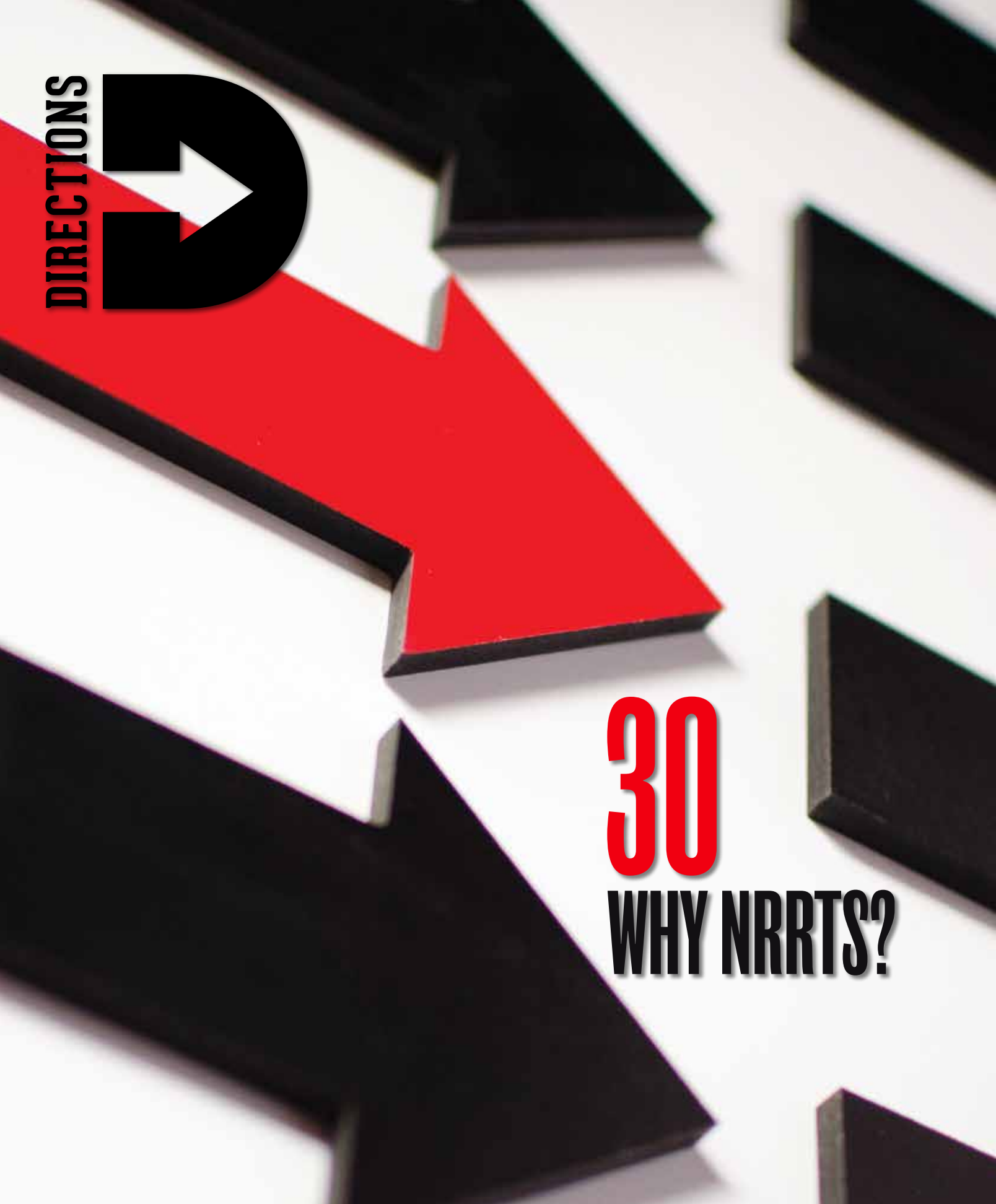

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CONFERENCE SCHEDULE

LEADERSHIP DAY
TUESDAY, APRIL 29, 2014

7:30am to 8:30am	Registration
8:30am to 5:00pm	General & Breakout Sessions
6:00pm to 8:00pm	"CRT United" Reception

CRT focused presentations for providers and manufacturers will include: healthcare reform trends; views from an industry CEO panel; financial management best practices; CRT related revenue opportunities; using technology and social media; handling hearings and audits; and more.

ADVOCACY DAY
(includes Medicaid Summit and CELA)
WEDNESDAY, APRIL 30, 2014

7:30am to 8:30am	Registration
8:30am to 5:00pm	General & Breakout Sessions
5:00pm to 6:00pm	Congressional Prep

Funding and advocacy sessions for CRT stakeholders will include: Medicare and Medicaid updates; federal and state CRT legislative activities; using state protection and advocacy resources; lesser known funding sources; prep for visits with Congress; and more.

CAPITOL HILL VISITS DAY
THURSDAY, MAY 1, 2014

9:00am to 5:00pm	Capitol Hill Visits
5:00pm to 7:00pm	Debriefing Reception

Our annual presence in Washington has been a key factor in the progress to date on our legislation to create a Separate Benefit Category for CRT. Consumers, clinicians, providers, and manufacturers will take the CRT message directly to Congress through in-person meetings on Capitol Hill.

in this issue

The Official Publication of
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Bennewith is vice president of Government Relations, United Spinal Association. Bennewith advocates for legislation and regulations regarding disability and health policy at the federal and state level and works closely with a range of stakeholders in the durable medical equipment and supplies, prescription drug, public health and disability communities. She graduated from Brandeis University and received her Master of Public Administration from American University. SEE PAGE 50

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

ANN EUBANK, LMSW, OTR/L, ATP

Eubank is vice president of Community Initiatives for UsersFirst, a program of United Spinal Association. SEE PAGE 50

LESLIE FITZSIMMONS, PT, ATP

Fitzsimmons is a treating therapist at Lakeview CP School in Edison, N. J. In an effort to improve the quality of life for her clients with poor head control, she created the i2i head and neck positioning and support system, which is now manufactured by Stealth Products. Fitzsimmons presents throughout the United States and internationally. SEE PAGE 40

MICHELLE LANGE, OTR, ABDA, ATP/SMS

Lange is an occupational therapist with more than 25 years of experience in the area of assistive technology. She is the former clinical director of the assistive technology clinics of Children's Hospital of Denver and is now in private practice. Lange's work in assistive technology includes a broad range of roles and services. She is a well-respected lecturer, nationally and internationally, and has authored seven book chapters and more than 175 articles. SEE PAGE 44

ELISA LOUIS

Louis is president of Thomashilfen. SEE PAGE 20

ANDREA MADSEN, ATP, CRTS®

Madsen is a NRRTS at-large director. Madsen works for Med City Mobility in Rochester, Minn. SEE PAGE 26

MIKE OSBORN, ATP, CRTS®

Osborn is president of NRRTS. Osborn has been a NRRTS Registrant since 2000 and is part owner of Alliance Rehab & Medical Equipment in Ozark, MO. SEE PAGE 30

KESHA PILOT

Pilot is a consumer advocate who attended the National CRT Conference in that capacity. SEE PAGE 14

JOSHUA I. SKORA ESQ.

Skora is an attorney in the Health Care Group of Brown & Fortunato, P.C., a law firm based in Amarillo, Texas. Skora represents HME companies, pharmacies and other health care providers throughout the United States. He earned his undergraduate degree 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 32

ANDREA VAN HOOK

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

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TUESDAY, FEBRUARY 18, 2014
5:00PM TO 7:00PM PACIFIC

Positioning the Upper Extremities

JARROD ROWLES, ATP/SMS, CRTS®

WEDNESDAY, FEBRUARY 19, 2013
9:00AM TO 11:00AM CENTRAL

Positioning the Lower Extremities

STEPHANIE TANGUAY, OTR/L, ATP

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THURSDAY, FEBRUARY 20, 2014
5:00PM TO 7:00PM EASTERN

Aging with a Disability

SUSAN JOHNSON TAYLOR, OT/L

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

Using the Science of Materials to Compare Wheelchair Seating Support Surfaces

W. DARREN HAMMOND, MPT, CWS

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

POVs vs. PWCs

Clinical Indicators for the Power Mobility Spectrum

STEVE BOUCHER OTR/L, ATP

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TUESDAY, APRIL 22, 2014
5:00PM TO 7:00PM PACIFIC

Ethics for All

SIMON MARGOLIS, CO, ATP/SMS

THURSDAY, APRIL 24, 2014
5:00PM TO 7:00PM EASTERN

Advanced Positioning

Pressure Issues and the Latest Research and How This Impacts Our Recommendations

SHARON SONENBLUM, PH.D. AND TERESA CONNER-KERR, PT, PH. D., CSW, CLT

TUESDAY, MAY 20, 2014
5:00PM TO 7:00PM PACIFIC

Clinically Speaking

A Practical Guide to Evaluation and Documentation for Mobility Assistive Equipment

JULIE PIRIANO, PT, ATP/SMS

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WEDNESDAY, MAY 21, 2014
9:00AM TO 11:00AM CENTRAL

Seating Considerations for Clients with SCI

JILL MONGER, PT, MS, ATP

THURSDAY, MAY 22, 2014
5:00PM TO 7:00PM EASTERN

Optimizing Manual Wheelchair Propulsion

in Pediatrics, Product and Configuration Clinical Indicators

LAUREN ROSEN, PT, MPT, MSMS, ATP/SMS

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

Business Practices

Shaping the Future of CRT and the Professional RTS

WEESIE WALKER, ATP, SMS

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

Restraints and Wheelchair Seating and Positioning

BARB CRANE, PH.D., PT, ATP/SMS

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

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

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

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

Positioning out of the Box

Kinesio® Taping in Seating

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

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

Advanced Power Mobility

Emerging Technologies

LISA ROTELLI

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

Posture and How it Develops

Standing and Sitting Considerations for the Young Child

SHARON SUTHERLAND (PRATT), PT

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

Power Mobility Options

For Clients with Muscle Weakness

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

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

Self-Advocacy

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

GERRY DICKERSON, ATP, CRTS®

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

Dynamic Seating

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

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

"Traffic School"

Tips for Creating a Power Mobility Training Program

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

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2014 NRRTS WEBINARS

2014 NRRTS WEBINARS

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

Pediatric Power Mobility
Earlier Intervention

AMY MORGAN, PT, ATP

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

The relationship of Vision, Posture and Mobility
Implications for seating and mobility for neurologically involved clients

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

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

Back it Up!
Basics of Back Supports

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

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

Complex Rehab Mobility
Medicare Reimbursement Requirements and Documentation Strategies

ELIZABETH COLE, MSPT, ATP

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

Choosing the Best Therapeutic Support Surface

LINDA NORTON, OT REG.[ONT], MSCCH

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

WHO Training Materials
An Overview and Usage Suggestions

JAMIE NOON

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

It's More Than Just Physical
Considering All the Needs of Complex Clients in Seating and Mobility

TAMARA KITTELSON-ALDRED

IN THE WORDS OF CARNIVAL CONCESSIONAIRES,

'Ladies and gentlemen, we've got ourselves a winner'

WRITTEN BY: DANETTE BAKER

If Kesha Pilot were to write the familiar grammar school essay, "What I did on my summer vacation," hers would be a story filled with adventure, adversity and achievements.

For the first decade of her life, Pilot traveled the summer carnival circuit with her family. Each May, they would pack up the trailers with their games and concessions and travel throughout the central United States – North Dakota, South Dakota, Indiana, and Texas – returning home in late September weeks after school had begun.

While the rest of the family beckoned fairgoers to their familiar red- and white-striped tents to try a hand at tossing balls or satisfying their palates, Pilot would occupy her time on the midway rides or cruise the fairgrounds in her battery-operated red corvette convertible.

Life on the road was an adventure, but Pilot always looked forward to the fall when she and her mom would return to their home in Lufkin, Texas, so Pilot could attend school like other children her age. Pilot's brothers and sister – each more than 10 years her senior – had spent very little time in a classroom and were home-schooled instead.

When she was about 10 years old, Pilot and her mother gave up the nomadic lifestyle and settled down in Hot Springs, Ark., while her dad and her siblings stayed on the road, continuing to work the carnivals. Like most school-age children, Pilot looked forward to summers when the family was back together, but she also loved school and learning. She dreamed of the day she would don a cap and gown and walk across the stage.

But life sometimes has a way of interrupting our dreams. Pilot missed too many days her senior year of high school and did not get to graduate with her class. Crushed that something she had worked toward for so long was not a possibility, Pilot could have given up and just quit school – but giving up is not in her nature. She received her GED and got a job as a secretary for an oil and gas company, where she worked with her husband, Clay.

Work led the couple to Dallas, where the oil industry had boomed, earning the Pilots a comfortable living. By 2005, however, they had enough of big city life and traded it for the tranquil shores of Costa Rica, intent on living in simplicity on their savings, with their two dogs and cat, and helping those around them.

"In fact, after high school I filled out an application to the Peace Corp. Their response was 'We'd love to have you when you have applicable skills to offer.' "

"I had always wanted to be a doctor and travel to a country in need to help in a disaster or outbreak," Pilot said. "In fact, after high school I filled out an application to the Peace Corp. Their response was 'We'd love to have you when you have applicable skills to offer.' "

Four months later, the couple was back in Arkansas. Their dreams of paradise in Jaco, Costa Rica, were cut short by the unexpected costs of an Americanized culture in a foreign country. Also, just a month after entering the new country, the couple found out they were going to be parents.

"We were unable to find new sources of income and could live no more than four months on our savings alone," Pilot said. With the new responsibility of a child, they decided to return home.

(CONTINUED ON PAGE 16)

All was not lost on their return to Arkansas, however. Pilot enrolled in National Park Community College in 2009, and shortly thereafter, their son, Parker, was born.

Fast forward three years: Pilot had completed her studies and had been accepted as a transfer student to Henderson State University, where she would pursue her bachelor's degree in biology. She had received a prestigious Presidential Community College Transfer Scholarship, awarded to only one student each year. Her dream of applying to medical school was quickly becoming a reality.

Pilot was waiting tables at Outback Steakhouse in Hot Springs, Ark., during the summer of 2012 when she and Clay decided, although they were apprehensive, to make the weekend road trip to Key West, Fla., just before Fourth of July holiday for her sister's wedding.

"We were hesitant about making the trip because we were going to have to make it in such a short time," Pilot recalled. "But I really wanted to be there for my sister. I was so uneasy that I asked a clergyman I waited on that night before to pray for us."

Watching her sister walk down the aisle solidified Pilot's determination to be there for the event. As it turned out, they were among only a few family members that had been able to make it. "I was still smiling when we headed home," Pilot said.

By 3:30 a.m. Sunday morning, the Pilots were 18 hours into their 19-hour trip back home. Pilot was driving when she fell asleep and veered off the road, flipping the car into the ditch. Her husband and son, who were asleep, were unharmed. Pilot, however, immediately knew something was wrong – she couldn't feel her legs. Her first lumbar vertebrae in her spine had burst, and a piece of the bone bruised the spinal cord. At the hospital, the neurologist was initially hopeful Pilot would regain use of her legs because of some movement of her right leg and some stomach muscles were still responsive. After surgery, the paralysis moved up to T-7.

"The first thing that I wanted to do was drive again," Pilot said. Henderson officials had agreed to hold her scholarship for one year to give Pilot time to recover. Within six months of her wreck, Pilot was certified to drive with hand controls. She has been on a fast track since then to make sure the use of a wheelchair doesn't interrupt her dreams.

Following her wreck, Pilot spent three weeks in rehab at Baptist Health Rehabilitation Institute in Little Rock, Ark., and another three weeks at the Texas Institute of Rehabilitation in Houston, Texas. Upon returning home, she quickly identified many deficiencies in her community and set about to make changes. Through the peer support program at Baptist Health Rehabilitation Institute, Pilot met Erin Gildner and the two set out to establish a local chapter of the National Spinal Cord Association, primarily to support active lifestyles.

At the rehab facility in Houston, Pilot discovered accessible playgrounds, swimming pools and workout facilities as well as complex rehab technology equipment – and saw many of these missing from her own community. Their goal in establishing a local association chapter, Pilot said, is make the community accessible so everyone can be active and participate in the community.

"The World Health Organization coined the term community-based rehab, which really focuses on family-based activities that are accessible to all" she said.

For Pilot, that would mean playing with her son at the local playground instead of sitting in her chair parked on the sidewalk. And she would love nothing more than to get back on the biking trails she and her mother used to enjoy. For the latter, there are hand cycles, but with an average non-reimbursable cost of $4,500, owning one outright is unrealistic for many.

"Through this association, I would love for us to be able to offer hand cycles for loan to our members; providing access to equipment will give our members an outlet to a healthier lifestyle," Pilot said.

At the rehab facility in Houston, Pilot was also introduced to complex rehab technology such as standing frames. Fortunately, her insurance allowed for Pilot to have an Easy Stand Glider at home. Others are not as lucky.

Not only does Pilot believe a standing chair can improve cardiovascular health, circulation, prevention of atrophy, and bowel and bladder function, but it also serves as her reminder that she is the same person as before the accident.

"I recently got a Permobil Helium Lifestand, a rather lightweight manual standing wheelchair. This gives me the freedom to not only get a glass out of the top cabinet, but also look at my husband in the eyes and my peers as well. It gives me the freedom to stand at any moment, increasing the time spent on my feet, so I can get all the health benefits of standing, anywhere I choose."

Pilot believes so strongly in access to such complex rehab technology that she took a stand on Capitol Hill in April during CELA and then in June for Roll on Capitol Hill with the National Spinal Association.

"The experiences really gave me the opportunity to introduce the legislators and their staff to someone who is living these challenges on a daily basis and to someone who has the potential to overcome them given the support needed," Pilot said. "Most of them really just don't know what we are up against because they have never had to deal with complex rehab and life in a wheelchair. I didn't understand either until it happened to me.

"The most important thing I can do is to keep telling them (legislators) and showing them that if they will support us with access to technology and rehab, we can get back into society and become tax payers again."

(CONTINUED ON PAGE 18)

Pilot is living proof. She returned to Henderson State University this fall, supported in part by her prestigious scholarship as well as two other scholarships. She plans to earn her bachelor's in biology and then apply to the University of Arkansas Medical Sciences for medical school or possibly another health professions program such as physician assistant studies.

Her dream of a career in health care may still be a few years away from becoming reality, but in many ways Pilot has already helped so many by speaking out on behalf of those who use wheelchairs.

CONTACT
Kesha may be reached at keshapilot@gmail.com.

DO WHAT YOU LOVE, LOVE WHAT YOU DO

German manufacturer, distribution company president finds position fulfills life's passion

INTERVIEW BY: DANETTE BAKER

Elisa Louis has woven a path to success by pursuing her passion. For Louis, that means making a positive impact in people's lives. As president of the North American headquarters of Thomashilfen, a German-based manufacturer and distributor of specialty medical equipment for children and adults, Louis is responsible for the sales, marketing and distribution throughout the U.S., Canada and South America. The company is well-known for its line of rehab strollers, car seats and sleep systems for children with special needs as well as the Thevo line of specialty mattresses for people with dementia, pain, Parkinson's disease, pressure sores, and those who use wheelchairs.

DIRECTIONS recently had the opportunity to visit with Louis about her work in the rehab/HME industry and her experiences in sales and marketing that propelled her to president of Thomashilfen.

How did you become interested in the medical equipment industry?

I started working for Bodypoint back in 1998 when B.L. Meyer hired me as the customer service manager. I had no idea what a powerful impact medical equipment could have on the lives of people with disabilities, as well as their families. It was amazing to have families tell me how much the products made a difference in their lives.

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

I have had a diverse and well-rounded career. After college, I worked for a year as a receptionist and later for more than two years as a lead agent in an import and freight forwarding business.

At Bodypoint, I started as the customer service manager and later became marketing manager. I was there when Bodypoint began distributing Thomashilfen products, and I worked on the early advertisements and sales launch of the products in the U.S. One fall, while working with our distributor at HCR in Tokyo, I had the opportunity to meet Thomashilfen CEO Gunnar Thomas. In January of 2004, B.L. Meyer started ExoMotion, which became the exclusive U.S. distributor for Thomashilfen. At the time, I was pursuing a marketing certificate at night at the University of Washington. As part of a class project, I helped Meyer write a marketing plan for ExoMotion. After completing my certificate, I joined a small company that produced video training programs, and I was a consultant for government agencies including the Department of Veterans Affairs.

But when Meyer called me in 2009 to see if I was interested in working for Thomashilfen, I jumped at the chance. I loved the company and the people and, as much fun as it was to work in the retail wine industry, I was so excited to return to an industry that really had won my heart and one where I knew I could help make a positive impact in people's lives.

Email marketing was new for this era, and I gained valuable skills in that area as well as developed my sales skills. Later, I was sales manager for a small company that made wine accessories, and I focused on large retailers. It was a lot of fun to work with and learn from people who knew a lot about wine. These experiences gave me a fresh perspective and really honed my sales skills.

"I also believe in pursuing your passion. In retrospect, every position in my career has given me a unique set of skills and experiences that helped prepare me for my current role."

But when Meyer called me in 2009 to see if I was interested in working for Thomashilfen, I jumped at the chance. I loved the company and the people and, as much fun as it was to work in the retail wine industry, I was so excited to return to an industry that really had won my heart and one where I knew I could help make a positive impact in people's lives.

Who has been instrumental in those accomplishments?

Two people really stand out: B.L. Meyer and Gunnar Thomas. Meyer was my mentor. She taught me about the industry and countless other things. We worked so well together. We worked hard, but with Meyer in the room you always find time for a good laugh. When she retired, Thomas offered me the opportunity to not only manage the Seattle, Wash., office, but also to acquire part ownership in the company. This family – Thomas, his parents and the extended family – have been true role models for me and made me feel like a part of the company family.

Thomas' grandfather, a carpenter, started the company by building a special mattress for his wife who had multiple sclerosis. Soon, word got out and others in their small town of Bremervorde (Northern Germany) took notice and the next thing you know building mattresses became a regular part of his business. I just can't say enough about the dedication and passion of this family and their business, which is now in their third generation. Thomas' brother and sister manage the commercial mattress division of the company, Lattoflex, which has become a leader in the European market.

Thomas' mantra is to work hard, but have fun along the way, a philosophy I believe in strongly.

What experiences helped you advance to your current position?

I graduated from college with a Bachelor of Arts in Asian Studies, which included a one-year study abroad experience in Japan focusing on intensive Japanese language courses. Back then, I certainly never imagined I would one day be the president of a German-based medical equipment company. But I'm a big believer in a liberal arts education, which offers a solid foundation for a career with many potential paths. I also believe in pursuing your passion. In retrospect, every position in my career has given me a unique set of skills and experiences that helped prepare me for my current role. I'm now leading a small team that is responsible for the sales, marketing and distribution of high quality, specialty medical equipment imported from Thomashilfen headquarters in Germany. From our office and warehouse in Seattle, we distribute throughout the U.S., as well as to Canada and South America.

How did you decide to pursue Asian studies?

When I was in high school, my family started hosting Japanese students. I found their lives and culture so interesting and wanted to take language classes. That was contrary to the expected business graduate for the University of Puget Sound. When I went to study abroad, my dad came across an article that reported a higher job placement rate for students with foreign language skills, helping to validate my choice. Later, I found out my university boasted higher job placement for graduates of the Asian

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DO WHAT YOU LOVE...
(CONTINUED FROM PAGE 21)

studies program, then any other major. Of course, I just had to share that with my dad. Most importantly, I have always thought you should pursue your passion and then find a way to make that work for you. Do what you love, and you'll love what you do.

What has kept you working in this industry?

I love helping people and working with others who share that same passion. It is a rewarding feeling like none I have experienced in other industries. That's what brought me back to the medical equipment world and what keeps me going every day. I truly love the team here; we are just an eclectic group. We all have different strengths and experience levels, but we are all engaged in the idea that we want to help others.

In 2011, you helped lead the company to adopt a new corporate identity. What inspired this change and what has been the outcome?

When Thomashilfen purchased ExoMotion in 2009, we realized our name was confusing to people. For legal reasons, we are still ExoMotion, but we do business as Thomashilfen to better connect our customers with the products and the brand. More importantly, our company name has meaning. Thomashilfen actually translates in German to "Thomas helps." Our mission is to not only create products that improve people's lives, but also provide friendly, helpful support for our customers. When you call Thomashilfen, you speak to a real person, and that could be anyone from a customer service representative to me. We strive to help anyone who has a question about our products or about navigating the medical equipment industry.

We get a lot of calls from families who have just received a diagnosis and find us by searching the web. We believe in finding the best products to meet their needs – even if it's not one of ours. The most important thing we can do as a company is help them understand the process, find the best product for their needs, and navigate access to services. In fact, we've had people say they are coming to Seattle and want to stop by just to say, "Hi." That's tremendously rewarding. Again, it goes back to the Thomas family philosophy, which helps us stand out. By the way, Thomashilfen North America is excited to be celebrating our 10 year anniversary this January!

Congratulations on the success. What's on the horizon for Thomashilfen in the next decade?

Historically, Thomashilfen has embraced innovation as the key to staying on the forefront of technology and new product development. We started as a distributor of children's rehab equipment, representing products from Scandinavia, but later took on the challenge to design and produce our own products, the first being our well-known EASyS pediatric wheelchair. Then we developed our patented MiS Micro-Stimulation® technology for pressure-care mattresses and have continued to find new ways to utilize it in a variety of products and applications. Most recently, we've applied it to children's seating with the ThevoTwist, which, in my opinion, offers amazing results for many children with low tone. A demand in the market, namely from German nurses, helped us create the ThevoSleepingStar, a sensory support mattress for children with special needs. And again, market-driven feedback spurred the development of Thevo mattresses for people with dementia, Parkinson's and pain. This fall, we listened to market feedback once again and launched our newest tRide pediatric wheelchair.

Looking ahead, our diversification will continue to be the key to our future success as well. Our goal remains to provide solutions to improve life and the overall health and well-being of people. We offer products for every age range and a number of conditions – from a child with spinal muscular atrophy type 1 to an elderly person with Alzheimer's disease. Because of this, I believe we are in a good position to continue our success. I feel very good about where we are headed.

> We started as a distributor of children's rehab equipment, representing products from Scandinavia, but later took on the challenge to design and produce our own products, the first being our well-known EASyS pediatric wheelchair.

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DO WHAT YOU LOVE...
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What challenges does Thomashilfen face in this ever-changing industry?

We are a small company offering high-quality products, navigating the challenges of an industry with shrinking Medicaid and private insurance reimbursement rates. We are continually looking for ways to offer our customers more value. For example, we are creating solutions to offer more growth range in our pediatric wheelchairs and offering adjustments that can be made without tools to reduce labor costs for dealers and make life easier for the end-users' families.

Our small staff is knowledgeable and willing to go the extra mile to serve our customers. We pride ourselves on answering calls personally and solving problems promptly. And while we import our products from Germany, we are dedicated to offering a full warehouse of products in Seattle so we can service our customers quickly. We often ship products out the same day or the next business day when we receive a purchase order.

What challenges do you see ahead for the industry as a whole?

Our industry is faced with the challenge of offering a broad choice of products to meet an even wider range of end user needs in an economic and political environment that is calling for limiting these options in order to cut costs. In the world of Complex Rehab Technology (CRT), one size does not fit all. I'm optimistic that things will work out, although it might be painful as we go through the process, since there are still a lot parties that have to be educated about the value of CRT.

What roles outside of your corporate position do you have in the medical equipment/complex rehab industries [boards, association memberships, etc.]?

I have been active in supporting the Western Washington chapter of the Alzheimer's Association in its fundraising events. I also enjoy attending fundraisers for children with special needs. I try to look for opportunities to connect with local organizations supporting causes near and dear to my heart. As a company, I would love to dedicate more to organizations such as Families of Spinal Muscular Atrophy. They are an amazing community we have connected with through their embrace of our EASyS Stroller. The other side of our business, elder care, has inspired my personal involvement with the Alzheimer's association – my grandfather passed away from Alzheimer's.

In a small company, leadership usually has multiple roles and responsibilities. What does a typical work day/week look like for you?

When you work for a small business you wear multiple hats, and my situation is no different. I don't really have a typical day or week, but that's what makes this position so interesting and fun. I do like to start my day early, around 4:30 a.m., so I can get in a morning workout, my coffee, and a jumpstart on reading emails, and then be in the office by 7:30 a.m. My German colleagues are nine hours ahead, so that gives me a chance to communicate with them by phone or email before their work day ends.

During my workday, I focus on business strategy, developing new partnership opportunities and growing our existing ones. I am involved in regular marketing meetings and sales representative calls, too. I also pick up the phone and talk to customers. I have a terrific team who takes care of business and daily operations when I am on the road at a tradeshow, a sales meeting, or at a partner meeting in Germany.

What is life outside of the 9 to 5 like for Elisa Louis?

My husband and 6-year-old daughter are my world. They support me so much and share in my successes and challenges at Thomashilfen. In fact, for a couple of weeks last year we hosted the 16-year-old son of Gunnar Thomas' best friend. The teen did an unpaid internship for Thomashilfen North America to fulfill his German school requirement. We bonded so much with this fantastic young man, my daughter even cried when we took him to the airport and had to say goodbye.

In fact, she and I recently began classes on Saturday mornings at the German Language School of Seattle to pick up some of the language, (no easy task, by the way) despite the fact that my colleagues in Germany speak brilliant English.

My daughter and I also love to cook and bake together. At her age, she's already a little foodie and an aspiring chocolatier. I also take her to tennis and swimming lessons on the weekends. During her lessons, I enjoy watching her and socializing with her friends' parents.

Sometimes you'll find me helping my husband on the restoration of our 1919 vintage, Craftsman-style home here in Seattle, which will be a lifelong project we say. My husband is a brilliant carpenter, and I often am the gofer. In fact, we just completed the addition of a 153-bottle wine cellar and tasting room that is pretty fantastic.

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NEW NRRTS BOARD MEMBER THRIVES ON INDUSTRY'S CHALLENGES

WRITTEN BY: JULIE BARNETT

Andrea Madsen of Rochester, Minn., lives in a very medically centered community. As home to the Mayo Clinic, the first and largest integrated not-for-profit medical group practice in the world, it's arguably one of the most medically focused communities in the nation.

Madsen, ATP, CRTS®, began her career 10 years ago in the billing department of Med City Mobility in Rochester. Before that she had been a pre-med major in college, but soon found a different calling.

"I realized that medicine was not for me," she said. "It just seemed too distant from the patient, it felt as though there would be no connection, and that was important to me."

Madsen said she really took to billing, reimbursement and the policy side of the seating and mobility business.

"This was a very young company when I started, just a couple of years old, which gave me the opportunity to help establish the rehab department and shape it, to really grow with the company," she said, noting that she now serves as the manager of the company's complex rehab department.

> "I'm proud of our industry for taking up this fight for our consumers."

She enjoyed the challenge of the billing side, as well as advocating to build an important piece of equipment to meet a client's need. "One thing about me – I like a challenge," she said.

"I'm fortunate to work with people every day who challenge me and help me to grow," she said. "And it's wonderful to see the impact firsthand our work can have for them."

Madsen now has a new challenge on her horizon. New to the NRRTS board of directors, she volunteered to serve as an at-large director. "I felt like this position would provide a better opportunity in getting close to the front lines of advocacy and policy. I'm really excited to get started," she said.

She continued, "When I started here, it was such a young company and I had the opportunity to make my own way. But I always felt the impact of policy change after it had happened. I want to be involved early in the process, in changing minds and educating policymakers to guide clients through the complicated processes," she said. "It's up to us to make it as easy for them as possible."

Madsen believes standing together is important for the industry.

"A core focus of the assistive technology industry is to continue to differentiate our practice from traditional durable medical equipment, and to be able to educate policy makers, referral sources and funding sources," she said. "Many don't understand how critical this service is to our clients."

She noted that a large number of medical patients come to Rochester who don't have access to these services.

"Because there is such a small percentage of utilization over all of our products, these products are oftentimes not considered critical pieces of rehab," she said. "And we do have a consumer base that is not used to making a fuss to get what they need. It's a never-ending struggle for them.

"I'm proud of our industry for taking up this fight for our consumers."

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NEW NRRTS BOARD MEMBER...
(CONTINUED FROM PAGE 26)

Those daily face-to-face interactions with her clients are what Madsen finds most rewarding about her profession.

"When working in billing, I was often the bad guy who would have to say no," she said, noting that it now gives her an advantage in helping to navigate funding hurdles and in explaining to clients what to expect. "I know what the funding timeline looks like."

> "Our commitment to continuing education takes us leaps and bounds beyond in providing excellent service."

Madsen says one of the biggest challenges facing the CRT profession is in differentiating itself.

"It's so important that we explain how what we do is different than traditional durable medical equipment," she said. "It's oftentimes hard to explain the breadth of what we do."

Madsen believes the industry has changed a lot in 12 years, and mostly for the positive.

She finds the policy requirement of RESNA certified ATPs is an important step to bringing recognition for the work CRT professionals do.

"Our commitment to continuing education takes us leaps and bounds beyond in providing excellent service," she said.

She finds the industry has become a lot more political with advocacy and grassroots efforts to make sure these patients have what they need, and that those efforts result in a greater sense of camaraderie.

"Even as competitors, there's a sense that we're all in this together," she said.

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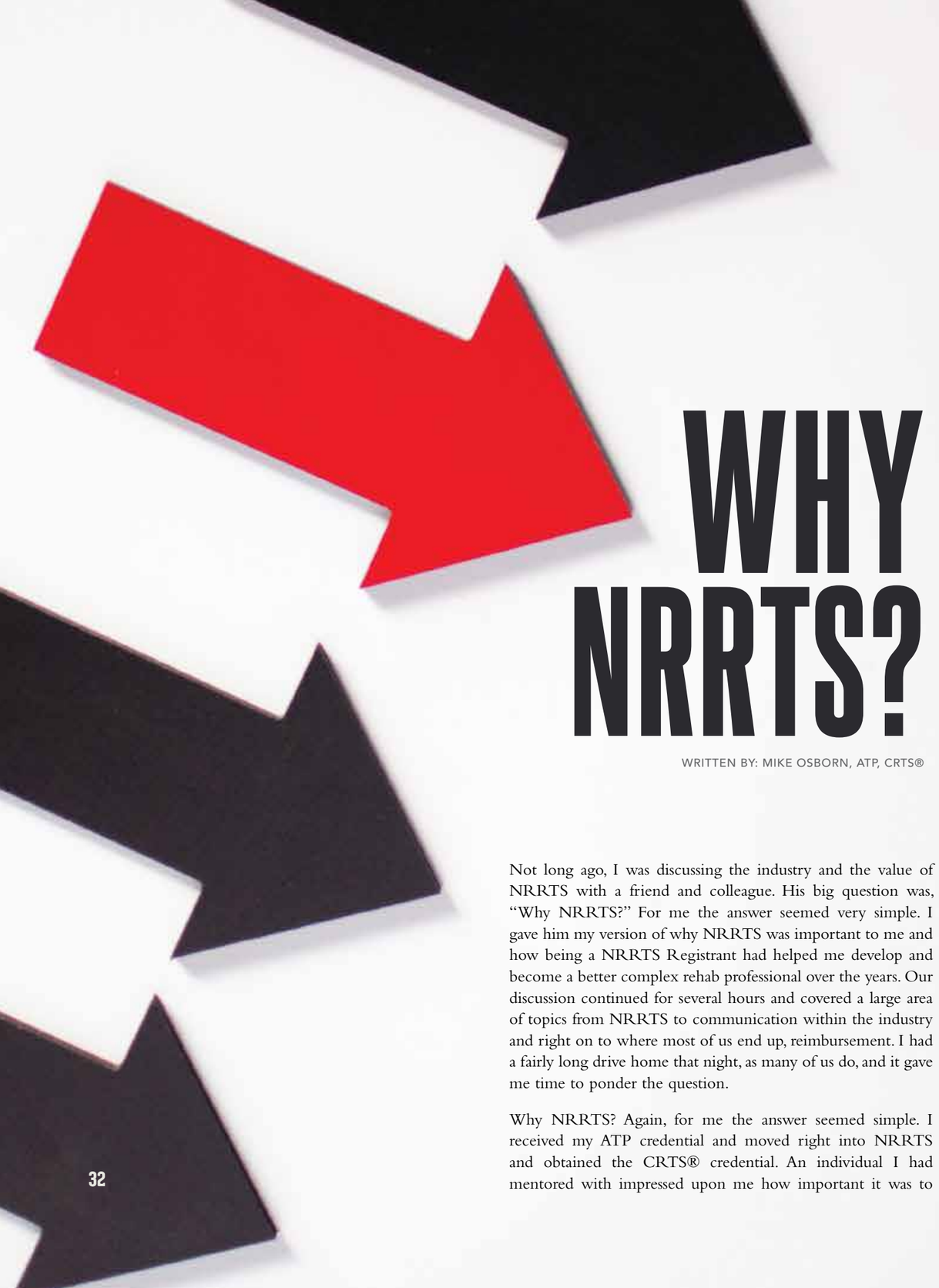

WHY NRRTS?

WRITTEN BY: MIKE OSBORN, ATP, CRTS®

Not long ago, I was discussing the industry and the value of NRRTS with a friend and colleague. His big question was, "Why NRRTS?" For me the answer seemed very simple. I gave him my version of why NRRTS was important to me and how being a NRRTS Registrant had helped me develop and become a better complex rehab professional over the years. Our discussion continued for several hours and covered a large area of topics from NRRTS to communication within the industry and right on to where most of us end up, reimbursement. I had a fairly long drive home that night, as many of us do, and it gave me time to ponder the question.

Why NRRTS? Again, for me the answer seemed simple. I received my ATP credential and moved right into NRRTS and obtained the CRTS® credential. An individual I had mentored with impressed upon me how important it was to have continuing education and never stop trying to improve one's self. This made perfect sense to me, because that was how I had been raised as a child. Always strive to be your best and do more than is expected or required of you. He was convinced NRRTS was the association developed for the complex rehab professional and run by complex rehab professionals. It was a group of individuals who understood what we do, how we do it, and most importantly the obstacles we are up against to do it.

Over the years, I think NRRTS has evolved to support the complex rehab professional in not only understanding the obstacles that are faced, but also by attempting to provide resources to assist in overcoming those obstacles. As I continued the drive home I ran through a list of reasons to answer his question. Why NRRTS?

One of the first things that jumped out to me was the strong code of ethics and standards of practice that NRRTS has in place. I have had the pleasure of serving on the NRRTS board for a few years now, and I am proud to say these areas are extremely important to the board. Our code of ethics is enforced with diligence and timeliness not seen in many areas of our industry. The ethics and standards of practice are what we can hang our hat on as a professional registry, and they are not taken lightly. There are even some states that require their complex rehab professionals to be NRRTS Registrants and one of the reasons is the idea of accountability that comes with that code of ethics.

NRRTS has developed a network of professionals across the country. Clients or referral sources have the ability to pull up the NRRTS website and look for a provider with a NRRTS Registrant employed wherever they may be traveling and know they can count on that individual and company to assistant them with their equipment needs.

The industry is changing, and it has become more and more difficult to keep up with the changes and requirements. NRRTS has developed an interactive website that provides unlimited resources. The newly updated reference library provides a wide variety of articles, case studies and other resources for review.

The ability to obtain all of your continuing education units from your office or home by attending one of the many NRRTS webinars is also a major benefit these days. Visit www.nrrts.org/webinars for the 2014 schedule.

The National CRT Leadership and Advocacy Conference in Washington D.C., that NRRTS assists in putting on has become one of the larger yearly attractions for the Industry. Visit www.nrrts.org/crtconference or see page 5 for more information.

NRRTS has built strong relationships with other organizations such as NCART, RESNA, AA Homecare and many others to assist in the development and passing of the Separate Benefit Category. With the industry changing and the issues and obstacles continuing to appear in the road ahead of us, it is important that we, as a CRT professionals, are involved and share our story, but more importantly share the stories of our clients. NRRTS provides a multitude of information to the CRT professional so involvement and awareness is made possible.

All of these things come to mind as I think about "Why NRRTS?" and why it is important for me to be apart of such a strong and unique professional association. However, while all of these things are important and allow me to do my job better, are they the real reasons to be apart of NRRTS? I guess for me it goes back to a statement I made earlier – always strive to do your best and do more than is expected or required of you. Isn't that what we try to instill in our children for them to achieve more than expected? Isn't that what we look for as owners and employers, individuals who don't stop at being satisfied but push through for greater things?

I read once that we should all set our goal to be uncommon. That is the NRRTS Registrant. You have sought out to expect more of yourself than the requirements set for you. When someone looks a NRRTS Registrant up on the website or sees the RRTS® or CRTS® on a business card they can be assured the individual they are working with has dedicated themselves to the industry because they have obtained more than the industry has asked of them.

I guess for my first president's article I want to say thank you for your loyalty, passion and dedication to NRRTS and to the industry. The real question to ask is not why NRRTS, but why not NRRTS?

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POST THE SCOOTER STORE:

WHAT ALL MEDICARE SUPPLIERS NEED TO KNOW ABOUT WHEELCHAIR REPAIRS

WRITTEN BY: JOSHUA I. SKORA, ESQ.

Competitive bidding has driven hundreds of durable medical equipment (DME) companies out of business, and in many instances, left beneficiaries with the burden of finding repair services on their own. Ever since The Scooter Store went out of business, beneficiaries have had to scramble to find suppliers willing to repair broken equipment placed by The Scooter Store. Suppliers have been hesitant to make repairs because they were uncertain if they would ever get paid, or worse, get audited. Centers for Medicare and Medicaid Services (CMS) has not provided adequate guidance, and competitive bidding has left both contract and non-contract suppliers in a catch-22. Should suppliers help beneficiaries repair their wheelchairs, and if they do, how will they get reimbursed from Medicare?

While it is true suppliers have no obligation to repair beneficiary-owned wheelchairs, if proper protocol and adherence to detail in billing is followed, it can be a lucrative business. The DME universe is split between contract winners and non-winners, making it all the more important for non-winners to seek out creative business opportunities. Wheelchair/DME repair just might be one of those areas, because Medicare allows for the repair and replacement 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, non-winning suppliers may provide loaner equipment while repairs are being made and bill Medicare for a one-month rental if reasonable and necessary.

Suppliers have been wary to take on wheelchair repairs, especially The Scooter Store wheelchairs, because it has been unclear if suppliers can bill for repairs since The Scooter Store wheelchairs may still be under the rental period. Why would a supplier want to take on the risk of no reimbursement if they do not have to? On Jan. 16, 2014, CMS attempted to alleviate some of these concerns by stating the following in the weekly MLN Connects:

Effective Oct. 24, 2013, The Scooter Store transferred title to capped DME rented to Medicare beneficiaries. Medicare beneficiaries now own this equipment. Medicare can pay for repairs to this equipment performed on or after Oct. 24, 2013, if the contractor determines that the repairs are reasonable and necessary in accordance with Medicare regulations and program instructions.[1]

This CMS announcement seems to give all Medicare suppliers permission to repair The Scooter Store wheelchairs because those wheelchairs have been declared beneficiary-owned. It is possible CMS could deny these repair claims for lack of medical necessity documentation when the wheelchair was initially purchased, but since CMS has acknowledged this is an issue and title has transferred from The Scooter Store to beneficiaries, the risk has been reduced. It makes sense for CMS to pay for a repair instead of a new chair. Further, because reimbursement rates for repairs are low, the risk of fraud is minimal. It is our opinion that the risk of audit is minimal in such cases. This means all Medicare suppliers, if they follow the rules and procedures set forth below, can submit claims for repairs, labor and possibly loaners.

Repairs and Labor

Medicare allows reimbursement for repair of medically necessary beneficiary-owned DME equipment, including all types of wheelchairs and scooters.[2] Medicare will not allow reimbursement for repair of rented DME, because the cost is considered part of the monthly rental allowable. For beneficiary-owned equipment, Medicare provides coverage for repairs to equipment that is owned by a beneficiary and allows separate billing for labor costs. These repairs must be reasonable, necessary and make the equipment operable.[3] For wheelchairs, repair charges must be reported using the HCPCS code applicable for each part(s) necessary for the repair and HCPCS code K0739 for labor: K0739 - Repair or non-routine service for equipment other than oxygen requiring the skill of a technician, labor component, per 15 minutes.

Claims for repairs must include narrative information itemizing each repair and the time taken for each repair. Also, the repair claim must indicate the equipment is beneficiary-owned (non-rented and out of warranty).[4] Repairs, unlike replacement, of beneficiary-owned equipment, do not require a new prescription.[5] K0739 claims are reported in units of service, each representing 15 minutes.[6] A unit of service includes basic troubleshooting and problem diagnosis and does not provide payment for travel time or equipment pick-up and/or delivery. Based on the type of equipment and the part being replaced or repaired, payment may be limited to certain allowable units of service, regardless of actual repair time. Claims for repairs of any beneficiary-owned equipment will include at least two HCPCS codes: the K0739 code for each 15-minute interval of labor time (assuming there is not a specific allowable for the repair) and the code(s) for the malfunctioning wheelchair part(s) necessary for the repair.[7] CMS's Repair Labor Billing and Payment Policy limits the amount of units of service allowed for common repairs.[8] Many wheelchair repairs will likely require more labor than the two or three units allowable under the labor pricing policy. Suppliers should familiarize themselves with the labor unit chart before submitting repair claims.

Unfortunately, as with rental equipment, CMS includes pick-up, delivery time and costs in the allowable for the piece of equipment or part that needs repair.[9] The only adjustable fee is tied to the cost of labor, calculated in 15-minute units. Suppliers cannot charge beneficiaries additional pick-up and delivery fees because it would be outside of the assignment fee and a violation of the supplier standards. On an assigned claim, suppliers may not charge a beneficiary for these additional costs. However, on a non-assigned claim, the beneficiary will be responsible for the difference between the submitted charges for the repairs and the amount Medicare pays.[10] But, if the beneficiary assigns its benefits to a supplier, and the supplier charges the beneficiary to go to the beneficiary's home for pick-up and delivery, there is some risk CMS would assert that the supplier has violated Medicare rules by collecting amounts in addition to the Medicare-approved charge for an item or service. It is important suppliers tell beneficiaries whether they accept assignment or not.

CMS Rules and Regulations for Wheelchair Repairs and Submitting Claims

CMS provided detailed rules for DME repairs and replacements under competitive bidding in a MLN Report.[11] The rules apply to both contract winners and non-winners. Listed below are some of the rules applicable to wheelchair repairs, and these must be followed for proper reimbursement and to avoid potential audits:

• If the repair of a competitively bid, beneficiary-owned equipment requires the replacement of a part to make it serviceable, that replacement part may be obtained from either a contract supplier or any other Medicare-enrolled supplier.

• Parts include components that are needed to repair the base equipment. Parts also include certain specified items (i.e., tires, batteries and wheels (e.g, casters) that may be replaced in their entirety.

• Options and accessories such as elevating leg rests, adjustable armrests, and seating systems are composed of many component parts. These items are eligible for repair under these provisions. The entire accessory or optional item must not be replaced as part of the repair as they are considered separately covered items, not as a component part of the base equipment.

• Miscellaneous parts that are not identified by a specific HCPCS code are billed using HCPCS code K0108 for wheelchairs, and paid based on the contractor's individual consideration of each claim.

• Medicare pays the single payment amount for the replacement part if the HCPCS code for the part is a competitively bid item in the CBA and is used to repair base equipment that is also a competitively bid item in the CBA. Otherwise, Medicare payment for the part is based on the lower of the actual charge or fee schedule amount for the replacement part.

• The RB modifier must be used with the HCPCS code for all replacement parts furnished in conjunction with the repair of beneficiary-owned base equipment. If the replacement part is a competitively bid item, suppliers must use the KG, KK or KY modifier, when appropriate, in addition to the RB modifier to identify the competitively bid item used in repairing competitively bid base equipment.

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POST THE SCOOTER STORE *(CONTINUED FROM PAGE 33)*

• The supplier must have information in its records documenting what item is being repaired, why the equipment needs to be repaired, why replacement of the part is needed to repair the base equipment, and any other information specified by the DME MAC. There must be sufficient detail to justify the units of labor charged to K0739.

• Medicare payments for replacement parts that are competitively bid items and used to repair competitively bid base equipment must be made on an assignment-related basis.

o In situations in which a supplier is repairing beneficiary-owned, competitively bid base equipment and bills for replacement parts that are competitive items, the supplier must submit a separate claim for the labor component and/or non-competitively bid part(s) and separate claim for the competitive bidding part(s) if, and only if, the supplier is not accepting assignment for the labor component and/or non-competitive bidding part(s). In these instances, the charges being submitted for the competitively bid replacement parts must not be entered on the same claim with the charge for the labor and/or the non-competitively bid part(s).

• Beneficiaries are required to obtain replacement of all competitively bid items that are not part of a repair from a contract supplier when these items are furnished to a beneficiary in a CBA. This includes replacement of base equipment and replacement of parts or accessories for base equipment that are being replaced for reasons other than repair of the base equipment. For example, replacement of a beneficiary-owned seat cushion used with a standard power wheelchair must be obtained from a contract supplier in all cases.

The following wheelchair items are eligible/not eligible to be billed by non-contract suppliers when furnishing repairs:

• Not Eligible:

o Replacement seat cushions (E2601 thru E2608, E2622 thru E2625)

o Replacement back cushions (E2611 thru E2616, E2620, E2621)

• Eligible:

o All other options and accessories are eligible for repair for beneficiary-owned standard power wheelchair, POV, complex, and rehabilitative power wheelchairs.

(CONTINUED ON PAGE 37)

POST THE SCOOTER STORE
(CONTINUED FROM PAGE 34)

Loaners

While the beneficiary-owned item is being repaired, a temporary replacement piece of equipment will be covered and suppliers can bill for the one-month rental allowable. Medicare will pay for loaner equipment for items that will take longer than 24 hours to repair.[12] If suppliers wish to provide loaners, they must use HCPCS code K0462 and no modifiers are required: K0462 - Temporary replacement for beneficiary-owned equipment being repaired, any type.

Suppliers billing temporary replacement equipment under HCPCS code K0462 must provide information pertaining to the beneficiary-owned equipment and the temporary replacement equipment submitted with every claim. The claims must include a description of the equipment being used as a temporary replacement, a description of the beneficiary-owned equipment being repaired (manufacturer, brand name, model name or number, date of purchase), and an explanation of the necessity of the item.[13] Medicare will pay for loaner equipment based on medical need as long as the rental of the loaner for one month and repair charges does not exceed the purchase price of a new piece of equipment. Medicare will pay one month's payment per piece of loaner equipment per repair.[14] This code should not be billed for rental equipment, as temporary replacements during rental repairs is included in the monthly allowable.

Conclusion

Suppliers need not be afraid to do repair work on beneficiary-owned wheelchairs. If the rules are followed correctly, all Medicare suppliers are eligible to repair beneficiary-owned wheelchairs and will get reimbursed for cost, labor, and potentially one-month rental for the provision of a loaner chair. New prescriptions are not required to repair beneficiary-owned wheelchairs, which means keeping track of beneficiary doctors and medical necessity determinations is not essential. Non-competitive bid suppliers should examine this repair/loaner model to determine if there is sufficient economic incentive. It appears to be a way for non-contract suppliers to bill Medicare for parts, labor, and loaner equipment and, at the same time, provide grateful beneficiaries the repair services they have been seeking ever since competitive bidding began.

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References

1 See MLN Connects, Weekly Provider eNews (January 16, 2014).

2 42 C.F.R. § 414.210(e)(1).

3 Id.

4 See NHIC, Corp, DME MAC Jurisdiction A, Ask-the-Contractor Teleconference Q&A – December 12, 2012, TMP-EDO-0049 V2 (Posted, January 11, 2013).

5 Noridian, "Repair and Replacement Workshop Q&A," at https://www.noridianmedicare.com/dme/train/presentations/repairs_and_replacements_q_a.pdf.

6 For the 2014 chart containing state-by-state HCPCS code K0739 unit rates, see https://www.noridianmedicare.com/dme/fees/docs/2014/labor.html.

7 The line narrative (NTE 2400) for K0739 should include the description and need for the repair along with the time taken for each repair. In addition, the claim header (NTE 2300) should include information on the base piece of equipment as follows:

• Date of Purchase

• HCPCS Code or Narrative Description

• Indication of Beneficiary Ownership

Example: "RPRs to PT owned PRIDE JAZZY610 K0011 PWC PUR 41630" (51 characters).

See supra note 4.

8 Noridian, Repair Labor Billing and Payment Policy (2/25/09), at: https://www.noridianmedicare.com/dme/news/docs/2009/02_feb/repair_labor_billing_payment_policy.html.

9 Noridian specifically addressed this issue of pick-up and travel time in its DME FAQs page and said:

Q. For repairs, may travel time be charged using the A9900 procedure code for DME supply or A9270 non-covered service?

A. Travel time is included in the reimbursement of parts and labor and MAY NOT be paid separately. If a supplier chooses to bill separately, code A9901 (DME delivery, set-up, and/or dispensing service component of another HCPCS code) must be used. This code is autodenied as a CO denial. HCPCS code A9270 must not be used.

The Noridian FAQs page can be found at: https://www.noridianmedicare.com/dme/news/docs/2007/10_oct/repair_replace_faqs.html

10 71 FR 65884, 65919 (Nov. 9, 2006).

11 See CMS MLN Report, DMEPOS Competitive Bidding Program – Repairs and Replacements, ICN 905283 (March 2013).

12 See supra note 4.

13 Id.

14 Id.

WHAT'S UP FOR 2014?

WRITTEN BY: DON CLAYBACK

Ready or not, we have entered a new year and have plenty of CRT issues and initiatives underway. We wanted to review where we are headed with our federal Separate Benefit Category (SBC) legislation and also share the details of the 2014 "CRT event of the year." So, let's get started.

Federal SBC Legislation

Yes, we are still working on this! When the Separate Benefit Category initiative started, we said getting our Complex Rehab Technology (CRT) legislation passed would be a marathon, not a sprint. And so it has been. While we have not crossed the finish line, we have passed key mile markers and are making solid progress toward our ultimate objective.

The year 2013 was a busy year. It included the reintroduction of our House of Representatives bill in March, the introduction of a Senate companion bill in May, a wide variety of individual and group advocacy activities, the securing of support from 86 House members and seven Senators. Furthermore, in mid-December Sen. Charles E. Schumer, D-N.Y., proposed to the Senate Finance Committee that our CRT legislation be attached to a larger year-end Medicare bill (Sustainable Growth Rate legislation to delay scheduled cuts to physician payments).

The goal of the National CRT Conference is to bring CRT stakeholders together in one place for high value education, networking and advocacy.

Unfortunately, Schumer's year-end CRT amendment was not accepted by the Finance Committee. Very few amendments were added. However, it's extremely significant that he took the opportunity to attempt to get our bill attached. It shows his serious commitment to help us move this forward and definitely elevated the credibility and attention to our legislation. His action is an important development to share with your own Senate offices as you ask them to sign on.

These incremental steps toward passage did not come easy. We want to send out a huge thank you to all the people and organizations that pushed for support of the CRT legislation with their members of Congress in 2013. It definitely paid off.

Our progress is directly attributable to the collective persistence of dedicated consumers, families, caregivers, clinicians, providers, manufacturers, disability rights advocates, and others who took the time to ask their members of Congress to help protect access to CRT. We've proven that taking the time to make the initial contact and doing the required follow up does, in fact, produce results. But it does take time, and it does take persistence.

On Jan. 1, 2014, H.R. 942 had 86 representatives signed on with strong bipartisan support from 58 Democrats and 28 Republicans. We have solid key house committee support with 13 members on the Ways & Means Committee and nine members on the Energy & Commerce Committee.

On the Senate side, S. 948 had seven senators signed on with bipartisan support coming from five democrats and two republicans. We have good Senate committee support with three senators on the Finance Committee and one Senator on the Health, Education, Labor and Pension (HELP) Committee. However, we definitely need more Senate co-sponsors as we move ahead.

The good news is we carry our positive 2013 legislative momentum into 2014. Congress will be very busy in the first few months and the year also includes November elections. An election year always comes with its own dynamics.

Our overall plan for 2014 continues to focus on two activities: the first being securing more co-sponsors in both the house and Senate, and secondly, having targeted discussions with the staff and members of the key House and Senate committees. On the House side, we need to get to at least the 100 member co-sponsor mark. That will be the house assignment for CRT stakeholders for early 2014. On the Senate side, we need to see a significant increase in co-sponsors. That will require a renewed outreach to your senators.

Please visit www.access2crt.org and review the co-sponsor list, which is arranged by state so you can see which members from your state have signed on. More importantly, you can see who has not signed on. They need to hear from you and others in your state.

The site has all the information you need to tell the CRT story and ask for support of our legislation. To help in your efforts, you can download and distribute the CRT Legislation Information Pack that contains the key details and documents relating to our bills. It's a great tool to get your member educated and signed on.

National CRT Conference

This is going to be a don't miss 2014 event! NCART and NRRTS are partnering to hold the second annual National CRT Leadership and Advocacy Conference April 29 through May 1, 2014, at the Hyatt Regency Crystal City in Arlington, Va. This will build on last year's first-ever national CRT conference, which generated high attendee ratings and requests to make it an annual event.

The three day program includes:

Leadership Day – CRT focused presentations for providers and manufacturers to include: health care reform trends; views from an industry CEO panel; financial management best practices; CRT-related revenue opportunities; using technology and social media; handling hearings and audits; and more.

Advocacy Day – Funding and advocacy sessions for CRT stakeholders to include: Medicare and Medicaid updates; federal and state CRT legislative activities; using state protection and advocacy resources; lesser-known funding sources; prep for visits with Congress; and more.

Capitol Hill Day (CELA) – Our annual presence in Washington has been a key factor in the progress to date on our legislation to create a Separate Benefit Category for CRT. Consumers, clinicians, providers, and manufacturers will collectively take the CRT message directly to Congress through in-person meetings on Capitol Hill.

The goal of the National CRT Conference is to bring CRT stakeholders together in one place for high value education, networking and advocacy. It allows providers, manufacturers, clinicians and consumers to collectively focus on important CRT issues and activities. This has never been more important than it is today, so visit the NCART or NRRTS website, get more details, and sign up!

Remember the CRT Motto

We all know CRT coverage and funding challenges continue on the federal and state levels. Thanks for the continued support and work to ensure people with disabilities can access CRT and supporting services they require. There's never been a better time to remember the words of the late anthropologist Margaret Mead, which have been adopted as our CRT Advocacy Motto: "Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has."

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POSITIONING THE HEAD: STRATEGIES TO IMPROVE HEAD CONTROL AND POSTURE

WRITTEN BY: LESLIE FITZSIMMONS, PT, ATP

Head position is a quality of life issue. Good head position and being able to "look someone in the eye" is your first opportunity to connect with another person. It is usually the initial indicator of how a person is truly feeling and creates a first impression. When a person is unable to lift his or her head independently, this opportunity is often lost. A head down position is often mistaken as a "tuned out," "I'm not interested," "don't bother me" type of body posture – when in reality this posture may be a genuine inability to hold one's head up as a result of weakness, tone or poor seating. But this is just the tip of the iceberg when it comes to the reasons that good head position is so important.

Improved head position means improved breathing, swallowing, heart rate, communication, learning, visual field, and comfort, as well as decreased influences of abnormal tone and reflexes. We will discuss each issue in-depth to really drive home the point that these are not small issues and that just tilting the chair to provide gravity assist is not always the best solution!

Breathing: When there is good anatomical alignment of the neck, the airways are in an optimal position for respiration. Think of CPR – it is not performed in a head down position. Very often a head-down position is accompanied with a rounded back (kyphotic posture) with protracted shoulders. This causes compression of the lungs and **hypoventilation.**

Lower oxygen levels result in the heart having to work harder – increasing heart rate and causing fatigue. When writing your letters of justification validating the need for a more supportive headrest system versus a simple occipital pad, pertinent objective, comparative information can be obtained using a pulse oximeter. Take readings in both head rests, deriving differences in heart rate as well as O2 levels. It is also relevant to comment on any changes in breath sounds, depth and rate of inspiration.

Swallowing: Inability to safely ingest food and obtain proper nutrition has a very significant impact on medical status, growth, fatigue and function. Aspiration of food can result in aspiration pneumonia, which can ultimately be fatal. Many of our clients lack the ability to smoothly coordinate the rhythmic sequence of suck-swallow-breathe that assures a safe swallow. They have problems with lip closure, coordinated tongue movement and management of their own saliva, resulting in excessive drooling. When the head is down it is difficult for the lips to form a more natural barrier and keep the food or secretions inside the mouth.

The mouth (oral cavity) is the point of ingestion, but also plays a major role for air exchange. Under normal conditions the nose serves as the primary air entrance. The ports for air and food meet at the throat (pharynx). This is in the area of the **Hypo pharynx,** which serves as the gating zone where respirations and ingestion must alternately use the same space. It is the job of the epiglottis (a piece of cartilage tissue found at the base of the tongue) to stand guard at the entrance of the glottis.

During typical swallowing, the hyoid bone is elevated, which pulls the larynx upward and allows the epiglottis to fold over and prevent food from entering the trachea (windpipe) while it directs the food to the esophagus. When there is poor head and neck position (neck hyperextension, forward flexion, lateral flexion or any combination), the epiglottis is put at a poor mechanical advantage to appropriately function, often resulting in incomplete covering of the trachea and leading to aspiration. Often hypotonic clients are reclined and/or tilted to provide gravity assist for head position.

The trouble is that gravity also assists in having the food quickly fall back toward the pharynx , as well as interfering with more controlled mastication or manipulation of the food. Presenting or receiving food in a head down position can also be difficult and dangerous. Often the swallow is incomplete and food tends to spill out or "pocket" at the sides of the mouth. Once the head is lifted, food may fall to the center of the mouth at a later time resulting in the client attempting to complete the swallow unsupervised and increasing

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POSITIONING THE HEAD...
(CONTINUED FROM PAGE 40)

aspiration risk. "What you do at the hips, you see at the lips!" was a catch phrase that one of our speech therapists brought home from a conference, reinforcing the fact that poor pelvic position, unsuitable seating choices and improper set-up of a wheelchair can effect trunk alignment, head position and swallow, but that is enough info for another article.

Again when writing your letters of justification, pertinent objective, comparative information can be reported regarding the time spent consuming a meal, amount of food consumed within a certain time frame, anxiety level, any observed coughing, choking, etc. If safe swallowing is questionable for your client, I can't stress enough the importance of a referral to a **qualified speech therapist** who will make appropriate recommendations. There is no catch-all recipe for the many clients who present so uniquely and have very specific needs. Should your client require a **video fluoroscopy**, be sure the testing site will allow the study to be performed in the client's personal wheelchair with all of the secondary supports routinely used during mealtime. This can make a big difference in the findings.

Communication: As we all know, communication occurs through many avenues. Since many of our clients are non-verbal, it is even more imperative that we be able to read their body language and facial expressions. Often eye gaze is used with a low tech communication system (such as an E-Tran) or with eye gaze systems on speech generating devices to indicate needs or wants by looking at specific areas. When using augmentative equipment it is often helpful to face the user for improved interpretation. If someone is verbal, an erect head position encourages increased chest expansion and breath support, as well improved projection in the right direction. When the head is down the client projects into the chest or lap which diminishes volume and intelligibility.

Vision: Our client's **visual field** may be grossly limited if we have not assisted them in achieving neutral head alignment. Instead, a head down results in looking at the floor and a hyperextended head results in looking at the ceiling. We have taken away another avenue of learning, social interaction and inclusion. If the remedy is tilting back or reclining the client to provide gravity assist, this encourages downward gaze or leaves them with an unstimulating view of the ceiling (unless they are at the Sistine Chapel!). Reclined **leisure sitting** encourages passivity as compared to an upright forward lean, **active sitting** posture.

Caregiver/Social Aspects: When a client's head is upright, appearance is improved, with resulting positive comments and improved self-esteem. If the caregiver does not have to spend half of his or her day helping to reposition and the other half of the day constantly reminding the client to "fix your head," there is decreased energy consumption and a much less stressful environment for everyone involved. It is especially important during transportation that the client's face is visible to the caregiver, allowing monitoring of medical status, seizures, etc.

Comfort/Contractures: Over time, a static position will result in over lengthening of one group of muscles and shortening of the opposing muscle group. Lost range of motion can interfere with basic ADL needs including hygiene and dressing. The activities can become painful for the client to perform even with assistance due to contractures. The over lengthened muscle group is put at a decreased mechanical advantage, making it even more difficult to develop any strength or control.

Influences on Tone and Primitive Reflexes: Excessive tone and repetitive spastic patterns of movement can make it very difficult for the client to comfortably maintain a well aligned seated position, impacting every quality of life issue listed above and then some. **Primitive reflexes** are intricate patterns of movement in response to sensory stimuli to the head and neck that cause major changes in muscle tone and posture throughout the entire body.

Now comes the "If" section! **If** the client has retained obligatory **primitive reflexes** or the reappearance (frontal release sign) of these, **a poorly supported head and neck can contribute to the facilitation of these reflexive patterns of movement.**

If there is no intervention to help maintain neutral head and neck alignment, merely allowing the chin to rest on the chest may facilitate a **Symmetrical Tonic Neck Reflex, STNR**, resulting in flexion of the upper extremities and extension of the lower extremities, setting the scene for a more kyphotic , tight upper torso. Conversely, if the neck is allowed to hyperextend, it will facilitate extension of the upper extremities and flexion of the lowers. Both impact pelvic position.

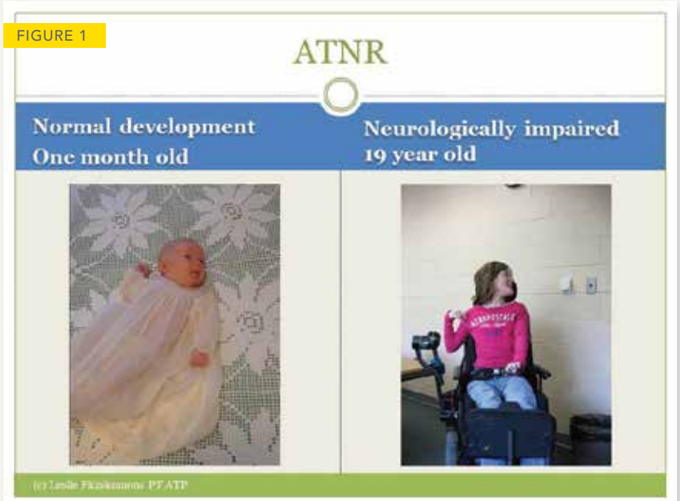
If your client has difficulty lifting his or her head in a linear path due to muscle imbalances, causing them to rotate and turn their head to the side while lifting, this may be the source of getting stuck in the problematic pattern of an evoked **ATNR** (***see Figure 1)***. An **Asymmetrical Tonic Neck Reflex, ATNR**, is facilitated by active or passive turning of the head to the side, resulting in flexion of the arm, leg and trunk on the skull side and extension of the trunk and extremities on the face side, often referred to as the fencing posture. If it is left unaddressed, it can lead to chronic asymmetrical posturing that may result in scoliosis, pelvic obliquity, windswept lower extremities and hip problems.

If you note changes in tone when you tilt or recline a client in their wheelchair (maybe you are using gravity to assist getting your client back in their wheelchair and it becomes increasingly difficult to secure pelvic positioning belt), it is possible you are eliciting a **Tonic Labyrinthine Reflex (TLR)**. The supine position, TLR, will **facilitate** extensor tone throughout all four extremities, neck and trunk. The client will often present thrusting or sliding out of their chair, making it difficult to remain comfortably seated.

If there is inadequate head support and poor suspension in the wheelchair, making for a bumpy ride, the sudden drop or backward movement of the head may elicit a **Moro Response** causing extension of the trunk and extremities in a startle pattern, **followed** by withdrawal into a flexed posture.

If there is stroking of the cheek or perhaps cutaneous stimulation via contact with the headrest or an accessory in that area, the client may turn their head to that side due to a **ROOTING** response. This can easily lead to an **ATNR** response as well. Am I saying a head and neck maintained in neutral alignment will directly affect the integration of primitive reflexes? No. **But if we do not** intervene and we allow (or in some cases even encourage through switch placement) the facilitation of these patterns of movement to be repeated numerous times an hour or day, we will likely strengthen the patterns and incur the secondary problems associated with them. If you are interested in more specific information on primitive reflexes, interventions and positioning suggestions please visit the NRRTS website for additional information.

FIGURE 1



I am hoping by reviewing these reflexes, stimulus and response, we can establish that although the pelvis is the foundation of any seating system and most certainly affects head position, it cannot be ignored that reciprocally, the head and neck are also key points of control and can affect the position of the pelvis and entire body. These prolonged and repetitive postures may contribute to numerous future problems including contractures, scoliosis, pelvic obliquity, rotation, windswept lower extremities, hip subluxation/dislocation, as well as sheering, which can contribute to skin breakdown. These are indeed major quality of life issues.

My goal is to encourage you to be aware of just how significantly headrest and neck support choices impact your client's life. Using tilt as your only solution might further exacerbate problems. It is important to give your client options and opportunities to trial the many different products available to provide them with the support they require to not just cope, but improve his or her life. Thanks for reading and thanks to all the staff and students at NJID whom I learn from every day.

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HEADS UP!

WRITTEN BY: MICHELLE L. LANGE, OTR, ABDA, ATP/SMS

Head control is very dependent upon a number of factors, including overall position, vision and trunk and head postural control and stability. An upright head position optimizes function such as eating, swallowing, breathing, and visual regard of the environment. In clients with significant physical limitations, the head may provide a means of access to assistive technology, whether a head array to drive a power wheelchair, eye gaze to control a computer or activation of a switch to play with adapted toys.

Brian is a 6-year-old boy with the diagnosis of cerebral palsy and cortical visual impairment (CVI). He was seen for an evaluation to determine the best access method for his speech generating device (SGD). One of his parents' main concerns, however, was the position of his head. Brian kept his head forward most of the time and would actively pull forward when tilted. If I was going to find his best means of access, then he needed optimal positioning as well.

Current equipment: Brian was seated in a tilt-in-space manual wheelchair with a linear seating system comprised of a biangular back, anti-thrust seat, lateral trunk supports, lateral pelvic supports, anterior trunk support (shoulder straps), medial knee abductor, pelvic positioning belt, shoe holders with straps and a head support. His head support was a Stealth i2i with chin prompt and occipital pad. A swing away assembly on the head support held a spot pad with a switch velcroed to it by the left side of his head (for access to the SGD) and a speaker on the right side that provided private listening of auditory cues from his SGD during scanning.

Current posture: Brian was positioned in a slight posterior pelvic tilt with a 90 degree trunk-to-thigh angle. The angle of the back canes to seat rails, as well as the seat-to-back angle was actually open (greater than 90 degrees). It is always important to measure the client to determine the actual seated angle. His head was either hanging forward or hyperextended when upright (see Figures 1 and 2). This hyperextended position was the only way Brian could keep his head upright without his head falling forward. He did not have adequate head control in the current seating system to balance his head in a more neutral position.

Problem List: The medial knee abductor was too far back and was behind the knees, rather than between them. The lateral pelvic supports were too tight, causing potential discomfort and making it tougher to position his pelvis well on the seat.

Seating Evaluation: Brian was examined in supine on a mat on the floor and sitting on my lap while I sat in a chair, as no mat table was available. He has very low tone in his trunk and neck. This has reportedly worsened since placement of a Baclofen pump last fall. I recommend the family discuss this with the rehab team. The dose may need to be decreased if trunk control has worsened. Brian requires a slightly open seat-to-back angle to prevent moving into a posterior pelvic tilt due to range limitations at the hips. His parents reported that he has bilateral hip dysplasia, which causes discomfort and limits his sitting time in this seating system.

Seating Interventions: Several changes were made during the evaluation that improved overall posture, including opening the seat-to-back angle to accommodate range limitations, moving the medial knee abductor forward, widening the lateral pelvic supports, adjusting the position of the headrest and increasing the angle of the back over the biangular break. By opening the seat-to-back angle, his posterior pelvic tilt was decreased and trunk control was improved as a result. Increasing the angle of the biangular back maintained the desired amount

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> One of his parents' main concerns, however, was the position of his head. Brian kept his head forward most of the time and would actively pull forward when tilted.

HEADS UP! *(CONTINUED FROM PAGE 44)*

of hip flexion, but facilitated increased trunk extension, which in turn facilitated better head control (see Figure 3). Most importantly, this position improved function. Brian was able to visually observe his environment, demonstrated improved swallow and could access his left head switch with better control and consistency.

Brian spends so much time with his head hanging forward that he has very elongated neck extensors. He does have a Hensinger and swirl collar at home. He may benefit from using these periodically to prevent further elongation of the neck extensors if he is in a position where his head tends to hang forward.

Access: Brian uses a switch by the left side of his head to access his SGD He also has a personal speaker on the right side for auditory scanning as he does not see the SGD well due to cortical visual impairment. His access was adversely affected by his constant forward head position. With the changes to the seating system, his head control was improved and

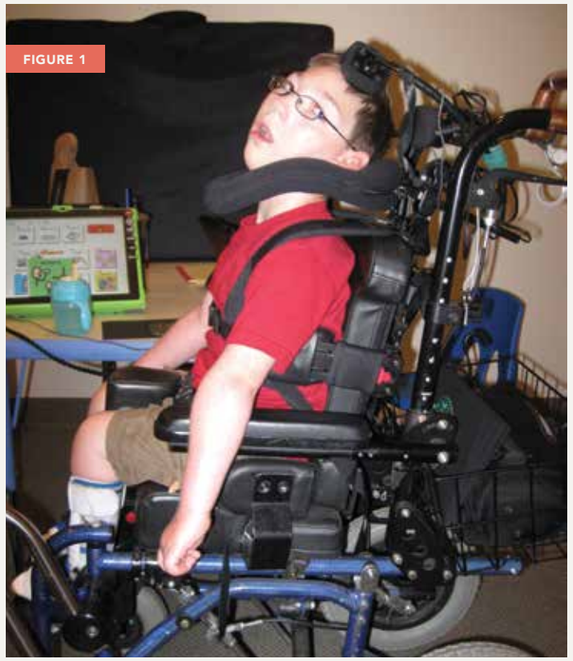
FIGURE 1

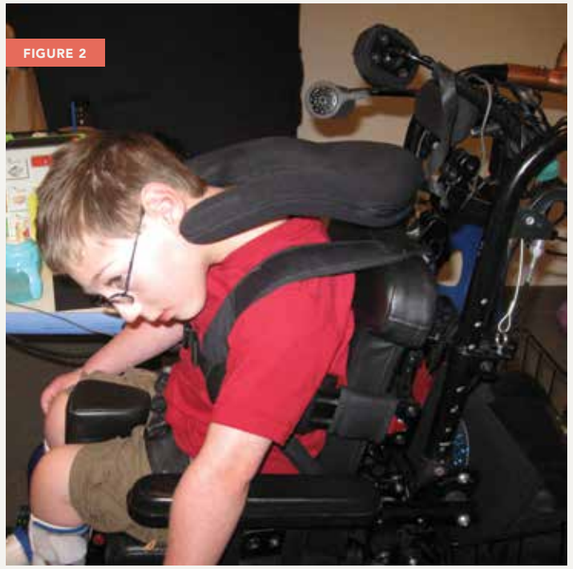
FIGURE 2


FIGURE 3

FIGURE 1 *(TOP):* BEFORE SEAT ADJUSTMENTS, THIGH- TRUNK ANGLE IS TOO CLOSED, AND NECK IS HYPER EXTENDED.

FIGURE 2 *(ABOVE):* TRUNK AND HEAD HANG FORWARD BEFORE SEAT ADJUSTMENTS

FIGURE 3 *(RIGHT): AFTER ADJUSTMENTS, THE THIGH-TO -TRUNK ANGLE IS MORE OPEN*, HEAD POSITION IS IMPROVED.

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HEADS UP! *(CONTINUED FROM PAGE 46)*

subsequently his access. The switch was moved down closer to the left cheek bone so that a smaller movement is required (the original switch location is seen in Figure 1 and required neck hyperextension to activate as he had insufficient lateral head movement in this position). A spot pad was placed at the right side of the head to provide more lateral support and the speaker was placed near this. He may also benefit from a left spot pad to stabilize against with the current AbleNet Spec switch just distal to the pad to further increase stability for access. He would then pivot off of the pad to access the switch. The occipital pad on the current head support was quite small and a larger, more contoured pad was recommended to increase occipital support.

I'm always amazed at how even slight changes in seated angle and position of components can have such a dramatic effect on the posture of the clients I work with. Brian didn't need a new seat or wheelchair in this case. He didn't even need a new head support to improve his head position. He did require an assessment to determine why he was assuming his current seated posture and to then determine what needed to change to provide a more functional posture. I'm excited to see how he progresses with his communication.

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COMPLEX REHAB TECHNOLOGY ON OUR MINDS

WRITTEN BY: ANN EUBANK AND ALEX BENNEWITH

As spring approaches, advocacy for complex rehab technology (CRT) is in full swing. Advocates across the country are passionate, informed and organized – ready to collaborate with the supplier and clinical communities throughout 2014.

United Spinal Association will be pushing hard through 2014 to make Ensuring Access to Quality Complex Rehabilitation Technology Act of 2013 (H.R. 942/S. 948) a reality for the hundreds of thousands of individuals with spinal cord injuries and disorders and other disabilities who rely on Medicare. These individuals have every right to participate in society as they choose – by going to work, attending school, worshipping, visiting their physicians, shopping, and engaging in social and community activities.

The cause for access to CRT continues to build throughout the community of people with disabilities... **We thank you for partnering with us** - let's see what we can make happen in 2014!

United Spinal Association, along with the UsersFirst program, spearheaded a successful advocacy campaign as part of National CRT Week last August and we are in the process, along with our colleagues in the rehab and supplier communities, in turning that National CRT Week into a National CRT Year.

To that end, in addition to the National CRT Leadership and Advocacy Conference this April, complex rehab technology was selected as one of three signature public policy issues to be addressed at this year's National Multiple Sclerosis Society's Public Policy Conference to be held in Arlington, Va., from March 10-12, 2014. United Spinal Association and the National Coalition for Assistive and Rehab Technology will be addressing the more than 300 multiple sclerosis activists in attendance in an effort to prepare them to tell policymakers why H.R. 942 and S. 948 must be enacted into law in 2014. Access to wheelchairs that meet medical and functional needs is important to many disability organizations.

Wheelchair users are being hit hard, as you all know too well. Last year, the K0009 code was eliminated, some CRT codes were converted to capped rental items (which goes into effect this April). Face-to-face requirements are now in place for common repair parts such as wheelchair locks and seat-belts, including reductions in consumer access to wheelchair repairs due to CMS's bidding program. Enough is enough!

United Spinal and UsersFirst have been an integral part of the dialogue on Capitol Hill and with CMS on all of these issues and be assured that we will continue to do so. Earlier in January, United Spinal, NCART, the ITEM Coalition and the Clinician Task Force met with the CRT legislative sponsors to discuss legislative strategy for 2014, and they told us that the time is now as physician payment reform is being addressed in Congress to push for CRT legislation. With an expanded consumer base including the National Multiple Sclerosis Society, the ITEM Coalition, the ALS Association and others advocating along with us within the clinician and supplier communities, United Spinal is predicting that 2014 is going to be a good year.

The cause for access to CRT continues to build throughout the community of people with disabilities. United Spinal and UsersFirst welcomes all stakeholders to unite and organize with us. We are a very strong voice together. If you would like to be keep track of our activities, please like us on Facebook (Facebook.com/UsersFirstAlliance) and register on our list (www.usersfirst.org/forms/join.html) to receive important policy updates.

We thank you for partnering with us – let's see what we can make happen in 2014!

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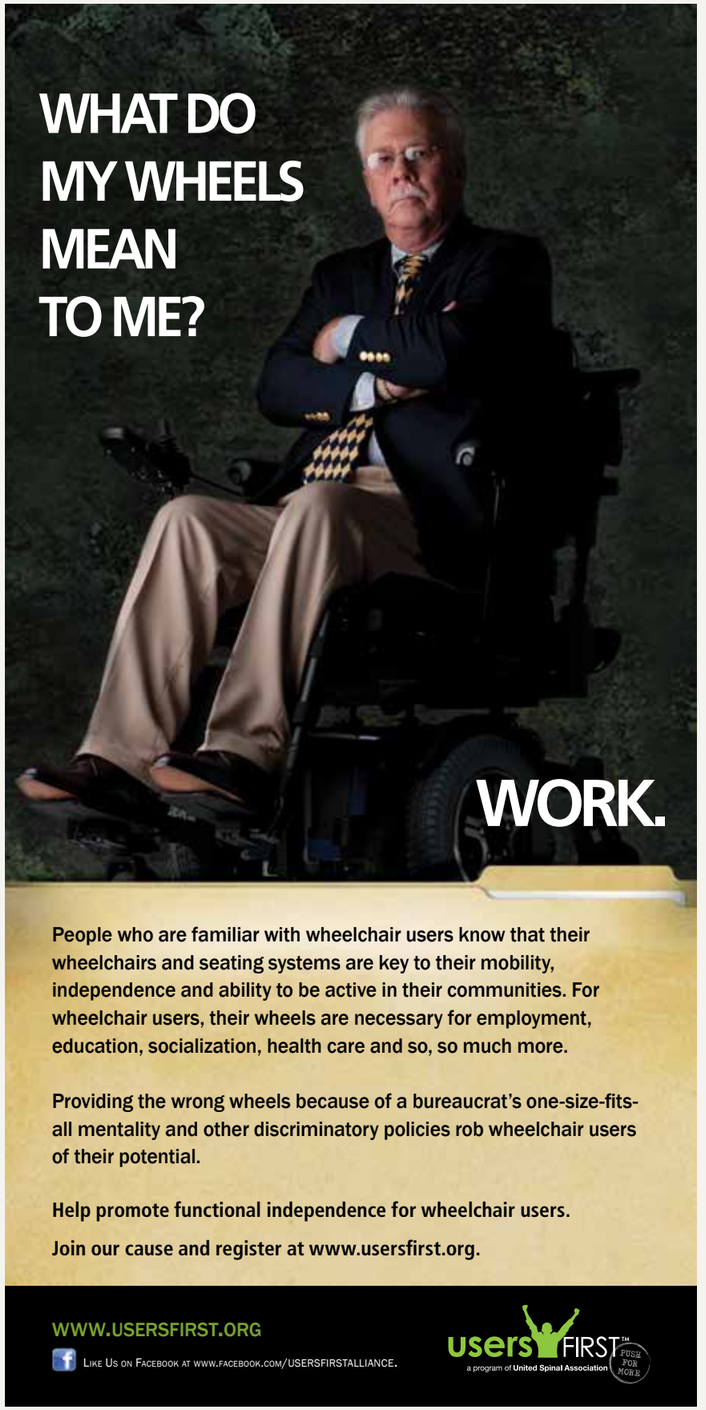

WHY THE SMS? RECENT SMS CERTIFICATE HOLDERS AND A PROVIDER HAVE THEIR SAY

WRITTEN BY: ANDREA VAN HOOK

The Seating & Mobility Specialist (SMS) certification is an advanced certification for professionals who work exclusively in seating and mobility. It recognizes and identifies rehabilitation professionals with advanced clinical knowledge, expertise and skills. In contrast, the Assistive Technology Professional (ATP) certification is an entry-level certification designed to establish a base level of knowledge among all assistive technology professionals, which includes not only seating and mobility, but also augmentative and alternative communication, computer access, job accommodations, and more.

Right now there is no regulation or requirement for professionals to obtain the SMS certification. However, some employers, such as Quantum, have begun to emphasize the SMS certification.

"Quantum is very proud of our emphasis on ATP/SMS certification for our complex rehab team members. We have been looking for these qualifications in new rehab product specialist hires, and provide reimbursement to those currently on our team who pass the ATP/SMS exams," said Julie Piriano, director of Rehab Industry Affairs. "We believe that field representation with ATP/SMS certifications offers our complex rehab providers and consumers the highest level of professionally-based service."

"I feel it is essential to have a knowledgeable therapist with expertise in seating and mobility as a crucial part of evaluations and recommendations, at least with the more involved children and particularly the medically fragile child."

There are approximately 122 SMS-certified individuals currently active in the United States and Canada. RESNA launched the Seating & Mobility Specialist exam in 2009, due to community input expressing a need for an advanced certification. The exam focuses specifically on seating, mobility and positioning. There are 165 questions, and it includes photographs and videos. Questions cover performing an assessment; funding resources, coverage, and payment; implementing an intervention; outcomes assessment and follow-up; and professional behavior. An active ATP certification is a prerequisite for the SMS.

Craig Kraft, seating coordinator at Shiners' Hospital for Children in Tampa, Fla., passed the SMS exam in July 2013. He's held his ATP certification since 2004 and has been working in pediatrics seating and mobility for more than 20 years. He didn't need the SMS certification for his job, but after volunteering on RESNA's Professional Standards Board, which oversees the certification programs, he decided he needed to "walk the talk."

"Many providers do what they have to do to get by because it's not required," he said. "But I believe that if you are in the field long enough, and your primary responsibility is seating and mobility, then you will need to get your SMS certification because eventually, everyone else will have it. That's what happened with the ATP certification."

Alice-Marie Laverdiere decided to go after ATP and the SMS certifications right away, to augment her master's degree from California State University-Northridge in assistive technology and human services. She obtained her ATP certification in September 2012, and followed that with the SMS in February 2013.

"I wanted a way to differentiate myself from other therapists who were active in wheelchair service provision," she explained. "I trusted my clinical skills, but wanted to go back and see if I could still pass the theory aspects of the SMS exam." Laverdiere found her certifications very helpful as she began building a career in international circles. "I recently have been involved in global issues in wheelchair service provision with United Cerebral Palsy Wheels for Humanity and with the World Health Organization that I believe would not have happened for me without the ATP and SMS certifications," she said.

Michele Audet is a clinician who received her ATP in 2001, but didn't try for her SMS certification until last year.

"Equipment options in the '90s and before were limited and not particularly hard to keep up with. That is not the case any longer," she said, in explaining her decision. "I feel it is essential to have a knowledgeable therapist with expertise in seating and mobility as a crucial part of evaluations and recommendations, at least with the more involved children and particularly the medically fragile child."

Despite her years of clinical experience at Children's Healthcare of Atlanta, Ga., Audet found the SMS exam challenging. "It really was very detailed and at an advanced level," she said. "Now that I know the detail and depth of knowledge needed to pass the exam, if I were hiring someone, the SMS certification would be a significant plus in their advantage." Laverdiere found Audet's experience with the exam mirrored her own. "Many of the questions were based on picking not just the correct answer, but the best," she explained. "The exam was formulated to differentiate a 'true' clinician with experience from someone new to the field that only had book knowledge. I was surprised how well the exam captured that."

(CONTINUED ON PAGE 54)

WHY THE SMS?
(CONTINUED FROM PAGE 53)

Kraft found his employer's reaction to his SMS certification gratifying. "Our PR department announced it to everyone in the hospital," he said. "They put the news on the hospital Facebook page, and many people in the community reached out and congratulated me. This made me feel that my employer values my contributions and respects my dedication to seating and mobility for our patients."

In addition to having an active ATP certification, eligible SMS exam candidates must have at least 1,000 hours of direct, in-person consumer service delivery experience in seating and mobility at any time during their career, and demonstrate initiative in two out of seven professional service categories within the past five years. The CRTS® designation in good standing from NRRTS fulfills one of the professional services categories. Information about the professional service categories, and what qualifies, is available on the RESNA website at www.resna.org/certification. The exam fee is $250, and it is offered during specific testing windows throughout the year. Check the website for application submission dates and testing windows.

Everyone interviewed believed the SMS certification has given them increased authority and perspective, within their own teams and departments as well as with outsiders.

"The SMS certification is a great opportunity for wheelchair providers who may be the unlicensed professional in the team evaluation to show their professional commitment to those licensed individuals they work with," Kraft said. "The SMS tells consumers and other professionals that they are serious about their commitment to seating and mobility."

Julie Piriano finds that policymakers pay attention to her certifications. "Having my SMS certification not only demonstrates my dedication to the specialized nature of these products and the services required to provide them, I believe it has increased my credibility with members of Congress, CMS and others when discussing coverage, coding and payment policies that impact the provision of these items for persons with a disability," she said.

In addition, Laverdiere believes that certification shows a commitment to advancing the field. "I would recommend the SMS certification to anyone who has years of experience in the seating field, who is progressive and wanting to expand the impact they can have in this industry," she said.

For more information on the SMS certification, visit www.resna.org/certification.

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NRRTS registrants

Congratulations to the newest NRRTS Registrants. NOV. 14, 2013 THROUGH JAN. 27, 2014

Alicia Correa, RN, BSN, ATP, RRTS®
Bexar Care
7410 John Smith
Ste 108
San Antonio, TX 78229
Telephone: 210-614-3804
Fax: 210-614-3805
Registration Date: 12/2/2013

Richard Evan Franklin, ATP, RRTS®
Mobility Central, Inc.
400 Old Town Road
Vestavia Hills, AL 35124
Telephone: 205-916-0670
Fax: 206-942-2534
Registration Date: 11/26/2013

Donald J. Shiplett, ATP, RRTS®
Motion Mobility and Designs
6490 Prowler St. NW
North Canton, OH
Telephone: 330-244-9723 x.109
Fax: 330-244-9730
Registration Date: 1/9/2014

Jason Tate, ATP, ATP, RRTS®
Rehab Medical
2700 NE Expressway
Atlanta, GA 30345
Telephone: 404-320-9150
Fax: 877-813-0205
Registration Date: 12/19/2013

Faith Uzebu, RRTS®
Durable Medical Supply
720 Glynn St
Fayetteville, GA 30214
Telephone: 770-719-9998
Fax: 770-719-9970
Registration Date: 1/6/2014

Emily Williams, ATP, RRTS®
National Seating & Mobility, Inc.
646 Oliver Drive
Montgomery, AL 36117
Telephone: 334-273-1112
Fax: 334-273-1148
Registration Date: 11/26/2013

new ATP

Congratulations to NRRTS Registrants who earned the ATP credential. Depending upon their registration date, they will be awarded CRTS® upon completion and approval of the renewal following fulfillment of required registration.

Nov. 14, 2013 through Jan. 27, 2014

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Alisa K Adams Consultants, LLC
Atlanta, GA

Keith C. Davenport, ATP, CRTS®
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Woodbury, GA

Jeff Johnson, ATP, CRTS®
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Lindsey Rea, ATP, CRTS®
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former NRRTS registrants

The NRRTS Board determined RRTS® and CRTS® should know who has maintained his/her registration in NRRTS, and who has not. For an up-to-date verification on Registrants, visit **www.nrrts.org**, updated daily. NOV. 14, 2013 THROUGH JAN. 27, 2014

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