use some of the cutting edge technology that is out there today to make a difference. Taking it further, more time for clinicians to spend with their clients in clinic, during evaluations, on delivery and the same for ATPs and service/delivery technicians. Restrictive funding is not just affecting products but the time that these dedicated professionals can spend ensuring what they are prescribing is correct and appropriate. Lastly, I would love to see all the hard work of NCART and so many others fighting on our behalf rewarded with the creation of a separate benefit category for Complex Rehab Technology by passage of H.R. 942 and S-948.

I would love to see consumers with a louder voice, because they are ones who should really be driving what we are doing. We can't do it all by ourselves and, frankly, when we do, it can appear self-serving. We need the consumers to have a louder voice in dictating what it is that we manufacture for them and how it gets prescribed. And I would like to see us kick back a little bit to the rehab I knew, which was not cookie cutter or out of the box, but instead each person got a customized solution based on diagnoses and individual physiological and environmental needs. Custom is not a dirty word and does not necessarily mean fabrication, expensive and restrictive. It just means no two consumers are identical: they live in different places and have different needs and expectations. Once again these things are kind of pie-in-the-sky ideas. There is just so much out there that we could be exploiting, and I just don't think we are … I will step down off my soap box now!

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

Motion Concepts is proud to be a Corporate Friend of NRRTS. At this time I am not serving on any boards or associations.

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

As we all know there is no such thing as a typical work week. I am incredibly fortunate that I have worked from a home office for the last 11 years. It takes dedication and willpower on those really nice days, but I wouldn't trade it for the world.

When I'm not in my home office, I'm traveling. A typical work week finds me, like today, on a plane at 11:30 a.m. to Dallas. Last week I was in Cleveland, the week before I was in Toronto and before that, San Diego. Next month it is Dusseldorf, Germany, so a lot of travel, but at Motion Concepts, we really don't have cut and dry jobs. We all wear a lot of hats. On any given day you might find me teaching a class, working with our marketing team to create literature or advertisements, working with our national accounts, buying groups and independent partners on contracts, training sales reps and providers or just trying to stay on top of the day-to-day. I also work closely with our team in Toronto on product development and design. When I'm on the road one of my main focuses, beyond trying to drive business, is to work with providers, clinicians and consumers and listen to them and hear what they would like to see in our products. We are truly an outside-in company in terms of design. Everything we make came, in some way, from a suggestion from the field. So I take lot of that back to our engineers

and that turns into products that people see, which is probably one of my favorite parts of what I do. It takes me back to my roots.

Every day is different. There is not a cut and dry nice, neat work week. Plus Motion Concepts has expanded our presence globally into Europe, Australia and New Zealand, and so I was on a conference call Friday morning at 7:00 with the people in Europe, so that definitely keeps things fresh and different.

What's life outside of the 9 to 5 like for Brad Peterson?

Well, you are hearing it now (in loving, constructive tone, Brad politely tells his 3-year-old to please be quite for just a few more minutes while he finishes a phone call). When I'm not traveling and not at work, I have a wife and two children, a soon-to-be 3-year-old and 1 and one-half year old, who are definitely my priorities. The kids keep us busy! I also work around the house, and I love to golf – that is probably my favorite leisure time activity. I also ride my bicycle, but not as much as I would like to anymore.

> I would love to see consumers with a louder voice because they are ones who should really be driving what we are doing. We can't do it all by ourselves and, frankly, when we do, it can appear self-serving. We need the consumers to have a louder voice in dictating what it is that we manufacture for them and how it gets prescribed.

What has kept you working in the industry?

Passion. I love this industry; I love the people. We have such a unique, amazing job that we are able to see immediate feedback from our work. We are able to recognize immediate gratification by changing someone's life, by making someone more independent, helping someone medically cope with the day-to-day challenges they face. I love to innovate and really enjoy the manufacturing portion. I look back on those first years when I wanted to go get my master's in physical therapy and, although I would have loved to have been a physical therapist, I'm glad I didn't because it may have taken me away from where I am now. I consider myself extremely fortunate that I am able to, although not as much now in my current role, touch people clinically and be able to understand their needs and to build things and see how they change people's lives. It's an amazing opportunity and responsibility that we all have, and one we should not, must not take lightly.

Many of us got into this because of a necessity. We saw things we wanted to change or things that we thought could be done better. And to a certain extent there are a lot of us that still see things that could be done better, and we love the challenge. I think a lot about the industry is about embracing the challenge and facing the difficulties and working to deliver the best products and solutions that we can.

CONTACT
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NOTES FROM THE FIELD:

Moore draws inspiration from forward-thinking influences

WRITTEN BY: JULIE BARNETT

Luke Moore considers Steve Jobs, Bob Dylan, Patty McCord and Monty Moran some of his greatest professional influences, because they all have something in common.

"Whether it's Dylan at Newport, Jobs at the Macworld Expo, McCord with Netflix's culture deck, or Moran with Chipotle's radically different approach toward owning a restaurant, they saw into the future and produced something new," he said. "These were not just regurgitated versions of what their peers were doing, but something people didn't even yet realize they wanted. I try to emulate that approach in everything I do, and not simply use my competitors' business practices as a reference point."

Currently, Moore works for Provider Plus Inc. in St. Louis, Mo., a full-service home medical equipment (HME) provider that has 10 locations throughout Missouri, Illinois and Kansas. He serves as director of the Complex Wheelchair Department where he oversees the sales, customer service, billing and repair functions of the department. In addition to managing these functions, Moore spends his time working in a clinical setting alongside a physical or occupational therapist, completing home assessments, deliveries and fittings, and of course, ensuring the appropriate paperwork for each step is completed correctly and on time.

"They provided me with the education and opportunity to sit for the ATP exam."

"We are fortunate to be in-network with almost every major private insurance company, and we won the Medicare competitive bidding in every category we wanted," he said.

Moore began his career when he was just 18 years old when he was hired by a pharmacy that had started providing HME products.

"At the time, it was just me and two other people in the brand-new department," he said. "Each of us filled several roles – especially early on. I just kind of volunteered to take on the power mobility products in addition to all the other roles I was filling."

He said in the early days, that really meant one or two consumer power mobility product sales per month, but that portion of the business really began to grow.

He then went to work at a company that specialized in complex rehab technology products where he started out as a repair technician. "They provided me with the education and opportunity to sit for the ATP exam," he said. "I'm incredibly grateful to them for giving me that opportunity."

After working in more of a sales role for a time, he was offered the position to lead the Complex Mobility Department he is in now. "When I started with Provider Plus Inc., their complex mobility department was really an afterthought for most referral sources," Moore said. "Over the last five years, due to the high skill level and hard work of my team, Provider Plus Inc. has become a leader in the industry in the St. Louis region."

He says he depends heavily on staff member Dean Wolaver. "He is my right arm, and he is the best co-worker I've ever had. The quality of his work, the quantity of the work he produces, his attention to detail and his ability to clearly and succinctly communicate with both customers and referral sources makes him invaluable to me," Moore said. "The

(CONTINUED ON PAGE 35)

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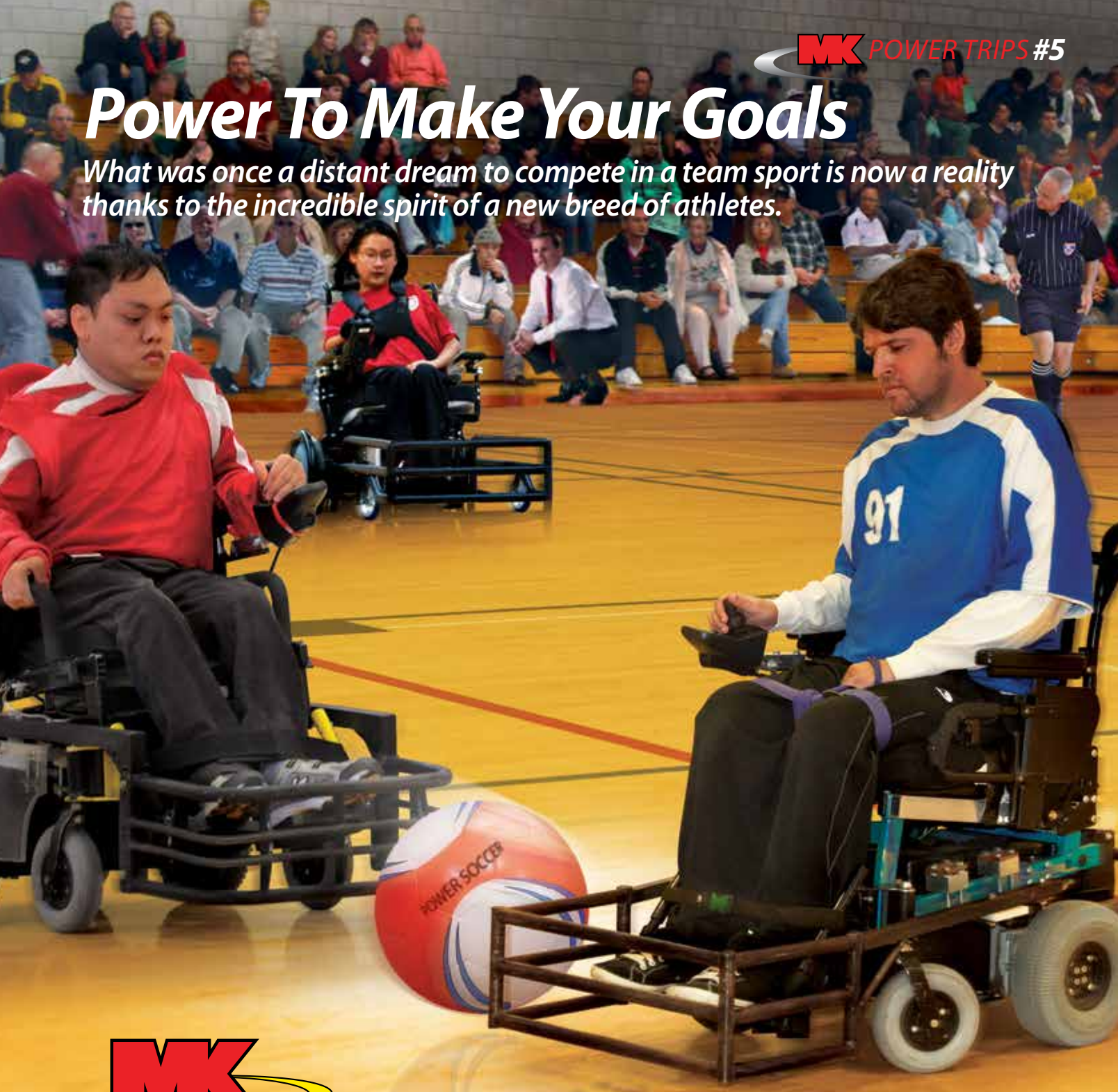

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To protect the interests of your customers and your business, we invite you to invest in the future of CRT by joining the National Coalition for Assistive and Rehab Technology. NCART works with policy makers, legislators and others to establish and 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!

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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.

NOTES ON THE FIELD
(CONTINUED FROM PAGE 32)

success that the Provider Plus, Inc. Complex Mobility Department has realized is because of people like him."

He described some of the practices he's implemented that sets his team apart.

"First, we require that a physical or occupational therapist evaluation be completed for every power mobility device we provide through Medicare. It doesn't matter if it's a van-style power wheelchair or a basic power scooter – I insist on it," he said. "We inform customers that this is necessary if they want us to provide their equipment. The customer is better served, because they receive a much more comprehensive evaluation than what is completed by a physician alone.

"Second, I implemented gathering delivery pictures," he continued. "Whenever I work with a physical or occupational therapist for an equipment evaluation, every effort is made to take two pictures of the customer in the equipment at the delivery. Those are then emailed to the therapist who completed the equipment evaluation."

This accomplishes three things: the therapist knows when the customer received their equipment – they know the order didn't get dropped, and that it was followed through to completion in a timely fashion; the therapist can see from the pictures that the recommended equipment wasn't substituted out for something cheaper; and the therapist can get a sense of how the delivered equipment fits the customer.

"Third, we complete a home assessment before we request funding for every powered mobility device we provide. At the home assessment, we always bring a sample piece of equipment for the customer to trial in their home," he said. "This ensures we and the customer are on the same page in regard to what exact piece of equipment we are requesting funding for. They get a realistic expectation of what the equipment looks like, how it fits them, how it maneuvers throughout their home, and what it can and can't do. This eliminates the situation of showing up to deliver a piece of equipment that already has funding secured for it, just to find out that the customer has unrealistic expectations."

Some of those unrealistic expectations Moore mentions include:

- The customer wanted a scooter and not a power wheelchair.
- The customer thought that they would be able to fold up the power wheelchair, and that it would only weigh 10 pounds.
- The customer thought his 85-year-old wife would have the physical capability to frequently disassemble and reassemble his new power scooter.
- The powered mobility device would be able to run at 20 miles per hour.

"Finally, whenever I or one of the other RTSs in my department completes an evaluation/home assessment for a complex piece of equipment, that same person must do the delivery and fitting," Moore said. "We don't have a repair technician/delivery technician deliver the equipment – it must be the RTS. I believe it's somewhere between unethical and just downright lazy for someone other than the evaluating RTS to deliver and fit a complex wheeled mobility orthotic. There is better continuity of service with the customer since they're dealing with the same person."

Moore believes the industry's biggest challenge is also its biggest opportunity. "We need to change the perception that we're just glorified golf cart salesmen," he said. "We need to build the reputation that we are clinically and technically trained specialists who configure and fit highly customized orthotics."

CONTACT

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CMS FINALLY PROVIDES MEDICAL NECESSITY DOCUMENTATION GUIDANCE FOR WHEELCHAIR REPAIRS

WRITTEN BY: JOSHUA I. SKORA, ESQ.

Since The Scooter Store went out of business, Medicare beneficiaries who obtained title to their wheelchairs have had difficulty finding durable medical equipment prosthetics, orthotics and supplies (DMEPOS) suppliers willing to make repairs. Suppliers have been hesitant to make repairs, because they are concerned they will not get paid, or worse, will be audited for improper or missing medical necessity documentation. It has been unclear if Centers for Medicare and Medicaid Services (CMS) required the suppliers making repairs to have in their files the original medical necessity documentation for the equipment. Due to these difficulties, and many complaints from beneficiaries and suppliers, CMS finally provided guidance to the durable medical equipment administrative contractors (DME MAC) explaining what documentation is required when conducting medical review of DMEPOS repair claims.

On Aug. 1, 2014, CMS issued Change Request 8843, Transmittal 533 (Pub. 100-08), which adds a section to the Medicare Program Integrity Manual (PIM) addressing supplier documentation for DMEPOS repair claims. The effective date for the new PIM provision is Nov. 1, 2014. The stated purpose of the transmittal is to "provide guidance to the Medicare Administrative Durable Medical Equipment Contractors when conducting medical review of DMEPOS repair claims." The new section of the PIM will read as follows:

This process may take some time, but now there is some assurance that suppliers will get paid for their work.

5.8.1 Suppliers Documentation for DMEPOS Repair Claims

(Rev. 533, Issued: 08-01-14, Effective: 11-04-14, Implementation: 11-04-14)

When reviewing DMEPOS claims for repairs, contractors shall only review for continued medical necessity of the item and necessity of the repair. Contractors shall not expend resources to determine if the requirements for the initial provision of the DMEPOS item as/when it was originally ordered were met. For example, even though a face-to-face encounter is required for the initial provision of certain wheelchairs, it is not needed for the repair of a wheelchair already covered and paid for my Medicare. However, documentation from the physician or treating practitioner that indicates the wheelchair being repaired continues to be medically necessary is required. For this purpose, documentation is considered timely when it is on record in the preceding 12 months, unless otherwise specified in relevant Medicare policy.

In addition, the DME MAC shall ensure that the supplier's record includes the nature of the repair required and work performed to restore the item to its functionality to meet the Medicare beneficiary's medical need.

These instructions do not replace or alter other longstanding instructions related to coverage and payment for reasonable and necessary repairs and maintenance and servicing of DMEPOS items. Contractors shall continue to adhere to these program policies and procedures. Examples include, but are not limited to, Chapter 15, section 110.2 of the Benefit Policy

Manual and Chapter 20, sections 10.2 and 40 of the Claims Processing Manual. Contractors are also reminded that parts and labor covered under a manufacturer or supplier warranty are not to be considered reasonable and necessary under regulation; therefore, contractors shall determine for each claim whether billed parts and labor are covered under a warranty. For reasonable and necessary parts, payment is made on a lump sum basis based on the contractor's individual consideration of a reasonable payment amount for the part. For reasonable and necessary labor, payment is based on a reasonable fee established by the contractor for labor associated with repairing the item.

This new PIM provision clearly allows suppliers to repair broken wheelchairs without obtaining the original medical necessity documentation. If Medicare paid for the wheelchair, the DME MAC will not question its original medical necessity. However, suppliers must obtain proof of continued medical necessity as of the time of repair. The DME MACs will accept medical necessity documentation from up to 12 months prior to the date of repair. If there is no medical necessity documentation from the physician or practitioner within the past 12 months, the beneficiary or the supplier will have to obtain the documentation to ensure the supplier is authorized to make repairs. This process may take some time, but now there is some assurance that suppliers will get paid for their work.

Now that the durable medical equipment (DME) universe is split between competitive bid contract winners and non-winners, it is all the more important for non-winners to seek out creative business opportunities. Wheelchair/DME repair is a unique opportunity because Medicare allows for the repair of beneficiary-owned items by any Medicare-enrolled supplier. Labor required to repair equipment is not subject to competitive bidding and will be paid according to Medicare's general payment rules. If the guidelines are properly followed, suppliers may provide loaner equipment while repairs are being made and bill Medicare for a one-month rental if reasonable and necessary. This can be a potentially lucrative business model for any DME supplier, especially starting Nov. 1, 2014 when the new PIM provision goes into effect.

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CONGRESS RETURNS FROM AUGUST RECESS

WRITTEN BY: DON CLAYBACK

Congress came back to Washington on Sept. 8 from their August recess and it was evident that complex rehab technology (CRT) stakeholders took the opportunity during that time to connect with their members.

Thanks to the persistent outreach by CRT supporters during August the "Ensuring Access to Quality Complex Rehabilitation Technology Act" (H.R. 942/S-948) gained 12 new co-sponsors. That consisted of 11 co-sponsors in the House and 1 in the Senate. This was a great jump in a 30-day period.

That brings us to 159 Representatives signed on to H.R. 942 and 21 Senators signed on to S-948. The additions maintain solid bipartisan support and include members of the key congressional committees that have jurisdiction over the Medicare program. It shows that the ongoing communication between CRT stakeholders and their members of Congress is paying off.

Attendees from last year gave the conference very high marks.

Thanks to everyone who made the CRT legislation part of their end of summer activities. Your emails, calls and visits do produce results. Keep up the good work. You can view the current list of co-sponsors by state at www.access2crt.org.

As we head into the fall, it will be a busy time for Congress. Elections are coming up, and members will be using their limited time in Washington to determine what legislation they will consider before year end. We need to continue to work to elevate the CRT bill and push our Congressional supporters to make it a priority for passage as part of whatever larger Medicare legislation that is brought up for a vote in the future.

Remember to use the resources at www.access2crt.org to help in your advocacy efforts. Thanks to all for continuing to share the CRT message with your members of Congress.

National CRT Awareness Week

The second annual National CRT Awareness Week was held the week of Aug. 18 and proved to be a big success in spreading the CRT message. There were a variety of advocacy activities during that week and at other times throughout the month. These included:

- The Consortium for Citizens with Disabilities, a coalition of more than 100 national disability groups, sent a letter directly to the four Congressional sponsors of our CRT legislation thanking them for their leadership and underscoring the need for passage of the bill.

- Several providers hosted their representatives at their businesses for a discussion and tour. The members got to see firsthand what CRT is all about and hear about our legislation and the current problems compromising CRT access.

- Users First initiated a "CRT Thunderclap" campaign focused on getting their members to email Congress about our CRT legislation to generate more awareness and support.

- United Spinal Association sent out a request to its state chapter leads and members asking them to contact their members of Congress and get them to sign on to the CRT bills.

• I was given the opportunity to speak on the VoiceAmerica internet radio show "Disability Matters with Joyce Bender." This allowed me to provide an overview of our Congressional legislation and discuss our National CRT Awareness Week initiative. As a follow up, we have been scheduled to be a featured guest on a November show that will be focused on CRT, the access issues that exist, and the changes that are needed.

CMS Proposed Rule on Competitive Bidding Pricing and Alternative DME Payment Methods

CMS issued Proposed Rule CMS 1614-P for public comment on July 2. Included in this Proposed Rule were a variety of potential significant changes impacting access and payment relating to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) benefit.

The DMEPOS aspects were in two areas: (a) proposed methodologies to implement the use of information from the DMEPOS Competitive Bidding Program (CBP) to adjust the fee schedule amounts for durable medical equipment (DME) in areas where CBPs are not implemented; and (b) a proposed limited phase-in of bundled monthly payment amounts for the equipment, supplies, accessories and any necessary maintenance and repairs for certain DME, including standard manual wheelchairs and standard power wheelchairs, furnished under the CBP in place of capped rental policies.

On Sept. 2, NCART submitted 15 pages of detailed comments and recommendations to CMS in response to the items contained in the Proposed Rule. You can view a copy of the letter at www.ncart.us. We will be meeting with CMS to review our comments in advance of the issuance of a Final Rule. The final changes could impact DME access and payment starting as early as Jan. 1, 2016.

Expansion of Medicare PMD Prior Auth Demonstration

As reported, effective Oct. 1, CMS will be the expanding the Medicare Prior Authorization (PA) for Power Mobility Devices (PMDs) Demonstration to 12 additional states. The states to be added are Arizona, Georgia, Indiana, Kentucky, Louisiana, Maryland, Missouri, New Jersey, Ohio, Pennsylvania, Tennessee, and Washington.

This is an expansion from the initial seven states that are currently under a PA PMD Demonstration that began Sept. 1, 2012, and concludes Aug. 31, 2015. CMS indicates that the 19 states that will be under the PA PMD Demonstration accounted for 71 percent of Medicare's payments for PMDs in 2012.

The PMD codes included in the Demonstration are: Group 1 Power Operated Vehicles (K0800 through K0802 and K0812); all standard power wheelchairs (K0813 through K0829); all Group 2 complex rehabilitative power wheelchairs (K0835 through K0843); Group 3 complex rehabilitative power wheelchairs without power options (K0848 through K0855); Pediatric power wheelchairs (K0890 and K0891); and Miscellaneous power wheelchairs (K0898).

The policies and processes to be used in the additional 12 states will be the same as those currently being used in the initial seven states. For further details visit http://go.cms.gov/pademo.

2015 National CRT Conference

Save the dates! NCART and NRRTS will be holding the third annual National CRT Leadership and Advocacy Conference March 10 through March 12, 2015, at the Hyatt Regency Crystal City in Arlington, Va.

The three-day program will follow last year's successful format: Leadership Day-CRT focused presentations for the management teams of providers and manufacturers; Advocacy Day-Funding and advocacy sessions for all CRT stakeholders; and Capitol Hill Day-Consumers, clinicians, providers, and manufacturers will collectively take the CRT message directly to members of Congress through in-person meetings.

Attendees from last year gave the conference very high marks. More details will be shared as we move ahead, but in the meantime block those dates on your calendar.

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USE OF KINESIO TAPING® AS AN ADJUNCT TO POSITIONING

WRITTEN BY: KATHERINE CLARK, MOT, OTR/L AND ERIN POPE, PT, MPT

Introduction

For patients with complex neuromuscular conditions, providing stability has been the hallmark for seating and positioning. Dynamic positioning components offer many benefits including increased comfort and tolerance to seating, improved sensory processing and attention, and increased opportunity to engage in task specific learning[1]. Kinesio Taping® is a method of functional taping that has long been used in the orthopedic and athletic training fields[2]. It may also be used for the complex neurologic patient to promote desired alignment for 24-hour positioning, inhibit destructive postures, and incorporate the benefits of dynamic supports into seating and positioning.

What is Kinesio Taping®?

Kinesio Taping ® is a method of functional taping that has a wide variety of applications, including those designed to assist the body to hold a joint or position, increase proprioception and body awareness, and/or position a part of the body in better alignment. Kinesio® Tape is an elastic tape which has a similar thickness and weight to skin. Figure 1 demonstrates the flexibility of Kinesio® Tape as it is applied to a client's abdomen. It is designed to be breathable and waterproof, and can be worn for at least three to five days per application. The elasticity of the tape and ability to allow normal range of motion is a significant contrast to other widely known taping methods, and can greatly impact a patient's tolerance for wear.

It is designed for use by professionals in advanced medical settings, such as physical therapists, occupational therapists, athletic trainers and nurses.

The properties of Kinesio® Tape have effects on five major physiological systems including skin, fascia, circulatory/lymphatic systems, muscles and joints.

Once applied, the tape lifts the top layer of the skin, taking pressure off of deeper layers and structures. This, in turn, can lead to increased blood flow, increased lymphatic drainage, decreased edema and pain, and increased kinesthetic awareness[2]. It has been proposed that the cutaneous stimulation of taping may increase motor unit firing[7,11] and the improved circulation is thought to lead to improved muscle performance[2].

Patient Populations

Kinesio Taping® has long been used in the orthopedic and athletic training fields to augment traditional treatment but can be used with a myriad of diagnoses. The technique has seen a recent jump in popularity, particularly among professional athletes. It is designed for use by professionals in advanced medical settings, such as physical therapists, occupational therapists, athletic trainers and nurses. It is often used in combination with traditional therapeutic interventions and a wide variety of techniques and applications can be learned through professional course work. Techniques can be used to address muscle imbalance/postural insufficiency, circulatory and lymphatic conditions, ligament/tendon/joint injuries, fascial adhesions and scars[4,5].

Current literature on Kinesio Taping® outcomes is limited. Outcomes cannot be fully supported by evidence and the information that is provided is often inconsistent. Proposed benefits include increased muscle activation, but results have been inconclusive in healthy adults[6,7]. Research has shown an improvement in range of motion in healthy adults and those with pain, but further studies are needed[8]. Pilot studies in children with cerebral palsy have shown initial promise in dynamic activities and postural control[9], as well as improved sitting posture when taping was combined with physical therapy intervention[10]. The changes in postural control noted in these pilot studies are consistent with our experience when using

this intervention with children and adults with cerebral palsy or other neuromuscular diagnoses.

The Need for Dynamic Movement

Adaptive equipment that offers a stable base is critical for complex patients with neuromuscular conditions to actively participate in daily tasks. Currently, static supports are often used and needed to provide trunk stability, but this can negatively impact movement and active participation. Decreased opportunities for movement often inhibit skills such as weight shifting and reaching, which are crucial for development of postural control. Dynamic positioning components provide many benefits including increased comfort and tolerance to seating, increased chance for movement, improved sensory processing and attention, and increased opportunity to engage in task specific learning. This presents options for repeated practice of a task with controlled movement, thus gaining experience with active control of movement within the task. When this is incorporated into adaptive seating, the use of head or chest supports or more restrictive positioning components may decrease.[1]

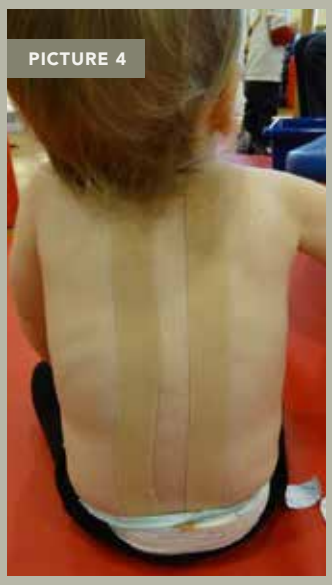
As an example, meet our friend "A," shown in picture 2. He is a 6-year-old boy with cerebral palsy and complicating diagnoses of continuous athetoid movement, dystonia, hearing loss, epilepsy, and cortical visual impairment. He was presented to our clinic in need of a new standing device. He was previously using a supine standing frame, but this was not well-tolerated due to issues with the static head support. The head support on his stander caused his cochlear implant to fall off and limited his

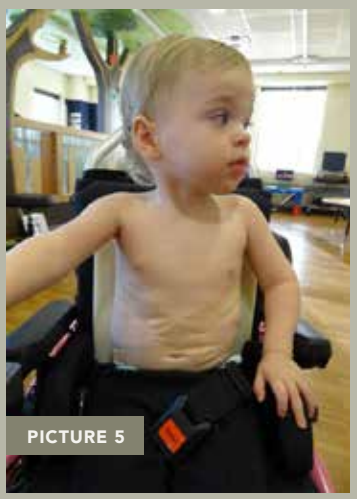
(CONTINUED ON PAGE 42)


PICTURE 1


PICTURE 2


PICTURE 3


PICTURE 4


PICTURE 5

PICTURE 1. *Note the longitudinal stretch of Kinesio® Tape as it is applied to this child.*

PICTURE 2. *Kinesio Taping® to facilitate muscular contraction of the rhomboids and paraspinals to assist with head and trunk control in a prone stander.*

PICTURE 3. *2-year-old child with spinal muscular atrophy during assessment for Kinesio® Taping.*

PICTURE 4. *Kinesio Taping® to facilitate muscular contraction of the paraspinals to assist with spinal alignment in sitting.*

PICTURE 5. *Kinesio Taping® applications provided the trunk stability necessary for this child to reach and access all joystick controls.*

USE OF KINESIO TAPING ®...
(CONTINUED FROM PAGE 41)

ability to develop head control and visual skills. Kinesio Taping® was trialed to assist with head and trunk control while using a prone stander and was found to be a successful intervention for this patient. With a home program for taping in place, his family chose to pursue a prone stander to increase strength and functional vision during standing.

Indications for Use as a Positioning Support

While typically considered a therapeutic intervention, examples such as the above have pushed us to think of Kinesio Taping® as a part of the positioning system. The unique properties of Kinesio® Tape, including its elasticity, long wear time, and breathability, make it particularly effective when used as a dynamic support. In our experience, it has proven very useful as a dynamic support to gain functional skills for a new system. It is also ideal during periods of growth or changes in functional status when existing equipment is no longer adequately supporting the patient. In these instances, Kinesio Taping® can be an effective strategy to improve function and positioning or increase comfort within a positioning system.

Assessment as a Dynamic Positioning Component

Evaluation for Kinesio Taping® should be performed by a medical professional trained in its applications, indications and contra-indications. Kinesio Taping® should not be performed on clients with allergies to adhesive or tape, compromised skin integrity, active infection or a history of blood clots. A thorough mat assessment should be completed, including examination of muscle tone, range of motion, strength and postural control. It is essential to have a strong grasp on the client's primary impairments and resulting functional limitations to determine the most appropriate taping applications. During the assessment, pay close attention to the level of support the patient requires to maintain the desired alignment and stability. This will guide the clinician to impairments to target and to determine if a corrective or facilitation technique is more appropriate.

> Kinesio Taping® may be an effective strategy to have in your clinical tool box to assist with positioning, particularly in times when dynamic supports are indicated.

Other factors to consider include amount of body hair, patient/family compliance and tolerance to taping due to wear time and sensory thresholds. Patients with impaired sensory processing may have difficulty tolerating taping for extended periods. As Kinesio® Tape is designed to be worn for days at a time, it may need to be removed and reapplied by the patient or family, particularly when used with positioning equipment. Compliance with wear times and applications are crucial if Kinesio Taping® is to be a safe and effective support. While there is not a specific prescribed dosage for Kinesio® Taping as a postural support, we have noted that wear time of approximately three to five days with consistent reapplications as indicated can help promote or maintain desired postures. Applications may need to be repeated or modified over time as clinical presentations change.

To illustrate this process, we will discuss "B," a 2 year old with spinal muscular atrophy type II. She was participating in trials for power mobility and struggling with stability during reaching. Lateral supports and a chest harness had been trialed, but were found to be too limiting for reaching all joystick controls. Picture 3 shows her presenting posture: forward head, trunk rounded and leaning to the left, propping on bilateral forearms. During the mat assessment, she was noted to have decreased balance reactions due to poor activation of her trunk musculature. "B" was able to achieve midline posture with light manual cueing, so applications to target muscle facilitation of the paraspinals and abdominals were chosen (see pictures 4 and 5). Picture 5 shows her posture after both Kinesio Taping® applications. With taping in place, she was able to participate in power mobility trials

and independently access all controls. "B" did so well with Kinesio Taping® that she used this as a support in her manual wheelchair to improve propulsion until funding was available to pursue a power wheelchair.

Summary

Kinesio Taping® techniques can be applied for a wide variety of patients and many therapeutic purposes. Clinicians must rely on all available resources for positioning equipment and supports, especially with the constraints of funding. Kinesio Taping® may be an effective strategy to have in your clinical tool box to assist with positioning, particularly in times when dynamic supports are indicated. It may be a useful strategy during periods of growth, following a change in physical status, or during the lengthy process of evaluation and funding of new equipment. It can also be particularly helpful to increase comfort within a system, and when addressing a dynamic, functional skill within the positioning system. Kinesio Taping® is likely not a long-term solution for positioning needs but can be effective short term, for intensive intervals to decrease destructive postures, or during trial periods to allow the clinician time to fully assess postural supports.

For more information or to pursue certification in Kinesio Taping®, please contact the Kinesio Taping® International Association.

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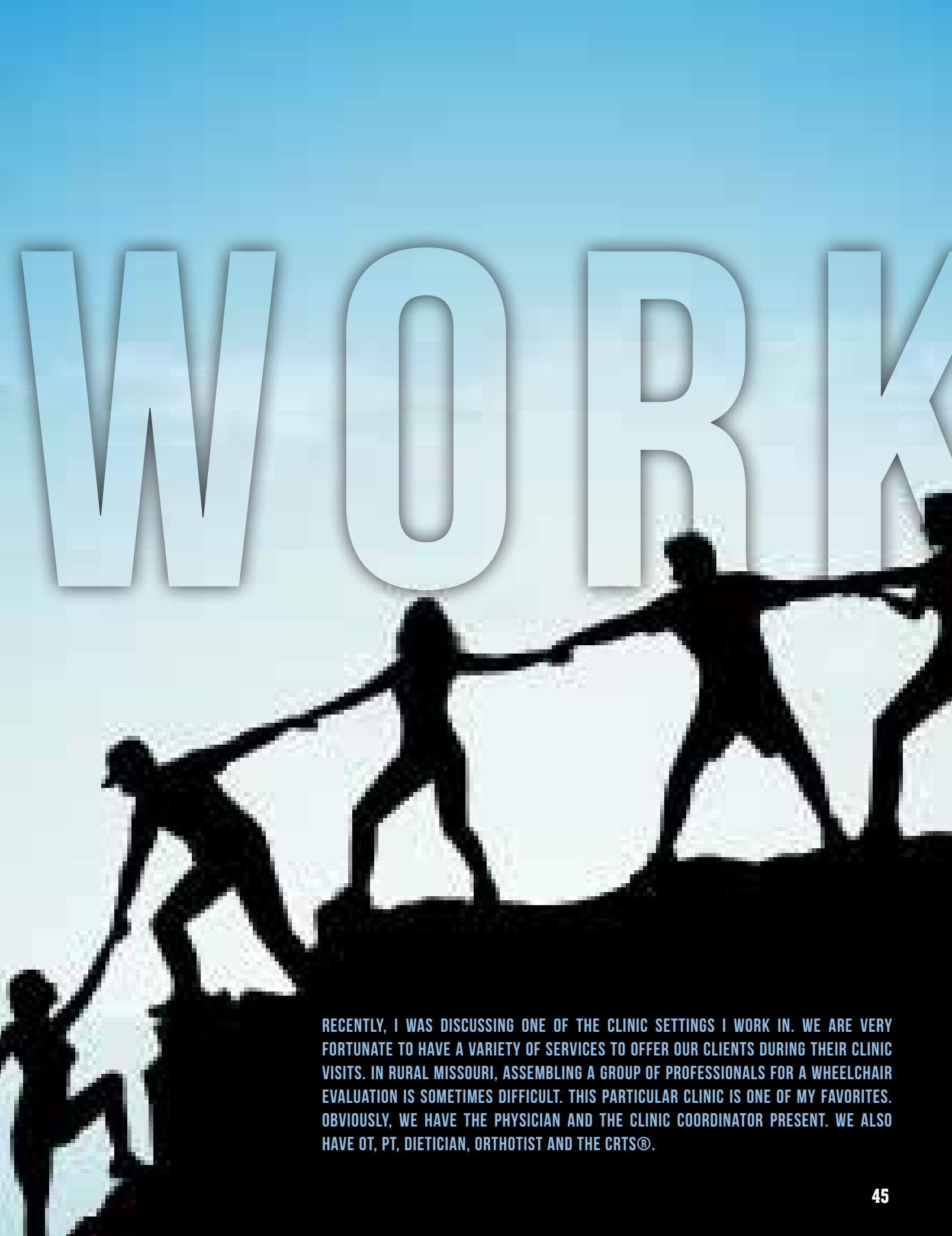
TEAM

WRITTEN BY MIKE OSBORN, ATP, CRTS®

"THE STRENGTH OF THE TEAM IS EACH INDIVIDUAL MEMBER. THE STRENGTH OF EACH MEMBER IS THE TEAM." -PHIL JACKSON

WORK



RECENTLY, I WAS DISCUSSING ONE OF THE CLINIC SETTINGS I WORK IN. WE ARE VERY FORTUNATE TO HAVE A VARIETY OF SERVICES TO OFFER OUR CLIENTS DURING THEIR CLINIC VISITS. IN RURAL MISSOURI, ASSEMBLING A GROUP OF PROFESSIONALS FOR A WHEELCHAIR EVALUATION IS SOMETIMES DIFFICULT. THIS PARTICULAR CLINIC IS ONE OF MY FAVORITES. OBVIOUSLY, WE HAVE THE PHYSICIAN AND THE CLINIC COORDINATOR PRESENT. WE ALSO HAVE OT, PT, DIETICIAN, ORTHOTIST AND THE CRTS®.

TEAMWORK...
(CONTINUED FROM PAGE 45)

I have learned that as professionals who participate in the clinic, we are much more effective when we are able to work together as a team. The quality of the outcomes, as we all know, is increased when we can assemble a full team for the assessment. When any part of the team is missing or unavailable, the demand falls on another member of the team. The process is changed, and responsibilities are greater. Trying to gather the necessary information becomes more difficult. We have all at one time or another experienced the difficulty of not having a full team involved. The gathering of information or scheduling of a second visit is sometimes a must in order to get everything you need to achieve a quality outcome for the end user and their family.

"ALONE WE CAN DO SO LITTLE, TOGETHER WE CAN DO SO MUCH."
-HELEN KELLER

I find the same thing is true in our office. The process from beginning to end takes more individuals being involved than just the CRTS®. The intake and scheduling must take place. The initial visit with the end user during the wheelchair evaluation occurs. In most cases the equipment requested has to be prior-approved and precertified, so there is another individual or department involved in the process. Once we have approval, the equipment is ordered and put together. Now the CRTS® can deliver and properly fit the complex rehab technology equipment.

The billing must be done, and the accounts receivable works overtime in today's industry to collect the correct allowable for the equipment provided. Let's not forget one of the most important members of the "TEAM," the service department. Many times these are the individuals who can make or break a company. I think many times it is forgotten how many members of a team are involved for one piece of equipment. If any one of the team members doesn't perform, we lose the quality of our outcome. I have a good friend who refers to his sales manager as an offensive coordinator, and his service manager as a defensive coordinator. Being a sports fan, I love that analogy, and it brings me back to the team approach.

It's easy to see how important a team is when you look at our daily tasks as CRTS® or even the operation within our companies. What about our industry? I have seen firsthand over the past several years what NRRTS has been able to achieve with a working board of directors functioning as a team. The last several years, the CRT conference has gone from a small event to what I considered last year as my best trip for education, networking and an incredible Hill visit supporting the Separate Benefit Category for Complex Rehab. Talk about teamwork! The CRT conference requires a number of individuals from different parts of the country to work together in order to pull off such an amazing event. The NRRTS staff starts early and works diligently making plans and preparations for the conference. The NCART staff also works tirelessly scheduling visits, so we are able to make the trip to the Hill the most effective it can be. The two – NRRTS and NCART – with many more sponsors put many hours and dollars into the conference. And I say again, if any one of the team members fails or falls short of achieving their tasks, the quality we see as attendees can not happen.

So, I suppose what I am building up to is that we as NRRTS Registrants and as an industry are a "TEAM!" We are gaining momentum and getting close with our push for H.R. 942 and S-948. We need to stand together and become a team now more than ever. We have come a long way from meetings in the hall ways of Capitol Hill. Start making plans now for visits with your representatives and senators and if you already have a good relationship keep in touch with them. NRRTS and NCART have information on their websites you can share with them regarding both bills. Plan to attend the CRT Conference in 2015. The dates are already in place, March 10-12.

In every article I talk about NRRTS Registrants as uncommon. It's because it's easy to focus on what works for "me," but it takes a lot more dedication and character to focus on what's best for the "TEAM."

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"TEAMWORK IS THE SECRET THAT MAKE COMMON PEOPLE ACHIEVE UNCOMMON RESULT."

-IFEANYI ENOCH ONUOHA

SERVICE HISTORY

WHAT YOU DON'T KNOW COULD HURT YOU

by Dick Fuller

Having worked with defense attorneys on injury cases involving complex rehab technology (CRT) mobility products, I can tell you that one of the first areas scrutinized is the service history of the device. Opposing attorneys will look closely for any possibility of error or omission involved with repairs, adjustments and maintenance of the product.

With most CRT (and home medical equipment, for that matter) providers, service history is usually limited to only those repairs that were actually billed. Completely invisible are the many minor repairs and adjustments our technicians routinely perform.

In the event of an injury lawsuit, these non-billed and unrecorded repairs done by the technicians need to be included in a detailed service history of the product so that your legal defense team can demonstrate your company's diligence and commitment to taking care of your customer. You should expect that the plaintiff's attorneys will dig for anything that could be used, valid or not, to portray your business as having a disregard for customer safety and equipment maintenance.

I have seen with many providers that non-billed repairs are usually not included in the service history of the product, or they are difficult to retrieve. Service history based primarily on just those repairs that were submitted for reimbursement hugely understates the support you in fact provide by as much as 50 percent. This gap could be used to inaccurately construe your company as a shoddy business that skimps and even avoids supporting the service needs of your customer.

SO WHAT SHOULD THE PROVIDER DO?

Your billers already categorize your repair work by funding source: Medicare, Medicaid, private insurance, etc. So it would seem simple enough to add another category to document and record the non-billed or no-charge repair work for each product by serial number.

BUT, SOME COMPLICATIONS EMERGE.

Here's what often happens: Your billing staff receives the completed service order with the technician's notes, and the biller prepares the claim and generally won't attempt reimbursement from a funding source known not to cover that procedure. If you store the original service orders, you have a fighting chance to piece together the service history, but from my experience, retrieval of the key information you need is haphazard and often inadequate. And when offered up in court as evidence of

your repair work, the patched together approach does not make a good impression.

Compounding the problem is that technicians rarely write down everything they did. The completed service order frequently covers only the parts replaced, and is blank on relevant work such as rerouting cables, checking connections, tightening fasteners, adjusting wheel locks, instructing customers on how to safely use the equipment, etc. Technicians do much more than merely swap parts.

So the first step (with my acknowledgment that it isn't easy) is to insist and make sure your technicians write down all of the work they did. "Replace parts as listed" won't do.

The second step is make sure the technicians don't self-edit what they write on the service order. They may have heard that troubleshooting won't get paid (although private insurance sometimes will), so they see no point in noting that kind of work on the service order. Service history that is incomplete loses much of its value.

The third step is to capture the complete information (including non-billed work) and organize it so it can be retrieved easily and should the need present itself, be presented favorably.

That brings up the sensitive issue of non-billed labor that some funding sources routinely deny paying. OK, we know that Center for Medicare and Medicaid Services (CMS) won't cover certain repairs (like troubleshooting) that we have to do, but I strongly encourage you to not to let this become such a distraction that you ignore the existence of other categories of non-billed labor that should be tracked.

The successful service department accepts that there are certain situations where you really can't, or perhaps shouldn't, charge for repair labor.

The critical point here: It is impossible to have a complete service history without accounting for the no-charge work.

In the auto repair business, they have identified some key categories of unbilled labor, and while in a perfect world these costs wouldn't exist, they are accepted in the car trade as being an expected cost of doing business. And as with other costs, they need to be tracked and managed.

If we take what has proven successful in the auto business, tweak it a bit for CRT and it could look like:

CATEGORIES, NON-BILLED REPAIR LABOR:

- Funding source will not cover
- Warranty labor performed in behalf of manufacturer at no charge
- Internal warranty: no-charge rework for repairs that we did, our fault
- Internal warranty: no-charge rework for repairs that we did, not our fault
- Customer accommodation ("goodwill")
- Drive time

With the exception of the first category (funding source refusal to reimburse), the other categories are modeled after those identified and commonly used by the auto repair industry and recognized as legitimate costs of doing repair business.

Without tracking and identifying the types of no-charge repairs being done, you have little chance of coming up with the kind of complete service history you may wish you had when hit with a lawsuit.

OTHER VALUABLE BENEFITS OF TRACKING NO-CHARGE REPAIRS THAT MAY NOT BE IMMEDIATELY APPARENT:

- Have a more complete picture of the work your technicians are doing;
- Manage and control these costs that if left in obscurity, could escalate and remain difficult to detect;
- Collectively as an industry, begin the data accumulation process to be able to quantify the cost and time of providing so many services for free.

As convincingly demonstrated in other industries, tracking your non-billed repairs is well worth the effort.

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KINESIO TAPING®:
A CASE STUDY FOR USE AS PART OF PATIENT POSITIONING INTERVENTIONS

WRITTEN BY: KATHERINE CLARK, MOT, OTR/L AND ERIN POPE, PT, MPT

Introduction

Working with patients with a variety of physical disabilities and complex positioning needs creates a challenge to find that "just right" fit when evaluating for seating and positioning equipment. Many patients require significant supports to maintain biomechanical alignment and limit the progression of postural deformities. Although we want patients to be as active as possible, with each support added the possibility for movement is decreased.[1, 2, 3] How can we support opportunities for movement and strengthening while simultaneously providing supported alignment? How can we help our patients become active participants in their environment instead of passive observers? Most importantly, what can we, as clinicians, do to ensure our equipment recommendations are both functional and comfortable?

These challenges drive us to think critically, and explore new possibilities. With an ever expanding array of positioning equipment available, the options are many. Nevertheless, there are cases where the "just right" fit remains out of reach. After years of navigating this challenging process and struggling to achieve both stability and movement in a positioning system, we began to think outside of the box and explore new positioning supports. Using Kinesio Taping® to promote specific postures and desired movements in our patients was proving to have great potential by using an existing intervention in a new way as a postural support.

What is Kinesio Taping®?

Kinesio Taping® is a method of functional taping using elastic tape. There are a variety of applications to help support or hold a joint or position, increase proprioception and body awareness, and/or position a part of the body in better alignment.[4, 5, 6] This tape has most commonly been used for orthopedic patients and athletes. It has gained visibility in recent years at the Olympics, as well as in many televised sporting events. The brightly colored tape adorning the shoulders of Kerri Walsh as she went for the Olympic gold has become increasingly popular and is beginning to be used more widely across settings. One such setting includes use of Kinesio Taping® for the population of complex neurologic patients.[7, 8] Kinesio Tape® may be used to promote desired alignment for daily positioning, to inhibit destructive postures, and to incorporate the benefits of dynamic supports into positioning systems for these patients.

Over the last several years, using Kinesio Taping® applications on a population of patients with cerebral palsy and other neuromuscular disorders afforded us many opportunities to observe its positive effects. We have seen a number of great success stories, and have been pleasantly surprised at the impact of this intervention. We have learned that Kinesio Taping® can be a successful intervention to achieve the goals of optimizing function in positioning equipment. The results of a taping trial often led us to make different equipment choices when Kinesio Taping ® was used as an adjunct to the positioning system.

Background

Levi is one of our very young and success stories. When he entered our care, he was 2 years old with a history of prematurity and diagnoses of periventricular leukomalacia,

Most importantly, what can we, as clinicians, do to ensure our equipment recommendations are both functional and comfortable?

cerebral palsy, hemiparesis, spasticity and cortical visual impairment. He attended group therapy sessions twice a week for two and a half hours where he received occupational, physical and speech therapies. He also attended aquatic therapy bi-weekly and received in-home early intervention services intermittently through his county. Medical interventions included oral baclofen daily and periodic Botox injections. Additionally, Levi had bilateral upper extremity splints and ankle-foot orthotics.

Seating

Prior to beginning therapy at our center, Levi had already received a Zippie® TS manual wheelchair. His seating system included a headrest, lateral trunk supports, four point anterior chest harness, pelvic belt and footrests. The supports and features of this wheelchair theoretically had everything Levi and his family should need for daily use. However, his posture in this chair was not ideal and his family did not use the equipment regularly. Levi's mother noted his posture was becoming increasingly rounded, and he was less active in this seating system than in floor positioning or a stroller. Additionally, Levi would soon be a big brother, and the breakdown and lifting of his wheelchair for transport was much more cumbersome than using a standard stroller. With visible benefits not outweighing the challenges at that time, Levi's family used the wheelchair sparingly. Our goals for seating were to assess his current posture, work on movement and strengthening, trial dynamic supports, and determine how to provide Levi with more movement

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KINESIO TAPING®...
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and active participation in his seating. Our hope with this plan was to increase functionality for Levi and his family to use seating equipment more regularly.

Levi presented with rounded shoulders, scapular winging, flexor posturing of his right arm, forward head posture, rounded trunk and often leaned to his right due to increased right side involvement (see Picture 1). As a result of this posture, therapists and family noted a number of deficits. Increased use of tilt was being used to help manage his rounded trunk and forward head. While tilting his wheelchair back was certainly appropriate in many situations, it was not a solution for all environments. In fact, the increased use of tilt had a number of negative functional implications for Levi. This passive positioning in his wheelchair limited his active weight shifts and ability to participate in transitional movements. It made reaching very challenging, and led to decreased opportunities for play. Visually, tilting left him staring at the ceiling which was less than ideal for his visual development, contributed to poor head and neck posture, and limited his opportunities for learning and social engagement. Finally, his rounded posture and limited ribcage mobility greatly decreased his breath support, which made talking quite challenging.

While these concerns were being addressed through therapy, it was important to find ways to address his positioning needs in all environments. Levi was a young boy who would need much equipment for daily positioning in the future. However, with equipment trials in process, a plan was needed to meet his needs using items his family could already access. The challenge became finding ways to help promote good posture and alignment in the home environment, through modifying

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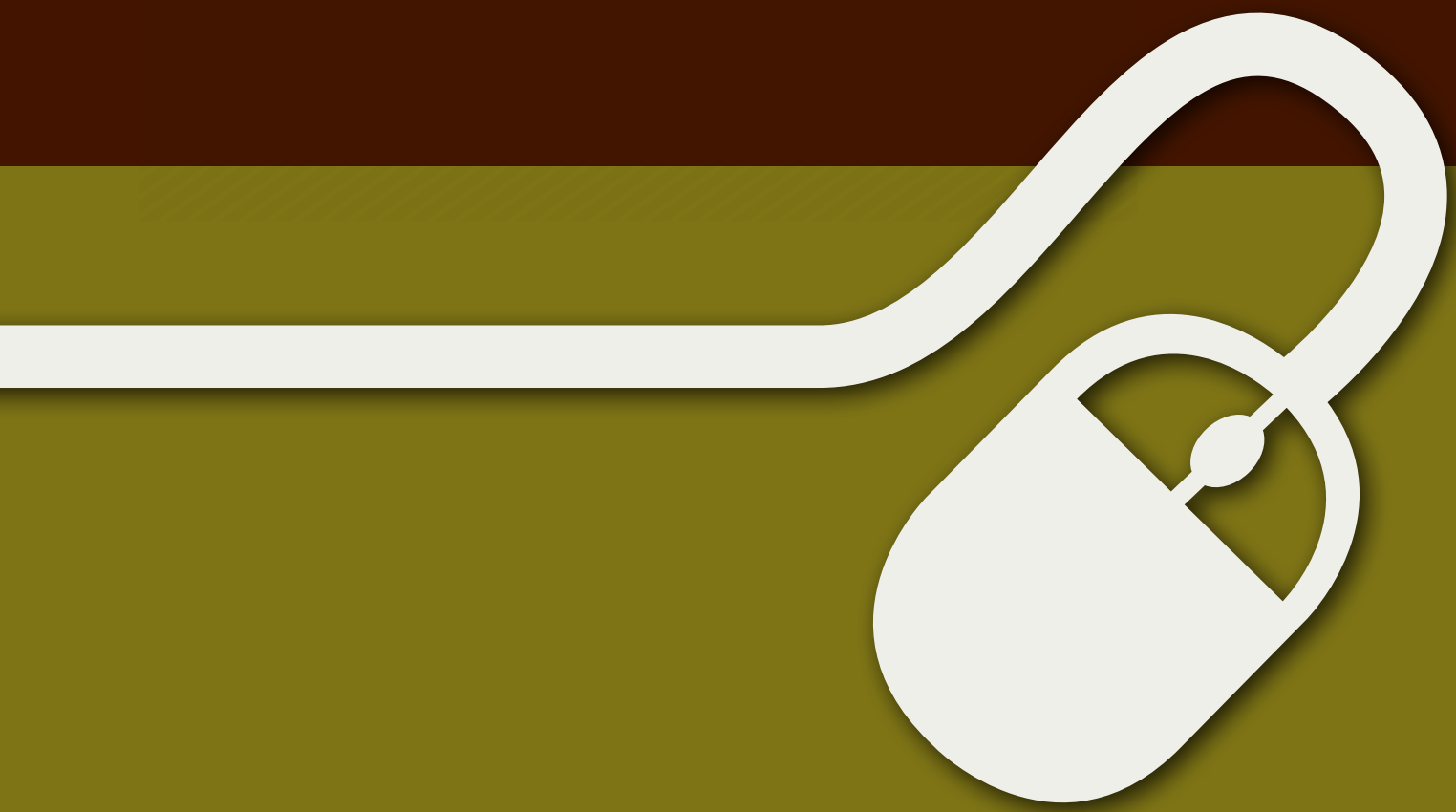

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commercially available items, or teaching new strategies for positioning. Kinesio Taping® was a helpful tool, which was trialed to assist with promoting these postures at home. Applications were used to inhibit shoulder rounding, trunk rounding and forward head posture, while concurrently supporting the shoulder girdle in better alignment. With consistent applications and parental compliance with home positioning and activities, gradual improvements in his rounded posture were noted. As he progressed, less supportive Kinesio Taping® applications were needed and different Kinesio Taping® methods to facilitate active extension, improve postures and promote desired movement patterns were utilized. In therapies and at home, it was noted Levi was more active in sitting postures, more playful and interested in toys, and more socially engaged.

In a relatively short period of three to four months from entering therapy and beginning trials of Kinesio Taping®, Levi's posture completely changed. As illustrated in Picture 2, Levi went from a forward flexed, rounded and passive posture, to a much more active and upright posture. He demonstrated decreases in trunk rounding, scapular

PICTURE 1: *Early sitting posture, with significant trunk rounding in November 2012.*

PICTURE 2A: *Rounded posture in seating prior to Kinesio Taping®.*
PICTURE 2B: *Improved upright posture after Kinesio Taping®.*

PICTURE 3: *Improved postural control in February 2013, while seated in equipment with less supports.*

PICTURE 4	BEFORE	AFTER
TOTAL TIME VOCALIZATIONS RECORDED	7:06 MINUTES	7:27 MINUTES
FREQUENCY OF VOCALIZATIONS	11:00 MINUTES	48:00 MINUTES
GREATEST NUMBER OF SYLLABLES PER BREATH	4:00 MINUTES	6:00 MINUTES
AVERAGE NUMBER OF SYLLABLES PER BREATH	1.45 MINUTES	1.66 MINUTES

PICTURE 4: *Data taken from videotaping of speech output in one session, before and after Kinesio Taping®.*

PICTURE 5A & 5B: *Standing posture and manual supports, before and after Kinesio Taping® in one session.*

PICTURE 6: *Walking in gait trainer with less supports.*

winging, right upper extremity flexor posturing and the need for upper extremity propping and trunk supports for stability and balance. Increases were noted with extension and upright trunk posture, postural control and balance, initiation and speed of righting reactions, and sitting endurance. He also demonstrated more lower extremity weight bearing, initiation of sit to stand transitions, weight shifting and trunk rotation during reaching and play, and a better upright head posture for visual attention and social interaction.

What began as an intervention to promote desired postures in commercial equipment at home during equipment trials, led to drastic changes in posture that completely changed his equipment plan. Levi went from requiring a tilt in space wheelchair with full support, to being able to maintain upright posture in a saddle seat with less supports (see Picture 3). Instead of adding or altering supports on his wheelchair, we were able to take them away and even considered completely different types of equipment and seating.

The positive results and impact of Kinesio Taping® carried over to many other areas as well. Levi was now able to maintain a more upright trunk posture, with decreased shoulder and trunk rounding and a more open chest. This improved posture placed him in better biomechanical alignment in order to take deeper breaths. He was also learning to use his core muscles more consistently, and we began to target his core strength and ribcage mobility with Kinesio® Tape applications. The results were much more drastic than we could have imagined. Not only did he have better breath support, he was demonstrating greater endurance for sitting postures

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and was talking much more and much louder. When testing his breath support with his speech therapist before and after Kinesio® Tape was applied, significant improvements were noted (see Picture 4). Additionally, his mother consistently reported that he talked more, made new sounds and talked louder.

Standing and Gait

These positive impacts carried over into other facets of Levi's positioning needs, including the supports he required for standing and gait. Before Kinesio Taping® was started, Levi presented with a crouched posture, left hip rotation and knee hyperextension, trunk rotation, uneven weight bearing through legs, and decreased control for reaching during supported standing. After Kinesio® Tape was applied, he required less support for standing, and displayed less trunk rotation and hyperextension of his left leg with improved bilateral weight bearing. Additionally, his reaching improved and he was more active in standing (see Picture 5). These changes led to different equipment choices. Levi required less supports for standing and was able to tolerate prone standers with a higher activity level and increased overall endurance.

Initially, Levi used a Pacer gait trainer with a chest prompt, pelvic seat and ankle prompts. While in this gait trainer, Levi relied heavily on the pelvic seat and leaned forward into the chest prompt during ambulation. He demonstrated a scissoring gait pattern with decreased step and stride length and relied heavily on extensor tone to initiate movement. As his trunk control improved through therapies and Kinesio Taping®, Levi was able to remove supports from his gait trainer. He was gradually able to walk without the pelvic seat and decreasing use of the chest prompt as his ability to actively use the forearm prompts improved. Within two months, Levi was demonstrating emerging skills for use of a posterior gait trainer, with only a pelvic prompt, chest strap, and handles (see Picture 6). His gait pattern improved dramatically with much less scissoring. Increases were observed in trunk extension and upright head posture, active hip and knee flexion, step length, reciprocal stepping, speed, and endurance.

Summary

Determining the right equipment to meet the positioning needs of a patient is a challenge. It is like a puzzle with many pieces to consider how to find that "just right" fit, and really see the whole picture. Considerations for dynamic positioning are a crucial part of the process, to optimize comfort and function. As clinicians, we need to use every tool in our box to achieve this goal. While Kinesio Taping® may not be a long term solution, it has proven to be very helpful for the right patient when used as an adjunct to positioning systems and interventions. As in this case with Levi, Kinesio Taping® can be a strategy to gain skills and improve posture. It can also promote desired positioning in less than ideal equipment scenarios. Furthermore, it can be helpful to simulate dynamic positioning strategies, and assist in determining equipment and supports to meet the patient's needs. When applied by a trained clinician, Kinesio Taping® can be a powerful tool and adjunct to positioning interventions, in order to achieve stability, active positioning, function, and comfort for our patients.

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ASSUMPTIONS AND CRT

WRITTEN BY: ALEXANDRA BENNEWITH AND JENN WOLFF

Firstly, as a wheelchair user, I assumed my supplier and initial therapist weren't doing something right when my chair was denied. What I later found out was that Medicare dictated what I "needed" according to antiquated rules, including the "in the home" clause. I was told I didn't need an ultra-lightweight chair for my use in the home and that what I did outside my home did not matter.

How can it not matter what I do outside my home when I drive, when I work, when I shop? I know as a therapist that I need to maintain my upper extremity health, that a lighter chair will keep me in a manual chair longer before having to progress to a power chair. I understand that having the right seating and postural support helps decrease pressure sores and promotes health in general. But my insurance doesn't think in those terms. So this becomes the "policy's" problem.

What I later found out was that Medicare dictated what I "needed" according to antiquated rules, including the "in the home" clause.

Secondly, I assumed that therapists who are in the rehab field automatically know what documentation is needed and how to do a complex seating and positioning wheelchair assessment. Most can do a simple wheelchair evaluation, but when you add the complication of pressure sores and postural instabilities a wheelchair user needs to go to a therapist who understands the intricacies of the body and chair. So this becomes the "seating and positioning specialist's" problem.

I also assumed that the therapist would have a thorough medical history and understand my needs without extra information from me. I only now understand the importance of wheelchair users taking a document with them to the evaluation with a complete medical history, complications/injuries, history of pressure sores, tendonitis, so the evaluating therapist can do their job better and document it to insurance. This becomes the "wheelchair self-advocate's" problem.

At one of my evaluations, neither the therapist nor the ATP had me get out of my chair to see how I truly sat or slumped. Maybe I would have qualified for a more adaptable chair? Maybe the therapist assumed I would bring things up because I am an occupational therapist? This becomes the "having the right team" problem.

The more I am involved in advocacy, I am finding how broken the whole system is and how many problems and issues there are. It is not just insurance and policies. It is not just some suppliers who sell equipment they can't service. It is not just a therapist

Potentially, this will keep the wheelchair user healthier, less prone to pressure sores, depression, upper extremity injuries and in turn actually save money in the long term.

who is trying to do an evaluation outside his/her comfort zone. It is the combination of outdated policies, some less qualified suppliers and the lack of guidelines for therapists and resources of who to send wheelchair users to for more complex evaluations.

Now I understand why the wheelchair user should work with a supplier close to home (when possible) with an experienced ATP, as well as with a seating and positioning specialist. I understand why a change in policy is needed, and why being aware of what the person needs in the home with a home visit, as well as changing the coverage language to incorporate daily activities, not just "in the home" matters. Potentially, this will keep the wheelchair user healthier, less prone to pressure sores, depression, upper extremity injuries and in turn actually save money in the long term.

Isn't that what the government wants, or is that an assumption too?

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CRT: BALANCING CLIENT NEEDS IN THE WORLD OF DECLINING REIMBURSEMENT

WRITTEN BY: JILL MONGER, MS, PT ATP AND ALLISON FRACCHIA, PT, APT/SMS

Discussing the finances of seating and mobility options can be uncomfortable, yet if the therapist and the supplier educate one another on basic components, they can work as a team to better inform the client on his or her options. Suppliers need to remember that therapists must evaluate clients and make recommendations as to what technology is needed to meet their clients' functional and medical goals, regardless of funding. Likewise, therapists need to understand the margins and cost of business that affects the supplier's limitations in provision of equipment. Open communication and basic understanding of one another's roles will enable the therapist and the supplier to better educate the client about the deficits and perhaps bring about a sea of change in the system.

Contributing to this care deficit is the ever-declining reimbursement of goods and services from insurance sources. Too often, suppliers find their hands tied in regard to equipment they can afford to provide, regardless of client's limitations, needs and goals. Suppliers face many insurance reimbursement issues including noncovered or noncoded items and insufficient payment allowables to purchase and provide the technology and services. In addition, they must follow complex mazes of medical documentation and paperwork trails. Finally, they are limited by contracts with certain insurance companies that prevent a client from paying the difference, paying for upgrades or paying for non-covered items. Unfortunately, many therapists and clients do not understand details and complications of insurance policy restrictions, leaving them with unrealistic expectations of what the supplier can and should provide.

Not only is reimbursement for equipment becoming more difficult, but reimbursement for therapy services is more challenging. Therapists are required to provide more objective data to support their treatment plans so that the provision of the therapy services will be reimbursed. In fact, there is much talk about clinics being reimbursed based upon performance outcomes. Therapists and suppliers must understand that various insurance companies limit precertifying appointments, use of Current Procedural Terminology (CPT) codes, and max units allowed for a given service. Traditionally seating and mobility clinics have not been big money makers in the outpatient arena; therefore, it is critical for therapists to be reimbursed for services provided. This is imperative in order for the seating/mobility clinics to stay viable.

The question then becomes, how do we as therapists and suppliers accomplish respecting each other's financial limitations for provision of equipment and provision of therapy services while still adhering to ethical standards of practice, which protects the rights of our clients? First and foremost, we must not take the "parental role" of determining what clients can "have" according to insurance. Instead, we need to help clients understand what technology is available to meet their needs, regardless of available funding. This is accomplished by performing full evaluations with determination of problems, goals, and features needed to meet their goals. We must document what is necessary to meet their needs as well as the limitations we believe the clients will experience if they are not able to receive products. Documenting what clients will not be able to do as well as their risks of accepting the features and technology that their insurance limits them to is a critical step. Does this mean that the therapist should ignore the fiscal limitations of the supplier? Absolutely

We must document what is necessary to meet their needs as well as the limitations we believe the clients will experience if they are not able to receive products.

not! If anything, this is a key chance for developing more open communication within the team. There should no expectation from the therapist or the client that the supplier can provide items regardless of reimbursement.

Once clients understand the sources of the limitations, they can be introduced to their role as self-advocates and work with their insurance companies to have access to the needed technology. Clients may need to contact their insurance companies when "contracts" or "code limitations" are limiting access. They may need to be educated about alternative funding, or they may need to exercise the right to use their own funding. As suppliers and therapists, we have to have a good understanding of these options ourselves, as portrayed in the following sample client case.

Sample Client Case

Mrs. S is a Medicare beneficiary with rheumatoid arthritis. She was referred to a seating clinic for a specialty evaluation following an appointment with her physician for a face-to-face evaluation. She was receiving skilled home health services using her Medicare benefit at the time of the clinic appointment, so a contract for the home health agency to pay for the specialty evaluation was obtained by the outpatient clinic. With the therapist and supplier present, Mrs. S began by explaining she had received a three-wheeled scooter two and one-half years ago and that it had never "worked well" for her. It had fallen over several times outside when she was using it, and it was not easy to maneuver inside of her home setting. She was interested in a power wheelchair at this time. There was no change of medical condition or functional status over the past two years. The supplier explained to the patient that her Medicare benefit would not cover a new mobility

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CRT: BALANCING CLIENT NEEDS
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product, and the appointment was concluded. The outpatient clinic was later informed that reimbursement for the physical therapy outpatient specialty evaluation was declined because the therapist had not completed an evaluation with a plan of care, goals and recommendations.

In this case, Mrs. S would have been better served by a comprehensive evaluation followed by clinical recommendations and explanation of the risks to her by not being provided with any new technology recommended. This would have allowed the outpatient clinic to appropriately bill for services. The therapist may have come to the conclusion that a group 2 power wheelchair would be the better option to allow for improved safety and accessibility within her home and surrounding property. If so, the next step should have been to consider and presenting options for funding of the device. Perhaps the patient would have been willing to pay out of pocket for the item. Since the supplier was contracted as a competitive bid provider, the option for that provider would have been to provide a non-coded "consumer" product, or the team could have referred the patient to a supplier who could have provided the coded group 2 technology with alternative funding using an ABN. There may have been alternative funding available to this client, including a family member, a church or an outside organization willing to assist in payment.

In conclusion, the CRT team must be strong, informed and work well together in a trusting environment. Therapists must learn and understand supplier's limitations in provision of products due to policy requirements, covered versus non covered items, and allowables versus cost margins. Understanding these areas allows the therapist to respect the supplier's limitations in provision of equipment. It also allows the therapist to assist the supplier in explaining equipment limitations and alternatives for funding for the client. Suppliers, on the other hand, must learn the limitations therapists and clinics face with funding for services including the need to precertify appointments, the maximum units allowed for a given service, and the required use of Current Procedural Terminology codes and G-codes. While therapists are under the obligation to let the clients know what technology is available and how it would help to meet their goals, suppliers provide a means through the tangled web of insurance and funding issues to meet those goals.

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RESNA CERTIFICATION COMPLAINTS PROCESS: WHAT YOU NEED TO KNOW

WRITTEN BY: ANDREA VAN HOOK

If you are a certified ATP or ATP/SMS, then you are already familiar with the Standards of Practice and RESNA Code of Ethics that every certificate holder promises to follow. What might not be as familiar is the complaints review process. This is an important tool that the RESNA Professional Standards Board, charged with oversight of the certification programs, uses to protect the integrity of the credentials.

The complaints policy, available on the RESNA website, is provided to every certified professional. It allows the Professional Standards Board (PSB) to take certain actions, up to and including revoking credentials. These actions can include reporting to legitimately interested entities, such as state licensing authorities, accrediting bodies, federal and state Medicare/Medicaid reimbursement authorities, other payers and employers. It can also include revoking or suspending certification, probation, and mandating that acts or behaviors be immediately corrected.

The complaints policy, available on the RESNA website, is provided to every certified professional.

How the complaints process starts

Anyone may file a written complaint through the RESNA website. The complaint must be in writing and cannot be anonymous. The complaint cannot be the subject of legal proceedings already under way or reasonably expected to be under way within three months and must explicitly grant permission to share the identity of the complainant and all information with the person who is the subject of the complaint.

Complaints covered under the RESNA policy

Complaints must be based on acts or behaviors that violate RESNA's Standards of Practice and Code of Ethics. This can include, but is not limited to:

- Providing false information on an application for initial RESNA certification or recertification;
- Submitting documentation in support of an application for initial RESNA certification or recertification that is altered, forged, or not an accurate representation;
- Receiving or providing to others copies or other reproductions of test items;
- Altering, forging or otherwise misrepresenting the ATP and/or SMS certification;
- Misrepresenting a certificant's current status of ATP or SMS certification;
- Having a state regulatory body, an employer, a professional association, or a payer (such as Medicare/Medicaid) take an action due to acts or behaviors that violate RESNA's Standards of Practice and Code of Ethics.

If an appeal is granted, the PSB chair forms an appeal panel of three additional members of the PSB not involved in the original proceedings, and the process starts again.

After a complaint is filed

The Complaints Review Committee (CRC), working in conjunction with designated RESNA staff, is responsible for handling complaints. The CRC has five members, of which two are also members of the PSB. At least three of the five members must hold current RESNA certifications.

The CRC contacts the subject of the complaint (called the respondent), and allows a time-limited opportunity to respond. The complainant is then given the opportunity to address any factual assertions made by the respondent within a specified time period. Once the initial response and comments deadlines have passed, the CRC forms a complaint panel that thoroughly reviews the complaint.

Anyone taking part on a complaint panel is required to preserve confidentiality and avoid prejudicing the outcome or exercising an improper influence. The panel may, at its discretion, ask for more information from either party. The CRC chair is responsible for ensuring that the decision-making shows due regard to the gravity of the situation and to considerations of confidentiality.

Appeals

Respondents to the original complaint may appeal the decision if they are able to demonstrate to the satisfaction of the PSB that there are grounds for an appeal. Relevant grounds include:

- Material deviation from the complaints policy
- Intimidation of any party involved in the proceedings

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- Conflict of interest or bias on the part of any person on the complaint panel
- Failure to disclose a personal or financial relationship between the complainant and members of the complaint panel or CRC chair.

If an appeal is granted, the PSB chair forms an appeal panel of three additional members of the PSB not involved in the original proceedings, and the process starts again.

For the consumer, the promise of RESNA certification is that those that achieve it maintain the highest ethical standards. As a result, many RESNA-certified professionals are already actively engaged in serving as mentors and thought leaders for their peers, and incorporate the RESNA's Standards of Practice and Code of Ethics into their own workplaces. The RESNA Professional Standards Board welcomes any comments and feedback on the complaints policy, the Code of Ethics, and the Standards of Practice. To access a copy of the complaints review process, visit http://resna.org/certification/complaints.dot.

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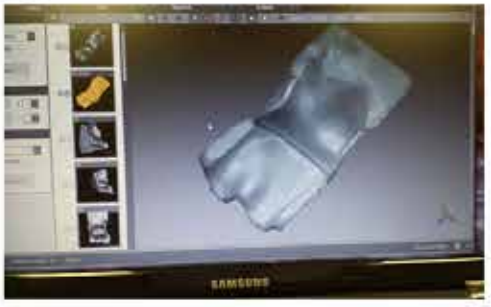

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THE LATEST UPDATE TO THE ON-GOING SAGA OF INCORRECT MEDICARE PAYMENTS

AND … SAME/SIMILAR DENIALS: WHAT CAN YOU DO TO HELP AVOID THESE?

WRITTEN BY: CLAUDIA AMORTEGUI

First, the update … If you read my article in the last issue of DIRECTIONS, you heard my call for some loud voices regarding Medicare's consistent wrong payment of many options on noncompetitive bid complex rehab wheelchair bases. Medicare are paying those options at the Competitive Bid Single Payment Amount versus the actual fee schedule, which is the amount it should pay when the options are on noncompetitive bid bases (all complex rehab wheelchair bases).

Since my article, Medicare has published CR8864. The good news: they actually published something. The bad news: it does not go into effect until Jan. 1, 2015, and only for dates of service beginning Jan. 1, 2015 and forward. It appears that they have shrugged off the fact that providers have claims with dates of service starting July 1, 2013, and forward that have not been paid correctly. This equates to 18 months of erroneous processing and wrong payments to providers. When it comes down to these claims there is still much unknown, I believe, to both Centers for Medicare and Medicaid (CMS) and the providers.

As of today, Sept. 12, 2014, I am still getting mixed stories from various Medicare representatives. I believe the mixed stories stem from overall confusion and people clearly not understanding the entire issue. One Medicare Administrative Contractor (MAC) jurisdiction manager told me that all jurisdictions were instructed by CMS not to reprocess any old claims until January. Another jurisdiction manager continually "will get back to me," and the two other jurisdictions are actually trying to reprocess. It just depends on whom you talk to. I did find out that CMS did not instruct the MACs not to reprocess, so obviously someone is confused. At this point, continue to call to get your claims reprocessed and paid correctly. For Jurisdiction A, fax your requests to re-openings and they will reprocess.

Another piece of bad news is that CMS has placed the burden on the provider to obtain proper reimbursement for claims processed incorrectly by Medicare. This should not be the case; however, CR8864 clearly states the provider must be the one to request the proper payment. Normally, if the payment errors are the fault of Medicare, then this burden is not to be placed on the providers – somehow they forgot this rule. There is a possibility that you will be able to submit a spreadsheet with all claims that need to be reprocessed, however they are still "working on it." Even with this possibility the burden falls on the provider to go through 18 months of claims, which show as paid, but just not paid the right amount. If you have not been tracking these, you need to start now and be sure to back track.

All I can say is … Get loud. Call congressmen, call Medicare, and do not just give up. You will be amazed at how much money is likely due to you.

Let's look into another headache …

As I work with providers, the biggest issue that seems to be consistent for all is the amount of same/similar denials from Medicare. I know this may seem very basic and you may roll your eyes thinking "I know this," but how well are you really doing with this issue?

This is not necessarily new news, but it's not like it used to be. The problem is that I'm seeing these denials grow, not only because of Medicare, but also because of the initial order. As much as everyone would like to blame Medicare (and I did above), this issue lies more on the shoulders of the providers, and in many cases the ATPs. So what can you do to help?

Whether you are the ATP working for a provider, the clinical referral, or even internal staff for a provider, you do have a responsibility if you are replacing equipment for a client. First things first … Medicare's rule for replacement of equipment is five years. This could work for some clients and for others it just won't. Unfortunately, there are only a couple reasons that the five-year rule can be broken.

> All I can say is... Get loud. Call congressmen, call Medicare, and do not just give up. You will be amazed at how much money is likely due to you.

• The equipment needs to be replaced due to irreparable damage caused by en event such as a natural disaster (i.e. hurricane, flooding), or something such as a car accident or a house fire. If it is due to a car accident, you need to be certain that the auto insurance will not cover the replacement. For Medicare, irreparable damage does not count everyday wear and tear – even if for that specific end user they have worn it into the ground from their normal everyday use.

• The equipment is stolen – but be sure to have a detailed police report.

• There is a change in medical condition, where the current wheelchair cannot be modified to meet their medical needs.

I hear many people who feel that overcoming one of the above is not very hard, or I hear people say, "but they have to have a new chair because their old chair is broken beyond repair." Again, if it is less than five years (to the day), all you can do is continue to repair the wheelchair and bill Medicare for those repairs.

The following are some things I strongly recommend doing to avoid same/similar denials:

• During the seating evaluation the therapist and ATP need to know if Medicare has another wheelchair or even a lower extremity prosthesis on file and if so, when it was funded. If the client does have current equipment that is less than five years old, it needs to be addressed in the clinical documentation. The only possibility of payment for a new wheelchair would be a documented change in condition.

• If no one is aware of other equipment and Medicare does not have anything on file, but the client talks about other equipment, the internal staff is going to want to dig a bit further. This may even take a call to Medicare to verify. Do no just "skip" over this information.

• Although the therapist documents a change in condition necessitating a new wheelchair base, the physician chart notes should also support this change. In addition, it is highly recommended that you obtain the clinical documentation from the period they received the original equipment. This will allow you to have the proof of how their condition was and how it differs now. This may not be easy to obtain, but it will be critical in your appeal fight since you will be denied up front for same/similar.

• Just because someone received the wrong piece of equipment to begin with does not mean we can replace it if it has been less than five years. Unfortunately, this is a large number of orders I see. It's no surprise – the people and the companies who were not in this business for the right reasons and who ultimately hurt this industry have left many of us in a big mess. When I look at these orders, it is clear that the client's condition has not changed; they just did not get the proper wheelchair. Medicare feels that if the physician reviewed all the documentation and actually prescribed the item and signed off on the detailed product description, then it should have met the client's needs. As we know, this was not always the case, but you cannot get stuck holding the bag. There are minimal options to overcome this, but be sure you are protected.

• If the current wheelchair can be modified to meet the client's needs (i.e. add a power tilt to a power base), then that needs to happen. If it cannot be modified, I would obtain something in writing from the manufacturer that is specific to that individual wheelchair.

As providers, you cannot simply say, "this client has to have this chair and we will fight and win this." If you do say this, you have to be prepared for a long battle. It will be best to have all your ammunition in hand before you make a final decision. If you are having problems getting the historical documents, get your client involved. When possible, get the therapist and physician involved as well. This is in everyone's best interest to obtain the new equipment in a timely manner and for the provider to be paid appropriately.

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