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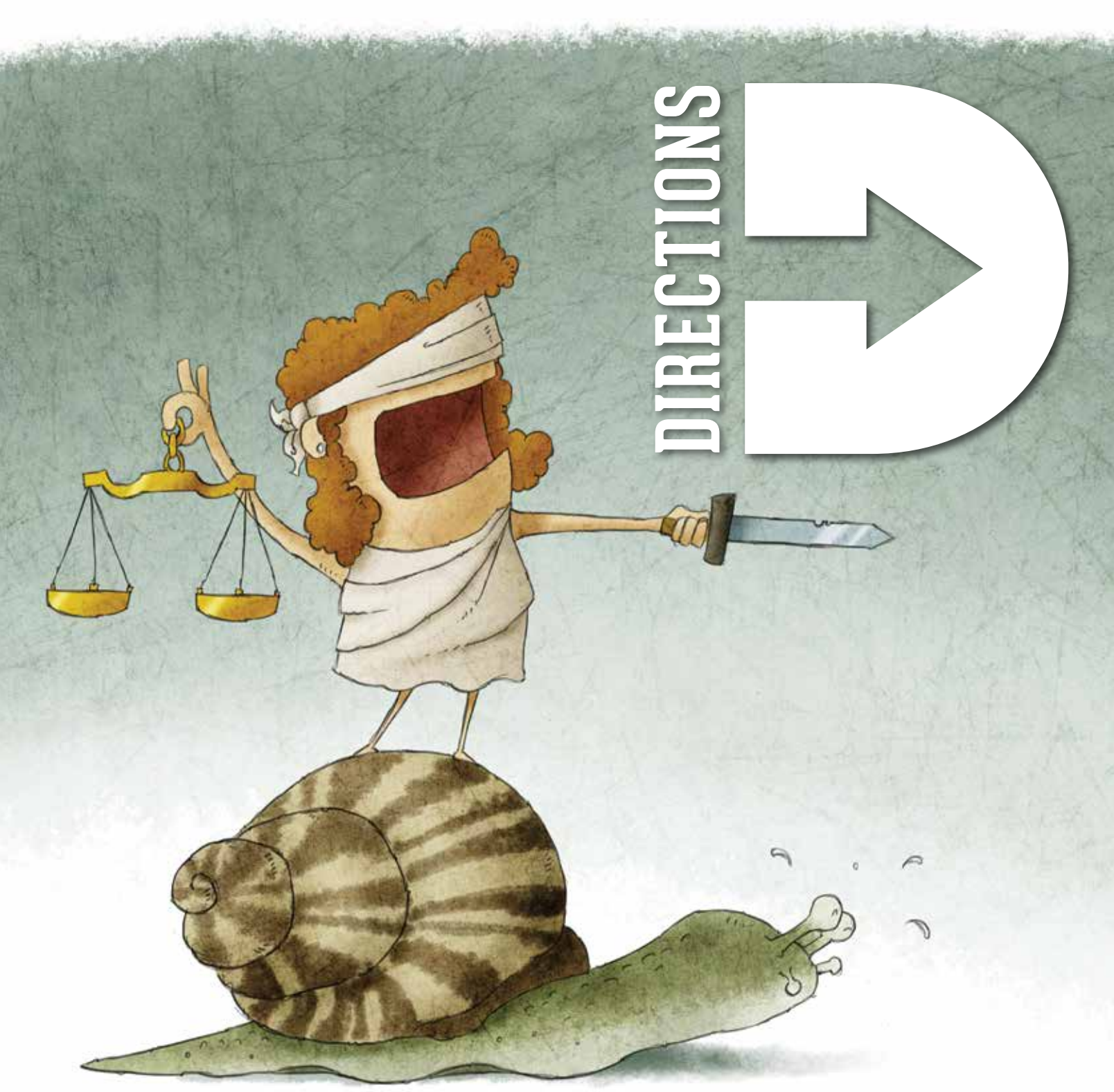

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NRRTS Registrants or Friends of NRRTS- $225
NCART Members-$225
Other Attendees-$295

CONFERENCE SCHEDULE

Leadership Day
Tuesday, April, 21, 2015

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

CRT focused presentations for providers and manufacturers to help them better manage and grow their businesses in these challenging times.

Advocacy Day
Wednesday, April 22, 2015

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

Funding and advocacy sessions for CRT stakeholders to help them better protect access to CRT on Federal and State levels.

Capitol Hill Visits Day
Thursday, April, 23, 2015

9:00am to 4:00pm – Capitol Hill Visits
5:00pm to 7:00pm – Debriefing Reception

Consumers, clinicians, providers, and manufacturers will take the CRT advocacy message directly to Congress through in-person meetings on Capitol Hill.

IN THIS ISSUE

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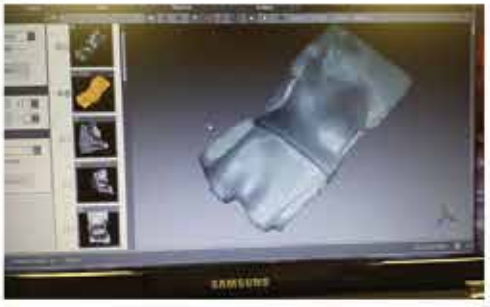

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CLAUDIA AMORTEGUI

Amortegui has her Master of Business Administration and more than 20 years of 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 durable medical equipment. This rare combination of industry experience enables Amortegui and her team at The Orion Group to assist Assistive Technology Practitioners (ATP), referrals, reimbursement staff and funding sources in understanding the reimbursement process as it relates to complex rehab. SEE PAGE 52

ALEXANDRA (ALEX) BENNEWITH

Bennewith is vice president of government relations for United Spinal Association. Bennewith advocates for legislation and regulations regarding disability and health policy at the federal and state levels. 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 50

DON CLAYBACK

Clayback is executive director of the National Coalition for Assistive and Rehab Technology. 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 34

THERESA L. GREGORIO-TORRES, OTR, MA, ATP

Gregorio-Torres is a senior occupational therapist in the TIRR Memorial Hermann Seating & Mobility Clinic and PRN, OT at University of Texas M.D. Anderson Cancer Center in Houston. She has worked in the area of spinal cord injury, amputee and musculoskeletal rehabilitation as well as seating and wheeled mobility provision for 35 years. She serves as an executive board member of the Clinician Task Force and is currently a member of the Consortium of Spinal Cord Medicine representing the American Occupational Therapy Association. SEE PAGE 56

JESSI HATFIELD

Hatfield is a consumer advocate who lives in St. Louis. SEE PAGE 16

JENNY LIEBERMAN, MSOTR/L, ATP

Lieberman is an advanced clinical specialist in the Department of Rehabilitation Medicine at the Mount Sinai Hospital in New York City. She has worked in the areas of general rehabilitation, acute rehabilitation, trauma and home care with pediatrics, adults and geriatrics treating a wide range of diagnoses. She currently oversees the Wheelchair Clinic at Mount Sinai Hospital and has been performing this duty since 2004. Lieberman received her master's degree in occupational therapy from Boston University in 1996. She is currently serving on the Clinician Task Force as the liaison to the AOTA. SEE PAGE 56

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

Lange is in private practice, Access to Independence, in Arvada, Colo. She is a Friend of NRRTS and is DIRECTIONS Clinical Editor. SEE PAGES 40 & 46

MIKE OSBORN, ATP, CRTS®

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

DAN PERKINS, ATP, RRTS®

Perkins is a NRRTS Registrant based in Chelmsford, Mass. SEE PAGE 26

ANDRINA SABET

Sabet is a physical therapist at Cleveland Clinic Children's Hospital for Rehabilitation. Her clinical practice includes infants in the NICU and toddlers through young adults in the Seating and Mobility Clinic. Sabet was a co-author on the RESNA position paper for pediatric power wheelchairs and is active within RESNA as chair of the Wheeled Mobility SIG. She has presented locally and nationally on positioning and mobility and frequently collaborates with manufacturers regarding product development. SEE PAGE 42

ANDREA VAN HOOK

Van Hook is the communications and marketing manager at RESNA. She has more than 18 years of 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 58

JILL S. VOGEL, JD, RN

Vogel is a health care attorney at Brown & Fortunato, P.C. She represents home medical equipment companies, pharmacies, hospitals, and other health care providers. She is Board Certified in Health Law by the Texas Board of Legal Specialization and the New Mexico Board of Legal Specialization. SEE PAGE 38

DOUG WESTERDAHL

Westerdahl is president of Monroe Wheelchair. Westerdahl has been in the medical equipment industry for 36 years. In 1995, Westerdahl was a co-founder of U.S. Rehab. Westerdahl is a former member of the board of directors of Rochester Rehabilitation Center, and for the last 15 years has served on the executive committee of SportsNet, a Rochester Rehab program designed to provide sports opportunities to athletes with a disability. Additionally Westerdahl serves on the board of directors of New York Medical Equipment Providers, and he is currently co-chair of the association's HME Service Provider Committee. He is currently on the board of directors and executive committee of NCART. Westerdahl is also a Friend of NRRTS. SEE PAGE 20

JENNIFER WOLFF, OTR/L

Wolff is the manager of UsersFirst, a program of United Spinal Association. Wolff is an occupational therapist and wheelchair user from Waverly, Iowa. SEE PAGE 50

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All participants must score a 70% on the post-test assessment to receive CEU credits.

TUESDAY, APRIL 14, 2015 | 7PM - 8PM (ET)

Ethics, Part 1: Moving through Specific Scenarios

WEESIE WALKER, ATP/SMS

This webinar presented by NRRTS executive director will provide an overview of the NRRTS Code of Ethics and Standards of Practice. Participants will learn about the NRRTS complaint procedure. Examples of how to apply these standards in everyday situations will also be presented.

Weesie Walker was an RTS for more than 30 years. She has served on the board of directors for NRRTS and GAMES as well as RESNA's Professional Standards Board. She has presented at the International Seating Symposium, National Seating and Mobility Symposium, Georgia AMES, American Occupational Therapy Association conference, and Canadian Seating and Mobility Conference. Walker is currently the executive director for NRRTS.

THURSDAY, APRIL 16, 2015 | 5PM - 6PM (ET)

Ethics, Part 2: Overview of the Code of Ethics and Standards of Practice

WEESIE WALKER, ATP/SMS

This webinar will discuss ethics using specific examples from everyday practice. Ethics and standards of practice affect our industry. It is critical that we all understand the consequences and implications of malpractice.

Weesie Walker was an RTS for more than 30 years. She has served on the board of directors for NRRTS and GAMES as well as RESNA's Professional Standards Board. She has presented at the International Seating Symposium, National Seating and Mobility Symposium, Georgia AMES, American Occupational Therapy Association conference, and Canadian Seating and Mobility Conference. Walker is currently the executive director of NRRTS.

TUESDAY, MAY 19, 2015 | 7PM - 8PM (ET)

Business Practices: How to Cope with the Changing Environment

GREG A. PACKER

This session will focus on current changes in the market associated with the Home Medical Equipment (HME) and Complex Rehab Technology (CRT) industries. If you have watched the current reimbursement trends reduce your profits, this course will help you understand the incremental dollars that are in our market. The coming storm has positioned a more complete client experience through trusted providers of products and services. You must move your business to the next level by developing new and emerging profit centers. We will review new areas of profit and process enhancement needed to stay competitive.

Greg A. Packer is president of U.S. Rehab, VGM Group Inc.'s alliance for high-tech rehab providers. His background, which includes sales management for Pride Mobility Products Corp. and Biocore Medical Technologies Inc., provides him with an understanding of the sales and product areas of rehabilitation technology. Additionally, he served three terms in the Kansas House of Representatives, so is familiar with the regulatory and governmental issues facing the Rehab and Home Medical Equipment industries. A graduate of Iowa State Universityin Ames, Iowa, he received his master of business administration degree from Baker University in Baldwin City, Kan.

WEDNESDAY, MAY 20, 2015 | 11AM - 12PM (ET)

Teenage Transitions

ANDRINA SABET, PT, ATP

Teenage years can be challenging under any circumstances. Add in the complications of a motor impairment and that challenge rises to new heights. Plans and pathways in adolescents are often shifting towards a more independent lifestyle. Mobility choices during this time are not only part of the success or failure of an adolescent's ability to achieve his or her goals, but also at times might influence the goals themselves. This webinar will utilize case studies and evidence from the literature to highlight the multiple factors that require consideration to optimize wheelchair prescription in this unique population.

Andrina Sabet is a physical therapist at Cleveland Clinic Children's Hospital for Rehabilitation in Cleveland. Her clinical practice includes infants in the NICU and toddlers through young adults in the Seating and Mobility Clinic. Sabet was a co-author on the RESNA position paper for pediatric power wheelchairs and is active within RESNA as chair of the Wheeled Mobility SIG. She has presented locally and nationally on positioning and mobility and frequently collaborates with manufacturers regarding product development.

THURSDAY, MAY 21, 2015 | 5PM - 6PM (ET)

Pediatric Power Mobility: Developing and Determining Readiness

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

When recommending a power wheelchair, a number of features must be considered, such as driving method, seating and drive wheel configuration. However, we first need to determine if the client is truly ready for a power wheelchair and, if not, develop readiness. This webinar will present strategies to determine and develop readiness.

Michelle L. Lange OTR/L, ABDA, ATP/SMS, is an occupational therapist with 25 years of experience and former clinical director of the assistive technology clinics of the Children's Hospital of Denver. She is a well-respected lecturer, nationally and internationally, and has written four book chapters and nearly 200 articles. She is the editor of "Fundamentals in Assistive Technology, 4th Ed.," and clinical editor of NRRTS DIRECTIONS magazine. Lange is on the teaching faculty of RESNA. She is on the RERC on Wheeled Mobility Advisory Board. Lange is a credentialed ATP and SMS and is a senior disability analyst of the ABDA.

TUESDAY, JUNE 16, 2015 | 7PM - 8PM (ET)

Power Wheelchair Access: Switch Assessment

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

Power wheelchairs can be accessed by joystick or alternative access methods. Most of these alternative methods are switches. This webinar will present assessment strategies to determine the optimal switch location and switch type to provide access. A switch site hierarchy will be presented along with clinical indicators for a variety of potential switch locations. A wide array of mechanical and electrical switches will also be discussed.

Michelle L. Lange OTR/L, ABDA, ATP/SMS, is an occupational therapist with 25 years of experience and former clinical director of the assistive technology clinics of the Children's Hospital of Denver. She is a well-respected lecturer, nationally and internationally, and has written four book chapters and nearly 200 articles. She is the editor of "Fundamentals in Assistive Technology, 4th Ed.," and clinical director of NRRTS DIRECTIONS magazine. Lange is on the teaching faculty of RESNA. She is on the RERC on Wheeled Mobility Advisory Board. Lange is a credentialed ATP and SMS and is a senior disability analyst of the ABDA.

THURSDAY, JUNE 18, 2015 | 5PM - 6:PM (ET)

Spinal Cord Injury: Balancing Pressure Relief and Postural Support

ANGELA DILLBECK REGIER, OTD, OTR/L, ATP

For individuals with SCI, adequate postural support serves as is a foundation for participation in functional activities. Without appropriate support, function and posture often become compromised. Due to the limited mobility and lack of sensation that often accompanies SCI, pressure relief is an equally important consideration. This course will review properties and application of primary and secondary support surfaces with the goal of promoting optimal postural alignment while maximizing support surface contact in order to prevent peak pressure areas and reduce risk of skin breakdown. Application of powered seating functions and client education strategies will also be discussed.

Angela Regier, OTD, OTR/L, ATP, is an occupational therapist with a clinical doctorate from Creighton University in Omaha, Neb., and is a RESNA-certified ATP. Her career has focused on spinal cord injury rehabilitation in inpatient and outpatient settings. She is currently supervisor of the Wheelchair Seating and Mobility Clinic at Craig Hospital in Englewood, Colo. She provides comprehensive seating and mobility intervention for individuals with traumatic brain and spinal cord injury. Regier has published on the topic of seating and mobility for acquired brain injury and spinal cord injury.

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FROM THE NRRTS OFFICE

SUCCESS IN OUR BUSINESS

WRITTEN BY: MIKE OSBORN, ATP, CRTS®

As I was driving this week, I heard something on the radio that made me stop and think about what I do and the industry in which I work – even the approach I take sometimes in doing my job. The individual speaking was giving his opinion or view on success in business. At first it made me laugh and then it started to sink in and make sense to me. He was expressing the concern toward only focusing on making a dollar. His point was, when we focus only on the aspect of money and make decisions solely on the outcome of money, success becomes much more difficult to achieve. If the goal to succeed is money, then it is never achieved because the drive is to always make more. The businesses that achieve success focus on the services they offer their particular consumers. The basis for success becomes about the level of satisfaction they bring to the end user. In our case, I plug in the outcomes we achieve.

Obviously, I realize we have to make a profit, and we have to keep ourselves in business to continue providing the services we do in the CRT industry. However, it does seem that today with all of the cuts in reimbursement, the obstacles in documentation, audits we face, and high priority on productivity and our time, we can easily lose the vision of what services we are offering. Is it offered with a high level of quality (outcomes), or is it offered with frustration and exhaustion after the many hurdles and hoops we continually jump through? I could go on and on about all the obstacles, but I guess that's my point. It isn't about the obstacles we face. It's about the outcomes we are able to achieve and the level of independence and function that what we do brings to those we work with that we need to focus on.

I realize as we move through the end of the first quarter of 2015, we are preparing for another long year of legislation. The difficulties of funding will always be there, but don't get caught up in the difficulties of our industry. Don't let the tug on your time or demand for more productivity cause you to lose sight of the success you have and the positive impact you can make. I have visited with many NRRTS Registrants over the past several years, and when we have the time to really discuss our industry, the conversation almost always turns to the successes we share. The stories of achievement and great outcomes overshadow the day-to-day challenges.

I CHALLENGE YOU TO TAKE A FEW MOMENTS EVERY DAY TO REMEMBER THE SMILE YOU CAUSED THE DAY BEFORE. I HAD A BUSINESS PROFESSOR IN COLLEGE ASK OUR CLASS ON THE FIRST DAY OF MY FRESHMAN YEAR, "WHY DO YOU GO INTO BUSINESS?"

After 21 years in the industry, I find myself at times concentrating on the obstacles in front of me and overlooking the successes of which I've been a part. I get caught up in "What do I do next?" instead taking a breath and enjoying what I just did. I challenge you to take a few moments every day to remember the smile you caused the day before. I had a business professor in college ask our class on the first day of my freshman year, "Why do you go into business?" Being young and full of energy, my answer – as was the majority of the class – was to make money. She corrected us, stating an individual goes into business to render a service. It took me a long time to come full circle back to that question, but she was correct. Give yourself an opportunity to enjoy what you do and know the service you are providing is what leads to the successes our companies have. Success comes from providing quality outcomes and doing it in a way that is enjoyable to you and the individuals you serve.

CONTACT THE AUTHOR

Mike may be reached at mosborn@alliancerehabmed.com.

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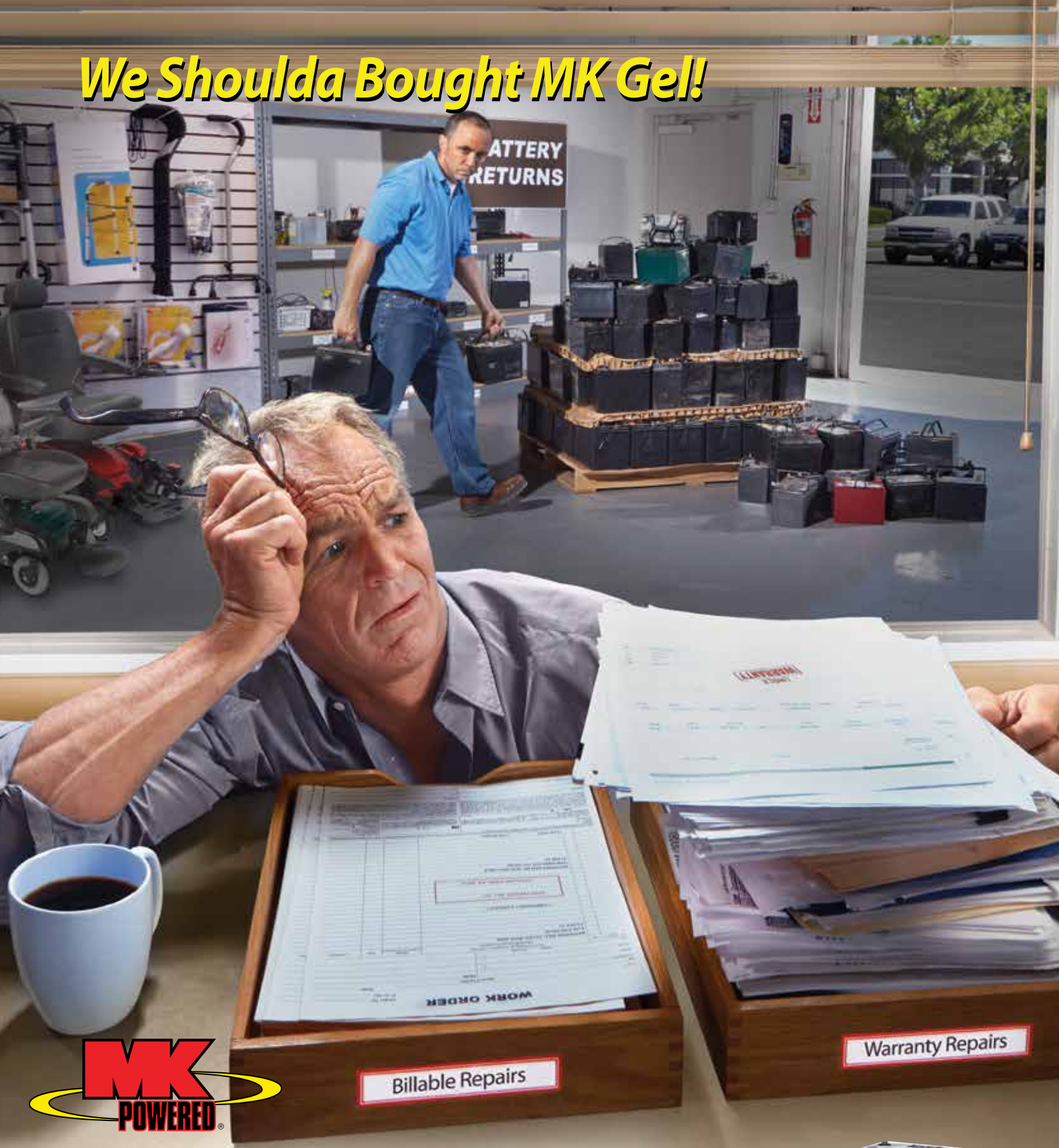

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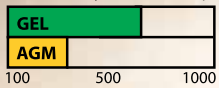

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LIFE ON WHEELS

JUST A REGULAR GIRL – NOT!

WRITTEN BY: ROSA WALSTON LATIMER

Jessi Hatfield describes herself as someone who loves fashion and fitness, "but I'm just a regular girl." Sorry to disagree, but anyone who comes in contact with this vivacious 30-year-old would consider her anything but "regular." Instead words such as energetic, optimistic and joyful seem more appropriate.

In May of 2005, Hatfield was a junior in college pursuing a degree in biology when an accident caused a spinal cord injury that left her with no movement or feeling from her waist down. "I didn't have any other injuries – no broken bones," Hatfield said. "I believe that made my recovery somewhat easier." Following surgery immediately after the accident, Hatfield spent six days in acute care and then moved to the Rehabilitation Institute of St. Louis for inpatient rehab. Hatfield explained that at times while she was in the facility she felt "sad, frustrated and angry," but there was never a point when she gave up. She committed herself to therapy and tried to focus on what was next. "I have a family friend who had a similar injury. He married and was working, so that was a good example for me," Hatfield said. "Yet I was with a lot of people in rehab who were having a hard time finding a reason to participate in therapy, so they could get better." Prior to her accident, Hatfield had considered a career as a physician's assistant or nurse, but now she realized those were not an option for her. While in therapy, she was surprised there wasn't any specific rehabilitation counseling available to the patients and began considering that as a possibility for her future.

"I LEARNED THAT NOT EVERY TRIP IS GOING TO BE PERFECT, BUT SOMETIMES IT'S WORTH IT JUST FOR THE EXPERIENCE. I WOULDN'T TRADE THE BAD FOR THE GOOD."

Her focus and determination put Hatfield on a fast track; after living with her parents for six months during outpatient therapy, she returned to school in January of 2006. "It wasn't easy, but I wanted to graduate as close to my original plan as possible." Hatfield took a full course load the spring and summer semesters and graduated at the end of the summer of 2006 with a bachelor's degree in biology. "It was tough. I was the only wheelchair student on campus, but I quickly learned I could do lots more than I thought I could. And I had some great friends to help me."

How to carry luggage


Jessi and Jamie Dive 1


Cozumel Dive


Jessi and Jamie Dive 2


Jessi dive boat

Two years after her accident Hatfield had a clear plan for her future: she would pursue an master's degree in rehabilitation counseling. "My first experience with traveling was when my parents and I drove to North Carolina to look at a graduate school. We decided to make this trip a vacation," Hatfield said. "I learned how to deal with accessibility challenges away from home, but things went smoothly and this experience gave me confidence to travel on my own."

Ultimately Hatfield chose Southern Illinois University at Carbondale for her graduate studies. "Carbondale has a strong adaptive recreation program," Hatfield said. "It is a great school for recreation therapy, and it had lots of adventure programs." While at Carbondale she started playing wheelchair basketball, began hand cycling and took her first white water rafting trip since her spinal cord injury. During graduate school, Hatfield flew for the first time as a wheelchair traveler. She values all of these experiences, because she was with others who had been injured longer. "I learned so much from others," she said. "I would be in a situation and think 'I'm not sure I can handle a transfer,' but, of course, I didn't say anything. I just watched the others and realized if they could do it, so could I."

Hatfield strongly encourages others with disabilities to travel and experience new things. "Of course it is better the more you know ahead of time, so think about what you'll be doing. For example, ask about specific things at the hotel you will need." She explained that even though there are more good resources online now, there just isn't a lot of practical information available. When planning a traveling adventure, communicate your needs in advance, ask specific questions and don't take anything for granted.

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JUST A REGULAR GIRL - NOT!
(CONTINUED FROM PAGE 17)

"I traveled to Amman, Jordan, with a group called Wheels for the World," Hatfield said. "We distributed wheelchairs to people in need, and it was a wonderful trip. But from an accessibility standpoint, it was awful." Hatfield had been in her wheelchair more than five years, and on this trip she faced challenges she hadn't faced in years. "I learned that not every trip is going to be perfect, but sometimes it's worth it just for the experience. I wouldn't trade the bad for the good."

After completing her graduate studies, Hatfield returned to the Rehabilitation Institute of St. Louis to fill the first full-time counseling position on staff. While working with those receiving inpatient therapies, she met Jamie Hatfield, an Air Force veteran who had a spinal cord injury and was in outpatient therapy at the same facility. What began with a conversation about hand cycling soon developed into a dating situation that led the couple to the altar in 2013. "There are a lot of things that are worthwhile that we enjoy," Hatfield said. "I feel I've challenged Jamie to do things he wasn't sure he could do, such as traveling."

Both are now certified scuba divers and volunteer with LifeWaters, a non-profit organization that promotes "independence, adventure and healing for veterans and civilians with mobility impairments." The group provides training and certification in adaptive scuba diving for divers. Hatfield has written about her diving experiences for the website, www.wheelchairtraveling.com, and describes diving as "lightness, freedom and joy. An individual can be healed by nature and by the community of people around you," Hatfield said. "I want other people to feel like they are equipped to go try something or to know what to expect if they want to do something new."

The couple is building a new home in a historic district in St. Louis, and Hatfield is determined that the first impression of the home will not be "this is a wheelchair accessible house." She describes the homebuilding experience as a challenge, yet she has enjoyed working with the contractor and helping him learn about accessibility issues. "I'm passionate about how the house should be and am determined to have a functional accessible home design that is also beautiful." Hatfield continues to work part time at the Rehab Institute and also works at the Veterans Administration hospital where her responsibilities are providing vocational counseling for veterans. Husband Jamie works in the information technology field.


Road crossing in Cozumel


STL Cardinals


KC Christmas


Wedding Ceremony


Wedding Dance


Park Handcycle

Almost ten years after her spinal cord injury Hatfield says her biggest challenge now is deciding where to focus her energy and passion. This "regular girl" says she's just trying to figure out how to combine the many things she loves without overcommitting. If the past decade is any indication, there's no doubt Hatfield will overcome this challenge too and continue to live a full, very active life.

CONTACT

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Tetherball

CULTURE CLUB

CUSTOMER SERVICE, CORPORATE RESPONSIBILITY, CREATE WINNING COMBINATION FOR MONROE WHEELCHAIR

WRITTEN BY: DANETTE BAKER

Doug Westerdahl's unique style of management has created a corporate culture at Monroe Wheelchair unlike the industry norm. He leads a team of more than 80 employees whose focus on customer service provokes unsolicited referrals and customer compliments and has the company's annual sales topping $20 million.

DIRECTIONS recently had the opportunity to visit with Westerdahl, president of Monroe Wheelchair, to learn more about his venture through the industry, secrets to his success and what's new on the horizon.

HOW DID YOU BECOME INTERESTED IN THE MEDICAL EQUIPMENT INDUSTRY?

In 1979 I received my college degree from Rochester Institute of Technology (RIT) with a major in accounting. RIT had a co-op program where I worked for our local county's Department of Social Services. In that role I met Bob Hall, owner of Northside Surgical, a local durable medical equipment (DME) company, who was looking to grow his business and needed some help managing that growth. I was hired as a manager and that gave me a chance to learn about the business. I knew with my personality, I wouldn't do well sitting behind a desk all day crunching numbers, but this gave me the opportunity to work in the storefront and learn a little about every aspect of the business.

IT HELPED ME GET MY FEET WET IN BEING A BUSINESS OWNER AND GAVE ME THE CONFIDENCE TO RUN A BUSINESS ON MY OWN.

After I had worked there for a couple of years, the owner expanded into rehab sales. That was in the early '80s when the rehab industry was in its infancy and the term CRT (Complex Rehab Technology) had not been defined. One of the most impactful things I remember from that time was the number of institutionalized adults I witnessed with severe skeletal deformities due to a lifetime of poor wheelchair positioning.

Options for seating and positioning were very limited as were manufacturers; there were only a handful such as Gunnell, Mulholland and Safety Travel Chair. Many people back then with diagnoses such as cerebral palsy were institutionalized. They weren't in group homes or living at home like many are today. The sling-seat, sling-back wheelchair, which most of them were confined to daily, was the worst possible thing to sit in for someone with a severe disability. It would directly cause the development of scoliosis, kyphosis or both, and their hips would rotate. That led to further deterioration of health such as digestive and respiratory issues.

Once I started to learn about the industry and seating and positioning, I realized what a significant difference seating and positioning can make in overall health for a lifetime. From that time on I knew I was in a career where I could make a significant difference in people's lives.

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

In 1986, I left my first job in the industry and joined Monroe Surgical. The owner at the time provided me with 25 percent sweat equity in the company, at five percent annually over a five-year period. Bruce Ferguson, the owner, was the manufacturing rep outside of the DME industry so he wasn't onsite often. I pretty much ran the business. I give Bruce credit for thinking of giving me ownership, because it locked me in. I didn't even think about going to work anywhere else.

That whole opportunity led to the future opportunity for me to buy the business. It helped me get my feet wet in being a business owner and gave me the confidence to run a business on my own. Bruce eventually sold out to Jim Travis, and he and I changed the name of the company to Monroe Wheelchair. We changed the name to better reflect who we were. We had decided to get out of the surgical supply and physicians supply business and focused mainly on wheelchair seating and positioning. In 2001, I bought out Travis and became sole owner.

Opening offices in Syracuse and Albany — 11 and 15 years ago respectively — expanded our business and geographic reach. Through networking, I met a couple of individuals working for other companies who approached me about coming to work for Monroe Wheelchair. We literally started those branches on their kitchen tables. Since then we've had to move four times in each of those locations due to growth.

Overall, our company has experienced an average growth of 8 percent per year in sales over the last 10 years. That is significant in an industry hit hard by frequent cutbacks, and we did that in spite of us not winning a single bid in competitive bidding. Our reputation in the industry, especially in New York, has resulted in many solid hires and I'm very proud of that. We now have 11 ATPs working for us across the state, which is considerably more than any of our competitors.

We also have reached the $5, $10 and $15 million annual sales levels, with projected 2015 sales of $20 million.

Our success is definitely the result of hard work by our staff and a commitment to our primary focus – CRT. There definitely have been challenges, but one thing we refuse to be is negative despite all the cutbacks. We fight like dogs against them, but when we know they are imminent, our leadership team meets to explore ways to overcome the cutbacks. We often put a dollar value on ideas, and it's been a very successful way for us to deal with those situations.

WHO HAS BEEN INSTRUMENTAL IN THOSE ACCOMPLISHMENTS?

Bob Hall with Northside Surgical, who gave my first job out of college; Bruce Ferguson, who purchased Monroe Surgical and gave me the opportunity to become his business partner; and Jim Travis, who taught me a lot about business and gave me the encouragement and opportunity to be an entrepreneur.

Also, 10 years ago I was fortunate enough to be part of an informal group of CRT company owners with Bob Hamilton, John Miller, Dan Craig, Bruce and Judi Bayes, Gary Gilberti, and Paul Bergantino. We met at one of our locations at least once a year and shared everything from sales strategies to personnel matters. We took our meetings very seriously and always had a pre-meeting agenda and assignments. Many of the things I learned in those meetings have become part of Monroe Wheelchair's core business practices.

Gary Schwantz gave me inspiration and taught me a lot about motivating people. He also introduced our management team to "Open Book Management," which focuses on top-down financial

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CULTURE CLUB
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transparency. I have a sign on my office wall that reads, "The key to success is to surround yourself with good people and never lose a passion for what you are doing." With that said, the most instrumental factor in our success over the years has been our Monroe Wheelchair staff. I truly believe I work with the best in the business! Lastly, my parents deserve much of the credit for my success in business. They always encouraged me and helped me believe I could do whatever I set my mind to.

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

We have always been a company of change. We are constantly re-engineering, modifying processes, looking for better ways to do things, challenging each other to improve, and holding ourselves accountable to our customers and each other. While it might not seem like a challenge in the literal sense, we will continue to challenge ourselves to find better ways to do things.

As for the industry, one of the things I have observed over the years is that it is impossible to anticipate what CMS (Centers for Medicare and Medicaid) is going to do, and that is a huge challenge. Over the last couple of years, there have been numerous Medicare policy/reimbursement changes that came directly out of left field. Applying competitive bidding rates to CRT accessories is a good example of that. To add to the frustration, the industry spends a lot of time developing and submitting well thought out comments that are most often ignored, such as with the Final Rule for coverage of complex rehab wheelchair accessories, which goes into effect next January.

WHAT'S ON THE HORIZON FOR MONROE WHEELCHAIR?

This year we will begin doing business in other states. We will also be opening an office in Buffalo by year's end. We are currently expanding our accessibility business into other markets, and we are adding negative pressure wound therapy to our wound care product mix.

We've always done stairway lifts and ramps, and we have done some vertical platform lifts. During the last year, we had the opportunity to hire someone from outside our industry who had a lot of sales experience. We brought him on board to expand our Rochester sales base in lifts, ramps and overall accessibility including ceiling track systems. He has done a great job for us, and now we want to expand that into our other markets.

Wound care is also one of our specialties and something we believe we do better than anyone in our market. We offer a variety of wound care products and employ a team of experts dedicated to this division of our company. Those individuals work with the clinical community to determine the best product for the patient. We also have a lot of expertise on coverage and managing the paperwork process, which is extensive in wound care, and we work closely with clinicians on pressure mapping to determine the patient's pressure point weaknesses and help pick the right products. During the last year we added negative pressure wound therapy products in our Rochester and Syracuse markets. It's a fairly new therapy, but has proven extremely successful in healing a wound.

WHAT AREAS IN THE INDUSTRY HAS MONROE WHEELCHAIR TAKEN A LEAD IN?

Customer service. Every business claims they have great customer service, but we spend a lot of time focusing on this with every person in the company. Regardless of what they do, they can know unequivocally that they have a major impact on customer service which ultimately increases sales. Not surprising, we receive the most compliments for our delivery tech and service techs. I think that is very different compared to a lot of companies. We also compensate those positions higher than most companies, so in turn we get great people with

OUR GOAL WAS TO CREATE A MISSION THAT EVERY EMPLOYEE COULD LIVE BY EVERY DAY AND RECITE. OUR VISION AND VALUES ARE MUCH MORE LENGTHY, AND THEY ARE EQUALLY AS IMPORTANT, BUT THE MAIN THING IS THAT THEY ALL LEAD BACK TO THOSE THREE SIMPLE WORDS, CREATING BETTER LIVES.

virtually no turnover in those positions. In fact, we get calls all the time about how professional our team members are — especially our delivery and service technicians — everything from how knowledgeable and caring they are to the fact that they took their shoes off when walked in a patient's home.

We know we are succeeding in customer care, as I receive an average of 20 unsolicited compliments monthly from our customers.

The other areas in which we lead the industry are wound care, education, open book management, charitable giving, IT, social media, retail sales and advertising. We've already talked about what we offer in wound care. Annually, we sponsor seating seminars in Syracuse and Albany where attendance averages 75 to 90 therapists in each of those markets.

Four years ago, we implemented open book management, something that I believe is pretty unique in our industry. Open book management plays a big part of our operations. Every employee knows everything about the company's finances, except other employees' salaries — everything from sales to product costs and profits. We believe this helps give them a sound knowledge of the company's financial status, makes them a partner in our success, and can also give them a sense of security in their jobs.

As a company, we commit $30,000 in our annual budget for local charitable giving. Additionally our staff has given more than $60,000 over the past 10 years to charities of their choice with money raised by paying $5 each Friday to wear jeans to work.

We also developed our own CRT company-specific workflow process software, Rehab Tracker, that manages everything in our business from order taking up to the point of billing.

While our employees are our primary reason for our success, overall, we have developed a corporate culture that I am very proud of in which everything we do supports our mission: Creating Better Lives. We realized about nine months ago that none of us could recite our mission statement, so a team of employees redefined our mission, vision and values. Our goal was to create a mission that every employee could live by every day and recite. Our vision and values are much more lengthy, and they are equally as important, but the main thing is that they all lead back to those three simple words, creating better lives.

WHAT CHANGES WOULD YOU LIKE TO SEE IN THE INDUSTRY?

There will be some people who disagree with me on this response, but I would like to see one industry association representing the CRT suppliers in the industry. Single representation would lead to a stronger presence and we could speak with a stronger voice. Additionally, it would help us on Capitol Hill where multiple industry organizations can sometimes lead to confusion with different messages being delivered.

We also need more people on the supplier side getting involved. That involvement must be either financially or by serving on working committees. For as long as I can remember it has been pretty much the same small group of people doing the bulk of the work in the CRT industry. Interestingly, that group of people gives their time and finances. We are all passionate about the work, but we need help pushing our initiatives over the finish line!

WHAT HAS KEPT YOU WORKING IN THE INDUSTRY?

I absolutely love what I do. In 36 years, I can count the days when I didn't want to come to work on one hand. I also love motivating our staff and giving them the opportunity to grow. We now have 85 employees, and we are truly a family dedicated to spending each day living out our corporate mission. For me personally, I keep a list as a reminder of the things working in this industry has taught me. Here are a few excerpts:

1. Don't be confrontational with government or private insurers. Boy, did I learn a hard lesson on that one!

2. Never forget to thank, recognize and reward the people who helped you get where you are.

3. Never get too high when things are going well and never get too low when things are going bad.

4. It's not all about the money… Be generous!

5. Being moved to tears is a good thing!

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

I am a Friend of NRRTS. I'm also a member of NCART and also serve on NCART's board of directors and executive committee. In addition, I serve on the New York Medical

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CULTURE CLUB
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Equipment Providers board of directors and co-chair the organization's HME Service Provider Committee. For the last 15 years, I have served on the executive committee of SportsNet, a Rochester Rehab program designed to provide sports opportunities to athletes with disabilities. Additionally, I'm a former member of the Rochester Rehabilitation Center board of directors and, in 1995, was a co-founder of US Rehab.

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

I work primarily from our Rochester office where we start each day with a 10-minute huddle with our leadership team. We present our victories and celebrations from the previous day, priorities for the day, and "stucks," anything we are stuck on and could use help with. There are seven of us on our main leadership team, which leaves little time for discussion in these huddles, because we stick to the 10 minutes religiously. These meetings, however, keep us more in tune and aware of what everyone is doing. We also have weekly hour-and-a-half leadership team meetings where we focus on our annual goals. Personally, my daily priorities typically focus on private or government insurer work, new business opportunities, business metrics and software enhancements. I also spend some time each week on industry association committee and subcommittee work.

"THE KEY TO SUCCESS IS TO SURROUND YOURSELF WITH GOOD PEOPLE AND NEVER LOSE A PASSION FOR WHAT YOU ARE DOING."

WHAT'S LIFE OUTSIDE OF THE 9 TO 5 LIKE FOR DOUG WESTERDAHL?

My wife, Holly, and I have six grown children ranging in age from 22 to 34 who all live in Rochester. Five of them work for Monroe Wheelchair. Their jobs include service technician, claims process coordinator team leader, customer service manager, claims coding expert, and director of public relations. I have a lot of friends who are jealous, because their kids graduate and move out of town. For me, I prevented that by hiring them! We also have three grandchildren, ages 4, 6 and 9, and a 2-year-old niece who keep us grounded and always make us smile.

I was lucky enough to grow up in the Finger Lakes of New York and made it a lifetime goal to purchase a second home on one of the Finger Lakes. Two years ago, my wife and I fulfilled that dream by purchasing a home on Conesus Lake.

At 57, I still go tubing and water skiing, and we just love spending time at the lake with family. To get to our place, you have to drive down a hill. Every time I make that drive, as I turn to go down the hill, I can just feel myself relaxing. Fortunately, the lake house is just as close to work as my primary residence, so I can get to either home easily as I leave work. Our family also loves the ocean, and we spend a week in Emerald Isle, North Carolina, almost every summer.

CONTACT

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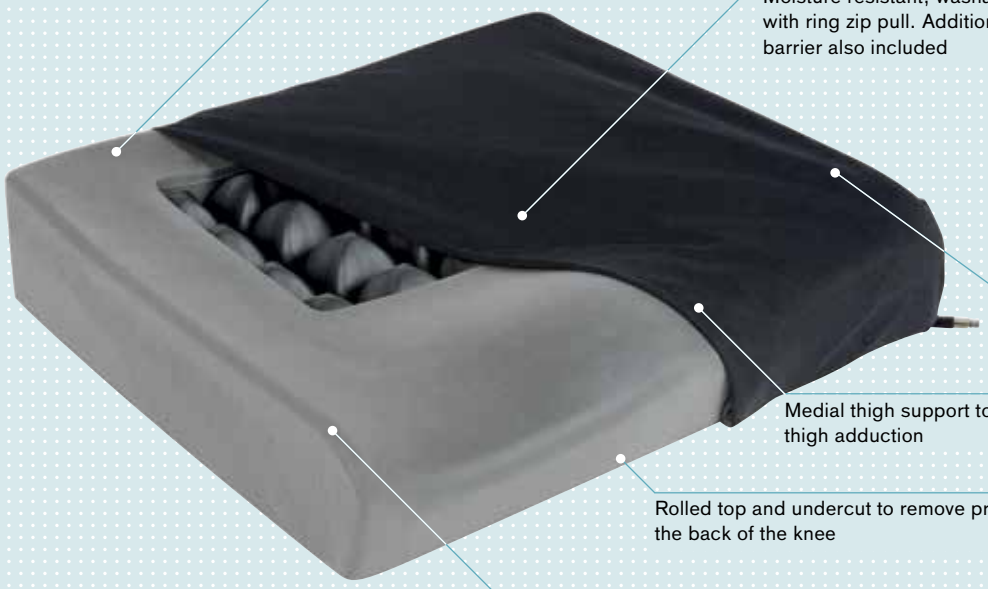

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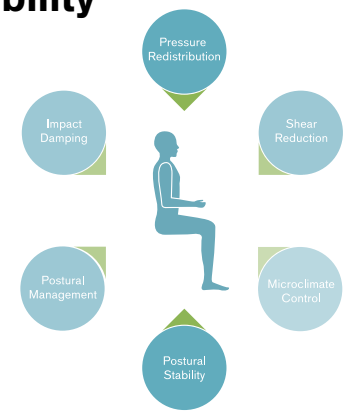

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NOTES FROM THE FIELD

WRITTEN BY: JULIE BARNETT

A CHANGE FOR THE GOOD

PERKINS LEAVES PRIVATE SECURITY FIELD FOR CHANCE TO MAKE POSITIVE IMPACT ON LIVES

Dan Perkins, ATP, RRTS®, hasn't always been in the complex rehab business. In fact, he was in the private security field for years before he made a major career change.

Perkins serves as manager of complex rehab at Alternative Care Providers Inc., a locally owned durable medical equipment and custom rehab provider that has been in business for more than 20 years servicing Southern New Hampshire and Eastern Massachusetts, including the Boston area. Perkins joined NRRTS in October 2014, so he is one of the newest NRRTS Registrants.

"As an ATP, most of my day is spent working with clients and therapists, usually in the home or rehab environment," he said. "In addition to the typical high-end manual and power chairs, I often provide other equipment such as standers, bathing systems, gait trainers and other assistive devices."

But Perkins used to spend his days a bit differently.

"I was in the private security field for over 25 years and was ready for a change," he said. "I started as a delivery technician and have held the position of facilities manager, retail manager and customer service manager.

"I was attracted to this industry because of the personal involvement and impact I could have on improving people's lives," he continued. "I also found the variety of work interesting and rewarding."

He found the dedication of others in assistive rehab to be contagious.

"The founder of ACP (Alternative Care Providers Inc.), Michael Schleipfer, was a dedicated and committed ATP," he said. "He was my inspiration and mentor. My greatest joy is working with our clients and referral sources."

"I HAVE ALSO BENEFITED GREATLY FROM THE COMPLEX CASE STUDIES. OF COURSE, I LOOK FORWARD TO DIRECTIONS MAGAZINE. I AM ALSO VERY APPRECIATIVE OF THE ROLE THAT NRRTS PLAYS IN SUPPORTING OUR INDUSTRY AND ULTIMATELY OUR CLIENTS."

In addition to Schleipfer, he finds inspiration among many of those he encounters day to day.

"I am often motivated and impressed by the level of commitment many of our vendor and supplier reps have shown," he said. "Jeff Randall from Invacare and

Ted Cossette with the Comfort Company come immediately to mind. The members of our local medical equipment dealers

"THE GREATEST OPPORTUNITY FOR ME IS THE ABILITY TO MAKE A POSITIVE CHANGE IN SOMEONE'S LIFE!"

association, HOMES, have also been a great inspiration and support."

Perkins said he has really found NRRTS registration to be a great source of support, as well.

"I love the webinars – live and recorded – that are available through NRRTS," he said. "I have also benefited greatly from the complex case studies. Of course, I look forward to DIRECTIONS magazine. I am also very appreciative of the role that NRRTS plays in supporting our industry and ultimately our clients."

Supporting those clients is what the industry is all about, Perkins said, but acknowledged that it isn't always easy.

"Our biggest challenge is funding and regulations," he said. "Some of the denials I've experienced would boggle any sane person's mind. What is truly unfortunate is that the people who often

suffer most from this 'bureaucracy-run-amuck' are the people who are least able to defend or advocate for themselves – the elderly or severely impaired."

Perkins many years ago attended St. John's Seminary, a Franciscan Friars Institution. "I realized there the equality of all people and the positive experience that true service can provide," he said.

"The greatest opportunity for me is the ability to make a positive change in someone's life!"

CONTACT

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Audits, ALJ, An

WITHOUT SOLUTIONS TO THE CURRENT CMS SYSTEM, CRT SUPPLIERS, CONSUMERS WILL CONTINUE TO SUFFER

Written by Danette Baker

swers

In August, Scott Scobey finally made the decision to close the doors to Low Country Mobility. It was not a decision made lightly, but Scobey, an ATP, was tired of fighting a seemingly broken system to keep his business in Savannah, Ga., afloat.

"Competitive bidding, cuts in reimbursement, changes in policy… all these put together have made it very challenging especially for the small suppliers," said Rita Stanley, Vvice president of government relations for Sunrise Medical and regulatory committee chair at the National Coalition for Assistive and Rehab Technology (NCART). "The larger suppliers obviously have more revenue, not to say this is easy for them to sustain, because they usually get hit with more audits, so they are dealing with larger quantities of these problems.

"For independent suppliers, if they get hit with a request for refunds and it's at a time when they have Medicaid delaying prior authorization, or maybe they have lost a managed care contract, when you put it all together it has made it very difficult and number of small suppliers have either closed doors completely or sold out to larger national chains because they didn't have the ability to sustain going forward."

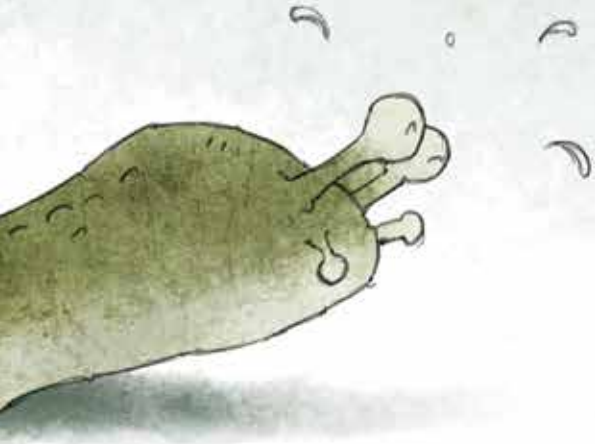
"I DIDN'T ALWAYS DOT ALL THE 'Is' OR CROSS ALL THE 'Ts' EXACTLY LIKE THEY (MEDICARE) WANTED," SCOBEY SAID. "BUT I'D TAKE IT THROUGH THE PROCESS UP TO THE ALJ AND ALWAYS WIN."

For Scobey, the proverbial straw that broke the camel's back came when he learned that a backlog in the Administrative Law Judge (ALJ) dockets would delay hearing of his claims for two to three years.

Scobey started Low Country Mobility in 1995 with a $12,000 loan and a line of products from Invacare. He spent 15 years in the industry, eventually specializing in complex rehab technology. Through the years, he, like many in the industry, had battled the occasional audit — mostly cited on technicalities.

"I didn't always dot all the 'Is' or cross all the 'Ts' exactly like they (Medicare) wanted," Scobey said. "But I'd take it through the process up to the ALJ and always win.

"I did the best a one-man-show could do. I had to be knowledgeable on everything. I got as much prior authorization as necessary, had the documentation, but more and more it just didn't seem to be enough."



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By last August, Scobey had five claims waiting for review by the ALJ that represented about two-thirds of his annual income.

"I have no doubt those would have gone in my favor as well," Scobey said. "But that was too much to absorb. I had to cut my losses and move on."

Situations such as Scobey's have become increasingly familiar.

The caseload for the 65 ALJs increased 184 percent from 2010 to 2013 going from 92,000 to 460,000. In July 2013, the Office of Medicare Hearings and Appeals (OHMA) temporarily suspended acceptance of new claims to allow the ALJ to catch up. At the time, the ALJ predicted wait times for a hearing to exceed 16 months, according to a letter from ALJ Chief Nancy J. Griswold that was sent to those who had filed for ALJ hearings.

WHY THE BACKLOG?

There are two levels of audits through the CMS: the MACs, or Medicare Administrative Contractors, who process Medicare claims, and the RACs, Recovery Audit Contractors, who review claims that Medicare has paid to determine if the claims have been paid appropriately.

"BUT THERE TRULY ARE INDIVIDUALS WHO NEED THIS EQUIPMENT AND ARE BEING DENIED THE ABILITY TO GET IT, AND THE BURDEN FOR GETTING THEM THE EQUIPMENT IS BEING SHIFTED MORE AND MORE TO SUPPLIERS. THEY ARE THE ONES RESPONSIBLE FOR GETTING ALL THE DOCUMENTATION FROM THE PHYSICIANS."

The problem, said Don Clayback, executive director of NCART, is the result of two distinct issues. First, claims are being denied when submitted initially by the Medicare Administrative Contractors MACs and the first two levels of appeal through the Centers for Medicare and Medicaid (CMS) are "not functioning right to address minor technicalities that may result in a denial," he said, giving examples of technicalities such as missing signatures and inconsistent dates. These technicalities force suppliers to take their appeals to the ALJ level to have the denial reversed, where more than half are ruled in their favor, according to a 2012 study by the Department of Health and Human Services Office of Inspector General. Results from that study revealed that providers filed 85 percent of cases at the ALJ level and of those, more than half fell in favor of the appellant.

Second, Clayback said, is the increase in post-payment audits, and Recovery Audit Contractors RACs making inappropriate claims for recoupment, which are also forcing suppliers to appeal to the ALJ.

CMS established the RAC program in 2003 with the goal of ensuring correct payments to providers and suppliers for claims submitted for reimbursement under Medicare Parts A and B. During the initial three-year pilot of the program, more than $900 million in overpayments and $38 million in underpayments to Medicare were identified, resulting in the program being made permanent under the Tax Relief and Health Care Act of 2006.

Clayback agrees the audits are needed as safeguards in the Medicare systems. However, the concept has been taken beyond the intent.

"The problem," Clayback said, "is the fact that these contractors are incentivized to deny claims as they are paid a percentage of the payments they recoup from 'inappropriately' paid Medicare claims. They have a financial incentive to be much more aggressive in finding inappropriately paid claims.

"There also is a lot of leeway for interpretation because the paperwork is fairly complex for a lot of these claims and in many cases the auditors are second-guessing the prescribing physician."

Peggy Walker, billing and reimbursement adviser for U.S. Rehab, explained the intricacies involved in filing a claim. For example, a manual wheelchair can't just be "wheelchair." The description has to say "standard wheelchair" or "lightweight wheelchair."

"There have been so many changes with the competitive bidding modifier issues and then we have the added face-to-face issues for products and suppliers are not used to having to provide so specific, detailed written orders prior to delivery. And they are not being told how specific the order or how detailed the product description needs to be."

"There are also very specific date stamp requirements on when products are ordered by the physician, when they are received and when they are delivered. You can't assume that, say for instance, a hospital bed delivered on the same day a patient is discharged from the hospital had doctor's orders for that piece of equipment before it was delivered, but nine of 10 claims will be denied for orders on the same day if you can't prove you got the order prior to delivery.

"There also is a problem of inconsistencies between contractors and between reviewers at the different levels. One contractor will be very specific in regard to a legible signature where another won't. Then when you take it to redetermination, that reviewer may overturn the contractor's denial on a signature but deny the appeal because of missing initials or signature of the person who date stamped an order."

Denise Leard, said the CMS oversight was based on the fraud back in 2005-2006 where a group of suppliers in Houston were filing bogus Medicare claims for durable medical equipment (DME) causing CMS to tighten its purse strings, especially for DME claims.

"DME became the poster child for fraudulent cases," said Leard, an attorney with Brown & Fortunato, PC, in Amarillo, Texas, and a member of the Health Care Group. "Also, because you didn't have to be a licensed clinician to supply DME, we were the low-hanging fruit.

"I get it, you need to tighten up the rules to make sure that people are not getting power chairs just because they don't want to walk and instead want to ride around the Grand Canyon on their vacation or so they can be more comfortable during the day when they are out shopping," Leard said. "But there truly are individuals who need this equipment and are being denied the ability to get it and the burden for getting them the equipment is being shifted more and more to suppliers. They are the ones responsible for getting all the documentation from the physicians."

In addition, Stanley added, an individual might have a very clear medical necessity, but not have the specific diagnoses listed in the policy for that piece of equipment so the supplier's only course of action is to take it to an ALJ hearing to get coverage approved.

THE PROCESS OF APPEALS

When an audit determines a provider or supplier has been overpaid for a claim, they have 120 days to final a redetermination request; however if the request is not filed in 30 days, CMS begins to recoup denied funds by deducting payments from future claims, Leard said. The situation is repeated at the reconsideration level, where the supplier has 180 days to file the request, but CMS will begin the recoupment process within 60 days if the request is not filed.

"So really they have taken away from the supplier the time needed to build the case," Leard said. "But if it's an extrapolated audit, I have to get that filed because my client doesn't have a million dollars laying around so we have to rush to file the appeal. Many suppliers simply can't afford to have the funds recouped."

"THERE SHOULD BE ACCOUNTABILITY, BUT IT'S GOTTEN TO THE POINT FOR SUPPLIERS THAT THE PROCESS IS CONVOLUTED."

The reviewers generally can reopen claims filed up to four years ago, unless they suspect fraud in which the time frame is extended to seven years, Leard explained. "Most of the time you will see them go back a couple of years, but even then the documentation can be vastly different from what is now required."

For independent suppliers, all the company's resources get redirected to gathering documentation, further complicating their income situation, Leard said.

One of the other issues that has caused not only confusion among suppliers in submitting claims, but also the increase in denials is that CMS has taken away the reviewer's option to use clinical inference, she said. "Before, a CMS reviewer, who might also be a nurse, would look at the claim and use clinical reference, on, say an oxygen claim … for a patient with COPD. and think, 'Oh, this person has COPD which is known clinically to only get worse, so yes, they are going to have a continued need for this oxygen claim.' They are not allowed to do that anymore. Now, if the claim does not state all of those givens, it is denied. "

Given all the challenges and discrepancies with the Medicare audit system, industry leaders

(CONTINUED ON PAGE 32)

"I don't think anyone would sit back and say there should not be oversight," said Stanley. "There should be accountability, but it's gotten to the point for suppliers that the process is convoluted.

"What I think is most concerning is that it is creating an incredible financial hardship for suppliers. If you have an audit, and you have a substantial amount of money taken back due to clerical errors but not out of question of medical need or you have population of people you serve who have a medical need but fall outside of policies you can very quickly get to a point where it is a big dollar amount. Very few companies in this industry right now can sustain their business if they either aren't getting paid for what is being put out in the field or they received payment and the government is asking for that money back so its harming suppliers and making the sustainability of their business challenging.

"BUT IF WE COULD IDENTIFY AND UNDERSTAND THE TOP FIVE TO 10 MOST COMMON REASONS THAT ARE CAUSING SUPPLIERS TO HAVE TO GO THE ALJ TO GET RESOLUTION, THEN MAYBE WE COULD SOME WAY ADDRESS THOSE AT THE GROUND LEVEL."

"But then there is the impact on Medicare beneficiaries. Before, a supplier who knew the consumer met medical necessity would provide the equipment and then take that request straight to the ALJ and ultimately would get paid, because there was never a question about medical necessity. Suppliers cannot do this anymore, because they know they are looking at multiple years before they can even think about getting paid.

"So not only is the backlog affecting suppliers from getting paid, but it also is causing that one opportunity that beneficiaries have to feel that someone is willing to take that risk for them and still provide that piece of equipment. They can't feasibly do that anymore. I think that is why there is so much sense of urgency both in industry and various members of Congress to try to understand why we are in this situation because it has created a real serious situation on the side of suppliers and for the consumer."

THE SOLUTION

Conversations are already taking place not only about how to clear the ALJ backlog, but also about keeping it from occurring again. At the OHMA's Administrative ALJ Appellant Forum held about a year ago, discussion focused heavily on the issues of the first two levels of appeal. According to reports from the forum, CMS defended the system saying there was a process in place allowing a case to be reopened at the first two levels of appeal if the appeal was based on a technical issue.

Walker argues the process isn't working and that providers are told to take it to the ALJ where the denial will be overturned.

"There is no quick fix or easy solution to repair the system, and it's going to take work from all levels," Clayback said. The solution is twofold, he said. First, MACs must use the first two levels of review more effectively, resolving denied claims so the ALJ is not necessary. Second, he said, requires more controls over the auditors, holding them accountable for overzealous claims for recoupments.

"The industry is working on these things through discussions with CMS and by pursuing legislation in Congress.

"There are also policy and administrative changes that CMS can make such as implementing a penalty for the RACs above and beyond returning the money they recouped."

Walker added that improved communications from CMS would also go far in helping suppliers understand the agency's requirements. In the meantime, she suggested suppliers follow "Medicare Minutes," a video blog by Dr. Robert Hoover, medical director for DME MAC Jurisdiction C.

Stanley proposes the industry take a proactive approach in addressing the top reasons suppliers are getting denials that require an ALJ hearing.

"I don't think any of us want to approach CMS with the idea that we want the to relax all of their policies because it's just making it too hard to do business," she said. "But if we could identify and understand the top five to 10 most common reasons that are causing suppliers to have to go the ALJ to get resolution, then maybe we could some way address those at the ground level."

Seat cushions for example, Stanley said, are pre-identified. "In coverage determination for seat cushions, we could say here are four diagnoses that

have routinely been left out of the diagnoses, and we're seeing case after case of denied claims being taken straight to the ALJ, again adding to backlog so we are requesting you reconsider broadening policy of, for example, the I59 codes to include these.

"NCART has tried numerous times to convey to CMS we prefer a collaborative effort. Not that we expect CMS to invite us to the table and make us equal partners, but at least be more transparent in sharing data and information and be open to brainstorming about what it would take to solve some of these issues that are not only causing the backlog but also are impacting financial unsustainability for suppliers, which will eventually cause lack of access for consumers."

Until there is a fix, Walker recommends suppliers not only paint a picture with their claims, but also write a road map to avoid an audit on technicalities:

- Use a cover sheet and call attention to the very specifics of signatures including what page they can be found on.
- Make sure every date stamp is signed by the person who receives the documentation. Don't rely just on the date at the top of the fax, for example.
- If the therapist or physician's notes are not legible, have someone in their office type them and certify they are an accurate representation.
- Be brief and to the point with your documentation, so the reviewer doesn't have as much text to read through.

"It's going to be a continual challenge and will probably be years before a real impact is seen," Clayback said. "But if we don't make a concerted effort to turn things around, we are going to see more and more companies going out of business and more and more consumers struggling to get the equipment they need."

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CRT UPDATE

COMPETITIVE BID PRICING FOR CRT WHEELCHAIR ACCESSORIES

WRITTEN BY: DON CLAYBACK

As reported in the last column, the Centers for Medicare and Medicaid Services (CMS) has announced it intends to apply Medicare Competitive Bid pricing to wheelchair accessories used on complex rehab wheelchairs effective in 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.

The policy change impacts up to 171 wheelchair accessory codes and could result in payment cuts ranging from 20 percent to 50 percent. If this change is not rescinded, there will be major decreases (or outright elimination) in access to individually configured complex rehab wheelchairs for people with disabilities who rely on this specialized equipment to meet their medical and functional needs.

This major threat to access does not just impact Medicare beneficiaries. The negative consequences will extend to other children and adults with disabilities who are covered by Medicaid and private health insurance plans since many other payers follow Medicare policy.

Unfortunately, this is another example of an unwarranted attack on the ability of people with disabilities to access important individually configured equipment they rely on. To prevent significant access problems, we need Congress to intervene and require CMS rescind this policy change:

• It is in violation of legislation (the Medicare Improvements for Patients and Providers Act of 2008) that exempted complex rehab power wheelchairs and accessories from the Competitive Bid Program.

THERE STILL IS TIME TO SIGN UP FOR THE THIRD ANNUAL NATIONAL CRT LEADERSHIP AND ADVOCACY CONFERENCE APRIL 21 THROUGH APRIL 23, 2015, AT THE HYATT REGENCY CRYSTAL CITY IN ARLINGTON, VA.

• It is contrary to subsequent Medicare policy created by CMS following the legislation which provides for accessories on complex rehab wheelchairs to be paid at established fee schedule amounts.

• It is using information obtained through the CBP that relates to standard wheelchair accessories and inappropriately applying it to Complex Rehab wheelchair accessories that were not part of the Competitive Bid Program.

Thankfully, as of this writing a congressional letter to CMS on this issue is being circulated within the House of Representatives. The bipartisan letter points out the problems with this change and asks that CMS issue a rescission and announce that the current payment policy for wheelchair accessories used on complex rehab wheelchairs will be maintained. Prior to being sent to CMS, the letter is being circulated within the House to allow for other representatives to add their signatures. The more representative signatures, the more weight the letter will be given.

Should CMS not agree to voluntarily rescind this policy change, we will continue to work with our congressional champions and move to the pursuit of a legislative solution this year.

This is a critical Complex Rehab Technology (CRT) access issue and the engagement of all CRT stakeholders is needed as we move ahead. We need to let all the members of Congress know this is an important matter and secure their assistance. Visit www.access2crt.org to obtain more information including the NCART position paper, "Call To Action," and tools to assist in your outreach to your members.

PASSAGE OF FEDERAL CRT LEGISLATION

As we enter the month of April, we have a clear path to move forward the "Ensuring Access to Quality Complex Rehabilitation Technology Act." The bill will be reintroduced shortly by

Sens. Thad Cochran, R-Miss., and Chuck Schumer, D-NY, and Reps. Jim Sensenbrenner, R-Wis., and Joe Crowley, D-NY.

The 2015 bipartisan bill remains basically the same as last year's. However, our Congressional sponsors agreed to add legislative language to address the inappropriate reclassification of certain CRT items by CMS from the routinely purchased payment category to the capped rental payment category. The new language will require that CRT items be paid on a purchase basis, unless the beneficiary elects to exercise a rental option.

As to stakeholder activities, the initial focus is to re-sign all of last year's co-sponsors. While not automatic, as long as CRT stakeholders follow up with those offices it should not be difficult. Other activities will center on securing new co-sponsors; working with the Senate Finance Committee and the House Ways and Means Committee to gain input and support; and obtaining a favorable Congressional Budget Office financial score.

On the health care side, Congress must take up legislation to further delay or repeal the Medicare sustainable growth rate methodology which, if not delayed, will result in physician fee cuts of more than 25 percent. This will be the first Medicare legislation in the new year and presents a potential opportunity to get our CRT legislation included as part of a bigger health care bill. If we are not able to get attached to the sustainable growth rate bill, we will be pursuing other opportunities later in the year.

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

(CONTINUED ON PAGE 36)

COMPETITIVE BID PRICING...
(CONTINUED FROM PAGE 35)

DON'T MISS THE NATIONAL CRT CONFERENCE

There still is time to sign up for the third annual National CRT Leadership and Advocacy Conference April 21 through April 23, 2015, at the Hyatt Regency Crystal City in Arlington, Va. NCART and NRRTS are again bringing CRT providers, manufacturers, clinicians, consumers, and other stakeholders together in one place for high-value education, networking and advocacy. You can get more details and register online at www.ncart.us or www.nrrts.org. Don't miss this opportunity for ideas to strengthen your business or practice and to promote the CRT advocacy message with Congress.

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A PATIENT'S TOOLKIT FOR RESOLVING INSURANCE DENIALS

WRITTEN BY: JILL VOGEL, JD, RN

Q. What legal options do patients have to battle an insurance denial? What resources are available for the average person who can't afford an attorney?

A. Dealing with an insurance denial requires organization, communication and persistence. By being proactive, many insurance disputes can be avoided altogether or resolved relatively quickly. As the saying goes, "an ounce of prevention is worth a pound of cure."

Read your policy. It is important to review the health insurance policy to learn which benefits are (and are not) allowable and how soon an appeal must be submitted if a claim is denied. If you have questions about coverage, call the insurer or ask your provider's billing department to pre-verify your coverage. It is also important to know the co-pay and deductible amounts and when the deductible period begins.

Good recordkeeping is a must. This includes keeping copies of receipts and keeping track of how much of the policy deductible has been met. These records will be helpful if you need to file an appeal later on. If you call your insurer or your health care provider with questions, keep a call log with detailed notes including the dates, names and information provided.

Read the explanation of benefits (EOB). The EOB from the insurance company explains what medical treatments or services were paid (or not paid) on the insured's behalf and the amount of the insured's financial responsibility for the service. The EOB should be reviewed for accuracy as soon as possible to avoid missing appeal deadlines. Contact the insurer about questionable entries on the EOB or if you disagree with how the claim was handled.

THE PROCESS IS OFTEN TIME CONSUMING AND CHALLENGING, ESPECIALLY WHEN ALSO DEALING WITH HEALTH ISSUES. SEVERAL FREE OR LOW COST RESOURCES ARE AVAILABLE FOR ASSISTANCE IN DEALING WITH DENIED CLAIMS.

If a claim is denied, get a copy of the denial letter from the insurer. The denial letter will state why the claim was denied and how you can appeal the decision. Often, denials result from clerical errors that are easily fixed. For example, if the denial was caused by a billing error, call your provider's billing department and ask them to clear up the issue with the insurer.

If the denial was not due to a billing error, or the billing error is not easily resolved, you will need to appeal the denial. The denial letter will include information regarding how long you have to appeal the denial, and where to send your appeal letter. Follow the appeal directions exactly and do not miss the appeal deadline.

When preparing the appeal letter, be sure to address the specific reason for the denial and include specific facts that the insurance company may not have had at the time of the decision. For example, if the reason for the denial is that the service or item is not considered medically necessary, it often helps to have your health care provider write a letter on your behalf explaining why the service or item is medically necessary. If you ask your health care provider for such a letter, provide a copy of the insurance company's denial letter and allow ample time for your provider to prepare the letter. Unless the insurance company requires otherwise, the provider's letter should be included with your appeal letter.

Typically, the appeal process includes the initial appeal, a second level internal review (if needed) and an external review by an independent review organization (if needed). The process is often time consuming and challenging, especially when also dealing with health issues. Several free or low-cost resources are available for assistance in dealing with denied claims. For example, the Medicare Beneficiary Ombudsman helps

Medicare beneficiaries with Medicare-related complaints, grievances, and information requests. Many states offer consumer assistance programs through the state attorney general's office. Additionally, local legal aid organizations may provide legal assistance at low or no cost. Contact your local bar association or legal aid clinic for more information.

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MEDICAL FOCUS

CORTICAL VISUAL IMPAIRMENT

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

Many of the clients who we work with have visual issues that may be related to their primary diagnosis. Vision not only impacts a person's ability to move throughout his/her environment, but it can also impact posture.

Vision is a complex process. The visual system is a part of the central nervous system. The lens of the eye focuses an image onto the retina, a light-sensitive membrane on the back of the eye. If the image is focused in front of the retina, a person is near-sighted (myopia); if the image is focused in back of the retina, a person is far-sighted (hyperopia). In astigmatism, images are not sharply focused on the retina due to the shape of the cornea. Visual acuity is primarily the focus of images and has to do with the eye itself. But there is much more to our vision. The focused image is then sent to the brain via the optic nerve. The brain interprets or processes the visual information along with other related information including hearing and proprioception. Visual perceptual skills include depth perception, tracking and the ability to pick out a specific object (i.e. a spoon) in a field (i.e. a silverware drawer).

Cortical or cerebral visual impairment (CVI) results from a neurological problem in the visual processing center and visual pathways of the brain, not from a physiological problem with the eye itself. CVI is caused by a lack of oxygen, injury or infection to the areas involved. As such, this is commonly seen in clients with cerebral palsy, hydrocephalus, brain injury or meningitis. This has been termed cortical blindness in the past, but this is an older term, as these clients usually have some vision and the condition tends to improve with time. In CVI, the eye sees an image and sends this to the brain, but the information is not properly processed or integrated because of abnormal brain function. Specifically, clients with CVI may have difficulty sustaining focus on an object and filtering out peripheral visual information.

Clients with CVI often:

- see certain colors or contrasts better
- have varying visual abilities throughout their day
- have delayed visual responses
- assume specific head positions to improve ability to see objects
- glance at objects repeatedly, rather than sustain visual contact

CVI is diagnosed and treated by someone termed a behavioral or developmental optometrist. Vision therapy may also be provided by specially trained clinicians.

How does CVI affect posture? Many clients will hold their head forward and look at objects out of the sides of their eyes. As a result, the client rarely is in contact with the head support. The client may need to assume these postures for optimal vision throughout their day. Some clients with CVI will have enough vision to use power mobility, particularly indoors where less depth perception is required (i.e. drop offs) or with supervision.

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RESOURCES:

AMERICAN ASSOCIATION OF PEDIATRIC OPHTHALMOLOGY AND STRABISMUS, HTTP://WWW.AAPOS.ORG/TERMS/CONDITIONS/40

COLLEGE OF OPTOMETRISTS IN VISION DEVELOPMENT, WWW.COVD.ORG

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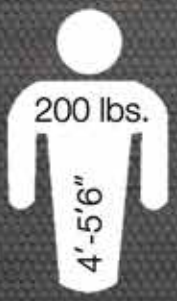

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CLINICAL CORNER

SEATING AND MOBILITY PROVISION WITH TEENS:

A TIME OF TRANSITION

WRITTEN BY: ANDRINA SABET

Growing pains in adolescence encompass the entire spectrum. Physical changes often capture the spotlight but are closely intertwined with character development. This is a time when boundaries are questioned, pushed and often broken and moments can begin to define individuals. More often than not, these defining times emerge out of engagement in family, social and academic life. Physical barriers to participation are often a hallmark component of disability. Technology, equipment and education when well implemented can often minimize these participation barriers. When this technology and equipment is not well prescribed or when education is lacking, barriers can be magnified rather than eliminated. Pathways to independence are rarely downhill and coordinating a team approach to equipment provision that facilitates the emergence of a successful individual somewhere along the way has its ability to challenge the strongest leadership.

Frequently adolescents are caught in between pediatric- and adult-based services, which can create a gap in professional skill sets to optimize equipment for this age group. Diagnoses such as cerebral palsy and myelomeningocele can often conjure up images of children of elementary school age or younger. These diagnoses are considered non-progressive, meaning the disease or injury process does not worsen with time. However, many secondary changes occur as a result of the primary impairment that can have a detrimental effect on function as that child moves toward adulthood.

Families, the individual and sometimes the professionals can be easily trapped in a pediatric mindset where concepts such as pressure ulcers, pain and spinal surgery fall under the misperception that these concerns are down the road. As a result, these adolescents and caregivers often find themselves in new territory when contractures, scoliosis, and fatigue seem to suddenly appear. A need may be created to consider equipment use or replace current equipment. Many of these complications can surface during a mobility evaluation, creating opportunities for education as well as entry points for referrals for supplementary medical assessment and intervention. All too frequently, adolescents with long-term diagnoses have exhausted their interest and participation in regular therapy and there is a void in service provision to smooth this multifaceted transition to adulthood.

Physically, adolescent growth spurts often coincide with worsening joint contractures as well as an increase in progression of neuromuscular scoliosis and pelvic asymmetries. Muscles under the influence of spasticity often lose the extensibility of fibers that are found in typical muscle composition. This decrease in inherent flexibility becomes problematic during a growth spurt when bone growth requires a corresponding increase in muscle length. From a seating perspective, changes in lower extremity range of motion, particularly hamstring muscle length and hip flexibility can directly impact posture and mandate changes in wheelchair configuration. In addition to the seating itself, the orientation of the system through both tilt and recline can help functionally compensate for muscle length and tone changes. For example, if extensor muscle recruitment creates anterior progression on the seat surface, a combination of tilt and recline may allow for the individual to independently reposition themselves, decreasing reliance on a caregiver. Unique combinations of lateral tilt, anterior tilt and pre-cline to the typical posterior orientation changes should also be considered to increase variety in positions for task performance as well as to compensate for a loss of flexibility in cervical musculature which may limit visual field through poor head orientation. In many instances, creative opportunities for supplemental positioning including nighttime positioners and stretching through weight bearing in supported standing can assist with overall joint maintenance.

WHEN THIS TECHNOLOGY AND EQUIPMENT IS NOT WELL PRESCRIBED OR WHEN EDUCATION IS LACKING, BARRIERS CAN BE MAGNIFIED RATHER THAN ELIMINATED.

For many young people, a marked increase in the progression of neuromuscular scoliosis occurs during adolescence. In cerebral palsy there is a 30 percent incidence of scoliosis and for those in the more impaired range, there is a 50 percent risk of moderate or severe scoliosis by age 18. Duchene muscular dystrophy has a rate of scoliosis of 48 percent to 93 percent while spinal muscular atrophy rates vary from 58 percent to 95 percent with fluctuations based on classification and severity.[1] Many of these moderate-to-severe curves will warrant surgical intervention. From an equipment perspective, collaboration with physicians and surgeons is imperative to the timing of modifications to existing wheelchairs or prescription of new ones. If surgery is looming, discussion with the surgeon either directly through the seating clinic team or indirectly through an educated family member or wheelchair user can coordinate timing of post-op reassessment to minimize wait times for often already overdue equipment.

Skin integrity and pressure management are new considerations that are frequently not an issue with young children with neuromuscular impairments. Part of the aging process toward adulthood creates integumentary changes that affect both tissue resiliency and wound healing. In the young child during healing, collagen, elastin and granulation tissue form rapidly. As the child ages, these processes slow, which requires increased time for healing.[2] In addition to changes in skin composition, worsening pelvic asymmetries, hip dislocation or subluxation and spinal scoliosis can create asymmetrical sitting postures. All of this combined with the high probability of increased time in equipment as well as decreased opportunities for weight shifting can be problematic. For some, pressure management is not a new concept.

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SEATING AND MOBILITY...
(CONTINUED FROM PAGE 43)

However many teens or caregivers of teens have missed this component of their therapeutic routine and all too frequently, the introduction to weight shifting techniques and pressure management comes following the development of their first pressure ulcer. Further complications may arise as individuals may experience significant changes in voiding patterns or volume. In the presence of incontinence, the incidence of large volume voids can directly affect skin integrity from increased moisture. Explorations of alternative methods to manage incontinence are often overlooked if the problem has been long-standing. Identification and referral may need to be initiated by the seating clinic team as they may be the first specialty to identify this as a risk factor for optimal skin health.

THIS SHIFT IN DECISION MAKING FROM PARENT TO YOUNG ADULT CAN BE SIMPLIFIED BY DIRECTING THE EVALUATION TOWARD THE WHEELCHAIR USER RATHER THAN THE PARENT AND/OR CAREGIVER.

Emerging independence can be facilitated by incorporating the adolescent as a primary team member in equipment decisions. Family dynamics and historical practices can influence the adolescent's initiation to participate. This shift in decision making from parent to young adult can be simplified by directing the evaluation towards the wheelchair user rather than the parent and/or caregiver. There can be a tendency to use the current equipment as a framework for decision making. Though it is good practice to determine pros and cons of current equipment, present ingenuity and future insight can minimize the risk of duplicating a set of wheels that might have been perfect for a child but cannot well support the emergence and expression of a

young adult self. Discussing the environments and activities where the chair will need to function over the next five years in addition to the current environment is necessary to anticipate equipment goals. Though this consideration is important with any age group, the adolescent has the potential to transition between multiple school environments as well as the mobility constraints created by college campuses. It is often difficult for the user to anticipate the physical demand of negotiating the urban or rural campus. Assessment of community based function and/or encouraging local campus visits in either current or trial equipment can provide a framework for decision making.

The transition to community based aides on a college campus from family based supports in the home can create new dilemmas for sitting tolerance, environmental access, and self care. These aides may run late or not show up at all, requiring the individual to spend several additional hours in their wheelchair. Power seat functions, which may seem unnecessary to caregivers and adolescents with the sometimes unrecognized supports of their home environment, become critical to manage unanticipated extended periods of time in their chair. The addition of power recline and elevating leg rests to a system where tilt was previously sufficient can bridge the gap between the family home and independent living scenarios. Furthermore, the addition of anterior tilt may increase the opportunity to access lower table heights as environments increase in variety and decrease in predictability. College dorms often have significant space limitations. Consideration of combining equipment such as a power standing feature to replace a stationary stander that cannot travel to school, allows for the medical and functional benefits of standing to be continued rather than abandoned. These scenarios may be difficult to predict by families and therefore professional insight into potential future challenges will create an opportunity for discussion and thoughtful equipment decisions.

While functioning crystal balls are hard to come by, there are some trends in adolescent development in the presence of disability that need to be on the table for discussion and problem solving. While addressing all these issues in the seating and mobility evaluation can be a lengthy process, utilizing appropriate referrals to medical specialties can be an efficient way to manage complexities and identify solutions for seating related challenges. Re-engagement in short term physical or occupational therapy may be indicated to target goals of pressure management, weight shift techniques, fine tune transfer skills for sheer reduction, and train or re-train community based wheelchair skills. Above all, the education of the family and the adolescent, combined with the identification and consideration of this multitude of factors during the evaluation process, will optimize equipment choices for a more effective launch to adult independence.

Optimizing equipment prescription during transitional times should include:

- Medical referrals to specialists such as urology and orthopedics
- Therapy referrals
- Community based mobility assessment and equipment trial
- Consolidation of equipment to minimize transfers or space constraints
- Education regarding skin, sitting tolerance, and postural management
- Discussion about future plans and considerations to maximize independence

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REHAB CASE STUDY

A TRANSITIONAL DRIVER'S LICENSE:

MOBILITY AND TEENS

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

One of the unique aspects of providing power wheelchairs to children is that mobility needs tend to change. As children grow, less supervision may be required, the environments in which the child moves expand and motor abilities often change. Children with conditions such as Duchenne muscular dystrophy and spinal muscular atrophy, type II, may be transitioning to power mobility in the early teen years. Children with increased muscle tone as a result of cerebral palsy or traumatic brain injury experience a change in biomechanics due to growth, range of motion loss, orthopedic changes and ongoing tone management. These changes may affect the teen's ability to control the power wheelchair, and new drive controls may be required. Children with developmental delays who may have struggled with power mobility use at younger ages, may be developmentally ready for this task in the teen years.

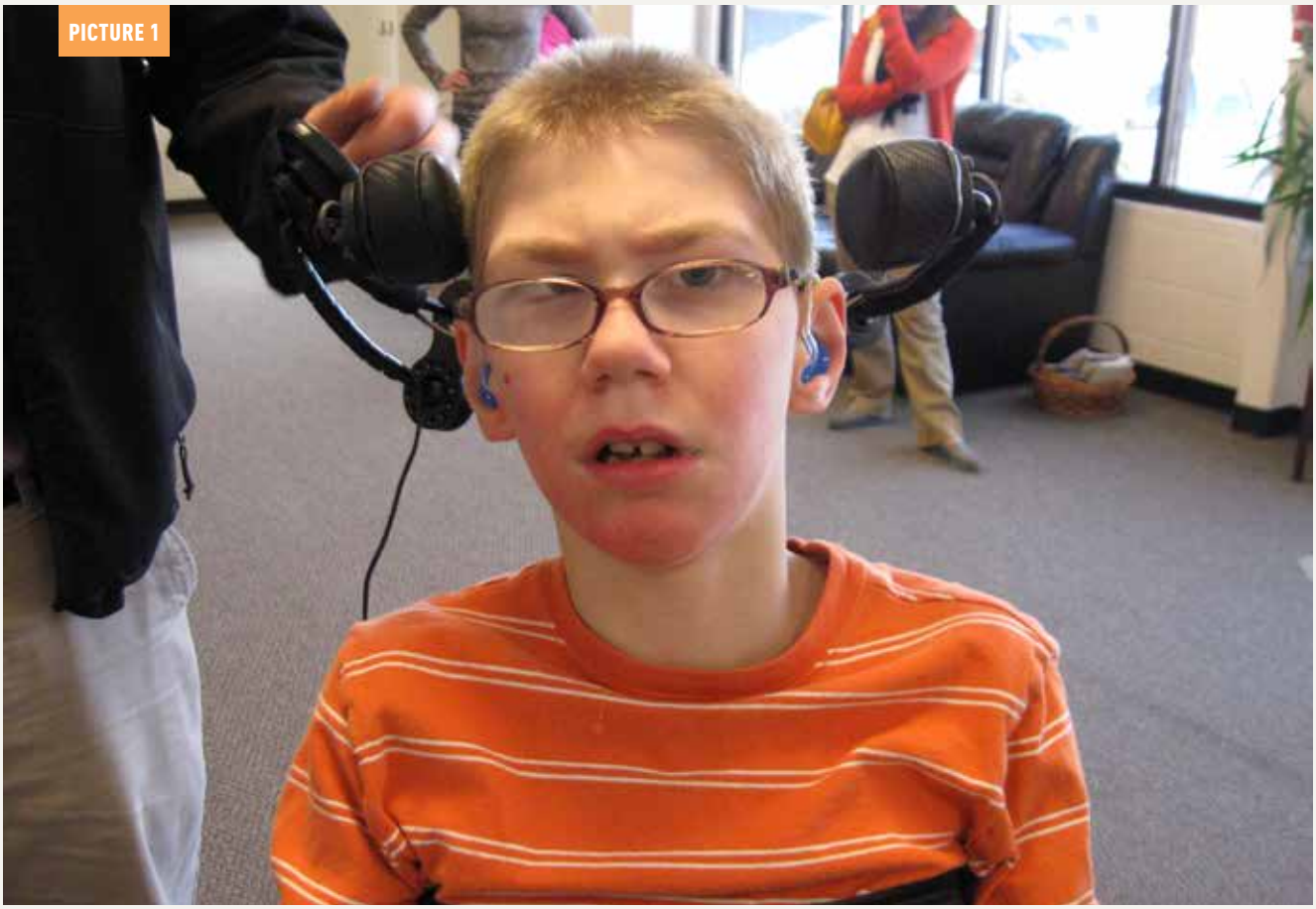
Jonathan is a 13-year-old teenager with the diagnosis of cerebral palsy. He was referred to this evaluator to assess his current seating and access to a speech generating device, as well as determine his potential to use a power wheelchair. Jonathan was seated in a linear seating system including an anti-thrust seat, biangular back, pelvic and thigh lateral supports, trunk lateral supports, shoeholders with ankle straps and head support. As he grew and the 90 degree footrest hangers were extended, the footplates began to interfere with the front casters, and so the family began to position him in a mild tilt at all times. He does not have adequate hamstring length for a different angle hanger. Despite his young age, Jonathan had a past pressure ulcer and was still getting red over his ischial tuberosities and sacral areas with prolonged sitting. He has a mild lateral scoliosis at this time and significant muscle tone. He has begun puberty, and his dad is very tall. As such, Jonathan could be entering a growth spurt which could lead to further spinal asymmetries. With the current pressure concerns and potential for orthopedic changes, a molded seating system was recommended to better address these issues.

HE NEEDED A LOT OF CALM AND SIMPLE REASSURANCE, AS HE CAN BECOME QUITE ANXIOUS AT TIMES AND THE ENTIRE EXPERIENCE WAS RATHER OVERWHELMING.

Jonathan had reportedly been evaluated for power mobility at ages 3 and 5 years, though a power wheelchair was not recommended at that time. The reasons were not clear, though it appears that Jonathan did not yet see a power wheelchair as a potential means to move around the environment, but rather as something the team was "making him do." This underscores the importance of approaching a power mobility evaluation at a developmentally appropriate level. It is critical to engage the child, to get down to their level, crack jokes about Sponge Bob, etc. Jonathan may still not have been ready at these young ages, but evaluation of young children can be a process over multiple evaluations. Unfortunately, Jonathan did not receive any pre-mobility training to develop his skills and prepare him for future power wheelchair use. Finally, it appears that the only access method trialed at these young ages was a joystick, and Jonathan has little volitional control of his hands, at least currently.

Back to present day. The team decided to wait for Jonathan to receive his new molded seating system, an Aspen Seating Orthosis (ASO), before performing a power wheelchair evaluation. This evaluator had been working with Jonathan to determine his best access method for communication and he was using a switch by the left side of his head quite well for single switch scanning. He demonstrated strong potential to use his head for driving, as well. Furthermore, Jonathan was doing quite well on his new speech generating device and demonstrating cognitive skills that indicated that he should certainly be able to understand power wheelchair use.

Jonathan's ASO was placed in a demo power wheelchair with a Stealth Products iDrive head array (see picture 1). This tripad headrest has embedded



Jonathan seated with head array

proximity switches for control of forward, left and right directional control. He very quickly demonstrated cause and effect, stop and go concepts, directional concepts and fair problem solving and judgment. At one point, he indicated that he wished to go outside. It was cold, and he was told that we could not do so. He drove with good accuracy directly to the door leading outside. We were so pleased with his driving abilities that we all went out with him for a while as he drove in the parking lot. When told it was time to go back in, Jonathan very intentionally avoided the ramp back to the entrance! He did not want to stop driving, despite the cold – a great sign! Jonathan demonstrated strong readiness for a power wheelchair, and I anticipated that he would be a proficient driver with some mobility training (see picture 2). He was very motivated and careful, even if he didn't follow directions to go back inside.

Next, the team needed to put together an order. Jonathan required more stability to optimize his driving and so a suboccipital pad was added to the head array. This pad not only provides stability, but also provides a "starting point" or template from which to move from to activate switches. A midwheel drive power base, the Permobil M300, was recommended as midwheel drive requires less switch activations

(CONTINUED ON PAGE 48)

Driving with the head array in a demo chair

A TRANSITIONAL DRIVERS LICENSE
(CONTINUED FROM PAGE 47)

to get from Point A to Point B than front or rear wheel drive configurations. This is because less switch activations are required to compensate for the front and rear casters. Tracking technologies were also recommended as this has been shown to increase efficiency (less switch hits, less time) for head array drivers by approximately 69 percent (Lange, Brown, 2013). A power tilt was added, so Jonathan could shift his weight; particularly important with his pressure issues. The R-Net 2 electronics were programmed in sequence, so Jonathan could access features such as reverse, speeds and power seating through the drive control without having to visually monitor the display. This required a reset switch, which was positioned by his left hand. Jonathan has adequate vision for driving, but not to read the display. Finally, an input output module and interfacing cable were required, so Jonathan could access his speech generating device through the left proximity switch of the head array from Auxiliary mode.

After Jonathan received his new power wheelchair, he was seen again. Speeds and acceleration had to be reduced a bit to allow Jonathan time to react and change course. He needed a lot of calm and simple reassurance, as he can become quite anxious at times and the entire experience was rather overwhelming. Once he was reassured and the wheelchair programmed, Jonathan settled down and drove his new chair with great potential. His team was instructed in some mobility training techniques, and I believe he will do quite well.

Jonathan may not have been ready for power wheelchair use at a younger age developmentally. Perhaps he could have been with pre-mobility training to develop the skills required. He may have simply required a different access method to provide independent mobility sooner. Even if Jonathan had been successful in power wheelchair driving at a younger age, his access could have changed as his body changed – particularly during those teen years.

If you are working with kids using power wheelchairs, keep an eye on them. As their bodies change from child to adult, physical growth occurs. Body changes can also lead to significant changes in function. A child who was able to get around in a manual wheelchair, may now require power, and kids who could drive a power wheelchair with one driving method may require another. One of the greatest challenges of assistive technology is meeting client's changing needs. A one-time evaluation is rarely all that is required. If a client requires new equipment or intervention, it isn't because we didn't get it right the first time, it may be because both client and the technology continue to change.

CONTACT THE AUTHOR

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USERS FIRST

CONSUMER EDUCATION IS CRITICAL

WRITTEN BY: JENN WOLFF AND ALEX BENNEWITH

As United Spinal Association's UsersFirst continues to grow into an expanded network across the country, connecting wheelchair users with each other and with policymakers, we are gathering user stories about the difficulty and frustration of getting a new chair.

From Leslie in Illinois, "Recently, I received …notice that Medicare denied a power chair for me. This was after eight months of my wheelchair supplier asking for [information] and repeat signatures from [the] doctor. All information was provided, but then Medicare ruled it was not sufficient [information] to support [the] need. I desperately need the chair as I am struggling with pressure sores from my feet rubbing as my current manual chair doesn't meet my needs.

"The sad situation is I have no documentation. I have asked for paperwork and was told no one had to provide it to me. It actually got to the point of Medicare [saying we won't pay that amount but will pay this much and I was told the wheelchair company accepted it but with the endless reviews it came back as not sufficient evidence for coverage. I have felt very left out of [the] process and have no idea where to get [information] on my rights or [navigating the] process]."

Let's work together to give wheelchair users instructions on documentation and advocate for full user access to medical records. Let's explain why users may not have received the "right" equipment. I hear many users criticizing the supplier when, in many cases, it is the insurance policy that causes the problem. It is a complicated process but it's time to educate the user so they can be best prepared.

"I most definitely qualify for the chair as my spine is severely affected as well as my hips, knees and feet. I also have an 'overgrowth' condition that affects my ability to sit. [I] also have vein and lymphatic malformation in my chest and underarm area as well as [my] trunk [and] legs. They impair my ability to propel a manual chair. I really feel I should be actively involved in describing my conditions, which are very rare, and how it affects my ADLs."

The user should be prepared to come to the evaluation with all the documentation he/she can regarding medical history and complications that may impact mobility, ADLs and insurance coverage (history of pressure sores, upper extremity dysfunction, COPD, scoliosis etc). He/She should have a list of daily activities completed during the day and list if there is something they no longer can do which may be due to incorrect positioning.

LET'S WORK TOGETHER TO GIVE WHEELCHAIR USERS INSTRUCTIONS ON DOCUMENTATION AND ADVOCATE FOR FULL USER ACCESS TO MEDICAL RECORDS. LET'S EXPLAIN WHY USERS MAY NOT HAVE RECEIVED THE "RIGHT" EQUIPMENT. I HEAR MANY USERS CRITICIZING THE SUPPLIER WHEN, IN MANY CASES, IT IS THE INSURANCE POLICY THAT CAUSES THE PROBLEM. IT IS A COMPLICATED PROCESS BUT IT'S TIME TO EDUCATE THE USER SO THEY CAN BE BEST PREPARED.

UsersFirst and United Spinal will be releasing updated resources shortly for clinicians, suppliers and wheelchair users and to help the user become an integral part of the seating and wheeled mobility evaluation. By working together and including the consumer as part of the team, documentation should be complete and your patient/customer will be more satisfied with the process. If they still are unhappy with the end

product due to insurance policies, send them to us. Have your customers visit the UsersFirst Mobility Map at http://www.spinalcord.org/resource-center/ for assistance in understanding the wheelchair evaluation, prescription, funding and delivery process. For more information, visits UsersFirst at http://www.unitedspinal.org/usersfirst-grassroots-action-network/.

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MEDICARE EXPECTS YOU TO ONLY THINK OF "TODAY"

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

As you work with your clients, the goal is to provide them with the equipment that will help improve their lives based on their condition. Whether you are a clinician, ATP, service technician, or even a customer service representative, you want the best for your client. Unfortunately, there tends to be one key item that gets in the way… Funding.

When it comes to coverage of equipment, Medicare and many other funding sources, only think of "today." They look at what the client needs to have at this moment and not their upcoming needs. As we all know, for many clients, this is not realistic.

When working with certain clients with progressive conditions, "today" can change very quickly. As we all know, diagnoses and their effects on clients is not a black and white topic. Clients with the same diagnosis will present differently and progress differently. Coming from the funding side, I understand this can differ for each individual. The determining factor for coverage will be the documentation.

WHAT MAKES THINGS A BIT MORE DIFFICULT IS THAT MEDICARE DOES NOT "DOWNCODE" ORDERS. THIS WAS A PRACTICE THEY HAD DONE FOR MANY YEARS BUT WAS ELIMINATED SOME TIME AGO.

There have been many times that I hear people say to me, "This client has ALS so this will all be paid, no problem." That statement could be wishful thinking for some, but in many cases very logical thinking. However, when I pull the file and see that the client had walked 10 blocks to the physician's appointment, there is a problem. Sadly, there is no question that the client will likely need extensive complex rehab equipment in their future, however the issue is that he had not even come close to that point based on the clinical documentation. This is where the funding source would not approve a full-blown system at that time. By all means, this example is an extreme, but I have seen it more than once.

The more common scenario I see is the orders for clients with ALS, MS or another progressive condition and per the documentation they are already having issues ambulating within the community and sometimes in their home. However, they have yet to be at the point of needing powered seating or other complex rehab options. Again, clinical documentation is key. If the funding source just sees this overall picture, they will likely not fund the full order (or flat-out deny the whole order, depending on their regulations). Again, I am not saying this is right, but it is policy for most.

When you think back to the introduction of the 64 power wheelchair codes in 2006, part of the mindset of the code "Group" was in recognizing complex rehab and clients with progressive conditions. For coverage of power wheelchair codes that fall within the Group 3 codes, the client must have a neurological condition, myopathy or congenital skeletal deformity. It was recognized that many of these conditions were progressive. Medicare wanted wheelchair bases that could be modified due to such progression. Most of the wheelchair bases that fall in this category have the ability to "grow" with the client's medical needs. With this in mind, an MS client, may start with a standard Group 3 power wheelchair base with a captain's seat, and then clinically progress, where they will then require specialized seating and power tilt. With the proper clinical documentation, a provider can then be reimbursed for modifying the wheelchair base by adding power tilt, rehab seat and proper seat and back cushions. It needs to be recognized that this occurs once the client medically needs the options – not before.

I have seen some cases in which a client's rapid physical progression is well-documented and some higher-level

Clinician Task Force

The Clinicians Task Force is a group of clinician...

- 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

options are funded up-front. However, it needs to be clear that the clinical documentation is very specific and historical documentation has also been obtained to support the fast-moving changes.

As much as we may not like this thought of only covering what is needed "today," if we step-back and place ourselves in the shoes of the funding source, it can make some sense. As noted in my first example, when a client is still walking blocks to his appointments there does not seem to be a reason why an extensive complex rehab system would be ordered at that time. Just looking at the basics, what if he/she loses a lot of weight and a different wheelchair/seating size is needed? Or what if after his/her own research he/she decides he/she wants a specific wheelchair model? Some of these what ifs could continue and force the need/want of a new wheelchair. I am not saying we should wait until we know every exact need, but the client at least needs to meet some minimum requirements. Again, the coding system was developed to "grow" with the patient. Many people do not realize that such modifications will be funded.

In numerous cases, the process of delivering the equipment takes an exhaustive amount of time. What I find is that in many of these cases the extra time is due to non-qualifying documentation and continually attempting to obtain something that does not exist. If I place myself in the shoes of the client, I have to believe that it is more frustrating to wait and then find that the outcome is no different had they known up-front. I also see that it can be unfair if someone truly needs the power wheelchair (or any wheelchair) base, but the order is stopped because the supporting documentation for the additional options (i.e. powered seating) does not exist. This leaves a client

(CONTINUED ON PAGE 54)

MEDICARE EXPECTS YOU TO...
(CONTINUED FROM PAGE 53)

without the item they desperately need at the time, while waiting for something that may not be necessary quite at that moment. What makes things a bit more difficult is Medicare does not "downcode" orders. This was a practice they had done for many years but was eliminated some time ago. Therefore, it is up to the provider to know what level of product the client qualifies for and then bill appropriately.

By no means does funding always make sense, but I do have to say that if we stick to some basics, life can be better for all. The client gets what he/she needs at that point; a provider gets funded, and does not have to worrying about recoupment in the case of an audit. I will say that for those clients who honestly are progressing at such rapids rates, providers do need to "fight" for specific equipment, however the specialized seating therapists and ordering physicians will have to do their part.

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THE CTF SUBMITS MOTION CONCEPTS FOR THE 2015 REPRESENTATIVE ASSEMBLY OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

WRITTEN BY: THERESA L. GREGORIO-TORRES, OTR, MA, ATP, CTF AND JENNY LIEBERMAN, MSOTR/L

Clinician Task Force (CTF) members are utilizing the platform of the American Occupational Therapy Association (AOTA) to broaden our reach and efforts to impact Complex Rehab Technology (CRT) related clinical practice issues. A CTF strategic priority is to mobilize clinicians from diverse settings and geographic locations to engage in CRT advocacy and training activities. We are leading a multi-pronged strategy within the AOTA to: 1) define Seating and Wheeled Mobility (SWM) professional competencies, 2) ratify the definition of CRT practice, and 3) promote CRT legislative and regulatory activities. An update follows including progress on issues related to CRT and Durable Medical Equipment (DME).

AOTA MOTION UPDATE

CTF members of the AOTA have been busy working within the AOTA organizational structure to formally define and delineate the SWM knowledge and skills necessary to serve in this ever-evolving area of occupational therapy (OT) practice. **The overarching CTF objective is to build capacity of the present and future OT workforce to ensure there is ample access to qualified and skilled clinicians to provide specialty CRT evaluations, and are knowledgeable about documentation and payment policies.**

For this reason, the CTF led an effort beginning in 2011 to bring a motion forth to the the AOTA Representative Assembly, the 65 elected-member representatives, including officers and non-voting members, which is the highest level policymaking body of the AOTA. CTF members Tamara Kittelson-Aldred, OTR/L, MS, ATP and Cindi Petito, OTR/L, ATP, CAPS, introduced to the AOTA Representative Assembly a motion entitled ***"Specialized Knowledge and Skills for Complex Seating and Wheeled Mobility in Occupational Therapy Practice."*** This motion charged the Commission on Practice to develop a knowledge and skills paper that defines CRT seating and mobility practice for occupational therapists differentiating entry level and advanced practice. A knowledge and skills paper is used by the association to provide a structure for acquiring competency in an area in which there are specialized evaluation and intervention processes. This motion unanimously passed the 2011 AOTA Representative Assembly charging the Commission on Practice with developing a knowledge and skills paper with a content outline, timeline and report back to the full AOTA Representative Assembly in spring 2012. The motion makers and subject matter experts worked to draft the knowledge and skills paper with guidance from the commission over an 18-month period. The timeline supported completion by the 2012 fall Representative Assembly online meeting, but was later amended to be completed by the November 2013 meeting. In February 2013, the motion makers and authors were informed that the commission had changed the intent of the motion without input from the assembly, and planned a position paper instead of the approved knowledge and skills paper.

An AOTA position paper is defined as an official stance of the association on a substantive issue or subject. Position papers are developed in response to a particular issue, concern, or need of the association and may be written for internal or external use. The motion makers asserted to the leadership and staff that a position paper did not adequately meet the intent of the motion and would significantly alter the purpose, scope and utility of the final deliverable. Unlike a position paper, a knowledge and skills paper was specified because it outlines a structure for the acquisition of competency in a specialized practice area, identifies the difference between beginner and advanced skill, and provides information on a pathway to develop advanced competencies.

The motion makers communicated with the Representative Assembly Coordinating Council in April 2013, and in late May the speaker of the Representative Assembly informed the motion makers that the council had decided to relegate the knowledge and skills paper to a position paper.

Members of the without involvement of subject matter experts developed the AOTA position paper entitled ***"Seating and Wheeled Mobility Position Paper"*** and submitted it to the AOTA membership for a brief open comment period in late August, 2014.

CTF members worked to obtain an extension to the public comment period and launched a campaign to educate stakeholders including academicians, SWM specialists, researchers, RESNA OT members, and OT supplier/manufacturer/professional educators to submit formal comments on the SWM position paper content. The CTF sent a formal letter specifying concerns with position paper inaccuracies and omissions, incomplete and outdated evidence and references, and overall concern about the credibility of the paper. This was sent to the coordinating council, the commission and elected Representatives of the assembly representatives in anticipation of the annual online RA Fall Meeting scheduled November 10 to 15, 2014. OTs were encouraged to participate in the AOTA "OT Connections," online member forum for discussion, dialogue, education and debate. This process was used to educate representatives responsible for voting about the concerns and inaccuracies of the position paper's content. At the Fall Meeting, the position paper was defeated with a resounding vote of 40 ayes to 9 nays. This was a direct result of the CTF and the OT SWM community coming together. The CTF views this defeat and outcome as a "sad win." We ultimately want an organization-wide policy but it must be accurate and define SWM practice.

ONE STEP FORWARD, TWO STEPS BACK

Despite the failed attempt to have AOTA establish an official document that would help define knowledge and skills that are necessary for OTs to provide ethical and competent OT services related to CRT, we continue to press on taking action toward attaining the outcome we desire. CTF members are continuing to strategize new approaches to further our mission and promote CRT issues in practice, payment, policy and advocacy activities within our respective organizations.

In February 2015, two motions related to professional standards and policies were submitted to the AOTA Representative Assembly. One was geared toward defining an organizational policy in regards to assistive technology and CRT. The other was a philosophical motion directed toward defining policy with statements supporting OT and AT/SWM provision. In addition, we are working toward a document that defines competency in the field of SWM.

We request that suppliers and manufacturers direct OTs employed within their organizations and referral sources they work with to participate in dialogue with their AOTA state representatives to vote in support of the proposed motions so that we are able to obtain widespread support and see the motions passed into AOTA policy.

IN CLOSING

The Clinician Task Force continues to work diligently to keep our professional clinical organizations informed of policies and legislation that negatively impact consumer access to medically necessary and appropriate DMEPOS and CRT.

Keeping our associations up to date and abreast of how regulatory and legislative changes are impacting clinical practice and the individuals we serve is necessary if we are to mobilize the clinical community to participate in issues related to CRT and DME.

CTF members regularly communicate with voluntary leadership and staff of our professional organizations including: the American Occupational Therapy Association (AOTA: 50,000 members), the American Physical Therapy Association (APTA: 90,000 members), the American Academy of Physical Medicine and Rehabilitation (AAPMR: 8,000 members) and the Association of Academic Physiatrists (AAP: 1,200 members).

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

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ETHICS AND STANDARDS OF PRACTICE FOR ASSISTIVE TECHNOLOGY PROFESSIONALS

WRITTEN BY: ANDREA VAN HOOK

Has this ever happened to you?

- After performing a complete assessment, you realize that a competitor's product would actually be a better fit for your client based on his or her needs.
- You know a certain piece of equipment would best meet your client's needs, but the cheaper option, which isn't as good, is covered and won't require extra paperwork.
- You recommend a new device for a client – something that will definitely help them function more independently. The client purchases the device only to have it sit in a closet.

Assistive technology professionals encounter these situations frequently. Sometimes, sorting out the right thing to do can be difficult. That's why the RESNA ATP certification includes a commitment to abide by the RESNA Code of Ethics and Standards of Practice.

Certification positions the ATP as a professional, not a technician. There's a big difference. A technician is associated with skilled labor or a trade, is versed in technique, has a relative understanding of general principles, and usually works in a supportive role to other professionals. The professional, however, possesses a large body of knowledge, is self-regulating, has autonomy in the workplace, and uses independent judgment and professional ethics to guide behavior.

THE STANDARDS STRESS COOPERATION, TEAM-BUILDING AND FOLLOW-UP; PROMOTE COLLABORATION; ENCOURAGE REFERRALS TO OTHERS AS APPROPRIATE; PROMOTE ETHICS; AND PROVIDE A PATH FOR THE ADJUDICATION OF COMPLAINTS.

Because ATPs work with vulnerable people who need technology in order to lead healthier lives, it is vitally important that professionals behave in an ethical manner. It's a good idea to periodically review the Code of Ethics and Standards of Practice and make sure you and your colleagues are in compliance.

CODE OF ETHICS AND STANDARDS OF PRACTICE

The RESNA Code of Ethics is a short statement comprised of eight standards. It states that RESNA members and credentialed service providers will:

- Hold paramount the welfare of persons served professionally;
- Practice only in their area(s) of competence and maintain high standards;
- Maintain the confidentiality of privileged information;
- Engage in no conduct that constitutes a conflict of interest or that adversely reflects on the association, and more broadly on professional practice;
- Seek deserved and reasonable remuneration for services;
- Inform and educate the public on rehabilitation/assistive technology and its applications;
- Issue public statements in an objective and truthful manner;
- Comply with laws and policies that guide professional practice;

Sounds easy, doesn't it? As you know, it's not. That's why in addition to the Code of Ethics, RESNA also developed the Standards of Practice, which are 22 rules that cover assistive technology service delivery. The standards stress cooperation, team-building and follow-up; promote collaboration; encourage referrals to others as appropriate; promote ethics; and provide a path for the adjudication of complaints.

To give you a sense of what's covered, here are three of the standards:

1. Individuals shall engage in only those services that are within the scope of their competence, their level of education, experience, and training, and shall recognize the limitations imposed by the extent of their personal skills and knowledge in any professional area.

2. Individuals shall offer an appropriate range of assistive technology services which may include assessment, evaluation, trial, simulation, recommendations, delivery, fitting, training, adjustments, and/or modifications and promote full participation by the consumer in each phase of service.

3. Individuals shall not engage in fraud, dishonesty or misrepresentation of any kind, or forms of conduct or criminal activity that adversely reflects on the field of assistive technology, or the individual's ability to serve consumers professionally.

The Code of Ethics and Standards of Practice is available on the RESNA website, in the "Get Certified" section under "Code of Ethics."

EDUCATING CONSUMERS

As a certified ATP or ATP/SMS, it's important that you educate your clients about what certification means and why they should care. RESNA has a new consumer-oriented brochure about the ATP certification that may help. A sample of the brochure is sent to each ATP upon achieving certification, and more copies can be ordered directly from the RESNA office for a nominal price. The brochure is also available as a free download from the RESNA

(CONTINUED ON PAGE 60)

ETHICS AND STANDARDS...
(CONTINUED FROM PAGE 59)

website. Visit the "Get Certified" section and click on "Marketing Your Credential."

MEET MELISSA CAMPBELL, RESNA'S NEW CERTIFICATION AND EDUCATION MANAGER

We're delighted to announce that Melissa Campbell has joined the RESNA team as the new certification and education manager, replacing Eric Nepomuceno who left the organization in November.

She has nearly 15 years of experience in the certification industry. Prior to RESNA, She was the manager of Certification Program Development at the National Institute for Certification in Engineering Technologies, where she developed high-stakes certification exams and experience criteria for engineering technicians. Melissa has recruited and trained volunteer subject matter experts, and facilitated workshops to conduct job-task analyses, write and review examination questions, and determine examinations' passing cut-off scores. She is excited to be working with the important body of knowledge represented by RESNA's ATP and SMS exams, and she looks forward to working with RESNA's volunteers and stakeholders to uphold the credentials' validity, fairness, reliability, and legal defensibility, as well as provide a variety of education opportunities to serve the assistive technology industry. She can be reached via e-mail at mcampbell@resna.org, or phone at (703) 524-6686 x306.

RESNA 2015 IS JUNE 10-14 IN DENVER, COLO. THE RESNA ANNUAL CONFERENCE IS A UNIQUE, MULTI-DISCIPLINARY CONFERENCE OF ASSISTIVE TECHNOLOGY PROFESSIONALS FROM ALL OVER THE WORLD.

RESNA ANNUAL CONFERENCE

RESNA 2015 is June 10 to 14 in Denver, Colo. The RESNA annual conference is a unique, multi-disciplinary conference of assistive technology professionals from all over the world. No other assistive technology conference connects professionals across all assistive technology specialties. There's several full-day and half-day instructional courses, more than 40 workshop sessions, several research-oriented platform and poster sessions, exciting and innovative plenary speakers, and an assistive technology exhibit hall. Early-bird registration ends April 29!

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Telephone: 217-241-1548 x.552
Fax: 217-241-0931
Registration Date: 1/29/2015

James A. Fiss, ATP, CRTS®
Alliance Rehab
10770 Midwest Industrial Blvd.
St. Louis, MO 63132
Telephone: 314-942-7590 x.19
Fax: 314-428-5500
Re-Registration Date: 3/13/2015

Scott Grant, ATP, RRTS®
National Seating & Mobility, Inc.
200 Roxalana Business Park
Dunbar, WV 25064
Telephone: 304-766-9317
Fax: 866-209-7063
Registration Date: 2/13/2015

David Wix, ATP, CRTS®
Professional Respiratory and Rehab
98B NorthStar Drive
Jackson, TN 38305
Telephone: 731-300-4784
Fax: 731-300-4783
Re-Registration Date: 1/30/2015

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 JAN. 28 THROUGH MARCH 17, 2015.

Albert Baxter, ATP, CRTS®
Independence On Wheels
Johnson City, TN

Cyle Cook, ATP, CRTS®
Mobility Warehouse
Stockbridge, GA

Brian Peacock, ATP, CRTS®
CareSource Mobility
Waco, TX

Josh Burton, ATP, CRTS®
Numotion
Norcross, GA

Michael A. Edney, ATP, CRTS®
National Seating & Mobility, Inc.
Asheville, NC

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 JAN. 28 THROUGH MARCH 17, 2015.

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

Paul C. Bale, ATP, Chattanooga, TN
Larry Ezzard, Norcross, GA
Christopher Garcia, ATP, Albuquerque, NM
Rob Hails, ATP, Earth City, MO
Rusty Horne, ATP, Middleburg, FL
Rashid Khan, Bellmore, NY
Michael R. Ruyman, ATP, St. Paul, MN
Adam Samuel, ATP, Dover, DE
Lawrence Schaffer, ATP, Chatsworth, CA
Tim Stanfield, ATP, Valdosta, GA
Linda Wilcox, ATP, Houston, TX

As Corporate Friends of NRRTS, these companies recognize the value of working with NRRTS Registrants and support NRRTS' Mission Statement, Code of Ethics and Standards of Practice.

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Hudson Seating & Mobility — Providing Technology for Independence
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Motion Concepts
nuMotion — Mobility starts here.
ottobock
Prairie Seating Corporation — Custom Contoured Cushions
Prime Engineering
PRM — The Power of Precision
Quantum
Ride Designs
rifton — Products for life from people who care.
Stealth Products
Comfort Company
Therafin Corporation
Thomashilfen North America
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Varilite

AFONS

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