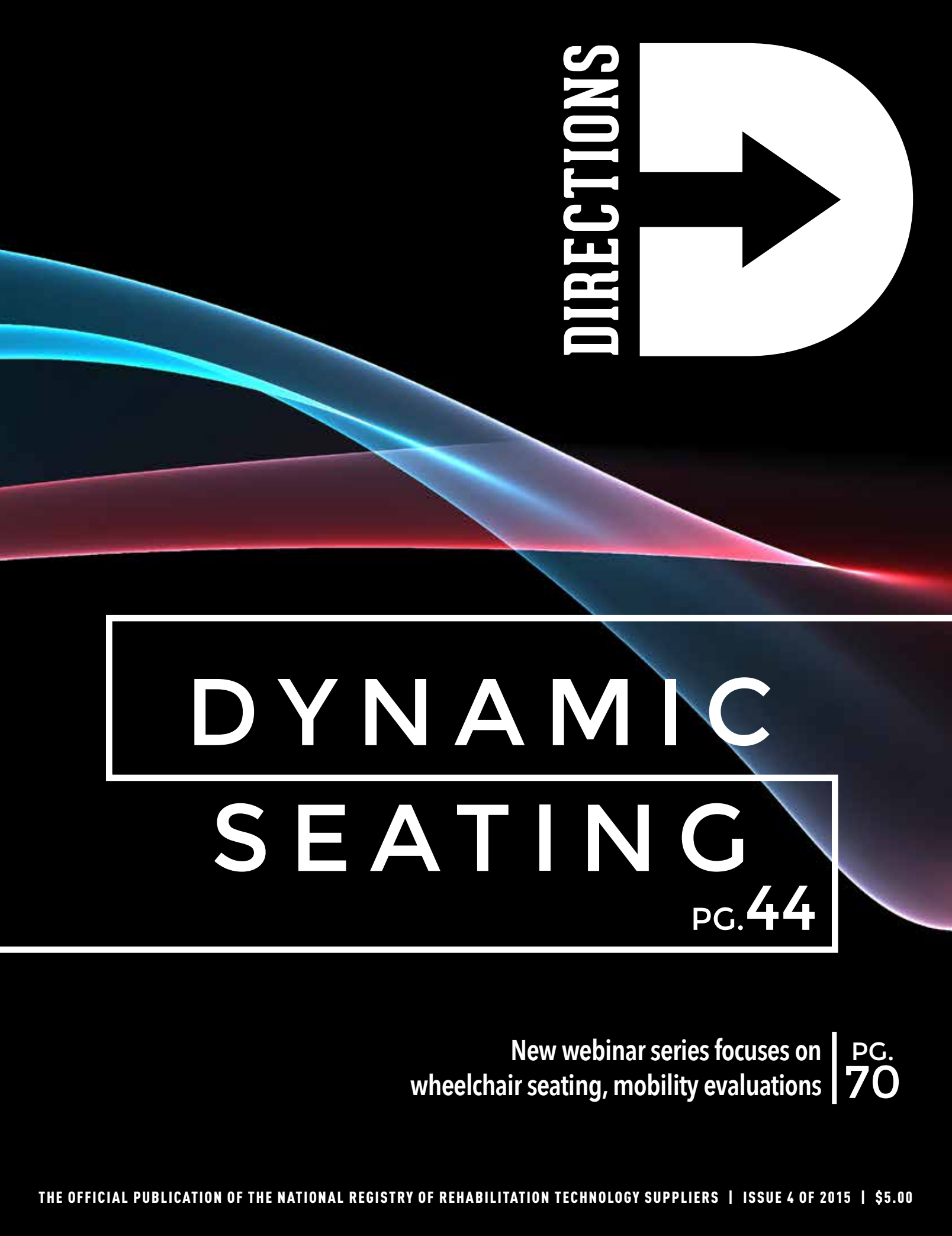

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New webinar series focuses on wheelchair seating, mobility evaluations

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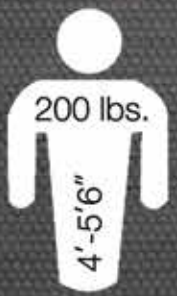

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TUESDAY, AUGUST 18, 2015 | 7PM TO 8PM (ET)

Encouraging Consumers to Become Advocates

JENN WOLFF, OTR/L

After participating in this webinar, you may want to change your wheelchair evaluations. By preparing the consumer for the evaluation (self-evaluation form, guidance on medical history), showing equipment options for inclusion in decision making, and describing the insurance process (including why you may not be able to provide the equipment he or she chooses), you will develop well-informed consumers and create advocates who will potentially gain self-confidence and self-worth and make positive policy change that will benefit everyone. By empowering consumers, you benefit them, and you might create an extremely loyal customer base. Resources will be provided to assist you with this process.

Jenn Wolff, OTR/L, began advocating in 2010 when Medicare denied coverage of a recommended wheelchair. She became a "roller" in 2003 because of a spinal cord tumor and earned a Master of Arts in Occupational Therapy in 2005 from the College of St. Catherine. She advocates in Washington, D.C., several times a year and as manager of UsersFirst tries to educate and motivate wheelchair users, friends and family to join the fight. She is also a board member of the Spinal Cord Injury/Disease Association of Iowa, a member of the Iowa Olmstead Consumer Task Force, and helps facilitate support groups for stroke, Parkinson's and SCI/D.

THURSDAY, AUGUST 20, 2015 | 5PM - 6PM (ET)

New RESNA Standard for Postural Support Devices: What Should I Know?

SPONSORED BY BODYPOINT

KELLY WAUGH, PT, MAPT, ATP, MEMBER OF CTF

In this webinar, participants are introduced to two RESNA Standards related to postural support devices (PSDs): the RESNA WC-3 Part 1 standard on body and seating measures and a newer Part 3 standard on PSD strength testing. The selection of the most appropriate PSD for a client should be partially dependent on the quality, design, safety and durability of the product. The new Part 3 standard, a PSD performance standard, specifies test methods that provide this important information. Utilizing the knowledge gained from both of these standards can improve outcomes for your clients and help to elevate the level of professionalism in our field.

Kelly Waugh, PT, MAPT, ATP, is a senior instructor and the clinic coordinator at Assistive Technology Partners at the University of Colorado in Denver. She is a physical therapist with more than 30 years of experience as an educator and clinician, specializing in the areas of wheelchair seating and alternate positioning. Waugh has participated in the development of wheelchair seating standards since 1998 as a member of ISO and RESNA standards committees. She has lectured extensively on the topics of wheelchair seating assessment, standardized seating measurement, custom contoured seating and nighttime positioning, to varied audiences nationally and internationally. She received her Bachelor of Arts in Human Biology and her Master of Arts in Physical Therapy from Stanford University in Stanford, California.

TUESDAY, SEPTEMBER 15, 2015 | 7PM - 8PM (ET)

Seating and Mobility for Persons with Cerebral Palsy

LAUREN ROSEN, PT, MPT, MS, ATP/SMS, MEMBER OF CTF

Individuals with cerebral palsy are each unique and should be treated as such. There is no "cookie cutter" seating and mobility device that is appropriate for all people with this diagnosis. There are some common issues such as spasticity, joint contractures, and decreased trunk control that individuals with cerebral palsy may experience. This course will discuss these common issues as well as seating and positioning supports that can assist in their management. Case studies with photos and videos will be used throughout to assist the attendee.

Lauren Rosen, PT, MPT, MSMS, ATP/SMS, is a physical therapist and seating and mobility specialist at St. Joseph's Children's Hospital in Tampa, Florida. She is the program coordinator for the Motion Analysis Center, a three-dimensional motion analysis lab where she also manages a pediatric and adult seating and positioning clinic. Rosen has been active in Durable Medical Equipment prescription for the past 18 years. She is on the board of directors of the Rehabilitation Engineering and Assistive Technology Society of North America. She has lectured and written articles on wheelchairs, seating and positioning, and standing.

WEDNESDAY, SEPTEMBER 16, 2015 | 11AM - 12PM (ET)

Different Strokes for Different Folks – Exploring Possibilities for Customizing a Seating System

SPONSORED BY SUNRISE MEDICAL

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

In the world of complex rehab, we often find ourselves faced with complicated scenarios that defy what textbook, conventional thinking, or an instruction manual would recommend we do. Having a basic understanding of the possibilities will not only benefit your clients, but it will also help you! During this one-hour presentation, we will discuss the advantages and flexibility of standard "out of the box" seating products. We will also review components that make up a custom configured seating system and considerations that come into play when recommending the most appropriate seating system for a client.

Angie Kiger M.Ed., CTRS, ATP/SMS, is the clinical channel and education manager for Sunrise Medical. She earned a Master of Education in Assistive Technology from George Mason University in Fairfax, Virginia, and a certificate in assistive technology from California State University at Northridge. Kiger has worked with infants, children and adults in inpatient and outpatient settings. In addition to working as a clinician, Kiger has served as an adjunct instructor at George Mason University and presented at numerous conferences in the U.S. and abroad.

THURSDAY, SEPTEMBER 17, 2015 | 5PM - 6PM (ET)

Considerations with Drive Control Access

SPONSORED BY PRIDE MOBILITY

JAY DOHERTY, OTR, ATP/SMS

Alternative controls come with complications of their own when setting up an end-user in a power wheelchair. The evaluation team often focuses on access to the electronics for driving before considering how power positioning or other components in the seating system may affect access to the input device. This course will review the considerations that must be examined when recommending alternative controls.

With 19 years of clinical experience, Jay Doherty, OTR, ATP/SMS, has a strong understanding of seating and positioning requirements, mobility equipment, and assistive technology. Doherty worked as a therapist on a seating team for 14 years previous to working for Quantum Rehab. Now as a regional manager for Quantum Rehab, he oversees a team of rehab product specialists for Quantum Rehab's Northeast Region and presents clinical education programs throughout the country.

TUESDAY, OCTOBER 20, 2015 | 7PM - 8PM (ET)

Pressure Ulcer Etiology – What is The New Evidence Telling Us?

SPONSORED BY ROHO

W. DARREN HAMMOND, MPT, CWS

Historically, pressure ulcer etiology has revolved around ischemic changes in the skin and soft tissue. However, recent evidence has demonstrated that deformation of soft tissue has earlier implications in pressure ulcer development versus just ischemia alone. Currently, there are various levels of clinical knowledge and experience when it comes to understanding pressure ulcer etiology and appropriate management strategies. Unfortunately, most health care practitioners do not understand the pathophysiology of pressure ulcers and the extrinsic and intrinsic risks, which need to be managed for successful outcomes. This webinar will review the current best evidence of pressure ulcer pathophysiology, with a focus on the new understanding of the significant role tissue deformation plays in the development of pressure ulcers.

W. Darren Hammond, MPT, CWS, has held clinical positions and faculty appointments in the U.S. for the past 21 years. In addition to being a board-certified wound care specialist by the American Board of Wound Management, Hammond's focus of treatment has been in the rehabilitation of individuals with spinal cord injuries. Throughout his career, Hammond has had extensive experience with seating and positioning, chronic wound management, pressure mapping and cushion and wheelchair prescription. He is currently the senior director of The ROHO Institute for Education at ROHO, where he lectures nationally and internationally on the subjects of chronic wound healing, pressure imaging, and seating and positioning options.

WEDNESDAY, OCTOBER 21, 2015 | 11AM - 12PM (ET)

Arthrogryposis - Challenges and Solutions When a "Non-Progressive" Diagnosis Progresses

KAY ELLEN KOCH, OTR/L, ATP

Arthrogryposis is a neuromuscular skeletal disorder that affects various joints in the body. It is congenital and classified as "non-progressive." Mobility is limited by the joints affected as well as muscular emaciation or weakness. Intelligence is not affected, but lack of mobility and exploration can affect development. As the child grows and develops, seating, positioning and mobility challenges occur. This webinar will review this disorder, orthopedic and therapeutic considerations, as well as positioning and seating challenges. Mobility and seating options and ideas for access for independent mobility will also be presented.

Kay Koch , OTR/L, ATP, has more than 30 years seating and wheeled mobility experience. She is a graduate of the occupational therapy program at The Ohio State University in Columbus, Ohio. Her focus has been on pediatric seating and positioning, wheeled mobility, and assistive technology solutions. Koch has spent her years as an OT in various roles including clinician, manufacturer rep, educator and in accreditation. She has presented at various national and international conferences.

THURSDAY, OCTOBER 22, 2015 | 5PM - 6PM (ET)

The Quarter-Inch Quandary: Minor Adjustments Can Make a Major Difference

ROBIN SKOLSKY, PT, ATP

This course will provide participants visual comparisons on how even small adjustments can make big differences in a wheelchair user's posture, function and comfort. We will compare "off-the-shelf" components to custom and explore creative ways to use items that are readily available. Before and after photos will demonstrate some of the significant changes achieved.

Robin Skolsky, PT, ATP, graduated with a Master of Science in Physical Therapy from the University of Miami in Coral Gables, Florida. She received her undergraduate degree from the University of Maryland, College Park, Maryland. She has worked almost 20 years as a physical therapist, and more than 10 of those has been full time in seating and mobility. Skolsky has worked in a variety of settings and with a variety of patients, from pediatrics to geriatrics. Her time is spent between Shepherd Center, Children's Healthcare of Atlanta and a students on the topic of seating and mobility and has presented at ISS. She also helped develop and implement a community "Advanced Wheelchair Skills Program" through Shepherd Center in Atlanta.

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MATTHEW J. AGNEW, ESQ.

Agnew is an attorney with the Health Care Group of Brown & Fortunato, P.C., a law firm based in Amarillo, Texas. Agnew represents home medical equipment companies, pharmacies and other health care providers throughout the United States. He earned his Bachelor of Arts from Wichita State University and his law degree from the University of Kansas School of Law. Agnew is licensed to practice law in Texas. SEE PAGE 36

CLAUDIA AMORTEGUI

Amortegui has her Masters of Business Administration and more than 20 years' experience in the DMEPOS industry. Her experience comes from having worked on all sides of the industry, including the DMEPOS Medicare contractor, supplier, manufacturer and consultant. For many of these years Amortegui has focused on the rehab side of the industry. Her work has allowed her to understand the different nuances of complex rehab versus standard DME. This rare combination of industry experience enables Amortegui and her team at The Orion Group to assist ATPs, referrals, reimbursement staff and funding sources in understanding the reimbursement process as it relates to complex rehab. SEE PAGE 56

ALEXANDRA (ALEX) BENNEWITH

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

DON CLAYBACK

Clayback is executive director of the National Coalition for Assistive and Rehab Technology (NCART). He has more than 25 years of experience in the Complex Rehab Technology and Home Medical Equipment industries as a provider, consultant and advocate and is actively involved in industry issues and a frequent speaker at state and national conferences. SEE PAGE 32

LAURA COHEN, PHD, PT, ATP/SMS

Cohen is the Principal for Rehabilitation & Technology Consultants in Arlington, Va. She is the executive director of the Clinician Task Force (CTF) a national group of seating and mobility clinicians working to influence Medicare and Medicaid coding, coverage, and payment policies for complex rehab and assistive technology devices. The CTF provides clinically relevant information about seating and wheeled mobility device assessment and decision making to policymakers to ensure appropriate access for individuals with disabilities. SEE PAGE 60

SUZANNE EASON

Eason has been an occupational therapist for over 25 years and the director of Occupational Therapy Support Services at St. Mary's Home in Norfolk, Va., for 16 years. Eason has found her calling as an advocate for individuals with complex medical conditions. Her motto: "We provide the foundations for function" has evolved into a small private practice. When not at SMHDC, she can be found at her busy home with her husband and 2 legged and four legged children. SEE PAGE 50

DELIA "DEE DEE" FRENEY, OTR/L, ATP

Freney has been an Occupational Therapist since 1978 in the San Francisco Bay area, California. She is an ATP who presently works at Kaiser Permanente as an OT Clinical Specialist with High Mobility in the Durable Medical Equipment Dept. Freney participates in seating and mobility clinic evaluations that include a variety of neurological and orthopedic diagnoses such as Spina Bifida, Cerebral Palsy, SCI, MS, MD, and ALS. SEE PAGE 44

BRAD HOWARD

Howard of Brown & Fortunato, P.C. is an attorney specializing in Health Care Litigation and Employment Law. Brad graduated from the University Of Texas School Of Law in 1991, and he works closely with the firm's health care clients throughout the country. SEE PAGE 36

KARA KOPPLIN

Kopplin is senior director of Efficacy Research and Standards for ROHO. Kopplin is an active participant and presenter at numerous scientific and clinical conferences, and regularly contributes to the RESNA and ISO standards committees. She holds a B.Sc. in Ceramic Engineering from the Missouri University of Science and Technology. SEE PAGE 68

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

Lange is in private practice, Access to Independence, in Arvada, Colorado. She is a Friend of NRRTS and is the DIRECTIONS Clinical Editor. SEE PAGE 40

ERIN MICHAEL, ATP/SMS

Michael is a physical therapist for Kennedy Krieger. Michael is also a Friend of NRRTS. SEE PAGE 28

DAVE NIX, ATP, CRTS®

Nix is a NRRTS Registrant who is co-owner of Alabama Wheelchair Specialists. SEE PAGES 26

MIKE OSBORN, ATP, CRTS®

Osborn is past president of NRRTS. Osborn has been a NRRTS Registrant since 2000 and is part owner of Alliance Rehab and Medical Equipment in Ozark, Missouri. SEE PAGE 12

KEITH SCHWARTZ MA, ATP

Schwartz was the owner of California Rehabilitation Equipment for more than 20 years, which provided custom wheelchairs and equipment to disabled individuals in three northern California counties. Currently Schwartz is employed by National Seating and Mobility and participates in daily high mobility clinics at several Kaiser Hospitals. As an ATP, he has worked with all segments of the population from pediatrics to geriatrics in providing mobility equipment. SEE PAGE 44

ANDREA VAN HOOK

Van Hook is the communications and marketing manager at RESNA. She has more than 18 years' experience working on successful, award-winning campaigns that promote equal access to health care, education and employment of diverse populations, including people with disabilities. SEE PAGE 64

TODD WALLING

Walling is senior vice president of sales, North America at Permobil. Walling is also a Friend of NRRTS. SEE PAGE 20

JENNIFER WOLFF, OTR/L

Wolff is the manager of United Spinal Association's Advocacy Alliance. Wolff is an occupational therapist and wheelchair user from Waverly, Iowa. SEE PAGE 54

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FROM THE NRRTS OFFICE

CREATING CHANGE

WRITTEN BY: MIKE OSBORN

2015 CRT EXPO

2015 CRT EXPO

As I sat in Washington, D.C., following the CRT Expo putting my thoughts together for my last president's article, I was trying to think of how to wrap up all my thoughts and feelings over the past two years. I have learned a great deal from several people over the past several years. I've tried to not only offer my thoughts regarding how important the CRT Provider is to our industry, but how important it is that we, as CRT providers, get involved with federal and state issues regarding funding, access and advocacy. We all – well, most of us – stay in the industry because of the passion we have for those we serve and the way we serve those individuals. The funding issues we face today are jeopardizing those current processes and quality service models. Access to CRT service and accessories is in real danger.

YOU ARE "UNCOMMON," OR YOU WOULDN'T BE DOING WHAT YOU DO! I CHALLENGE EVERYONE TO TAKE JUST A LITTLE TIME AND MAKE THAT EXTRA EFFORT TO CREATE CHANGE.

What better place to wrap up my thoughts than right here in Washington, D.C., with a CRT Expo? Well ... just as I started typing I received an email from my business partner and fellow CRTS® Justin Decker. He was sharing some incredible news about our state Medicaid system and a huge positive for those individuals we serve in Missouri. We, as an industry, speak often about grassroots, trying to make a difference locally to impact change on a larger scale. So rather than continue talking about what we need to do to create change, I thought I would quickly share what a few individuals and legislators did in Missouri that actually did create change.

It started more than two years ago with a conversation at a Medicaid meeting. Basically, Justin Decker and Mike Seidel (of Numotion) asked some very difficult questions regarding coverage and reimbursement. They were very clear explaining the impact these two areas were having on equipment and services that could be offered to those with significant needs in our state. Medicaid was also very clear that the only way to make change was through legislation. Medicaid was open to hearing the concerns and possible solutions, but at the end of the day they were only able to follow the current directives.

So the journey began! Through many conversations, legislators were sought out and found who would support change for CRT in Missouri. Justin Decker actually spearheaded this effort and started with the leadership committee. This took time and at first was somewhat discouraging. Eventually, a strong relationship developed with an influential state representative who saw the need for change and was willing to help steer us in the right direction. Soon, we had a meeting with the members of the appropriations committee. Mike Seidel & Melissa Pickering of Numotion, Justin Decker and I from Alliance Rehab and Medical Equipment, were sitting in a meeting explaining the importance for a separate line item for CRT. It was amazing how open everyone we talked to was in listening to the obstacles facing CRT users. Additionally, they actually offered us suggestions on what might be possible for impacting change. It wasn't always what we wanted to hear, but it was a conversation that was productive and moved us forward. Justin Decker and Melissa Pickering worked together to come up with proper language that would meet the

IT WAS AMAZING HOW OPEN EVERYONE WE TALKED TO WAS IN LISTENING TO THE OBSTACLES FACING CRT USERS. ADDITIONALLY, THEY ACTUALLY OFFERED US SUGGESTIONS ON WHAT MIGHT BE POSSIBLE FOR IMPACTING CHANGE.

requirements given to us by our legislators. It took some time but by the end of the first year we were able to get a separate line item for CRT established in Missouri.

The work wasn't complete yet, because we didn't have the funding in place to make change. However, it was a win because the state of Missouri recognized the difference between DME and CRT. Other providers were brought in for additional support, and several more Missouri legislators were now in support of our language. It took another year to see the final impact, but the last week in July 2015, the two years of work by many individuals, multiple CRT companies and a number legislators came full circle to make a major impact on CRT in Missouri and how those individuals in need of CRT services will receive it. Obviously, it is always an ongoing effort but for today, change was created.

I guess my final thoughts for this article is YOU can make a difference. It may not seem like it at first, and yes, there will be frustration. It will seem at times like your work is not being seen or heard. There will be those moments when it is easier to think someone else will do it. But that takes me back to my first article that stated who we are as CRT providers is also who we are as individuals. We seek more than the norm. No one can speak with the same passion about what is important to you as you can. You are "uncommon" or you wouldn't be doing what you do! I challenge everyone to take just a little time and make that extra effort to create change.

Then celebrate what we have accomplished as a CRT Industry.

CONTACT THE AUTHOR

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mosborn@alliancerehabmed.com.

LIFE IS CRAZY GOOD

WRITTEN BY: ROSA WALSTON LATIMER

On March 12, 2004, following a normal pregnancy and delivery, Dawn Krause gave birth to her second child, William. The infant's development seemed normal but as his four-month checkup was coming up things began to change. "He started to not track properly with his eyes," his mother said. "Feedings became an issue." Willy was having trouble swallowing properly, but his parents thought perhaps these problems were not that unusual for a developing infant.

Just three days before Willy would celebrate his four-month birthday, he suffered a grand mal seizure at home. His father, Todd, notified Dawn, who was at work, and immediately sent the infant by ambulance to the hospital in the family's hometown of Jackson, Michigan. Willy was given anti-seizure medication, stabilized and transferred to University of Michigan Mott Hospital in Ann Arbor, Michigan. "After an MRI we knew what the problem was," Dawn explained. "Willy was diagnosed with lissencephaly, a rare brain disorder. The Greek word literally means "smooth brain." During the 12th to 24th weeks of gestation, there had been a lack of development of brain folds and grooves. "Willy had no motor skills because he had no folds in his brain."

"BAD THINGS HAPPEN, AND GOOD THINGS HAPPEN. WE COULD LET THE ANXIETY AND DEPRESSION OF A TERMINAL DIAGNOSIS BRING US DOWN, BUT THEN WE WOULD ALL BE MISSING OUT ON LIFE."

Every aspect of this family's life changed dramatically. They were given the devastating news that Willy would not live to be 2 years old. "During the next 12 hours or so after we heard this, I cried and agonized over whether something I had, or had not, done caused this disorder in my baby. Then something just clicked," Dawn said. "We realized we couldn't know why this had happened, but Todd and I knew we could do this once we had a plan in place. I left any guilt I felt for Willy's condition at the hospital."

The family did make a plan, but the next several years were very difficult. "You get one life," Willy's mother explained when asked how her family was able to cope with their challenges. "Bad things happen, and good things happen. We could let the anxiety and depression of a terminal diagnosis bring us down, but then we would all be missing out on life." Dawn was a stay-at-home mom for the next eight years and took Willy with her whenever she needed to be away from home. Willy's younger sister, Gabby, was born. Dawn served as a parent representative on the board of the Early On Program in Jackson County and was PTA vice-president at her older son, Grant's, school. She also completed two bachelor's degrees from Michigan State University.

Willy at school

Willy at 4 months

When Willy reached his third birthday – an exceptionally significant milestone in his young life – he attended school at Lyle Torrant Center in Jackson. He also spent many days in the hospital. The child suffered pneumonia and respiratory issues for the better part of a three-year period. "My husband worked nights and so between the two of us and with the help of family, we managed to drive back and forth to the

hospital and to get Grant and Gabby to school and activities," Dawn explained. "We never let Willy stay by himself, not even for an hour." This experience was especially demanding. "Our other kids felt largely ignored and shuffled around." Dawn recognizes sibling issues as a serious matter in any family with a member who has special needs. "We were worrying about keeping Willy alive and also worrying about nurturing our other two children."

"Through the years, as we became more knowledgeable about Willy's needs and more confident in his care, life got better," Dawn said. The family moved to Ann Arbor to be nearer Willy's doctors. "It's more expensive to live in Ann Arbor, but once we were here we had less stress, less commuting time, a better house, and because both Willy's dad and I were hired at the University of Michigan, we had more money," Dawn continued. "Best of all, we hooked up with a fantastic pediatric home hospice team and enrolled Willy in a local school exclusively for special needs students." These circumstances kept Willy in a healthier environment resulting in fewer hospital stays. When he does need medical care, it is a two-mile drive to the hospital and clinic. Dawn realizes not every family dealing with extraordinary health issues can move their residence to be closer to high-quality medical care. "I would say that if you can't make the move to where the best doctors are, at least make an effort to be as close to support – family and friends – as possible," she advises. "If you can't live where the care is, then try to be where the support is."

The family's relocation made life a little more normal for Willy's family but with mixed results. "Unfortunately, this was the time that Todd and I realized our marriage was shot," Dawn said. "We had not had the time to focus on

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Willy at school


Willy with his dad, Todd


Willy and his mom, Dawn


Musical moment with Ted

LIFE IS CRAZY GOOD
(CONTINUED FROM PAGE 15)

'us' before, because Willy was so ill. Now that our family wasn't constantly living under the crisis of near death, we became more aware of other problems we had." Once again, the family put a plan in place and adjusted accordingly. The couple divorced and moved into apartments next to each other. "We had a good relationship and wanted to still be geographically close," Dawn said. "This has worked very well for us."

Now Dawn has remarried, and Todd is dating his high school sweetheart. Dawn and Todd share custody of their three children. Todd continues to work nights, so he can be involved in the lives of his children and handle responsibilities such as car pool duties. Dawn's job at Physical Medicine & Rehabilitation with the University of Michigan Health System allows her a great deal of flexibility and helps her balance her role as a mother and advocate. Dawn's husband, Ted, teaches at Central Michigan University two days a week and is a substitute teacher at Willy's school three days a week. "Todd's girlfriend helps, too. I have the children four days of the week, and Todd has them three. We all schedule outings and date nights around the children," Dawn said. "We have our ups and downs, but for the most part we have made a commitment to get along, work through issues and love the kids and take care of them the best we can as a team." Grandparents who live nearby are also part of this remarkably efficient team.

> "OUR SITUATIONS ARE LIKE THE WHACK-A-MOLE GAME – YOU GET HELP WITH ONE THING, AND ANOTHER THING POPS UP. I FEEL THAT IF I CAN DEAL WITH THIS, I NEED TO HELP OTHERS."

Willy just celebrated his 11th birthday. He doesn't walk or talk and is tube-fed. He has seizures daily. In addition to job responsibilities and normal family obligations and activities, this team of dedicated adults lovingly assists Willy through his life. Weekdays begin at 5:00 a.m. to allow time to prepare Willy for school. His mother outlines the schedule: "This means crushing up his medicine cocktail and flushing it down his g-tube as he can take nothing by mouth. We have to do his feeds and pills in a very tight schedule so as to not overload his belly. We get his bag ready with his afternoon meds, two feedings and other supplies. By 8:00 a.m. the bus comes to pick Willy up." Attending school is an extremely important part of Willy's life. "He gets a life of his own, because of school. Willy has his own teachers and his own curriculum. The boy loves music, swimming and field trips."

Willy returns home around 3:00 p.m. and receives the first of four feedings that will be given throughout the evening. The 11-year-old enjoys lying on a blanket in the living room or in his bed. "Sometimes we put a movie on for him," Dawn said. "If his respiratory condition is bad, we have a protocol we use which includes a chest vest, a nebulizer and suction." She explained that Willy doesn't realize he is sick. "He is protected, and every need is taken care of. We tease him about being spoiled." The child communicates with his eyes and smile. "You look for clues you've learned over the years. But, even now, if he's sick it is very hard to tell. Sometimes he'll just grunt – especially if he doesn't want to get out of bed in the morning."

Generally the families don't feel there is much they can't do with Willy, although traveling is very limited. "We are realists. There are some outings that aren't going to be fun, because of Willy's equipment," Dawn said. "We do the best we can with local outings to parks and things where we can spread out. The other kids can run, and Willy can roll! He loves to feel fresh air on his face. There are other things we would like to do but they just aren't in the cards right now. We don't consider this a problem – our first commitment and priority is Willy."

Dawn's perceptive, entertaining blogs (www.averypostmodernfamily.blogspot.com) occasionally present some probing questions prompted by having a child that is "terminally ill, but not actively dying" such as: "Is a longer life necessarily a better life?" She writes that she has learned to be honest and show the good, the bad and the ugly. "People need to know it is OK to be angry and feel the situation is hopeless. I'm usually peaceful and happy even when I am worried and stressed because I've figured out what really matters."

"Life is crazy, but good. Crazy good," Dawn wrote in a recent blog. She believes Willy has changed her as a person. "Not necessarily for the better; perhaps for the clearer. Things that are important are much clearer now."

While their focus is on helping Willy live, his parents are also taking steps to ensure that an end-of-life plan is in place. The Do Not Resuscitate order they have established for their special needs child has led to a conflict with the school he attends. "This is a parents' rights issue," Dawn said. "We want the school's policy to be tweaked, so other parents don't have to deal with this."

Advocacy is very important to Willy's family. "We've thrown ourselves into this special needs world." With the help of her boss, who is also one of

(CONTINUED ON PAGE 18)

LIFE IS CRAZY GOOD
(CONTINUED FROM PAGE 17)

Willy's physicians, Dawn has organized a Michigan chapter of "Reaching for the Stars," a national cerebral palsy advocacy foundation. As director, she is leading the state group in their efforts to increase communication and support for those dealing with chronic conditions affecting body movement and muscle coordination. "We all need education and support," Dawn said. "Our situations are like the Whack-a-Mole game – you get help with one thing, and another thing pops up. I feel that if I can deal with this, I need to help others." Dawn has also testified before Congress and recently attended the National CRT Leadership and Advocacy Conference, presented by NRRTS & NCART, in Washington, D.C.

The four steadfast adults who daily facilitate Willy Pickett's life are formidable examples of the power of common goals and dedication to a special needs child. "I think our confidence in dealing with our situation sometimes betrays how difficult things are," Dawn said. "But I think we've rocked it – we've thrived!"

Dawn has joked that perhaps the family will pitch their story to a television network. It would certainly be an inspiring reality show! If you see it in next fall's line-up, remember you heard it here first!

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Willy & Ted


Todd, Willy, Gabby & Grant


Willy at school


Willy with his four parents

"LIFE IS CRAZY, BUT GOOD. CRAZY GOOD."

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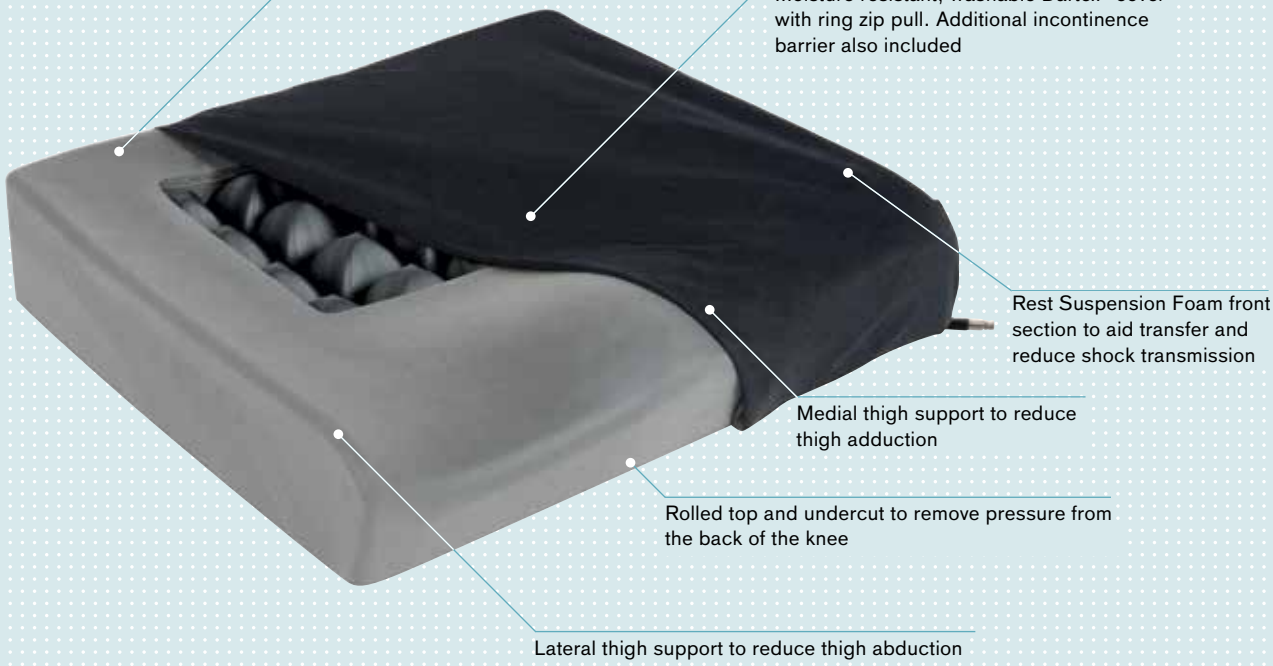

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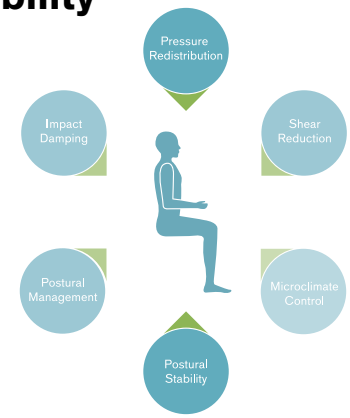

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AS LUCK WOULD HAVE IT

ACCIDENTAL ENTRY INTO INDUSTRY RESULTS IN FULFILLING, SUCCESSFUL CAREER

WRITTEN BY: DANETTE BAKER

Todd Walling planned for a career in health care. However, he never imagined that it would come from a sales position and certainly not one in complex rehab. But 15 years later, almost half of which have been with his current employer, Walling discovered this ever-changing, ever-challenging industry was right where he belongs.

DIRECTIONS recently had the opportunity to visit with Walling, senior vice president of sales for Permobil, and discovered how his accidental entry into the industry has led to a fulfilling career.

HOW DID YOU BECOME INTERESTED IN THE MEDICAL EQUIPMENT INDUSTRY?

Like a lot of people who work in the medical equipment industry, I kind of fell into it accidentally. In college I had my sights set on becoming either a dentist or a pharmacist. I actually worked as a pharmacy technician for five years, and I was set on making sure I was in health care in some sort of fashion. My first job out of college, I landed a position with Cardinal Health as a technology consultant. This was in the late 1990s, early 2000s, during the dot-com craze, and a lot of active server pages were being created at the time, and a lot of databases were going online. I kind of got the bug for that, and I went from health care into information technology. I was looking to further my career in information systems, and I found a job opening at The MED Group. In 2000, I began working for David Miller as a business information analyst. I was looking at trends in medical equipment purchases and then started coming up with different statistics and measurements.

Before long, Scott Austin, who at the time was running contracting for all The MED Group contracts, recruited me to his department, and I started working directly on contract analysis. That's where my career really took off. I began using some of the technology applications in a business perspective and that's when Scott (Austin) really began to push me to look at the business from an analytic perspective rather than just a gut feeling. Back in the day, there was a lot of business being done on handshake agreements and not a lot of numbers backing some of the things that were going on. Scott kept pushing me to create more data and produce more information. A lot of the data was looking at fiscal trends and what was being purchased in the industry and reaching out and getting surveys together on certain types of pieces of equipment and different companies. That's when I really started to learn about the industry as a whole and specifically rehab, learning the differences in the power chairs and manual chairs, etc. I discovered I really wanted to learn more about these products and services and not just the data behind it. Eventually, I moved into doing contract negotiations and then over time became rehab product manager for The MED Group, strictly working with rehab and mobility companies. So I was basically a sales representative for The MED Group to different manufacturing partners such as Permobil. In 2007, I got a call from Tom Rolick and Larry Jackson (president of Permobil North America) asking if I would want to come work for them. They were a fast growing company at the time, and had the best sales forces in the country, but they didn't have any sales data to report to the sales team. When I was recruited the first thing I did was create a sales reporting dashboard that encompasses product sales, sales by territory, sales by customer, etc. A lot of what we did seven years ago is still in existence today. I knew I wanted to be in health care, but I never thought I would be working with wheelchairs – that's for sure.

WHAT ARE SOME OF THE MOST SIGNIFICANT MILESTONES IN YOUR CAREER?

One of the greatest accomplishments of mine was doing the Permobil sales dashboard, and it has led to increased effectiveness in the field, awareness of the numbers, and continues to help drive our sales team each and every day. Personally, one of the most exciting and impactful milestones for myself at Permobil is being involved in the business plan around the M300 power chair. Back in 2008 and 2009, we were having discussions around whether the company needed to enter in the mid-wheel drive market. At the time, we only had front-wheel drive and rear-wheel drive power chairs, and there was

a big debate within the company on whether Permobil should even try to enter this market. One of the goals we identified was if we were going to enter the mid-wheel drive market, we were going to do so with the best mid-wheel drive chair available. Working with fellow colleagues on a business plan around the M300, we were able to drive it to our number one selling product within the first year, and today it remains the largest selling drive platform currently within Permobil U.S. I give credit to the research and development team at Permobil for identifying the issues with the mid-wheel drive and improving those as best as possible — the drive, the comfort and the suspension were all things we addressed. The high centering was a major issue at one time and Permobil engineers addressed that as well. The result was a different mid-wheel drive that no one had ever seen before. The continued success is due to the M300's stability and comfort, and the next version will be even more popular.

Additionally, a milestone for me as a regional sales manager, was when I really started to see people living with disabilities in our wheelchairs. Permobil has always been a leader in ALS technology and solutions for people living with ALS (also known as Lou Gehrig's disease or amyotrophic lateral sclerosis, which attacks motor neurons and cells that control the muscles). I had never really seen that impact until I got out in the field as regional sales manager. I gained a deep understanding and appreciation for what people with ALS go through. That was a milestone, perhaps not as easily measured as success in sales accomplishment, in my own personal development of understanding what we need to do every day to ensure the quality of our power chairs by making sure they are modu-lar and easily adapted so those who need them can remain mobile in their everyday lives. One example of this will always remain with me. I was at the Veteran's Affairs in Little Rock, Arkansas, and the physician informed me about a patient we were scheduled to see that day who had just been

I GAINED A DEEP UNDERSTANDING AND APPRECIATION FOR WHAT PEOPLE WITH ALS GO THROUGH.

diagnosed with ALS and was progressing rapidly. The doctor wanted to confirm we could deliver a wheelchair within the week. One of Permobil's goals for more than 10 years has been a commitment to a quick turnaround on ALS chairs. When the veteran came in, he was walking and then transferred into the wheelchair. I remember thinking, "This guy's doing OK. We'll get him a chair in plenty of time." So we did the evaluation, spec'ed the chair, and had it ordered that day. It was delivered within 48 hours. A week later, the sales rep

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called to tell me that our patient, the veteran, had passed away. I had been around a lot of people living with ALS but had never seen someone with the condition progress so rapidly. I realized then just how important it truly is for people to have their last days comfortable and mobile, and that's why it's so important for us to get that quick turnaround on our product.

WHO HAS BEEN INSTRUMENTAL IN THESE ACCOMPLISHMENTS?

I will give David Miller some credit. When he was at The MED Group, he taught me a lot. One of the things I will always remember from David is the way he treated his employees with integrity and respect. When it came to business, he was always focused on doing the right thing. He always told me, "If you focus on doing the right thing, good things will happen," and I always remember that from David. Scott Austin, who is now at Numotion, pushed me every day. He may not have even known that. Sometimes I didn't like it very much. Even today, he continues to push me to be better. Obviously, Tom Rolick and Larry Jackson who gave me the opportunity to succeed in sales at Permobil, was huge. One of things Larry has given me is the opportunity to think outside the box. If we see something that is not working, he gives me the ability to make changes to do things differently, and that's been a big part of my success.

YOU MENTIONED THE SUCCESS OF THE M300. WHAT OTHER AREAS OF THE INDUSTRY HAS PERMOBIL TAKEN A LEAD IN?

THAT'S WHERE MY CAREER REALLY TOOK OFF. I BEGAN USING SOME OF THE TECHNOLOGY APPLICATIONS IN A BUSINESS PERSPECTIVE AND THAT'S WHEN SCOTT AUSTIN REALLY BEGAN TO PUSH ME TO LOOK AT THE BUSINESS FROM AN ANALYTIC PERSPECTIVE RATHER THAN JUST A GUT FEELING.

Our entry into the mid-wheel drive platform was the one missing piece that Permobil had in terms of power mobility. Permobil acquired TiLite last year so we are now in the manual wheelchair business. Just this past May, we acquired The ROHO Group Inc., which is now part of our seating and positioning business segment. So we have power chairs, manual chairs and seating and positioning products, and going forward we envision filling in some of the gaps between those products. We are definitely not done in terms of acquisitions to fill in the gaps for seating and position products such as electronics and future technology that has not been developed yet. We want to be the world leader in Complex Rehab Technology (CRT) not just on power chairs and manual chairs, but on all the segments of CRT.

WHAT'S ON THE HORIZON FOR PERMOBIL?

Other than us acquiring products and companies to fill in those gaps, last year we introduced a piece of licensed technology that we partnered on with the University of Pittsburgh called the Virtual Seating Coach. It's a mobile application that's installed on the user's smartphone or tablet that interacts with the power chair. It reads power seating information and records that back to the user. Right now, this technology is primarily driven to improve patient compliance in seating regimens, but this is just step one of a long-term goal Permobil has of improving patient outcomes through new technology and applications. That's the biggest thing on the horizon for Permobil, other than the new products we just released this past year at ISS (International Seating Symposium). We are also going to be developing software applications to improve compliance and outcomes. Several studies over the years have shown that a lot of end users are not utilizing their power seating systems correctly throughout the day. Over time, they are seeing increased complications, such as pressure ulcers, for example. Specifically, at spinal cord facilities there is a lot being thrown at the end user when they get into a new power chair. Usually the last thing they are thinking about or remembering is what their therapist told them about how to use their tilt and recline system. We believe that with applications such as the Virtual Seating Coach, this will help them through their transition initially into a wheelchair to effectively utilize their seating system. Over time we look to advance this technology for use as a clinical tool as well. The idea is to not only give the end user reminders and help them, but also for clinicians as a recording of that information is reported back to a doctor or therapist

showing them how the end user is using the equipment, which will allow them to rule out any health issues related to the seating system or improper use of the seating system.

WHAT ARE THE FUTURE CHALLENGES FOR PERMOBIL AND THE INDUSTRY AS A WHOLE?

The challenges that face Permobil face the industry as a whole, and those are all centered around funding. The unannounced rate cuts like the ones that happened recently in Illinois make it hard to adapt to changes when they happen so quickly. Going forward, combating funding cuts will be the greatest challenge to the industry as a whole. Obviously, getting congressional support is one avenue to challenge these cuts. NCART is also currently working on the separate benefit category initiative, which will keep us from having to deal with these cuts that are coming in unannounced or being pulled into the home medical equipment spectrum. Identifying CRT as a separate benefit category will help improve this situation. It is still not going to stop Medicaid programs or insurance companies from pushing down allowables but it will definitely help us be able to monitor our industry as a whole. For Permobil, we will have to address pricing and other issues like that, but we will never give up on making sure we maintain our focus on the end user's needs. When Per Uddén founded the company almost 50 years ago, his purpose was to empower people through technology. We will continue this mission, but we also realize that it will take developing creative partnerships with dealers and therapists to make sure we are positioned for our products to get into the field. There is a lot of competition within this industry from the dealer side and the manufacturer side, but as an industry we must work together to stop such applications of pricing to CRT items that are resulting in these cuts. I encourage everyone to work through NCART right now to get with your congressmen and senators. This is definitely the single biggest challenge the entire industry is facing. I'm sure there are others, but it is the biggest one.

> "IF YOU FOCUS ON DOING THE RIGHT THING, GOOD THINGS WILL HAPPEN."

WHAT CHANGES WOULD YOU LIKE TO SEE IN THE INDUSTRY?

I've always wanted to see, but I don't know if we'll ever get there, product features and benefits driving selection for end users instead of allowables dictating them. There has always been a heavy emphasis on margins driving product selections, and going forward I would love for it to no longer be about margins but instead what's actually best for the client.

WHAT HAS KEPT YOU WORKING IN THE INDUSTRY?

I know every day when I come to work, no matter what I'm doing that day, I'm improving someone's life. It may sound cheesy or hokey, when those of us in the industry say that, but it's true. All of us working in this industry are improving people's lives. I can't imagine going to work in another industry where you are not doing what we are doing. I've grown up in the industry; it's been 15 years now. I've made so many friends, lifelong friends, that I can't imagine not working around these people. I think about some of the personal moments I've had beyond working with patients such as working with our sales reps at Permobil and being able to mentor them and help them through challenging situations and see them succeed. One of the things I enjoy about being in sales management is not so much the success we have as a group, but watching individual successes and knowing I'm a part of that. As a sales manager, you don't get all the glory for all the success, you usually get all the blame for the failures. What has been really fun for me – my "aha moment" – was my first year as a regional sales manager for Permobil and working alongside some veteran sales reps, many who had been with the company for more than 10 years, and actually seeing that I was making a difference for them as sales professionals. That's what kept me wanting to be in sales management — that ability to help people grow, help deal with issues, and find better ways to do things.

WHAT OTHER ROLES DO YOU HAVE IN THE MEDICAL EQUIPMENT/COMPLEX REHAB INDUSTRIES (BOARDS, ASSOCIATION MEMBERSHIPS, ETC.)?

I'm an active member in the ALS Association here in Middle Tennessee, and have been very involved in Walk to Defeat ALS. At Permobil, we have "Operation Permobil," which is our company team for the walk. Within that, we usually have contests to raise money. We try to get the competitions going between teams within Permobil to raise as much money as possible.

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AS LUCK WOULD HAVE IT
(CONTINUED FROM PAGE 23)

WHAT DOES A TYPICAL WORK DAY/ WEEK LOOK LIKE FOR YOU?

Well, completely different now in my role as senior vice president of sales. You don't know what is in store for you until you're right in the middle of it. And "it" changes daily. A lot of my work is around strategy and planning, which requires a lot of meetings. I work a great deal with our three regional vice presidents for sales. I'm also working with a new team at Permobil, clinical sales and outcomes, which focuses on educating the clinicians and ATPs in the field. So a typical work week for me is a lot of meetings and traveling to work with our key accounts.

WHAT'S LIFE OUTSIDE OF THE 9 TO 5 LIKE FOR TODD WALLING?

Well, it's more like 6 to 10 for me! With all the travel that my job requires, I try to spend as much time as possible with my family — my wife, Lisha; our 15-year-old daughter, Kennedy; and 7-year-old son Ashton. On the weekends, I try to sneak in some golf. I'd love to play more if I had more time. My wife and I like to travel internationally and hope to do more of that in the coming years. She was a flight attendant, so she gets the travel bug every once in a while. We've gone to Europe a few times, and we'd like to go back soon. So maybe down the road when things settle a little, we will take some more European vacations.

CONTACT

Todd may be reached at todd.walling@permobil.com.

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NOTES FROM THE FIELD

AFTER 41-YEAR CAREER, NIX STILL LOOKS FORWARD TO WORK EVERY DAY

WRITTEN BY: JULIE BARNETT

When Dave Nix began working in the Complex Rehab Technology (CRT) industry as a teenager, he never dreamed he'd still be doing it 41 years later.

Nix, an ATP, CRTS® and co-owner of Alabama Wheelchair Specialists, said the industry has changed quite a bit since those days.

"I began working in a small HME (home medical equipment) wheelchair shop in Tampa in 1974 while I was still in high school," he said. "We were doing some crazy things in rehab back at that time, all very primitive but it was fun work. Before any hi-lo bases were marketed, we made a seating system and mounted it to an old-style barber chair base so the family could raise and lower their child while he was seated in the chair."

Nix also recalled some of the equipment quirks from that time. "Our little Tampa shop also identified an electrical problem with Everest & Jennings power chair motors which caused them to begin running spontaneously," said Nix. "We isolated the problem and notified E&J working with their engineers to find a solution. As a teenager, I found the work fun and I knew I wanted to continue this kind of work. Little did I know 41 years later I'd be still at it."

"I ENJOY THE PATIENTS AND THEIR FAMILIES MOST OF ALL, MEETING THEM IN THE EVAL, DELIVERING AND FITTING THEIR CHAIRS, SEEING THEM YEARS LATER TO DO IT ALL OVER AGAIN,"

Nix spends his days, and many nights, at a single-location independent complex rehab operation, Alabama Wheelchair Specialists which he and his business partner, Mike Oliver, have owned since 2002. Oliver serves mostly pediatrics, while Nix serves mostly adults.

"Often my day starts at Spain Rehabilitation Center evaluating clients with the therapy staff," Nix said. "When I am not doing evals, I am either writing them up, discussing co-pay responsibilities with families, ordering the chairs and seating systems or delivering them to the patient.

"We're a small operation, two ATPs, a biller and two part-time techs, so my partner and I deliver and fit 100 percent of our orders," he said.

Nix said his favorite part of the job is the relationships, oftentimes long-term, forged with patients and their families.

"I enjoy the patients and their families most of all, meeting them in the eval, delivering and fitting their chairs, seeing them years later to do it all over again," he said. "I've seen children who are now adults and I've helped them with three or four chairs or more. It's by far the most fulfilling part of the work for me."

Nix said a couple of people specifically stand out when it comes to professional influences.

"One of my earliest influences back in 1988 or so was a guy in Birmingham, Greg Otwell. He's still in the business with NSM," Nix said. "He showed me a lot and shared his knowledge of seating/positioning with me even though I worked with his competitor.

"More currently, my business partner, Mike Oliver has been a huge influence. He's one of the most skilled ATPs I know and he's my best friend; makes it fun to go to work every day."

Nix has found NRRTS registration to be beneficial in his career. "The information NRRTS sends is key," he said. "Hearing about trends, legislative news and knowing they are watching the legislative landscape is critical to our success. Also their webinars make it so convenient to maintain our CEUs."

Nix sees both challenges and opportunities for the assistive technology industry in the future.

"WE ISOLATED THE PROBLEM AND NOTIFIED E&J WORKING WITH THEIR ENGINEERS TO FIND A SOLUTION. AS A TEENAGER, I FOUND THE WORK FUN AND I KNEW I WANTED TO CONTINUE THIS KIND OF WORK. LITTLE DID I KNOW 41 YEARS LATER I'D BE STILL AT IT."

"I think reimbursement continues to be the biggest challenge," he said. "Everyone wants to pay less for our services; we're all doing more with less these days."

As for opportunities, a particular aging demographic is key. "I'll echo what every speaker keeps saying and that is the greatest opportunity is the influx of Baby Boomers who will need some type of assistive technology," he said. "Identifying consumers who can pay for products and services is key. We're not where we need to be in this regard but we're seeing more people who need our services and can pay over and above, or sometime in spite of, insurance reimbursement."

CONTACT

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CLINICALLY SPEAKING

DISABLED ATHLETES ARE REAL ATHLETES

WRITTEN BY: ROSA WALSTON LATIMER

When we first spoke with Erin Michael about an article for DIRECTIONS, she told us she had three passions: seating mobility, advocacy and adaptive sports. Realizing we wouldn't have the space here to explore all three, we decided to focus on Michael's experience with adaptive sports. We feel certain you will find her dedication inspiring and her insight helpful.

Erin Michael, PT, DPT, ATP/SMS, is manager of patient advocacy and special programs at the Kennedy Krieger Institute's International Center for Spinal Cord Injury in Baltimore, Maryland. She is currently vice chair of the Wheeled Mobility and Seating SIG of RESNA. She is also founder/chair of Team Kennedy Krieger, a charity team that aims to increase the participation of people with disabilities in the annual Baltimore Running Festival. The group also funds adaptive sports teams and provides scholarships to adaptive athletes.

Why this passion for adaptive sports? In addition to recognizing the enormous benefit this type of activity offers her patients, Michael shared her personal connection: "I am an athlete – it is part of my identity. Working with my patients, I see that something can change in a split second. If something ever happened to me I would still be an athlete." She explained that if she lost her identity because she lost some function of her body, it would be more difficult for her to recover. "I stress-release through sports and have gained a lot of friends. I want to know if something ever happened to me I could still be involved in sports."

Michael's interest in adaptive sports increased when she and some of her colleagues were participating on a relay team in the Baltimore Running Festival four years ago. "A few of us were waiting for our teammates to come through and saw a couple of hand cyclists come by," Michael explained. "We were surprised there weren't more. We knew we had a pretty good pool of people to pull from and thought it would be cool if more of our patients were involved." The discussion progressed from there with two important questions: How to get patients involved? Where to get hand cycles?

> "I AM AS GOOD AS I AM, BECAUSE WHEN I WAS IN PT SCHOOL I WORKED WITH ATHLETES WITH DISABILITIES. EVERY SINGLE PERSON TOLD ME HOW BAD THEIR FIRST CHAIR OUT OF REHAB WAS, AND I LISTENED AND LEARNED FROM THEM."

Very soon after Michael began to explore the possibilities of greater participation by her patients in the festival, she began to interact with others who could help make this happen. Kennedy Krieger staff helped organize a race team. "I told our staff that we were going to be part of a race team and hopefully raise enough to buy a couple of hand cycles that we could loan to patients." However, within the hospital and through word of mouth, the team grew to more than 200 people who raised approximately $70,000. "We purchased six hand cycles. The next year we increased participation in the festival from two hand cyclists to 10 or 12." Collaboration efforts with the running festival organization continue to grow. "Now we've added a kids fun run – a

very short run for kids in manual and power chairs."

As Michael discussed the benefits of developing an adaptive sports program, she acknowledged that she is fortunate to work in an area where her patients have access to events such as the running festival. Developing an adaptive sports program can be a bit more challenging in a more remote area. "There may be a lower population to draw from and it may be difficult to arrange for people to meet together. Travel distance can also be a challenge." Michael explained that if developing team sports proves difficult, there are also individual sports that may be a better fit. "I have been lucky to have a good support system and others in this facility who can assist with the program," Michael said. "However, if you have a desire and a vision, you can overcome the obstacles."

BENEFITS

Every benefit an athlete gets from sports, the disabled also experience: the camaraderie of team sports, increased self-confidence and physical benefits in addition to simply enjoying the activity. However, there are increased benefits for disabled athletes. "For instance, when someone newly injured or a child who was born with a disability participates in an adaptive sports activity – team or individual – it lets them be at the same level with their peers," Michael said. "This activity puts them with others who are in a similar situation at a time when personally the recently disabled might not know what their life could be. In this situation an individual can be 'real' and feel comfortable relating true feelings. Seeing others who are functioning well and are happy can be very motivating!"

Participating in sports places disabled athletes in situations to learn from others with similar disabilities. "Without

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DISABLED ATHLETES ARE REAL ATHLETES
(CONTINUED FROM PAGE 29)

participating in adaptive sports, you might be the only disabled person you know," Michael explained. "In sports you instantly gain mentors – not just for the sport but for life. You'll interact with other disabled people who will help you become more independent; disabled people who have learned some 'tricks' to make life easier."

"Hand cyclists can go out and ride bikes with friends. Disabled athletes can even beat some of their able-bodied friends," Michael said. "Adaptive sports and recreational activities allow the disabled to think about what they can do and get out of their disability for a time."

WITH THE UNDERSTANDING AND COMPETENCE OF PROFESSIONALS SUCH AS ERIN MICHAEL THIS IMPORTANT STEP OF ADAPTING WILL BE A SMOOTHER, MORE REWARDING EXPERIENCE. ADAPTIVE SPORTS HAVE AN EXCITING AND REWARDING FUTURE, AS DO PARTICIPATING ATHLETES.

EDUCATION

"One very important element of developing adaptive sports is educating the community," Michael emphasized. "We work primarily with three sports – hand cycling, rugby and lacrosse – and with each of these we sponsor community events to foster a better understanding of disabled athletes. We invited a local university rugby team to volunteer at our wheelchair tournament." This type of involvement increased the awareness of others that disabled athletes are real athletes. "Some of the university players played an exhibition game in wheelchairs," Michael said. "The coolest thing to me is to see people who don't have a disability when they realize how awesome the disabled athletes are."

If you are interested in starting or increasing participation in an adaptive sports program, Michael suggested that you look at other model programs and learn from them. "Reach out to people who have started teams or activities in other areas and get to know people who are in the sport." Michael has found that people in adaptive sports and within the adaptive sports community are very willing to help. "No one is going to try to prevent you from doing this, especially in an area where there is a need."

EQUIPMENT

"Before we had formed a team we held rugby and lacrosse clinics that were open to the public. Athletes could come out and try the sport for the day," Michael said. Having the required special equipment can be a challenge. If someone hasn't participated in a sport before, it isn't feasible for them to purchase equipment. "A hand cycle can cost between $2,000 and $10,000 and the price of a sports wheelchair would be several thousand dollars. Everything requires a highly specialized piece of equipment; much more than an

able bodied person would have to invest. These folks have so many other challenges and expenses."

Some lacrosse participants who didn't have their own equipment used basketball wheelchairs and local equipment vendors loaned demo chairs. Equipment for rugby was more problematic as demos were not available. Athletes who were helping start the team borrowed used chairs from people who had gotten new chairs. "It is helpful to have some pieces of equipment available so people can try it before buying." Michael recommends reaching out to the community. "You might find a piece of equipment with some miles on it, but it could be refurbished. When you find funding you can get newer chairs," Michael said. "We have a fundraiser every year that supports us in purchasing equipment or sponsoring athletes and tournaments. We're still new at this, but we've had great support from the community so we've grown much faster than anticipated."

FUNDING

"There are grants available for those who need adaptive equipment," Michael said. "The opportunities are out there. You just have to be willing to put out the time to fill out the applications." Examples of funding sources are the Challenged Athletes Foundation that provides grants to athletes with a physical disability (www.challengedathletes.org) and the Kelly Brush Foundation (www.kellybrushfoundation.org). Another helpful group is the Bridge Program sponsored by ABC-Medical. This program offers scholarships and provides a calendar of adaptive sports events. (www.abc-med.com/resource)

Michael concluded by saying that some of her patients don't play the sports they played before. "These individuals can't quite go back to a previous sport because of the change in their lives. The benefits are still there. They simply find another space where they fit in." With the understanding and competence of professionals such as Erin Michael this important step of adapting will be a smoother, more rewarding experience. Adaptive sports have an exciting and rewarding future, as do participating athletes.

CONTACT

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CRT UPDATE

CRT LEGISLATION OVERSHADOWED BY OTHER THREATS

WRITTEN BY: DON CLAYBACK

While we continue to secure additional cosponsors and support for passage of the "Ensuring Access to Quality Complex Rehabilitation Technology Act" HR 1516/S 1013, there are two significant Medicare "changes" scheduled for January 1, 2016, that pose major threats to access to Complex Rehab Technology (CRT). Here's an overview of these pressing issues.

COMPETITIVE BID PRICING FOR CRT WHEELCHAIR ACCESSORIES

As reported, the Centers for Medicare and Medicaid Services (CMS) plans to apply Medicare competitive bid pricing to wheelchair accessories used on complex rehab wheelchairs effective January 2016. This change is in violation of Congressional legislation and subsequent Medicare policy decisions that excluded complex rehab wheelchairs and related accessories from the Competitive Bid Program.

This policy change impacts 171 wheelchair accessory codes. The annual Medicare spends on the accessories used with complex rehab wheelchair accessories is estimated at $123 million and the annual payment reduction is estimated at $20 million or about 16 percent.

In April, the House of Representatives sent a 101 signature bipartisan letter to CMS led by Representatives Bill Johnson (R-OH), Diana DeGette (D-CO), Mike Kelly (R-PA), John Larson (D-CT), Devin Nunes (R-CA), and Dave Loebsack (D-IA) Reps. Bill Johnson, R-Ohio; Diana DeGette, D-Colorado; Mike Kelly, R-Pennsylvania; John Larson, D-Connecticut; Devin Nunes, R-California; and Dave Loebsack, D-Iowa. The letter requested that CMS issue written clarification that accessories used with complex rehab power and manual wheelchairs will continue to be paid at Medicare established fee schedule amounts and that such amounts will not be adjusted based on Competitive Bid Program pricing.

Unfortunately in June, CMS formally responded to the House letter stating that it does not intend to follow the congressional recommendation. While the most appropriate solution remains for CMS to rescind the change, since they appear unwilling to do that we are working with Congress to provide a legislative solution.

In order to protect access for Medicare beneficiaries and other people with disabilities, Congress needs to legislate a "technical correction" to clarify that CMS cannot apply Competitive Bid Program pricing to accessories used with complex rehab power and manual wheelchairs to prevent the application of these payment reductions scheduled for January 1, 2016.

This is a critical CRT access issue and the engagement of all CRT stakeholders is needed as we move ahead. We need to let Members of Congress know this is an important matter and secure their assistance to fix it.

PROPOSED NEW MEDICARE "MISCELLANEOUS" BILLING CODES

In late June, CMS published details of a proposal to make significant changes relating to HCPCS codes E1399 "Durable Medical Equipment, Miscellaneous" and K0108 "Wheelchair Component or Accessory, Not Otherwise Specified." They allowed the public to submit omments until July 9. They indicated the coding and payment changes, once finalized, would be effective January 1, 2016.

The CMS proposal is that the two HCPCS codes be split into a total of six codes for: a.) inexpensive DME;

b.) other DME or expensive DME; and c.) replacement parts for DME being repaired. The following HCPCS codes would replace codes E1399 and K0108, which would be made invalid for Medicare claims processing purposes:

1.) KXXX1 Durable Medical Equipment, Miscellaneous, the Purchase Price Does Not Exceed $150

2.) KXXX2 Durable Medical Equipment, Miscellaneous, the Purchase Price Exceeds $150

3.) KXXX3 Wheelchair Component or Accessory,

Miscellaneous, the Purchase Price Does not Exceed $150

4.) KXXX4 Wheelchair Component or Accessory, Miscellaneous, the Purchase Price Exceeds $150

5.) KXXX5 Repair Part For Use With Beneficiary Owned Durable Medical Equipment, Other Than Wheelchair, Not Covered Under Supplier Or Manufacturer Warranty, Not Otherwise Specified

6.) KXXX6 Repair Part For Use With Beneficiary Owned Wheelchair, Not Covered Under Supplier or Manufacturer Warranty, Not Otherwise Specified

In addition to the new codes, there would also be specific payment amounts established for KXXX1 through KXXX4. The fee schedule amounts for KXXX1 would be $97.94 and for KXXX3 would be $72.56, adjusted by the 2016 covered item update.

The fee schedule amounts for KXXX2 and KXXX4 would be based on a capped rental basis not to exceed a period of continuous use of 13 months, with title to the equipment transferring to the beneficiary following 13 months of continuous use. For KXXX2 the fee schedule amounts would be $80.60 for rental months 1 thru 3 and $60.45 for months 4 thru 13, adjusted by the 2016 covered item update. For KXXX4 the fee schedule amounts would be $53.41 for months 1 thru 3 and $40.06 for months 4 thru 13, adjusted by the 2016 covered item update.

Payment for codes KXXX5 and KXXX6 would be made on a lump sum purchase basis in an amount based on the contractor's individual consideration of the item.

NCART, along with other CRT

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CRT LEGISLATION OVERSHADOWED
(CONTINUED FROM PAGE 33)

stakeholder groups, were able to submit comments to CMS by the July 9 deadline. We expressed serious concerns with the proposal and offered specific recommendations. You can view NCART's detailed comments at www.ncart.us, but here are some of the key points.

At the outset, we agreed with the need to develop additional distinct HCPCS codes in order to appropriately capture items that are currently billed as "miscellaneous" items. However, we expressed serious concerns that CMS continues to make coding, coverage and payment decisions which significantly impact access to important technology for people with disabilities in a manner that prevents stakeholder inclusion and meaningful discussion to arrive at the best outcomes.

This notice was not broadly communicated to the affected community of stakeholders, and providing a short period of time for the public to provide comments on a coding proposal with such broad implications to beneficiary access is grossly insufficient.

We stated that adequate and appropriate HCPCS codes are the foundation for coverage and payment policies that ensure appropriate access and the best health outcomes for Medicare beneficiaries. CMS has a responsibility to make coding decisions that do not impede appropriate access and unfortunately this proposed miscellaneous code set and related payment changes would result in serious access issues for people with disabilities.

Our specific recommendations centered on these points:

1.) We provided alternative codes and descriptors that should be used to better classify the products being provided.

2.) We stressed the need to maintain the current policy of determining payment amounts for miscellaneous codes based on the contractor's individual consideration.

3.) We stressed the need that the payment methodology allow the option for payment to be made as a purchase.

We will be following up with CMS on our comments and those submitted by other CRT stakeholder groups on the changes needed in order to avoid serious CRT access problems.

STAY TUNE AND STAY ENGAGED

Both of these issues need to be resolved by CMS and Congress as we move through the second half of this year. We will be issuing specific action steps through the various CRT stakeholder organizations so watch your emails.You can also register to receive updates and access additional information on these issues at either www.ncart.us or www.access2crt.org.

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LAW LIBRARY

SMOKE AND MIRRORS: DETERMINING WHO'S LIABLE WHEN EQUIPMENT BREAKS, FAILS OR CAUSES INJURY

WRITTEN BY: BRADLEY W. HOWARD & MATTHEW J. AGNEW

Supreme Court Justice Oliver Wendell Holmes Jr. commented, "Lawyers spend a great deal of their time shoveling smoke." When durable medical equipment ("DME" or "equipment") retailers, distributors and manufacturers sell DME that breaks, fails or causes injury, it is often difficult to see through the smoke lawyers shovel and determine who is liable. In determining liability, courts will look to case precedent, statutes, regulations and agreements among the parties. But typically, the agreement(s) among the parties have the most dispositive effect on the outcome of any litigation. These agreements are generally held in confidence, which requires a product liability plaintiff to allege liability against all parties involved, including the retailer, distributor and manufacturer. It is important for a DME business — big or small — to assess its potential liability exposure for the equipment it supplies, because when DME fails it often causes severe injury or death. This article provides a primer for DME retailers, distributors and manufacturers to begin analyzing their potential exposure to liability, should the equipment they supply fail.

WHAT IS PRODUCT LIABILITY?

State laws differ, but generally speaking, product liability law provides a legal remedy to the victim of an unreasonably dangerous and defective product if the victim was a foreseeable user of the product. A victim of a product defect must demonstrate that the product contained a design, manufacturing or marketing defect. A design defect is a defect in the product's design that makes the product inherently dangerous. A manufacturing defect is a defect in the product's manufacturing resulting in an unintended design that makes the product more dangerous than a consumer expects. A marketing defect occurs when the manufacturer fails to warn a consumer about a dangerous characteristic of a particular product.

AS A RESULT, THE PRACTICE OF LOANING EQUIPMENT TO OTHER INSTITUTIONS AND BUSINESSES IS COMMON. BECAUSE OF THE RISKS INVOLVED, THE PROCESS OF LOANING AND BORROWING EQUIPMENT SHOULD BE PROPERLY DOCUMENTED.

In the medical industry, product liability issues can arise under several common fact scenarios. Pharmaceutical manufacturers often face lawsuits from patients alleging a marketing defect for failing to warn a drug user about a particular side effect, such as the drug being associated with an increased risk for heart failure. DME manufacturers are often sued for design defects, with the plaintiff alleging that a defect in the design makes the DME particularly dangerous. Here are a few examples of recent DME product liability lawsuits:

- A quadriplegic sued a wheelchair manufacturer for a design defect alleging injuries to his head, neck, shoulders, upper back and spine when a safety component securing him to a moving van broke causing him to fall backwards.

- A CPAP user sued a CPAP manufacturer after tripping over the CPAP tubing. The user hit his eye on his nightstand resulting in the loss of all vision in one eye. The CPAP user alleged that the CPAP device was unreasonably dangerous due to a manufacturing defect, design defect and failure to warn.

- An oxygen patient's family sued five medical supply providers under the product liability theories of design defect and marketing defect alleging that the oxygen tank provided was defective and leaked oxygen resulting in a deadly fire.

- Recently, the Texas Supreme Court upheld the dismissal of a lawsuit against a ventilator manufacturer where the plaintiff alleged that a marketing defect caused the plaintiff's mother's death. The plaintiff's allegation was that the manufacturer failed to provide adequate instructions to the plaintiff's nurse resulting in the nurse's failure to properly adjust the regulator valve.

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SMOKE AND MIRRORS
(CONTINUED FROM PAGE 36)

DECREASING RETAILER AND DISTRIBUTOR LIABILITY

Product liability lawsuits are difficult, complex cases and they can be very costly to defend against. In a product liability lawsuit, plaintiffs often gather all potentially responsible parties and allege that all parties are responsible for the product's failure. It is within every DME business's interest to decrease its product liability exposure by implementing an anticipatory strategy that requires the business and its employees to: (1) insure the company against product liability loss; (2) inspect new and used equipment to ensure it will function as expected; and (3) instruct the user how to properly use the device in accordance with manufacturer instruction. The three Is — Insure, Inspect, Instruct — are designed to decrease your liability, while establishing a higher level of care for your patients.

A) INSURE

Insurance against product liability loss is a must for retailers, distributors and manufacturers. For Medicare suppliers, Supplier Standard 10 requires suppliers to have "a comprehensive liability insurance policy in the amount of $300,000 that covers . . . product liability and completed operations.[1] Although Medicare regulations only require $300,000 in insurance liability coverage, we encourage our clients to carry at least $1,000,000 in liability insurance. As previously stated, product liability lawsuits are costly to litigate, but more importantly, they are expensive to lose. For small business owners, having proper liability insurance coverage could mean the difference between surviving a product liability lawsuit and filing for bankruptcy.

B) INSPECT

DME suppliers should always inspect new and used equipment to ensure it will perform as expected. When it comes to new equipment, courts have generally concluded that a retailer does not have a duty to inspect for a hidden or concealed defect, but that a retailer is required to perform a reasonable inspection to ensure easily discoverable defects are addressed.[2] We will illustrate this responsibility by example.

EXAMPLE: A power mobility retailer displays power wheelchairs on its showroom floor. Several potential buyers touch, sit and test drive the PowerMobi 9000. One such potential buyer decides to purchase the PowerMobi 9000. Unbeknownst to the retailer, the PowerMobi 9000 has a manufacturing defect in the electrical system that accelerates the wheelchair to unsafe speeds. The PowerMobi 9000 also sustained damage on the showroom floor causing the seat to wobble, which could result in the user falling off while the power wheelchair is moving. What responsibility does the retailer have to inspect this machine, and if it fails to inspect the power wheelchair, for which defect(s) would the retailer likely be liable?

ANSWER: The retailer has a responsibility to perform a reasonable inspection to discover patent, but not latent, defects. The electrical system issue is a latent defect, meaning that it would be difficult for the retailer to discover the defect through reasonable inspection. But, the retailer has a responsibility to inspect the seat to ensure that it properly functions because any reasonable inspection of the power wheelchair would conclude that the seat is wobbly and requires repair. If the retailer fails to properly inspect the wobbly seat and the buyer is injured, the retailer would likely be liable for the defect.

Inspecting the equipment you sell — either as a retailer or a distributor — is critical to ensure that you are not putting an unreasonably dangerous product out onto the market. We encourage all of our clients to memorialize their DME inspections. To memorialize your inspection, provide employees with a checklist of inspection requirements and require your employees to fill out the inspection checklist each time an item is supplied to a patient. The DME company should retain a copy of the inspection checklist in the patient's file.

C) INSTRUCT

Under the Medicare Program, the duty to instruct a patient on how to safely and effectively use equipment is due at the time of delivery. Supplier Standard 12 requires program participants to "document that it or another qualified party has at an appropriate time, provided beneficiaries with necessary

IF YOU EMPLOY THE THREE Is — INSURE, INSPECT, INSTRUCT — YOU SHOULD MAKE SUBSTANTIAL HEADWAY IN PROTECTING YOUR BUSINESS INTERESTS AND DECREASE YOUR PRODUCT LIABILITY RISKS.

"SMOKE AND MIRRORS" IS A COMMON PLAINTIFF TACTIC USED TO ATTEMPT TO IMPUTE LIABILITY TO ALL PARTIES. PLAINTIFFS EMPLOY THESE TACTICS TO ENSURE THEY GET EVERY POSSIBLE BITE AT THE APPLE.

information and instruction on how to use Medicare-covered items safely and effectively.[3] In addition to the duty to instruct under the Medicare program, it is simply good business practice to properly instruct your patients how to safely and effectively use the DME supplied product. A court may consider the failure to properly instruct to be a marketing defect, which could result in a finding that the DME retailer is liable for whatever injuries arise from the failure to instruct. DME suppliers should provide written instructions, in addition to oral instructions, to the patient and memorialize the provisioning of instruction to the patient by requiring the patient to sign a statement indicating they understand the instructions provided.

SO, WHO IS LIABLE?

Determining liability for a hypothetical products liability case is complex and nearly impossible. In determining liability, your attorney would need to analyze the contractual agreements between the parties, previous case precedent, and state and federal laws. Commonly, plaintiffs will allege that every party is liable, but this is often far from reality. Agreements between the parties, particularly the indemnity clauses between the parties, will often determine who is liable for a product liability claim. To better protect yourself against these claims, consider having an attorney review your agreements with manufacturers, distributors or retailers. Through attorney-led contract negotiations it is possible to shift some of the product liability risk to the other party.

If you are presented with a product liability lawsuit, immediately contact your insurance provider. If your insurance provider covers the conduct alleged, the insurance company will be responsible for some or all of your legal expenses. If they deny coverage or provide a defense subject to a "Reservation of Rights," you must involve your personal counsel, not insurance defense counsel, to properly protect your interests.

Finally, if you are contacted by a patient, a manufacturer or an insurance company representative, including a private investigator, tactfully and professionally listen, but do not offer any "testimony" or statements, recorded or not, until you have conferred with your attorney. It is a dangerous game to engage people looking for ways to assert a claim against your company.

"Smoke and mirrors" is a common plaintiff tactic used to attempt to impute liability to all parties. Plaintiffs employ these tactics to ensure they get every possible bite at the apple. But, you do not have to be a victim of these tactics. If you employ the three Is — Insure, Inspect, Instruct — you should make substantial headway in protecting your business interests and decrease your product liability risks. Should you desire to further protect your business interests from the risk of over exposure to product liability, you should contact an attorney and request their assistance in reviewing your contractual arrangements.

CONTACT THE AUTHORS

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Brad may be reached at bhoward@bf-law.com

REFERENCES

1. 42 C.F.R. 424.57 (C)(10) (2015).
2. CARTER V. HECTOR SUPPLY CO., 128 SO. 2D 390 (FLA. 1961).
3. 42 C.F.R. 424.57 (C)(12) (2015).

MEDICAL FOCUS

TONE MANAGEMENT

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

Tone management encompasses medical interventions designed to reduce increased muscle tone. Reducing tone may result in increased function, improved postural control, improved range of motion, and increased strength in opposing muscle groups. These interventions may directly impact the seated posture of a client, as well as the postural support required in a wheelchair seating system.

What is muscle tone? Our muscles remain in a steady partially contracted state caused by a flow of nerve impulses. Tone is measured by the amount of resistance to movement. Muscle tone is controlled by two factors. First, inhibitory signals from the brain to the spinal cord release GABA to make muscles relax. Second, excitatory stimulating signals from the muscles to the spinal cord tell the muscle to contract. If this balance is normal, muscle tone is normal. In increased muscle tone, a lack of inhibition from the central nervous system (CNS) results in excessive contraction of the muscles and is generally due to damage in the brain or spinal cord.

Muscle tone can be decreased (hypotonia) or increased (hypertonia). Rigidity, often seen in clients with brain injury, occurs when tone is increased in both the flexors and extensors and is non-velocity dependent. Velocity dependent tone, often seen in clients with cerebral palsy, is an increase in tone in response to a quick movement of the limb which elicits a stretch reflex. Spasticity typically refers to muscle spasms which are increased with movement.

Specific tone management strategies include oral medications, injections, intrathecal Baclofen infusion and surgeries.

REDUCING TONE MAY RESULT IN INCREASED FUNCTION, IMPROVED POSTURAL CONTROL, IMPROVED RANGE OF MOTION, AND INCREASED STRENGTH IN OPPOSING MUSCLE GROUPS.

ORAL MEDICATIONS

Oral medications used for reduction of muscle tone include Dantrolene, Baclofen, Diazepam (Valium) and Tizanidine. The primary use of these medications may not be for tone reduction, but this may be one of the effects. These medications have a global impact on muscle tone. As such, if a client has high tone in the extremities, but low tone in the trunk and neck, these medications will reduce all tone and can lead to decreased trunk and head control. These medications, like most medications, also have side effects. A common side effect is fatigue. Some medications are also used to reduce extraneous movements commonly seen in clients with increased tone and include Artane and Modafinil.

INJECTIONS

Two primary injections are used to manage muscle tone – Phenol and Botox. A key advantage of injections over oral medications is a targeted reduction in tone, rather than a global impact. Many clients may take oral medications and still receive injections in specific muscle groups. Phenol injections destroy part of the motor nerve leading to a muscle belly. This reduces the flow of information between the muscle and CNS resulting in reduced tone. The motor nerve regrows and so the effects are temporary. Botox, or Botulinum toxin A, injections destroy some of the motor receptors in the muscle belly. Less of the muscle is able to contract, reducing tone. These receptors also grow back and so the effects are temporary. Phenol injections typically last longer than Botox, but are used in larger muscles and away for sensory nerves (as Phenol could cause damage to these nerves). The amount of Botox that can be used is determined by the weight of the client. The physician may be limited in how many areas can be injected by the total amount of Botox that can be safely used.

INTRATHECAL BACLOFEN INFUSION

One of the main side effects of oral Baclofen is fatigue. This same medication can be used in much smaller doses when administered intrathecally, reducing side effects. Intrathecal Baclofen Infusion (ITB) administers the medicine via a catheter from a pump placed in the abdomen to the intrathecal space, next

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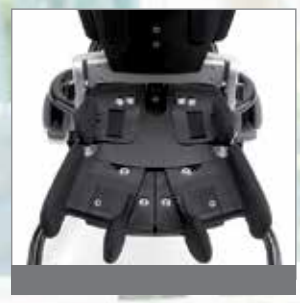
SNUG SEAT



DYNAMIC SEATING

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TONE MANAGEMENT
(CONTINUED FROM PAGE 40)

to the spinal cord. One advantage of ITB is more consistent delivery and resultant levels of Baclofen as compared to oral medication.

SURGERIES

The most common surgical procedure to reduce muscle tone is Selective Dorsal Rhizotomy (SDR). In this surgery, approximately 50 percent of the dorsal sensory roots from the spinal cord are cut, decreasing signals between the CNS and the muscles and resulting in decreased tone in the lower extremities. Reduction in tone in the lower extremities sometimes leads to a reduction seen elsewhere as overflow is reduced. This surgery is often performed in clients for whom the procedure may improve ambulation.

The wheelchair seating specialist often works closely with the medical team in determining the optimal tone management to meet positional and functional needs. The seating evaluation team may refer to the tone management team if increased muscle tone is negatively impacting posture and function. If the client experiences side effects such as decreased head and trunk control, this needs to be communicated back to the rehab physician.

For further information:

Spasticity Treatment & Management. Medscape. http://emedicine.medscape.com/article/2207448-treatment

What are some Muscle Tone Management Options for Cerebral Palsy? My Child Without Limits. United Cerebral Palsy.

http://www.mychildwithoutlimits.org/understand/cerebral-palsy/cerebral-palsy-treatment/cerebral-palsy-muscle-tone-management/

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RESOURCES:

UNITED SPINAL ASSOCIATION
HTTP://WWW.SPINALCORD.ORG

NATIONAL INSTITUTE OF NEUROLOGICAL DISORDERS AND STROKE (NINDS) SPINAL CORD INJURY INFORMATION PAGE
HTTP://WWW.NINDS.NIH.GOV/DISORDERS/SCI/SCI.HTM

PARALYZED VETERANS OF AMERICA (PVA)
HTTP://WWW.PVA.ORG

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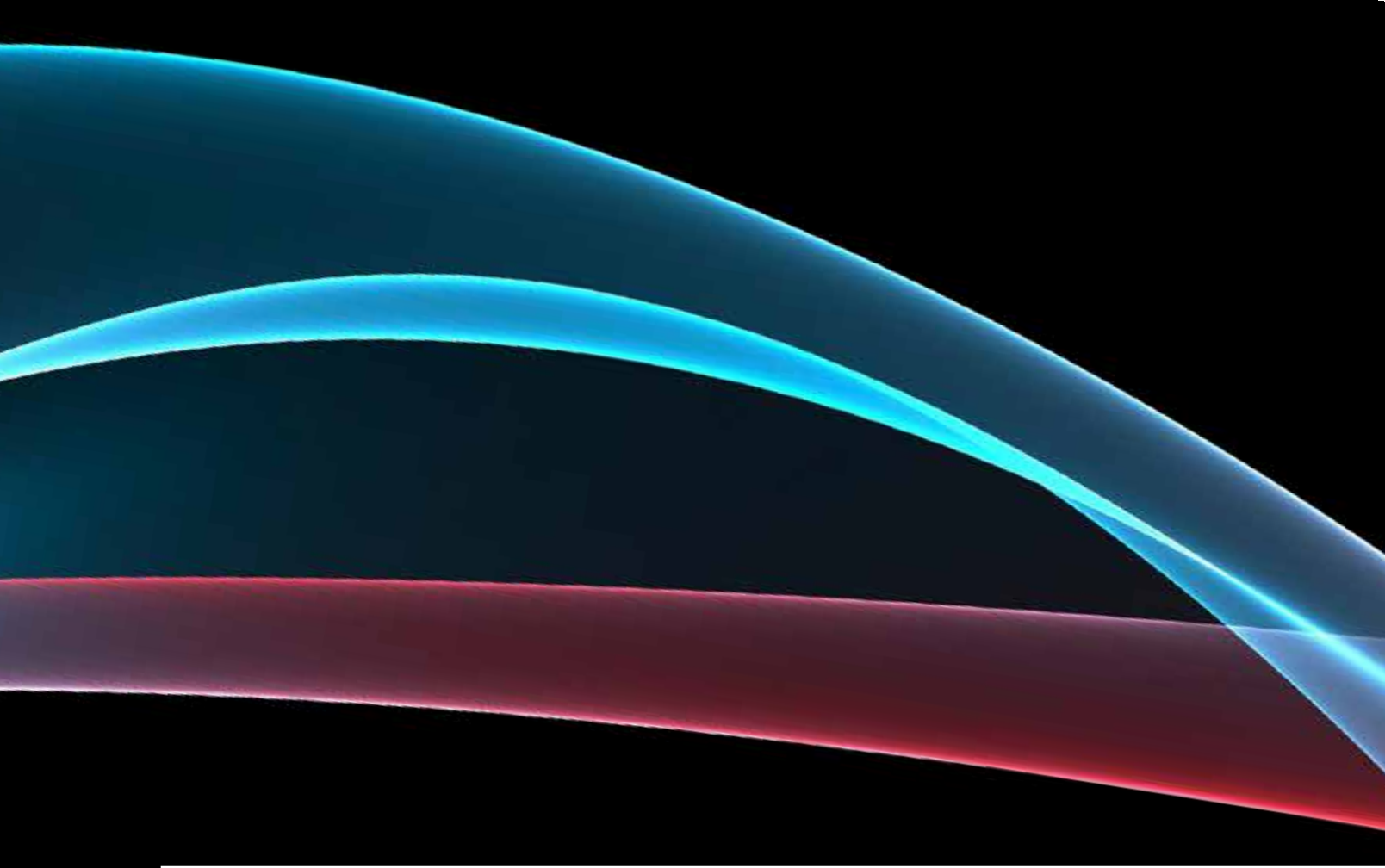

According to Wikipedia, the online encyclopedia, Yin and Yang are "opposite contrary forces that are actually complementary, interconnected, and interdependent as they interrelate to one another." "Dynamic" and "static" have these similar properties as we apply them to seating. The definition of "dynamic" is "of or concerned with energy or forces that produce motion," as opposed to static, which affects development or stability (Dictionary.com). For seating we'll use the word stable. For example, stabilize the pelvis to allow the user to engage in a dynamic or functional activity.

Client populations who would benefit from dynamic seating include:

- Pediatric
- Adolescent
- Adults
- Geriatric
- Frail Elderly
- Bariatric

Clients with the following diagnoses may also benefit from dynamic seating:

- Developmentally Delayed
- Autism
- Cerebral Palsy
- Spina Bifida
- Juvenile and Adult onset Arthritis
- Arthrogryposis
- Spinal Muscular Atrophy (SMA)
- Muscular Dystrophy (MD)
- Parkinson's Disease
- Spinal Cord Injury
- Multiple Sclerosis (MS)
- Brain Injury
- Huntington's Disease
- Amyotrophic Lateral Sclerosis (ALS)

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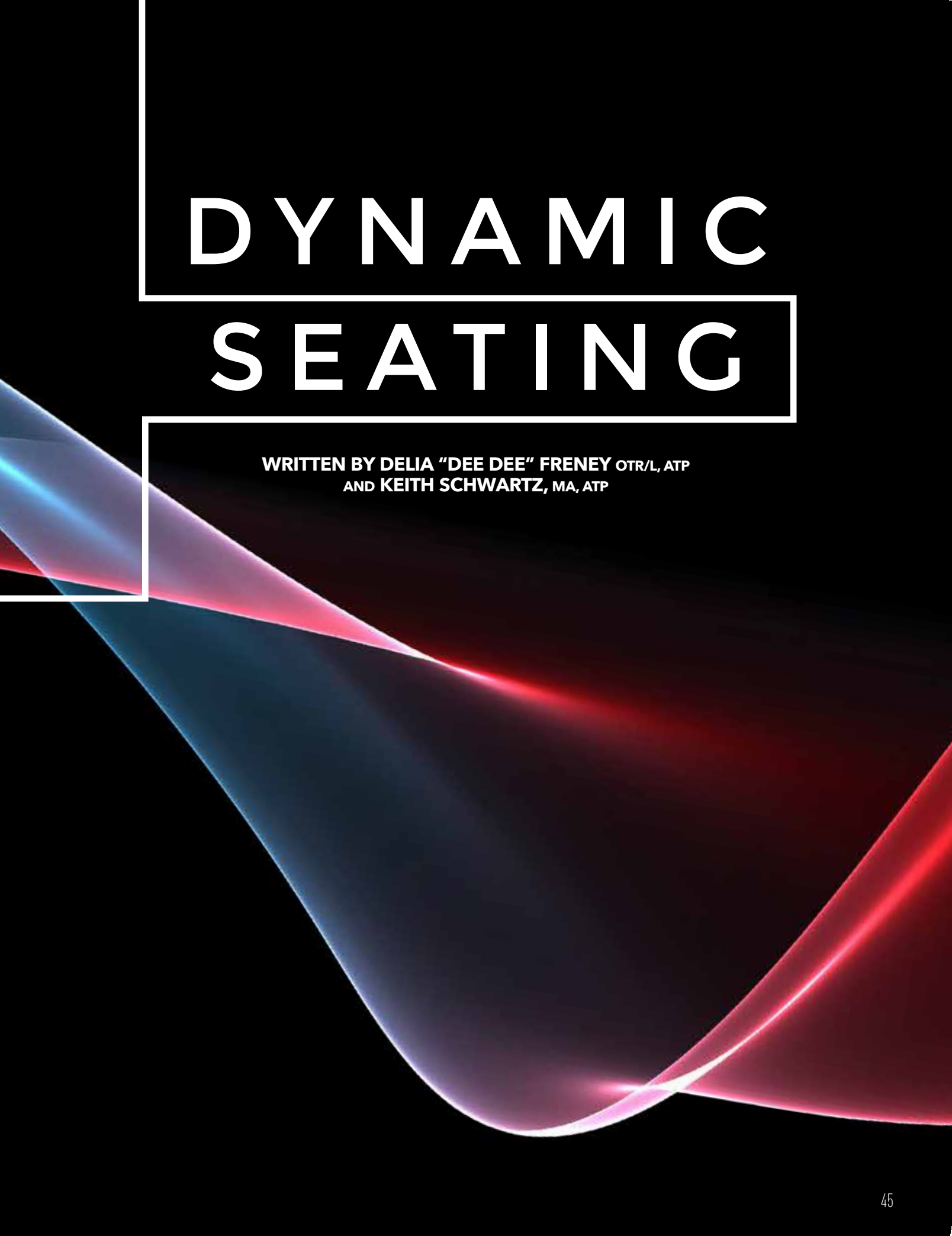
DYNAMIC SEATING

WRITTEN BY DELIA "DEE DEE" FRENEY OTR/L, ATP
AND KEITH SCHWARTZ, MA, ATP



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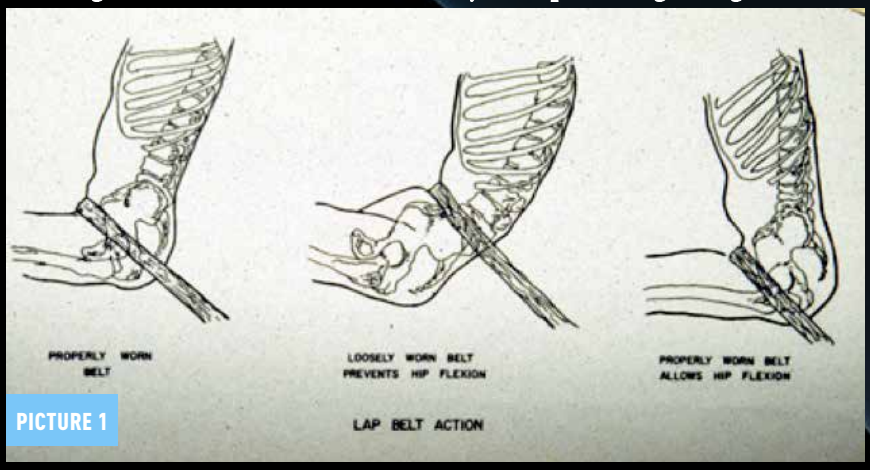
The term dynamic in seating can refer to the end user, the seating or the mobility base. Clinical goals for dynamic seating are to promote functional activities, to manage pressure and to accommodate voluntary and involuntary movements.

End user dynamic movements may range from small movements (i.e. in the ability to use an arm, hand or finger to drive a joystick) to large movements (such as extension patterns due to spasticity, dystonia or behavior that may put stress on the frame of a wheelchair). Some end users who appear to be sedentary, present with fixed deformities or minimal visible movements actually have subtle dynamic movements within their posture and supportive surface tissue. Dynamic voluntary and involuntary movements can be observed as coordinated and intentional or abnormal muscle tone such as spasticity, ataxia and dystonia.

THE DEFINITION OF "DYNAMIC" IS "OF OR CONCERNED WITH ENERGY OR FORCES THAT PRODUCE MOTION," AS OPPOSED TO STATIC, WHICH AFFECTS DEVELOPMENT OR STABILITY

Dynamic seating can be applied to the primary support surfaces (the seat and back), as well as secondary support surfaces (to support the head, pelvis, trunk and extremities). Dynamic seating components are mounted and integrated into the seating system to achieve postural support in a variety of planes. For example, anterior and posterior movement may be required to address flexion and extension.

Cushions can provide both static and dynamic support for the end user. Adjustable skin protection cushions using air are dynamic and require proper inflation to maximize clinical benefits. Positioning cushions with foam, honeycomb and similar materials provide support for stability. Hybrid cushions use a combination of stability (i.e. dense foam base) with dynamic components (i.e. air or fluid) and both support and protect the end user in wheelchair sitting. Custom molded cushions provide more stability to support fixed deformities in seating while the end user benefits from dynamic positioning through the wheelchair base (i.e. tilt). Mechanically dynamic seat cushions use alternating pressure cells.



PICTURE 1

Picture 1: Submarining

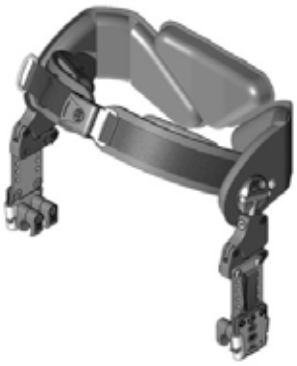
Positioning through both manual and power wheelchair bases can provide dynamic changes of position to manage pressure and provide functional positions to perform Activities of Daily Living (ADL) such as feeding. For example, a specialty seating company developed a power lateral tilt to allow an end user to drink with an adaptive cup independently and without aspirating. Another company developed a dynamic frame that allows an end user to posture into total body extension and return to a baseline position. Some wheelchair bases offer dynamic positioning in multiple planes of tilt and recline including lateral tilt, anterior tilt, and precline. Other dynamic options that do not change the seated angles include seat elevators and a power feature that brings an end user down to floor level for transfers and/or peer interaction for children.

Back supports typically provide stability. However, dynamic back supports with hardware attached to the back canes, allow dynamic movement by the end user. It is possible to limit and/or grade the distance and force of movement. Dynamic back canes which absorb force and flex with the movements of the user are available. For example, repetitive and/or extreme movements, often seen in Huntington's chorea, spastic or dystonic extension, athetoid movements or self-stimulating movements, often stress the frame of the wheelchair. Allowing the frame components to flex may reduce repeated repairs and replacement.

Placement of a support such as a

PICTURE 2

Picture 2: Dynamic pelvic belt



PICTURE 3

Picture 3: Dynamic Pelvic Stabilization

pelvic belt is important for the safety of the end user. For example, if improperly placed or mounted, "submarining" can occur and cause soft tissue trauma of the abdomen (see picture 1). This would be potentially harmful if a client is riding in the wheelchair as a passenger, especially if there is a sudden turn or stop during transportation. Dynamic pelvic belts are available which stabilize the pelvis and prevent submarining (if mounted at the correct angle), yet dynamically move with the end user for functional active movements (see picture 2).

Another solution is Dynamic Pelvic Stabilization (see picture 3). This intervention attaches to the wheelchair or other solid seating surface. Dynamic pelvic stabilization provides pelvic control and stability while allowing anterior and posterior pelvic tilt that may improve functional reach and overall postural stability (see picture 4 and 5).

Many other dynamic components can be mounted to or integrated into wheelchairs such as caster forks, rear suspension, head supports, footrest hangers and armrests.

A single dynamic component, such as a dynamic head support, may have multiple applications for function as described in these three case studies.

ASYMMETRIES DUE TO SEVERE SPASTICITY

Donald is a 44-year-old male with a primary diagnosis of cerebral palsy. He has severe spasticity in all his extremities. Although he wears a chest harness and a pelvic belt, his spasticity often causes him to be displaced from midline and his head then falls behind the head support. Once out of position, Donald requires assistance to reposition his head. Frequent tightening and adjustments to his head support are required secondary to the force of his spasticity. A dynamic head support was installed. When Donald extended, the dynamic head support moved with him and assisted with return to his resting position. A larger head support was installed on the dynamic hardware, which also aided in proper positioning of his head.

BEHAVIORAL

Daniel is 23-year-old male with a primary diagnosis of cerebral palsy. His previous wheelchair was a manual tilt in space wheelchair with a custom molded seating system. Daniel cannot verbally communicate, and when

(CONTINUED ON PAGE 48)

PICTURE 4

PICTURE 5

Picture 4: Reach with no pelvic stability
Picture 4: Reach with a dynamic pelvic stabilizer mounted to the frame

Photos courtesy of Bodypoint, Inc.

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he gets frustrated, he violently thrusts against the back and head support. The back posts, seating mounting brackets and head support have been repaired and replaced numerous times. Daniel received a new manual tilt in space wheelchair that had a dynamic back-rest. The new dynamic option reduced back cane breakage, but due to the intensity of his thrusting, the static head support still broke. Since a dynamic head support was installed, repairs and adjustments have not been needed.

REPOSITIONING

Mitzi is a 21-year-old female with a primary diagnosis of cerebral palsy. She is a student at a university who uses a power wheelchair with a tilt system for all of her mobility and positioning needs. Due to her severe spasticity, she has to frequently reposition herself throughout the course of the day. To do so, she tilts back to 50 degrees and then pivots off of her head support to move her body back into proper position. The head support was set in a very specific position to facilitate this repositioning. The slightest deviation makes her repositioning significantly more difficult. Numerous repairs were required due to the pressure that she placed on the static head support. Once this was replaced with the dynamic head support system, no further repairs have been needed and required adjustments have been significantly reduced.

FINDING A BALANCE OF STABILITY AND MOVEMENT IS KEY TO CLIENT FUNCTION. DYNAMIC SEATING CAN FACILITATE THIS BALANCE THROUGH THE PRIMARY AND SECONDARY SEATING SUPPORTS, THE WHEELCHAIR FRAME AND SEATING OPTIONS SUCH AS TILT.

The initial dynamic head support fitting took approximately 45 minutes to properly adjust this to meet her repositioning needs. When the head support was too far forward, the dynamic forces did not allow her to position herself back far enough on the seat. When the head support was too far back, she could not activate the dynamic force. Eventually, the correct position was achieved where she could use the dynamic force to reposition herself.

Finding a balance of stability and movement is key to client function. Dynamic seating can facilitate this balance through the primary and secondary seating supports, the wheelchair frame and seating options such as tilt.

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REHAB CASE STUDY

ENHANCING DEVELOPMENT WITH DYNAMIC WHEELCHAIR COMPONENTS

WRITTEN BY: SUZANNE EASON, OT/L

This article will discuss the concepts of how and why dynamic components on seating systems and wheelchair frames enhance a user's development via neuroplasticity. The case study will focus on the development of an 8-year-old boy with dynamic components on his wheelchair. Future research needs to include other methods of objective data gathering to support the use of dynamic wheelchairs and seating components for neuroplasticity.

I have been blessed with a profession which brings much satisfaction because I get to support individuals with complex neurological issues in meeting their mobility needs. I have been able to follow these individuals for years and have watched not only the individuals' progression, but the progression of the mobility equipment that improves independence. Within the last 20 years, neuroscience has transformed our understanding of how the brain works and how resilient it is. Can this understanding of how the brain works be applied to mobility systems to enhance an individual's development and function? I believe that allowing a seating system to move with an individual will enhance his or her development through neuroplasticity. Neuroplasticity is a broad term, referring to the creation of new neurons and the ever changing wiring that happens among all the neurons in the brain through interactions with our environment. The neuroplasticity is driven through experience-dependent actions. These actions follow specific rules:

1. Use It or Lose It
2. Use It and Improve It
3. Specificity
4. Repetition Matters
5. Intensity Matters
6. Time Matters
7. Salience Matters
8. Age Matters
9. Transference of Skills
10. Interference

(Kleim & Jones, 2008)

Number 7, Salience Matters, refers to the level of meaning an activity has to a person. This should be the first rule, because if the action doesn't have meaning, an individual will not pursue it, eliminating long-term results. Think of all those music lessons your parents made you take. Did you learn how to play that instrument? If so, you must have been very motivated. Experience-dependent activities enhance brain derived neurotrophic factor which enables a brain's recovery at the structural and chemical level. Brain derived neurotrophic factor is imperative in allowing new wiring and neuron connections.

Enriched environments that stimulate an individual to move and explore also enhance neuroplasticity. We are all familiar with the research studies that provide one group of animals with lots of opportunities to move and play while the other group of animals has limited access. The animals with enriched environments have more neuronal axons and dendrites than their comparison groups.

Seating systems have evolved over time. Sling seats and backs have been replaced with planar seating systems, supportive cushions and backs, customized production of complex body shapes and modular seating. As the science and technology improves, increased options are available for enhancing a person's development through seating and guided movement. Our community of manufacturers is developing more seating systems and components that can move with an individual if the user is motivated and able to do so, enriching his or her seated environment. The hope is that these initial movements will develop into new movements that an individual will be motivated to use. Other reasons for using dynamic components include, but are not limited to, enhancing arousal level, pressure relief, circulation, and integrity of materials, as well as extending the life of the system.

NEUROPLASTICITY IS A BROAD TERM, REFERRING TO THE CREATION OF NEW NEURONS AND THE EVER CHANGING WIRING THAT HAPPENS AMONG ALL THE NEURONS IN THE BRAIN THROUGH INTERACTIONS WITH OUR ENVIRONMENT.

There are numerous types of dynamic systems that work with body movements. From full systems, including the frame and the seating system, to individual components, which may include:

- separate seats or backs
- dynamic seat and back mounting hardware
- dynamic back cane mounts
- lateral trunk supports
- dynamic/stretch anterior trunk supports
- pelvic positioners
- head support hardware
- dynamic front hanger/foot plate mounts
- flexible shoe positioners
- custom dynamic component

All of these components can be adjusted to limit the amount of movement by increasing force of the dynamic mechanism, whether rubber bands, polymer density, plastic or metal thickness. For more information please refer to the seminar that Jessica Pedersen and I did on "Using Seating to Enhance Body Movement in a Wheelchair" at the 2015 International Seating Symposium in Nashville (reference below).

CASE STUDY

Jeff (not his real name) is an adorable 8-year-old boy who was born at 23 weeks gestation secondary to maternal infections. He was on a ventilator and was hospitalized for 10 months. He had grade 4 interventricular hemorrhages with hydrocephalus that was managed with ventriculoperitoneal shunts. This eventually led to periventricular leukomalacia. Jeff had numerous shunt revisions and currently has two internal shunts. Jeff came to live at our facility at 1 year of age. He had limited volitional active movement, no visual engagement and difficulty with staying calm. His first mobility system was a stroller base and supported him well, but did not allow for self-propelling and interaction with his environment. Jeff began to show improved volitional movement, as well as trunk and head control.

In 2010, when he was 3 years of age, we ordered him a mobility system that would encourage self-propulsion. On evaluation, Jeff had good alignment of his spine and pelvis and functional range of motion throughout his upper and lower extremities with the exception of limited ankle dorsiflexion. He had less active movement in his right arm when compared to his left. His gross motor abilities included rolling and when placed in sitting he needed support at his pelvis and trunk. We decided to get a reverse configuration manual wheelchair with a one arm drive and a simple planar seating system with lateral trunk supports, head support, pelvic belt and shoe holders. Jeff did well with this system until he started to rock it with side-to-side movement of his trunk. We decided to enhance this movement for two reasons: 1. To safely encourage this movement he was seeking; and 2. To help keep the wheelchair and seating system intact. We placed polymer washers between his seat mounting hardware and the seat rail and between his lateral trunk support mounting brackets at the point it attached to the back (see Pictures 1 and 2). The polymers we used were leftovers from various dynamic components. Jeff was able to rock side-to-side and the polymers absorbed this force and movement on each side. This provided the movement that he needed and craved, and his system remained in good working order. After the dynamic addition to his mobility system, Jeff began to show improvements in his gross motor skills. He is now able to go from supine to a seated position with no assistance and can sit for a prolonged period of time with supervision. The dynamic component to his chair enhanced his gross motor abilities. Jeff has grown considerably and we are looking at a new mobility system to further enhance his movements. At this point, because he doesn't pull to stand or ambulate, we are considering dynamic front hanger modifications along with the current use of polymers in the seat, back and lateral hardware.

Picture 1: Polymer between the back mounting track and lateral trunk support bracket.gravity distribution

Picture 2: Polymer between the seat rail and seat mounting hardware.

Measuring developmental abilities is only one way of verifying how dynamic seating can enhance an individual's life. Other objective methods that could measure improvement of brain

(CONTINUED ON PAGE 52)

ENHANCING DEVELOPEMENT ...
(CONTINUED FROM PAGE 51)

function are electroencephalogram (EEG), computed tomography (CT) scans, functional magnetic resonance imaging (FMRI) and functional near-infrared spectroscopy. I attempted to look at Jeff's EEGs to see if there were appreciable changes that could be correlated to the dynamic modifications but because these EEGs were more focused on seizure and abnormal activities, no changes were noted. A review of Jeff's numerous CT scans showed no progression of his periventricular leukomalacia, but no other changes were identified. This could be attributed to the radiologist's focus of looking for new medical concerns rather than anatomical improvements.

Through evaluation and trials, dynamic components enhanced Jeff's life by contributing to his overall improvement in gross motor skills through neuroplasticity. Further research is needed regarding other objective methods to demonstrate improved brain function through the use of dynamic wheelchair and seating components which will continue to drive our industry to produce new types of products that will get funded for the end user.

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COMPLEX REHAB TECHNOLOGY IS ON A ROLL

WRITTEN BY: JENN WOLFF AND ALEX BENNEWITH

In June 2014, we finished United Spinal Association's Fourth Annual Roll on Capitol Hill with an overwhelming amount of positive feedback and the number of co-sponsors on HR 1516 and S 1013 – the Ensuring Access to Quality Complex Rehabilitation Technology (CRT) Act of 2015 – continues to grow. More than 100 wheelchair advocates, clinicians and suppliers of CRT all roamed the halls of Congress together and participated in approximately 200 Congressional Hill visits on Tuesday, June 9, 2015, as part of the roll and since that date, in just a few weeks, we have seen an increase of 19 co-sponsors on the House bill to 115 total and two co-sponsors on the Senate bill to nine total.

SO WHAT CAN WE DO TO CONTINUE THE MOMENTUM?

1. Continue to put pressure on our Congressional members. Suppliers, clinicians, users of wheeled mobility, and other advocates should all bring this issue to all House and Senate legislators who have not signed on, especially those who signed on last year who are yet to sign back up. If we can figure out what each office needs, whether it is more data or consumer stories, we can help push them toward supporting the bills.

For legislators who have already signed on to HR 1516/S 1013, we must ask for their support in prioritizing CRT for passage, that is, championing passage of the House and Senate bills with the committees of Jurisdiction, Senate Finance, House Ways and Means, and House Energy and Commerce; build support for speeding up the request for an official CBO score; ask their colleagues to also sponsor the bill and think about in which legislative vehicles the CRT bills could be included.

2. Educate ourselves, our clients and each other on progress being made and how each of us are making strides in effective communication, advocacy efforts and public awareness of this issue. United Spinal Association's Advocacy Alliance conducted a Thunderclap message through social media coinciding with our Roll on Capitol Hill on June 9, in support of CRT to more than 130,000 people on social media. Think of it as an "online flash mob" to spread messages through Facebook, Twitter and Tumblr that cannot be ignored.

We need to continue to keep publishing personal stories of how the current policies are negatively affecting the end user via social media, newspapers and through national or local media. If you have a person willing to share his/her story, please send them to the Advocacy Alliance, http://www.unitedspinal.org/advocacy-alliance/ so we can get the message out there

THIS YEAR I AM GETTING THE SENSE THAT MORE AND MORE CONGRESSIONAL OFFICES ARE REALLY "GETTING IT." THE YEAR 2015 IS THE 25TH ANNIVERSARY OF THE AMERICANS WITH DISABILITIES ACT AND MAY VERY WELL BE THE YEAR OF PASSAGE OF CRT. LET'S MAKE IT HAPPEN.

3. Keep the hope alive. This year feels different than years before. In 2010, Congress was so focused on health care reform and the Affordable Care Act that we were largely ignored. The years since 2010 have led to better education and messaging all leading to last year and this year when CRT has had greater support and understanding.

This year, our fourth year back on the Hill, as part of United Spinal Association's Roll on Capitol Hill, I am getting the sense that more and

more Congressional offices are really "getting it." The year 2015 is the 25th anniversary of the Americans with Disabilities Act and may very well be the year of passage of CRT. Let's make it happen.

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ADMC… SHOULD WE OR SHOULDN'T WE?

WRITTEN BY: CLAUDIA AMORTEGUI, PRESIDENT, THE ORION CONSULTING GROUP, INC.

For many years, I have been asked about the use of ADMC – Advanced Determination of Medicare Coverage – and rehab orders. My answer has been the same since the beginning. In some cases I believe "yes," it is a good idea, and in many cases "no."

What is the right answer for your company? This will depend on your ATPs, referrals, internal staff and your overall process. Keep in mind, that an ADMC approval is not the same as the normal Prior Authorizations (PAs) received from other funding sources.

As a provider, you must always keep in mind that ADMC only reviews for medical need – not for other denial possibilities such as eligibility, other insurances and even same/similar equipment. Therefore, you must understand that you cannot "bank" on a guaranteed payment with no audit issues. Per Medicare guidelines, ADMC orders can still be pulled for audits, however, the ADMC approval should help you through any appeals process.

I always tell people, that ADMC does not give you the right to play dumb and/or simply not know the rules. I have seen ADMC approvals on items that I know should not be covered. At the end of the day, we are all human and mistakes may be made. If something is approved that you know should not be (i.e. a convenience item), then just be sure to follow the normal steps (i.e. obtain an ABN).

ALWAYS REMEMBER THAT YOU CAN STILL BE AUDITED. THE MEDICARE REVIEWERS CAN MAKE MISTAKES IN WHICH YOU CANNOT TURN A BLIND EYE, AND YOU ARE ADDING TIME TO THE OVERALL PROCESS

On the opposite side of approvals would be the denials that are received. In some cases, the denial is not a bad thing. As a provider you may be battling with a referral or client who believes they qualify, but you know they don't as they literally just walked through your door. ADMC will hopefully be the support you need in confirming the denial. The beneficiary/end-user will receive a copy of the denial, confirming that it is not your decision, it's Medicare's. If you were not planning on a denial, you still have some options:

1. Review the entire submitted file along with the full denial reason.

2. If you can find the answers to the denial reasons, then you will want to put together a short, but organized response as to where the information is located. For some very blatant misses, I have actually called Medicare and had the claim re-opened. You may not always get that option, but it does not hurt to try.

3. Keep in mind that you can only re-submit the order to ADMC one time after the initial denial. I hear much confusion regarding the one-time submittal. Some people believe you can only send in the ADMC request one time in a six-month period, which is not correct. You can submit the original request and if denied, you can resubmit one more time within the six-month period – therefore, you can technically submit the same ADMC request twice within a six-month period.

Some people will ask … "If I know the ADMC denial is wrong (i.e. a basic technicality that you plainly see on the documentation), can I just skip the resubmittal, deliver the wheelchair and file the claim as I normally would?" Unfortunately, this is not suggested at all. When you file the initial ADMC request, this information is logged. If the claim goes through the billing system and there is still a denial shown in the Medicare system, there is a very high likelihood of your claim being denied in the normal process. At that point you get stuck in the appeals process, which as we all know is not fun, nor short. I strongly suggest correcting the ADMC denial with a resubmission prior to delivering the equipment.

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- Expert practitioners
- Contributors to evidence based outcomes
- Advocates for end users and caregivers

Who

- Provide education, consultation and treatment
- Influence standards of practice with professional organizations
- Mobilize grassroots action for policy and legislative changes
- Promote "best practice"
- Contribute to the healthcare continuum

With the above basics in mind, when would I suggest ADMC? I do like it when I realize the client simply does not qualify and they do not want to believe you. Again, this should take the pressure off you, the provider. I am also a proponent of ADMC for the borderline clients. There are times my team and I will review an order and we literally feel as if we are on a fence I cannot decide which side we should be on. With all the shark news these days, it's as if we feel the sharks circling and we see no options. At that point, ADMC can be a great security blanket.

> "IF I KNOW THE ADMC DENIAL IS WRONG, CAN I JUST SKIP THE RESUBMITTAL, DELIVER THE WHEELCHAIR AND FILE THE CLAIM AS I NORMALLY WOULD?"

I am not a big fan of ADMC for those orders that I consider no-brainers – a high-level client (i.e. C4 complete SCI) with thorough seating evaluations and physician chart notes. In my opinion, there is no need to waste time. However, I also stress this is the importance of good staff – both internal and ATPs. You may have the "perfect" qualifying client, but if you do not know or understand the rules and technicalities, you can still lose. Your client might be perfect, but your documentation must be perfect too, right down to the required date stamps. This also means that if an owner or manager of the rehab business does not truly know the level of the staff knowledge, you cannot properly make an educated decision.

(CONTINUED ON PAGE 58)

ADMC ... SHOULD WE OR SHOULDN'T WE?
(CONTINUED FROM PAGE 57)

Simply put, it is my opinion that ADMC is not an all or nothing process. I do believe it is a good option for some orders. Always remember that you can still be audited. The Medicare reviewers can make mistakes in which you cannot turn a blind eye, and you are adding time to the overall process (approximately 30 days). In the same breath, the decisions can protect you and help you with both the end-users and Medicare themselves.

Don't forget, ADMC is not for all products. You can submit an ADMC request for the following items:

- E1161
- E1231 - E1234
- K0005
- K0009
- K0835 – K0843
- K0848 – K0855*
- K0856 – K0864
- K0868 – K0871*
- K0877 – K0880
- K0884
- K0886
- K0890 – K0891

** Only when billed with alternative drive controls*

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CLINICIAN TASK FORCE: PRELIMINARY REFLECTIONS ON THE SERVICE SPECIFIC PREPAYMENT REVIEW FOR SINGLE & MULTIPLE POWER OPTIONS

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

While Rehab Technology Professionals (RTPs) and clinicians focus on ensuring clients have access to appropriate and necessary Complex Rehabilitation Technology (CRT), payers are working to eliminate 'waste and abuse' in the DMEPOS benefit category.

One of the top priorities of the Centers for Medicare & Medicaid Services (CMS) is addressing improper payments. The four Durable Medical Equipment Medicare Administrative Contractors (DME MACs A, B, C, D) use error rates produced by the Comprehensive Error Rate Testing (CERT) program and vulnerabilities identified through data analysis and medical review of claims to determine where to target improper payment prevention efforts.

In April 2015, Jurisdiction C announced a service-specific prepayment review for HCPCS E1002 (Wheelchair Accessory, Power Seating System, Tilt Only) and E1007 (Wheelchair Accessory, Power Seating System, Combination Tilt and Recline, with Mechanical Shear Reduction). It is not uncommon for other jurisdictions to follow suit depending on their respective utilization, data analyses and error rates.

WHAT DOES THIS MEAN?

Due to an increase in utilization and denial rates, CMS and CMS contractors are taking a closer look at claims for E1002 and E1007 to prevent the initial payment of claims that do not comply with Medicare's coverage, coding, payment and billing policies.

This deserves some professional reflection on the part of CRT suppliers and clinicians. We should be curious when there are changes in practice patterns and seek to understand the underlying causes. Has utilization increased because of a change in the needs of the people we are seeing? Have we changed the way we practice, or the way we recommend tilt and/or recline systems? Why do we believe there has been an increase in utilization of tilt and/or recline?

A CLOSER LOOK AT THE LOCAL COVERAGE POLICY FOR TILT AND/OR RECLINE

Figure 1 from the Local Coverage Determination (LCD): Wheelchair Options/Accessories (L11451) details the coverage criteria for power tilt and/or recline seating systems (E1002-E1010).

FIGURE 1

POWER TILT AND/OR RECLINE SEATING SYSTEMS (E1002-E1010):

A power seating system – tilt only, recline only, or combination tilt and recline – with or without power elevating leg rests will be covered if criteria 1, 2, and 3 are met and if criterion 4, 5, or 6 is met:

1. The beneficiary meets all the coverage criteria for a power wheelchair described in the Power Mobility Devices LCD; and

2. A specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT) or physician who has specific training and experience in rehabilitation wheelchair evaluations of the beneficiary's seating and positioning needs. The PT, OT or physician may have no financial relationship with the supplier; and

3. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary.

4. The beneficiary is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or

5. The beneficiary utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; or

6. The power seating system is needed to manage increased tone or spasticity.

If these criteria are not met, the power seating component(s) will be denied as not reasonable and necessary.

Figure 1 - Local Coverage Determination (LCD): Wheelchair Options/Accessories (L11451) - Effective 10/31/2014 http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=11451&ContrID=140

The conundrum is that the coverage policy for power tilt and/or recline is identical. Does that mean every client who qualifies for a single power seat function (tilt or recline) automatically qualifies for a multiple power seat function (tilt and recline)? No.

Justification and rationale explaining why one power seat function alone will not meet the client's needs must be clearly documented in the client's record by the CRT team. The service-specific prepayment review is explicitly targeting this information.

COMMON REASONS FOR DENIALS:

According to the DME MAC Power Mobility Devices Denial Help Aid common denial reasons for power tilt and/or recline include the following:

1. The medical records do not document that the patient meets coverage criteria for a power tilt and power recline seating system and the system is being used on the wheelchair or that the patient uses a ventilator which is mounted on the wheelchair.

2. The medical records do not document that the patient's mobility limitation is due to a neurological condition, myopathy or congenital skeletal deformity.

3. Medical records do not document a high risk for development of a pressure ulcer and patient is unable to perform functional weight shift; or patient utilizes intermittent catheterization for bladder management and is unable to independently transfer; or power seating system is needed to manage increased tone or spasticity.

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CLINICIAN TASK FORCE ...
(CONTINUED FROM PAGE 61)

PREPARING FOR SERVICE SPECIFIC PREPAYMENT REVIEW

It is not merely enough to restate the words of the LCD in your documentation. It is necessary to provide the explanation on why the beneficiary needs the item, why one power function (tilt or recline) alone will not meet the client's needs, the beneficiary's diagnosis related to the need for the CRT system, the beneficiary's abilities and limitations as they relate to the equipment (e.g., degree of independence/dependence, frequency and nature of the activities the beneficiary performs, etc.), the duration of the condition, any change in condition, the expected prognosis, and past experience using similar equipment.

The Power Mobility Resource Center of DME MAC Jurisdiction C, CGS Administrators, LLC, is a rich, easily navigated resource. http://www.cgsmedicare.com/jc/coverage/mr/power_mobility_resources.html

Utilize these resources to assist you in preparing your documentation and when educating physicians and colleagues in understanding these complex policies.

Working with your colleagues and CRT team will help you to be prepared for the increased scrutiny of this targeted review.

1. Study the coverage policy and documentation requirements for tilt and/or recline systems.

2. Share this information with your CRT teammates (physician, therapist, company claims processors, etc.)

3. Participate in education and training with RTPs and clinicians to appraise rationale and justifications for one or more power seat functions.

4. Discuss recommendations with the client and CRT team. Explain tradeoffs for one or more power seat functions. Help your client understand what is covered versus noncovered and explain alternate payment options. Document the discussion.

5. Conduct an internal audit and peer review of claims with tilt and/or recline claims. Determine if documentation adequately justifies medical need and eligibility. Discuss findings and learn from your colleagues.

IN CLOSING

The Clinician Task Force (CTF) provides clinical guidance to policymakers to ensure clients have continued access to CRT products and services. Do you think the coverage policy for wheelchair options and accessories should be revised to differentiate eligibility for tilt and/or recline? Should CRT stakeholders take the lead and initiate a Formal Request for Reconsideration to the LCD for tilt and/or recline?

We are all called to utilize evidence-based parameters, analysis and sound decision-making in developing letters of medical necessity and justifying these components. It is not enough to do what we have always done. "Expert practice is defined as being able to do the right thing at the right time," says Ruth Purtillo, PhD, PT, FAPT.

CTF members are available to collaborate with RTPs to explore indications and rationale for one or more power options. Let's begin a discussion and work together to determine if a revised coverage policy is beneficial to ensure that clients with a medical need for tilt and/or recline are able to retain access to these options. Now is the right time.

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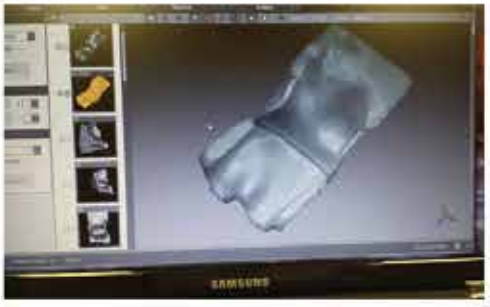

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RESNA: NEW POSITION PAPERS, ATP IN SPANISH, ADVANCED SEATING COURSE, AND MORE

WRITTEN BY: ANDREA VAN HOOK

RESNA has recently published two new position papers, available as a free download on the organization's website.

RESNA's Wheeled Mobility Special Interest Group has updated a previously published position paper, "The Application of Tilt, Recline, and Elevating Leg Rests for Wheelchairs," reflecting changes in technology and current best practices since it was first issued in 2010. Research citations have been updated to further justification of these features, which RESNA states is often medically necessary.

The RESNA Standards Committee on Emergency Stair Travel Devices has developed a paper on the use of evacuation chairs to provide guidance on available options used by individuals with disabilities during evacuations, as well as to provide evidence from the literature supporting the use of track-type evacuation chairs. The paper is a complement to the standard RESNA ED – 1:2013 American National Standard for Evacuation Devices Volume 1: Emergency Stair Travel Devices Used by Individuals with Disabilities.

"We found that stakeholders still had questions about appropriate use after reviewing the standard," explained Glenn Hedman, PE, CPE, ATP, RET, and chair of the committee. "The position paper is designed to help stakeholders understand the use of these devices and how emergency evacuation of individuals with disabilities needs to be included in every institution's emergency planning."

PETE STEPHENS, SHARED HIS EXPERIENCE BUILDING THE WORLD'S FIRST 3D-PRINTED CAR WITH INDUSTRY INNOVATOR LOCAL MOTORS. INTEREST IN THESE NEW TOOLS CARRIED OVER INTO POPULAR SESSIONS ABOUT WEARABLE TECH, GOOGLE GLASS, 3D PRINTING, APPS, AND MICROCONTROLLERS.

RESNA position papers summarize current research and best-practice trends in relevant areas of assistive technology, based on the consensus of experts and evidence. The papers are developed by professionals working in the field. While not intended to replace clinical judgment related to specific needs, the papers can be used by clinicians to inform decision-making and as justification for appropriate use.

To download, visit www.resna.org/position-papers.

ATP EXAM NOW AVAILABLE IN SPANISH

In response to a request from assistive technology professionals working in Puerto Rico, the ATP exam is now available in Puerto Rican Spanish. The Spanish-language exam can be accessed at any Prometric testing centers with a scheduled appointment. To request the Spanish-language exam, applicants must check the "Puerto Rican Spanish" option on the ATP application. To download the application, visit www.resna.org/atp.

ADVANCED SEATING & MOBILITY WORKSHOP

This two-day advanced course will be offered on October 29 and 30 in conjunction with Medtrade Atlanta at the Georgia World Congress Center. Taught by instructor Michelle Lange, OTR, ABDA, ATP/SMS, "Advanced Seating" will address:

- Common positioning challenges of the pelvis, trunk, lower extremities, upper extremities and head
- Positioning strategies, including primary seating surfaces and secondary supports
- Power wheelchair access methods, including alternatives to the standard joystick

- Common driving parameters and alternative access to driving
- Interfacing, infrared transmission, and mouse emulation

Medtrade will provide registered course attendees with complimentary Conference and Expo passes. RESNA is authorized by IACET to provide 1.2 CEUs for this course, and RESNA members receive a discount. To register or for information, visit www.resna.org/advanced-seating.

RESNA 2015 CONFERENCE HIGHLIGHTS

RESNA's annual conference, held June 10-14 in Denver, Colorado, was a rousing success, with conference attendance increasing 13 percent over last year's event. In addition, sponsorships more than doubled and the exhibit hall sold out.

"We added more interactivity and hands-on learning to the conference program this year, and we're gratified by the response," said Michael Brogioli, executive director.

A conference highlight was a plenary session about the Maker Movement and how new tools and micro-manufacturing can help transform assistive technology product development. The keynote speaker, mechanical engineer Pete Stephens, shared his experience building the world's first 3D-printed car with industry innovator Local Motors. Interest in these new tools carried over into popular sessions about wearable tech, Google Glass, 3D printing, apps, and microcontrollers.

The RESNA conference included the always popular Developers Forum, which provided a unique interactive opportunity for both large and small

(CONTINUED ON PAGE 66)

RESNA: NEW POSITION PAPERS ...
(CONTINUED FROM PAGE 65)

developers to receive feedback and discuss ideas for new products and enhancements with engineers, rehab technologists, therapists, consumers and others in the field of assistive technology. Attendees also flocked to exhibitor product demonstrations and participated in several networking events that encouraged collaboration and information sharing.

At the annual awards luncheon, RESNA presented its highest award, Honorary Fellow, to Jamie Noon, a wheelchair cushion designer, trainer and consultant to the U.S. Agency for International Development (USAID) and the World Health Organization (WHO). Noon is credited with the design of the patented "Hip Grip," developed by Beneficial Designs and available through Body Point; the "AirRx Cushion," developed by Seikman Consulting and available through AirRx Healthcare; and the patented "Flex Rim" developed by Max Mobility and available through Spinergy. He is also the principal designer of

AT THE ANNUAL AWARDS LUNCHEON, RESNA PRESENTED ITS HIGHEST AWARD, HONORARY FELLOW, TO JAMIE NOON, A WHEELCHAIR CUSHION DESIGNER, TRAINER AND CONSULTANT ...

two low-cost pressure relief cushions and numerous postural support devices for multi-country use in the developing world. RESNA recognized eight other professionals and one organization for contributions to RESNA and the field of assistive technology. For a complete list of the award winners, visit www.resna.org/awards2015.

RESNA 2015 sponsors included AT&T, the National Mobility Equipment Dealers Association, and Ride Designs (Gold level); Innovations Health, Permobil, and Quantum Rehab (Silver level); Invacare and Sunrise Medical (Bronze level); and the National Science Foundation, TREAT, and Paralyzed Veterans of America (student competitions).

Next year's conference is a collaboration between RESNA and NCART, the National Coalition for Assistive and Rehab Technology, with NRRTS as a participating partner. RESNA/NCART 2016 is July 12-15 at the Hyatt Regency in Arlington, Virginia. For more information, visit www.resna.org/conference2016.

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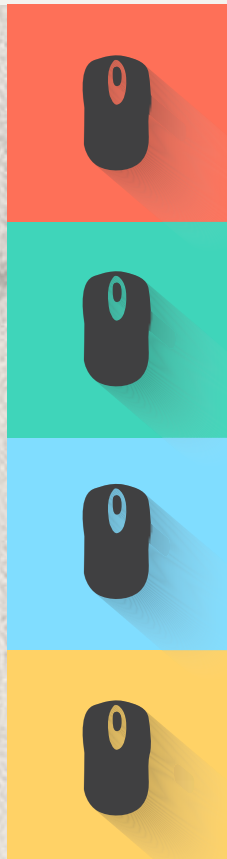

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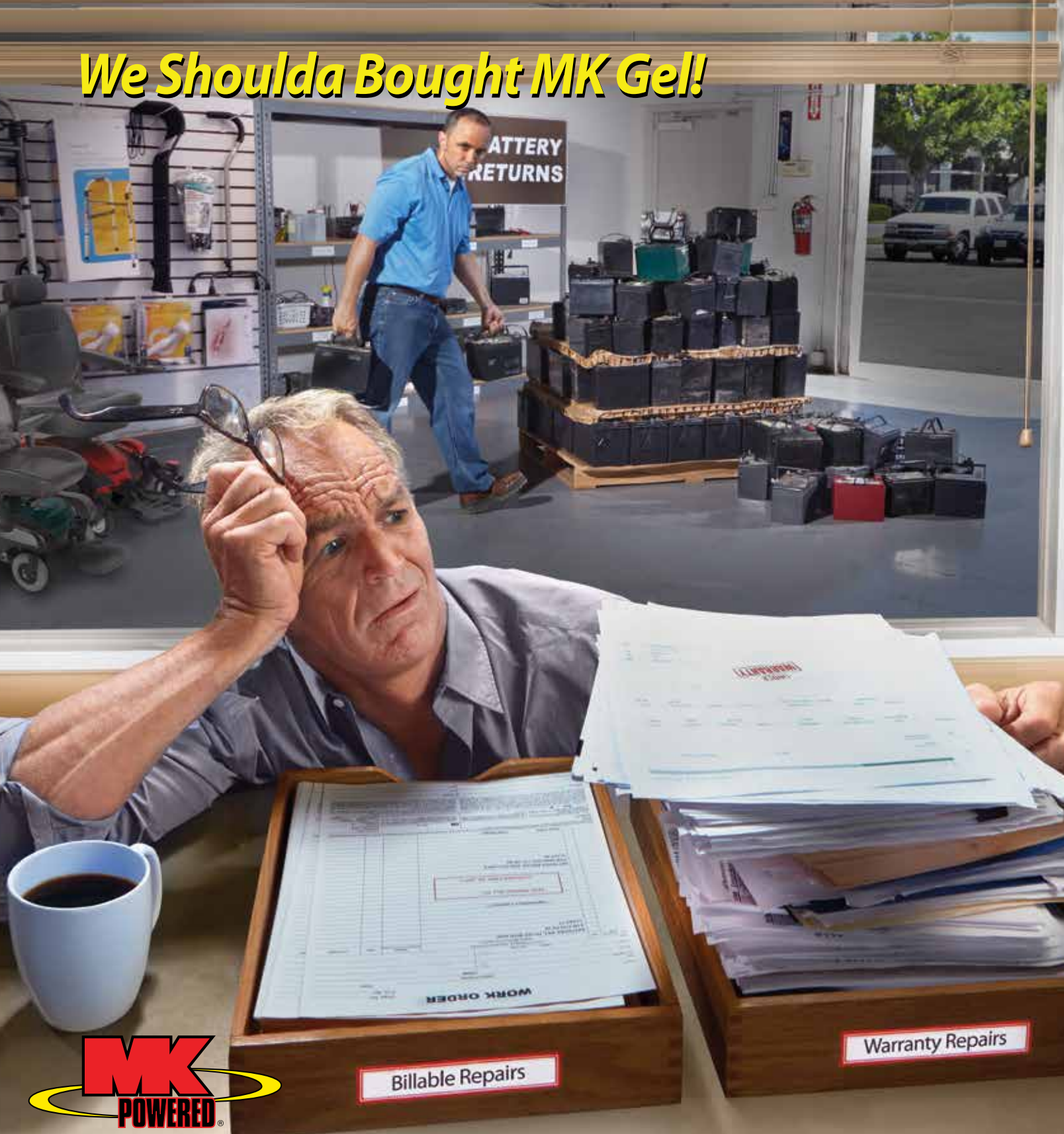

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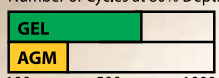

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New!

CFON FOCUS

THE PERFECT FIT IS EVER-CHANGING; THE DANGERS OF CONTOURED AND CUSTOM-MOLDED SEATING

WRITTEN BY: KARA KOPPLIN, SENIOR DIRECTOR OF EFFICACY RESEARCH AND STANDARDS AT ROHO

Can you still fit in the same jeans you wore five years ago? Consider your answer when you think about contoured and custom-molded seating. In concept, a custom cushion made specifically for an individual seems like a great seating solution. How could it not be when the individual's body is measured and molded to create the perfect fit? The answer might surprise you. Consider your own physique. Do you still fit in those jeans, that dress, or even those shoes you bought in 2010? Probably not. The same goes for contoured and custom-molded seating. They work in the short term, but often not in the long term. The body inevitably changes over time.

DO YOU STILL FIT IN THOSE JEANS, THAT DRESS, OR EVEN THOSE SHOES YOU BOUGHT IN 2010?

Standard contour foam cushions and custom-molded foam cushions are sometimes considered to be as effective as adjustable air-cell-based cushions at protecting the tissues. While these non-adjustable foam cushions can meet some specific needs and may be appropriate for certain individuals, most have significant drawbacks. From the start, there is typically a delay between the "fitting" process and the delivery of the finished product. Also, any surface with a fixed contour, even if it is custom molded or carved, is incapable of responding to an individual's changing needs over time, unlike an air-cell-based cushion. Additionally, contoured foam cushions do not adapt and respond to movements throughout the day, as an air-cell-based cushion does, and more problems can arise if the person doesn't sit perfectly inside the contours at all times.

Everyone's physique changes over time, and for many reasons, including weight loss or gain, musculature development or decline, disease advancement and even childhood growth. Throughout these changes, the shape of the contoured foam cushion will stay the same. The only option is to repeatedly purchase new cushions, which is expensive and time consuming, and in between replacements, there are periods of time when the individual will be forced to use a cushion that no longer fits. This may be detrimental to their daily routines and health. A custom-molded foam back is just as unyielding.

TYPICALLY, WITH STANDARD CONTOURED CUSHIONS, THERE IS A SHAPE MISMATCH EVEN AT THE TIME OF FITTING.

A recent study by Dr. Amit Gefen from Tel Aviv University demonstrated that a critical characteristic of an effective wheelchair cushion is the ability to adjust to the body to provide adequate immersion and envelopment (Journal of Tissue Viability 2014; 23:13-23). This can greatly reduce tissue deformations, thereby preventing the tissue and cell damage associated with deep tissue injury. The adjustable air-cell based technology proved to have these qualities and is measurably more effective in adapting to the changes in the body over time, as well as throughout the day. It protects the individual long after the product is prescribed. The need for the adjustability of an air-cell-based cushion to ensure efficacy "over time" is discussed in detail in Dr. Gefen's work (Ostomy Wound Management 2014; 60:34-45). In this article, the remarkable disuse-related physiological changes that occur to the body over months and years were reviewed and correlated to the need for adjustable air-cell-based seating solutions with the ability to accommodate and respond to these changes.

Specific to the custom-molded option, we recently studied the efficacy of custom foam cushions in protecting the seated individual and found that the "ideal" custom surface quickly becomes a hazard, as the cushion does not evolve with the person. The negative effects will only be exacerbated by the growth of a child or the physical changes an adult undergoes. These effects are summed up in the title of the scientific article: "Contoured Foam Cushions Cannot Provide Long-term Protection Against Pressure Ulcers for an Individual

with a Spinal Cord Injury: Modeling Studies" (Advances in Skin & Wound Care, 2014).

Typically, with standard contoured cushions, there is a shape mismatch even at the time of fitting. Even in the best case, when the contours are mapped to the individual's body, the risks increase when the individual moves throughout the day or their body changes over months and years. In effect, non-adjustable contoured seating surfaces may provide hazards from day one and will only get worse over time.

More information about the findings in this article can be referenced in the July edition of Advances in Skin & Wound Care, a peer-reviewed, multidisciplinary journal.

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New webinar series focuses on wheelchair seating, mobility evaluations

Finding qualified clinicians for seating and mobility evaluations can sometimes be a challenge, but a new series of webinars aims to bridge that gap. OccupationalTherapy.com will host a new "Back to the Basics" series of recorded webinars.

The webinars, which will provide CEUs for occupational therapists but are open to anyone, include the following topics:

- Wheelchair Seating Assessment
- Seating Interventions
- Seating: Matching Client Needs to Products
- Seating for Special Populations: Pediatric, Geriatric, Bariatric and Degenerative
- Augmented Mobility
- Dependent Mobility
- Manual Mobility for Self-Propulsion
- Power Mobility
- Durable Medical Equipment

Michelle L. Lange, clinical editor for DIRECTIONS and an OT who specializes in wheelchair seating and mobility, created the webinars and believes they will particularly help PTs and OTs who might not have the knowledge to participate in an evaluation.

"Rehab Technology Suppliers are often maligned for performing wheelchair seating and mobility evaluations without a clinician," Lange said. "Sometimes the problem is finding a clinician to participate in the evaluation, especially with clients who may not currently be receiving therapy services. More often the problem is finding a qualified clinician."

Lange said that while working with educational programs so that OTs and PTs come out of school with this knowledge has been proposed, in reality, clinicians can specialize in so many practice areas that providing all of this education and training is simply not feasible. Instead, more foundation information is provided and practical training tends to occur on the job.

"This series is designed specifically for a clinician who is not familiar with wheelchair seating and mobility and will also be made available to occupational and physical therapy students," she said. "University faculty can choose to assign the webinar content to students to provide a basic level of knowledge in this practice area – even if a faculty member is not qualified to teach this material."

A link soon will be on the NRRTS website to OccupationalTherapy.com listing all of these webinars with course descriptions and registration information. A printable flyer will also be available on the NRRTS website that you can share with interested clinicians.

OccupationalTherapy.com continuing education is available for an annual fee of $99, which includes access to any of their extensive list of courses available 24/7 to earn CEUs.

CONTACT

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NRRTS REGISTRANTS

Congratulations to the newest NRRTS Registrants. MAY 16 THROUGH JULY 28, 2015.

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Alternative Care Providers
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Chelmsford, MA 01824
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Fax: 978-418-0233
Registration Date: 5/19/2015

Zeb Dugan, ATP, RRTS®
Rehab and Mobility Systems
11395 N Saginaw
Clio, MI 48420
Telephone: 810-348-5929
Registration Date: 7/7/2015

Dana Thole, RRTS®
DME Shoppe
4300 Ford Street Extension
Unit 101
Fort Meyers, FL 33916
Telephone: 223-993-6707 x0
Fax: 239-936-7367
Registration Date: 6/9/2015

Chris Wallerich, ATP, RRTS®
First Medical Equipment
1701 Osborn St
Burlington, IA 52601
Telephone: 319-753-2802
Fax: 319-753-6337
Registration Date: 6/22/2015

CRTS®

Congratulations to NRRTS Registrants recently awarded the CRTS® credential. A CRTS® receives a lapel pin signifying CRTS® or Certified Rehabilitation Technology Supplier® status and guidelines about the correct use of the credential.

NAMES LISTED ARE FROM MAY 16 THROUGH JULY 28, 2015.

James Blair, ATP, CRTS®
Numotion
Lynn Haven, FL

Shaya Ellinson, ATP, CRTS®
Ocean Home Health
Lakewood, NJ

Nancy Greco, ATP, CRTS®
Phoenix Rehabilitation and Mobility
Chattanooga, TN

Bruce T. Green, Sr., ATP, CRTS®
Numotion
Tifton, GA

Joe Prieto, ATP, CRTS®
Superior Mobility
Torrance, CA

Dawn Ruth-Larson, ATP, CRTS®
Medical Equipment Specialists, Inc.
Cumming, GA

David Savage, RET, ATP/SMS, CRTS®
National Seating & Mobility, Inc.
Hatboro, PA

Chris Thompson, ATP, CRTS®
Integrity Medical
Savannah, GA

FORMER NRRTS REGISTRANTS

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

NAMES INCLUDED ARE FROM MAY 16 THROUGH JULY 28, 2015.

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

Raymond Berry, Richmond, VA
Jennifer Bithell, ATP, Reno, NV
Kecia Bolton, M.Ed., Duncanville, TX
Pete Clinard, ATP, Madison, TN
Trevor Couchman, ATP, Coralville, IA
John R. Craigs, ATP, Mesa, AZ
Bill Dickerson, ATP, Athens, GA
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Sherry D. Ginter, ATP, Crown Point, IN
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