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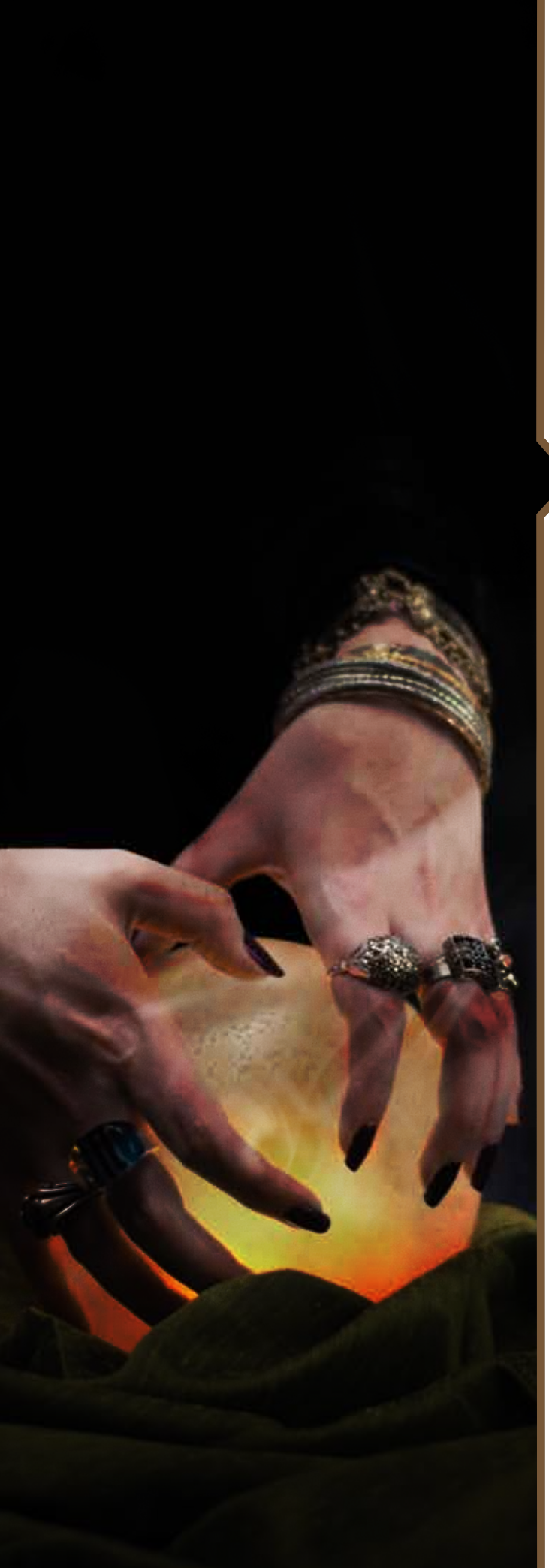

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Cara C Bachenheimer is senior vice president of government relations for Invacare Corporation. **See page 16.**

Don Clayback is executive director of the National Coalition for Assistive and Rehab Technology (NCART) and chair of the Separate Benefit Category Steering Committee. Clayback has more than 24 years of experience in the Complex Rehab Technology and Home Medical Equipment industry as a provider, consultant and advocate. He is actively involved in industry issues and a frequent speaker at state and national conferences. **See page 22.**

Carmen DiGiovine, PhD, ATP/SMS, RET, is a rehabilitation engineer and assistant professor in the Occupational Therapy Division, School of Health and Rehabilitation Sciences at The Ohio State University Wexner Medical Center. He also is program director for the university's Assistive Technology Center at Dodd Rehabilitation Hospital. **See page 38.**

Ann Eubank, LMSW, OTR/L, ATP, CAPS, is vice president of Community Initiatives for UsersFirst, a program of United Spinal Association. **See page 26.**

Michele Gunn, ATP, CRTS®, is NRRTS president. She works for Browning's Health Care in Orlando, Fla., and has been a NRRTS Registrant since 1996. **See page 8.**

Jody Hunt is a consumer advocate who attended CELA 2012. **See page 10.**

Keith Joliecour, ATP, CRTS®, is a new NRRTS Board Member. He works for United Seating & Mobility in Springfield, Mo, and has been a NRRTS Registrant since 2009. **See page 18.**

Wendy Koesters, PT, ATP, is a physical therapist at The Ohio State University Medical Center. She shares her time in the Assistive Technology Center as well as treating neurologically impaired individuals in an out-patient setting. The center allows her to evaluate, trial and treat adults with seating, positioning, skill training, and technology related needs. **See page 28.**

Michelle L. Lange, OTR, ABDA, ATP/SMS, is an occupational therapist with 25 years of experience. She also is the former clinical director of The Assistive Technology Clinics of The Children's Hospital of Denver. She is a well-respected lecturer, both nationally and internationally and has written seven book chapters and more than 100 articles and is the editor of *Fundamentals in Assistive Technology, Fourth Edition.* Lange is on the teaching faculty of RESNA and the University of Pittsburgh. She is on the RERC on Wheeled Mobility Advisory Board. Lange is a credentialed ATP, credentialed SMS and is a senior disability analyst of the American Board of Disability Analysts. **See page 50.**

Jill Monger, PT, MS, ATP, serves on the Executive Board of the Clinician Task Force and is the Wheelchair Seating and Mobility Clinic coordinator the Medical University of South Carolina in Charleston, S.C. **See page 34.**

Todd A. Moody, Esq., is a health care attorney with Brown & Fortunato, P.C., a law firm based in Amarillo, Texas. Brown & Fortunato's Health Care Group represents HME companies, pharmacies and other health care providers throughout the United States. **See page 42.**

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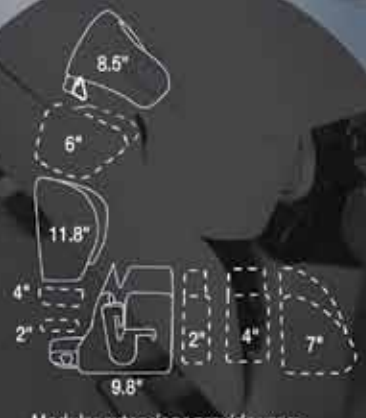

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How About a LITTLE Transparency?

Written By **Michele Gunn, ATP, CRTS®**

I HAVE HAD THE PLEASURE OF SERVING AS your president for the past year now and thought I might offer you a gift on our anniversary. Most of our daily lives are lacking any transparency so I wanted to share a little glimpse into your NRRTS government. Hopefully you will find it refreshing. As the board talks to Registrants, we often hear "What are you guys doing for me?" And more importantly, "What is going on with the money I send every year, and why should I renew my registration?" Once upon a time, just existing was good enough to get people to sign on. This is apparently not the case any more. So, here is a glimpse into the "oval office."

I have been on the board for a long time, so I can recall our beginnings and history. You have heard many times about our forefathers and why they felt NRRTS was necessary, but I am not sure you have heard much about the inner workings of previous boards. Early days were spent drafting by-laws and figuring out what directions we wanted to take. The supplier community had always been a part of other organizations without their own voice. Now that we had our own organization with a voice, what did we want to say and how would we get people to listen?

Most of our early communication was spent with the board and one staff person on a monthly call. We would also do our best to get face time together when we knew we were traveling to a common trade show or education event. As you can imagine, things were slow going. Back then, CELA used to have another name and was always held in St. Louis, Mo. These first leadership conferences were used to draft board members. We figured if you were interested enough in NRRTS to register, chances were you would be willing to serve on the board. I was recruited after attending two of these events.

While this worked in getting people involved, it did not solve the problem of getting face time together, so we started an annual retreat. The entire board gets together for a couple of days to brain storm and make plans to move projects forward. Until five years ago this was a very slow process as well. We would come out of these retreats with lists of great things we wanted to accomplish without the time or ability to actually do most of the items on the list. I need to remind you here that we on the board are just like you – seating folks who work the same hours doing the same occupation who somehow find the time to volunteer to do this crazy second job because we feel it is our responsibility to our chosen profession. When we realized we needed to hire an executive director and Simon Margolis stepped up to the plate, things changed. There was now someone who could move things forward. This was not easy to do, and he has become an expert cat herder over the years. He has had help. We say good bye to Judy Dexter and welcome her husband, Jim.

So enough history, here is the meat. What are we up to now and where does the money go? I hope by now you have heard of several projects we are working on. We prioritize projects to the best of our ability with the information we gather from the registry through surveys, our listserv, and individual interaction.

I think everyone will agree there is nothing more important than the Separate Benefit Category. We are all in on this one. We changed our annual leadership event to the CELA conference that it is today to get consumers on the Hill with us to tell our representatives we are no longer able to provide their needed interventions. CELA could not happen without our industry partners and sponsors. But at the end of the day, it is not a revenue generating activity. Because we wanted to keep the registration price low, we do not cover the cost of the event. NRRTS has always picked up the balance. There has been plenty of heavy lifting and our industry partners cannot do it alone. Financial contributions are necessary to have studies done and language written. We are also very active on the steering committee and in separate work groups such as the one for suppliers' standards. Now that H.R. 4378 is reality, we need to be present to make sure your voice is heard.

Our Outcomes Project with the University of Pittsburgh is finally providing the documented proof we have always believed to be true. The work going on both sides is an incredible effort. Unfortunately, it will not continue without funding. NRRTS will be contributing to the next step of the process. What happens after that is still undetermined.

One very tangible yet costly project is the webinars we host. We have always been concerned that our Registrants don't have access to quality, affordable education. Because of this, we knew the webinars had to be a benefit and not for

a fee. However, this does not mean they have no cost to the organization. As this project expands and we sell some seats to colleagues who are not Registrants, we may soon be close to a cost neutral situation.

I am not going to sing the praises of **DIRECTIONS**. I will just let you know most everyone who talks to me about it says it is the only publication they read cover to cover. Amy Odom does an amazing job. NRRTS is not a publishing house, this started as our newsletter. Enough said.

Our first attempt at a "raising the bar" initiative did not go as planned, but that is not a bad thing. We heard you. This year's retreat will be spent going over the recent survey, as well as being in D.C. seeking additional H.R. 4378 co-signers. Don't worry; this is not an expensive junket, more like a pizza in the room with beer on ice in the tub. Thanks to all who took the time to complete the survey. Most of us have been doing this for 20 plus years, so we can handle the criticism. Keep the dialogue open. Change is ever constant in our lives and will continue to be. The board has been charged with being reactive in the past and never proactive. You need to know the bar is going up no matter what we say, but we believe we can shape that path together.

Hopefully, you now have a better idea of what goes on behind the curtain. This is what we do with 13 volunteers, two and a half staff members and one intern. I am finished sharing for now. You don't get access to my tax returns. I am not up for re-election and do not think you would be impressed about tax returns or re-election!

CONTACT THE AUTHOR
Michele may be reached at mgunn@brownings.net or 407.650.9585.

Spider-Man, Clean Rooms and the WISDOM of an Old Mechanic

Written By **Randy Christian**

"MY PARENTS, MY FAMILY IN-GENERAL, ARE the kind of people who didn't like handouts or asking for help. Looking back, they probably should have said, 'Hey, I could use a little help here.' I've let myself run with that same thinking sometimes. I know it's a pride thing and you try to do it yourself, but there are times when you need to lean on a family member or good friend. Fortunately, I have both to lean on and count on when the going gets tough," Jody Hunt said.

Hunt was born in New Brunswick, N.J., and raised in Kendall Park, N.J., an idyllic little place that was once farmland, but in the late 1960s started to be eaten up by traditional housing developments that were prevalent so many years ago. It seems reminiscent of Marty McFly's neighborhood of Hill Valley, in the movie *Back to the Future*.

Hunt's friends lived within a stone's throw of the home where he, and his parents and siblings enjoyed a modest, but good life. His elementary school was literally right around the corner. His high school was a short distance away from home, too. Down the street lived a man who gave stacks of Marvel comic books to kids who would knock on his door at Halloween and heartily, exclaim, "Trick or Treat." For Hunt, they were a thousand times better than a popcorn ball or bits of saltwater taffy. In the blink of an eye the edible treats would be gone, but reading and remembering the adventures of Spider Man and his arch nemesis the Green Goblin and other Marvel superheroes would remain with Hunt forever.

HUNT AND HIS GRANDFATHER, 1998, ABOUT THREE YEARS AFTER HE BECAME DISABLED

Fortunately, Hunt had the opportunity to go back in time thanks to his grandparents who had lived "on the other side of the tracks" in a place called Monmouth Junction. It was barely a spec on the map, and as Hunt described, "out in the country." He remembers fondly learning to chop wood, pick berries and taking leisurely walks on dirt roads with his grandfather who he dearly loved. His grandmother played a key role in the lives of Hunt and his brothers and sister, too. There was nothing she would not do for her grandchildren. Monmouth Junction was a sweet place inhabited by good folks who believed your word was your bond and bartering for goods and services was a respectable way to make ends meet when cash was scarce.

For many years Hunt's grandfather owned a Gulf service station in Kendall Park. His dad worked as a mechanic there, too. Consequently, at a very early age Hunt worked alongside both of them pumping gas, changing oil and washing windows. It was the perfect place for Hunt to hone his people skills, as well as overhear tall tails told by some of the older boys who would frequent the service station. Often their stories were not suitable for youngsters of Hunt's age, so his dad made sure he was beyond ear shot of the burley boy storytellers.

Hunt would spend hours and hours observing his father and the other mechanics whose heads were under the hoods of every make and model of car imaginable – twisting wrenches, fighting grease, working and sweating to regain the perfect purr of a well-tuned engine. Hunt remembers his dad being a good mechanic who could tear apart an engine with the best of them, but after he'd put it back together, there always seemed to be a few parts leftover. Regardless of his dad's

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...The Wisdom of an Old Mechanic

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HUNT AND YOUNGEST SON BOATING ON LAKE WALLENPAUPACK

interesting mechanical method for fixing cars, Hunt wanted to be just like him. In fact, Hunt had his own pint-size mechanic's jump suit like his dad's that he wore with great pride every time he worked at the Gulf station.

Hunt loves his dad dearly, but is quick to admit his grandfather's strong will and independent personality had a significant influence on him as a boy and young adult. Through observing his grandfather, he also learned sometimes helping people took priority over the health of his business.

"My grandfather was kind of a staple around town. He didn't have a great business sense, but he knew how to treat people on a more personal level, so lots of times he would barter with people who were having a tough time. That wasn't real good for profits, but to this day I'll run into someone who fondly remembers my grandfather helping them out when they really needed help," Hunt said.

Yes, the generous nature of Hunt's grandfather was not the best for business. It was actually a changing gasoline industry, weak economy and stiffer governmental regulations that finally forced the sale of the little neighborhood Gulf station in Kendall Park, N.J. Even though the closure of the family business was hard on everyone, Hunt's dad wasted little time pursuing a new career. He found a job as a pest exterminator and dutifully stopped the spread of bugs until his retirement. His grandfather picked up his toolbox and hooked up with another local garage and worked as a mechanic and mentor to a truck load of young guys until he retired at age 85.

Hunt carried the work ethic and sense of responsibility he learned from his father and grandfather to all the jobs he had as a kid and an adult, whether it was delivering newspapers, yard work for Mrs. Owens or shift work at a local store called Drug Fair.

"I'd worked pretty much all my life. I wasn't super involved with stuff at school. It was more of just a stopping off

Hunt carried the work ethic and sense of responsibility he learned from his father and grandfather to all the jobs he had as a kid and an adult, whether it was delivering newspapers, yard work for Mrs. Owens or shift work at a local store called Drug Fair.

point for me. I'd go in, do my school work and then leave. Everything outside school was really my life," Hunt said.

Work did become Hunt's life, which left him little time to do things a lot of kids his age shouldn't have been doing, but were, particularly drugs and alcohol. He never saw the glamour in drinking all night, then puking your guts up the next day. He did, however, lock into a serious romantic relationship while still in high school. It continued after graduation and resulted in the birth of his first son. Hunt admits he was too young, as well as being ill prepared, for the responsibilities of fatherhood, but again leaning on the strong will and character of his father and grandfather, Hunt did what he had to do to take care of his new family.

–

Hunt worked as a produce clerk at Davidson Supermarket in Princeton, N.J., for several years. He liked the work and his coworkers, but left when he was passed over for a promotion due to a tangled web of circumstances involving a troubled supervisor. As faith would have it, Hunt happened upon a better job as a maintenance worker at a "start-up" pharmaceutical company. His supervisor was impressed with his work ethic and intelligence and could tell this sharp kid was capable of doing more with his life than mopping floors and scrubbing toilets. He told Hunt, "You shouldn't be here," so somehow, someway, Hunt was moved into the production side of the business. Hunt's people skills and willingness to work hard, whether night or day, paid off quickly. Soon he became a night crew supervisor, but with his newfound success came the tell-tale signs of a disease call Charcot-Marie-Tooth (CMT). It is a group of inherited disorders of the peripheral nervous system. It usually doesn't rear its ugly head until late in childhood or early adulthood. People in their early 30s or 40s can be victims of CMT, too. Symptoms are a progressive

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...The Wisdom of an Old Mechanic

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loss of muscle tissue and touch sensation across various parts of the body.

As the disease began to affect his work, Hunt would flashback to unexplainable balance issues he experienced throughout his life that might have been caused by CMT, especially his fear of stairs. In high school, it was the stairs he'd have to navigate from class to class. As a member of his brother's wedding party, he sweated bullets as he cautiously walked down a flight of stairs.

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The simple task of "gowning-up" for his work in the sterile environments of the pharmaceutical company caused him to be fearful, too.

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"Gowning-up" is the equivalent of putting on a jumpsuit. It required a person to lift their legs high enough to insert into the jumpsuit. "I worked and worked at lifting my legs and keeping my balance. It's normally a process you should be able to do rather quickly. I had to really work at it, and I did it," Hunt said.

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Even with all his diligence and tenacity, the yet to be diagnosed CMT along with another illness, sarcoidosis, began to take a major toll on Hunt's body. The sarcoidosis which caused him to run a high fever that compromised his immune system, was fought with Prednisone. He also loaded up on Tylenol in an attempt to control a skyrocketing fever. He had to continue working. He could not afford to lose his job, but finally while at work on April 1, 1995, his body could take no more. Hunt collapsed at work in the "Clean Room" and was rushed to the emergency room of a nearby hospital.

HUNT HOLDING HIS BEST FRIEND'S DAUGHTER'S LITTLE DUCKY IN MERCER COUNTY PARK 2012

Even though this was a tragic time in Hunt's life, it was the beginning of a search by physicians who found the CMT. He endured a battery of painful tests conducted by a number of doctors, including neurologists that probed his nervous system. At the same time he packed on the weight – more than 60 pounds – and soon weighed a whopping 240. It seemed as if someone had flipped a switch that caused his life to suddenly careen out of control. He was on the rollercoaster from hell. He struggled mightily to survive on his own terms, but it wasn't until he let go and welcomed the help and mentoring of several rehab industry professionals, including Mark Smith, that a sliver of hope began to shine on Hunt's life.

–

Today, Hunt's world is very different, but it has given him a fresh start, which includes using a wheelchair. Unfortunately, he and his wife are separated, but his mom and dad have welcomed him back home with open arms. He's focused on his health like a laser beam and is eating right and exercising regularly. He's lost more than 50 pounds and now weighs 195 pounds, and is even building some muscle. As Hunt says, "I'm in a good place right now."

His number one goal is to be a role model for his two sons. He wants to prove to them their dad is going to continue to make positive changes in his life. He's also ready to show the world people with a disability are capable of doing incredible things. He knows that can happen, thanks to the example set by the wonderful people he met at CELA.

"I met people who have taught me that everything you do, even the smallest thing, is a good thing. The obstacles they have overcome are a thousand times bigger than what I've had to overcome. I've learned so much from them," Hunt said.

Hunt is using what he has learned to become a strong, well-informed advocate for the members of his new CELA family. Like his grandfather, he will surely put their needs ahead of his even if it might cost him a buck or two. Hunt has the charm and character to help folks like himself get back on the road-of-life with a full tank of gas, plenty of air in their tires and a sparkling clean windshield that will allow them to see clearly both the obstacles and opportunities that lie ahead.

–

It's amazing what you can learn in a little Gulf service station in Kendall Park, N.J., from a bunch of grease monkeys and a wise old mechanic who knew that when you put people ahead of profits, you'll always be rich.

CONTACT
Jody may be reached at bgrant710@juno.com.

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CLOSING Arguments

Interview By **Danette Baker**

A CONVERSATION WITH CARA BACHENHEIMER OF INVACARE CORPORATION

CARA BACHENHEIMER'S work has taken her from the courtroom to Capitol Hill. In 1999, HME News named her one of the Top 10 Most Influential People in the HME Industry. For the past decade, Bachenheimer, senior vice president of government relations for the Invacare Corporation, has worked from her home base in Washington, D.C., lobbying Congress on behalf of the durable medical equipment industry.

DIRECTIONS recently had the opportunity to visit with Bachenheimer and learn more about her role with Invacare and the cases she currently has on the docket.

HOW DID YOU BECOME INTERESTED IN THE INDUSTRY?

Really, this is what I wanted to do coming out of college – focus on health care law and policy development. I had the opportunity in college to do an internship in London with a member of parliament who focused on policy development and that nailed it. So really, since the mid 80s, I've worked in the industry in one manner or another.

The first law firm I worked for out of law school actually represented the then National Association for Medical Equipment Services (NAMES), which later merged in 2000 to become the American Association for Homecare. I truly gravitated to home health and HME when I left the firm to cover Capitol Hill for a home health trade publication. I left the law practice because, at the time, I just didn't feel good about what I was doing. I wanted my work to have more of a positive impact on health care and people. As a lawyer, you don't always have the luxury of which side you are on, so I wanted to be in more of an active advocacy role. Since then, I've worked mostly for trade associations, and then came to Invacare 10 years ago (Bachenheimer is responsible for the company's federal lobbying activities). So really, since 1990 I've been lobbying in some manner for the industry. Now, I have the luxury day in and day out of doing something for an incredibly worthwhile cause.

> I wanted my work to have more of a positive impact on health care and people.

WHAT ATTRACTED YOU TO THE POSITION WITH INVACARE?

The people. I had gotten to know Mal Mixon really well. He is one of the pioneers in terms of understanding the importance of real political involvement, and he's a role model I think everyone needs to follow. His philosophy is political involvement is not an option, but an understood – it's our bread and butter.

Given Mal was at Invacare, (A. Malachi Mixon III is chairman of the board and CEO of Invacare Corporation), the decision was easy. I had gotten to know him and the late Dave Williams (former director of government relations for Invacare) when I was with the Health Industry Distributors Association and worked with them day in and day out on legislative and regulatory issues.

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

Unfortunately, there haven't been that many huge ones because of the complexity of many issues, but I have gotten great satisfaction out of small victories. One of the biggies, in the 1990s, was the Advance Beneficiary Notice. It ended up as a provision in the Balanced Budget Act of 1997, but to think it took seven years to allow consumers to pay the difference out-of-pocket for a product that was better suited for them just seems preposterous. We also had a legislative victory in 2008 when Congress delayed the Medicare DME bidding program.

Now, we are trying to replace the current Medicare DME bidding program with the alternative "market pricing program." That is really the most critical in terms of timing even though there are other issues of equal importance, such as the Separate Benefit Category for Complex Rehab Technology (CRT).

These changes involve a lot of people, so you really can't attribute the successes to one organization or one individual. That's one reason why the political arena is so interesting to me. Our success rate will always increase when you have more people involved.

WHO HAS BEEN INSTRUMENTAL IN THOSE ACCOMPLISHMENTS?

Immediately, the names Mal Mixon and Dave Williams come to mind. Dave was an incredible advocate for the industry at the local, state and federal levels. But a lot of what we do reinforces what the providers are doing at the local level. They have such an influence in educating and advocating at the grassroots level. Thank God there are more getting involved than there used to be.

HOW DOES AN ELECTION YEAR IMPACT YOUR WORK?

A lot of politicians are willing to be more responsive during an election year. They are trying to make sure they get re-elected! That can work in our favor. In the House, representatives are up for re-election every two years, so there is a tendency for our issues to have more of a focus in the House.

WHAT CHALLENGES LIE AHEAD FOR YOU IN THE NEXT FEW MONTHS? WHAT ABOUT AFTER THE ELECTION?

We definitely want to get the market pricing program passed into law and get rid of the current bidding program. That and the legislative initiative to create a Separate Benefit Category for CRT are the top two legislative priorities for us and the industry right now. Realistically, we have this year to get Congress to pass the market pricing program so that's a huge priority. The Separate Benefit Category has significantly more hurdles simply because it is an issue many on the Hill are not aware of. We cleared a big hurdle earlier this year by getting the bill introduced in the house (H.R. 4378). I see this year as the time to lay the groundwork. I've spent a lot of time with the Ohio delegation and have many of them up to speed and the rest are still learning. It takes a lot of time to get people to understand the details of this proposal, and particularly the impact it will have, including as a model for other payers.

During an election year, it is sometimes more difficult to get Congress' attention on complex issues, those up for re-election may just be focused on getting re-elected. The reality, which provides a glimmer of hope, is these issues are not traditionally slotted as republican or democratic. Moving forward with both, we often have to articulate the issues differently. Depending on whether we are speaking to a democratic or a republican audience, we'll emphasize beneficiary access or cost containment. The issues resonate well regardless.

YOU OBVIOUSLY SPEND A GREAT DEAL OF YOUR TIME ON CAPITOL HILL. WHAT DOES A TYPICAL WORK DAY/ WEEK LOOK LIKE FOR YOU?

There really is not a typical day. That is why I love my job. I'm on call 24/7. During a typical week, however, I will go to the Hill two to three days. In between, I do a lot of traveling to speak and I do a lot of phone work. Basically, I'm communicating continuously. I see my job as one in which I educate CMS (Centers for Medicare and Medicaid Services) and Congress about the impacts their actions can have on those we serve. I like to think of myself as the conduit to and from Capitol Hill to those who are working with clients every day in the field.

WHAT HAS KEPT YOU WORKING SO DILIGENTLY FOR THE SUCCESS OF THIS INDUSTRY?

That's something I get asked often. It does seem like we are always up against an obstacle, specifically funding cuts. The federal and state governments get more and more creative on cutbacks. But you take heart in the small victories, because you very rarely get a big one. I know this really sounds corny, but one of the biggest reasons I'm here is because the products we make really do make a big difference in the lives of those whom our customers serve.

I do a lot of speaking and working with consumer organizations, but there is always more that needs to be done. There never seems to be enough resources for the challenge, and we always need more people to get involved. But there is so much satisfaction in knowing we are making progress and we can be successful.

Again, it might sound corny, but I feel like I'm doing the right thing. It's a privilege to be in a position where doing the advocacy work will ultimately benefit those who need it.

JUST LISTENING TO YOUR SCHEDULE IS EXHAUSTING. WHEN YOU DO HAVE DOWN TIME, WHAT'S LIFE LIKE OUTSIDE OF THE 9 TO 5?

That's family time. I do normal stuff like read, workout and spend time with my family and friends. I like to cook so we enjoy having people over to eat. My husband and I have been married 24 years, and we have two children – a son in college and a daughter who is in high school. We enjoy vacations together and overall have a great family life.

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Dr. Smith's Tough Love Turns a "GREEN KID" into a Caring Treasure

Written By **Randy Christian**

"I really like what I do, and I still have a passion and desire to help people who need help. It's very gratifying to me. If it weren't, I would have looked for something else to do a long time ago."

- KEITH JOLICOEUR

WHEN MOST OF US THINK OF MICHIGAN, THE big cities of Detroit, Grand Rapids and Flint are likely to pop in our brain. Chances are, North Branch, Mich., does not, but thanks to Keith Jolicoeur we now know exactly where to find this small, rural, eastern Michigan town. The best and easiest path to Jolicoeur's hometown is to head due east out of Flint on I-69, 30 minutes or so. Next, head north on State Highway 24 for a short while, and lastly, turn back to the east on Highway 90 traversing wonderful, rich Michigan farmland. Unless you're desperately directionally challenged, in approximately 20 minutes you'll cruise into the little town of North Branch, population 1,027. There you'll find a few retail stores and a gas station or two. Now, that you've made it to North Branch, it's still another seven or eight miles to the 10 acres of Michigan the Jolicoeur family calls, home.

"I wasn't a farmer per sé, but I did work on some local farms, drove a tractor on occasion and baled a lot of hay. When I was 15, I went to work for a steak house and worked there through high school," Jolicoeur said.

Even though Jolicoeur and his family live in the country, his dad and other local folks would carpool each workday and make the commute to the big city of Pontiac. There they'd work their appointed shift at one of the General Motors assembly plants. As soon as the whistle blew marking the end of the workday, they would head back to the quiet, slower pace of rural Michigan. Jolicoeur said his Dad "made a decent paycheck" and provided well for his family, but it was up to the kids to earn their "spending money." In Jolicoeur's case, his money was used primarily to keep gas in his TransAm and fund the all-important weekend dates with some lucky girl.

As graduation grew near, Jolicoeur was still working at the steak house but knew it wasn't what he wanted to do with the rest of his life. Like many kids his age, Jolicoeur wasn't sure what he wanted to do. Enrolling at an area community college was penciled-in to his agenda, but it had yet to make it to his hot-list. Going to work at an auto plant like his Dad was also possibility. At this point in his life Jolicoeur's mind was filled with more questions than answers. Fortunately for Jolicoeur, he did answer the call from a friend who was working as an orthotist for a larger regional durable medical equipment company. Jolicoeur's friend informed him of a job opening and he applied. Would this be his first step down a career path? Only time would tell.

In 1990 Jolicoeur reported for his first day of work at Wright and Fillippis, a prosthetics and orthotics company headquartered in Michigan. When he walked through the front door for the first time Jolicoeur knew very little about the company or the products it made and sold. What he did know was his buddy was making "good money" and he got to wear a lab coat. That was enough information for Jolicoeur to feel certain his new job surely had more "upside" potential than working at a steak house. Jolicoeur was hoping his feelings would pay off because now he was also a young, married man.

Jolicoeur started his career at Wright and Fillippis as a delivery tech delivering oxygen and other medical equipment and supplies primarily to customers' homes. It was a real eye-opener for Jolicoeur. He saw first-hand the health challenges that seemed to plague many elderly folks. He began to question whether his golden years were really going to be all that golden. From time-to-time, he'd help assemble and then deliver a wheelchair. Fortunately for Jolicoeur business was booming so consequently he worked long hours, thereby accruing a lot of overtime. He, along with his new bride, was thankful for the bountiful work especially when it paid time-and-a-half.

As Jolicoeur learned more about his new company, the more he became fascinated with the orthotic side of the business. The more he learned, the more the notion of becoming an orthotist began tapping him on the shoulder.

As you might expect, Jolicoeur's small town work ethic did not go unnoticed and was justly rewarded. He soon acquired

additional responsibilities, which included helping with warehouse inventory. Assembling even more wheelchairs was also added to his daily list of chores. Next, he was elevated to the job of orthotic technician where he helped build support braces. For the next year and a half, Jolicoeur remained an orthotic tech. He was sure this was his life's calling, but unbeknownst to Jolicoeur, his boss had other plans for him.

"It was a very interesting time for me because I was beginning to plan on becoming an orthotist when all the sudden my manager wanted to talk to me. They had let go one of the seating specialists and needed a replacement. They thought I'd be a good fit," Jolicoeur said.

Jolicoeur's heart was, of course, set on becoming an orthotist, but his deep blue collar roots made him the kind of company man who was always willing to take on most any task put before him. It was a character quality that was certainly admired and appreciated by the company's leadership and is proof-positive that hard work and dedication remains an important rung on one's career ladder to success.

Even though the thought of moving into the world of wheelchairs was a bit scary, it became the defining moment in Jolicoeur's professional life. It was a moment that would move him from a career path to a career super highway. He never looked back.

For several months Jolicoeur played a dual role in his company, but the more he messed with the wheelchairs, the more it intrigued him. His meticulous tinkering with the wheelchairs was his self-designed training classes. There were a few mentors who were reasonably close and could give him some pointers, but for the most part, trial and error was his primary method of learning his new trade. Ironically, one of the best sources for learning the right and wrong way of accessing the needs of patients were the therapists and other rehab professionals he worked with at hospitals and clinics. One

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...Caring Treasure

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physical therapist who stands out from the rest is Ernestine Smith. She was one tough cookie who knew immediately that Jolicoeur was a novice and lacked much needed experience to accurately respond to the needs of her patients. She could have easily ended Jolicoeur's new career, but instead she saw a kid who wanted to learn how to do it right and was willing to accept a lot of tough love in order to do so.

"She has the type of personality that would make most people very uncomfortable. She was a very stern person and very matter-of-fact. It was intimidating to work with her, but at the same time I recognized she had a great amount of knowledge. I chose to "suck-it-up" and if she wanted to be a little rude to me, let it be," Jolicoeur said.

Obediently, Jolicoeur listened intently to Smith and then carried out her orders. His time spent with the therapist was priceless. The green kid soaked-up as much of her knowledge and wisdom as possible and soon had his own tool bag full of analytical skills to help him better serve patients and their families. He also gleaned a professional self-confidence that would help move his career forward.

The lessons learned from Smith crept beyond the nuts and bolts of the wheelchairs. She would regularly critique Jolicoeur on the finer points of how to present himself in professional settings. She steered him toward ways to gain the confidence and respect of both patients and coworkers. He learned how to constructively ask questions, too.

Smith was a proud African-American woman who Jolicoeur felt might have faced untold challenges while pursuing her physical therapy career. This may have contributed to her stern demeanor, but regardless, she earned his sincere admiration and instilled in him a desire to be a disciplined and courageous professional. Jolicoeur uses the lessons taught him by Smith even today.

There are many people throughout the years who helped Jolicoeur hone his skills, but it is his strong work ethic and selfless, humble character he inherited as a kid from the small town of North Branch, Michigan, that remains his personal and professional foundation. It's what constantly prompts Jolicoeur to always listen respectfully to his patients, parents, physicians, clinicians and even siblings as he seeks the best solutions. Yet, it is also those small town values that gave him his unassuming confidence to translate those conversations into a solution in which he believes.

In many ways he's still the kid who was born with the heart and mind of a jack-of-all-trades. It is that mixture of his skills that give Jolicoeur the ability to think beyond the obvious, to try something new, as well as a willingness to collaborate with other "jacks" who possess dynamic skills that can help give more freedom and comfort to those with disabilities.

"I kind of 'cut my teeth' in this industry with pediatrics, which is usually a bit more difficult. I was really taken back by the first kids I came across who had severe scoliosis or orthopedic deformities. When I walked into one of those situations I thought to myself, 'What in the world am I going to do?' " Jolicoeur said.

Jolicoeur immediately recognized the severity of the patient's spinal deformities, yet he was smart enough to know he lacked the experience to tackle this new challenge alone. Immediately he sought help from professionals, both inside and outside his company. After much digging, Jolicoeur uncovered someone who owned his own molding company. Together, they devised a custom seating solution that fit the patient's unique needs perfectly. This early learning curve Jolicoeur had to navigate was more of a blessing than a curse and thanks in part, to his egoless personality that always puts the patient's well-being first.

1. HANGING OUT AT HOME WITH FAVORITE GIRLS: WIFE LISA, AND DAUGHTERS, HOPE & ZOE **2.** ENJOYING THE NATURAL BEAUTY OF COLORADO WHILE ON VACATION, 2012 **3.** GIRLS HAVING FUN AND BEING SILLY AT A NEAT RESTAURANT WE DISCOVERED. **4.** FAMILY DAY: HANGING OUT AT LAKE FELLOWS, A COUPLE MILES FROM HOME **5.** HANGING OUT UNDER A PAVILION AS WE FINISH UP A DAY OF OUTDOOR ADVENTURES

Like many others in his profession, Jolicoeur looks to the future of the industry with a healthy dose of anxiety and trepidation primarily fueled by continued cuts in funding. He and others understand the funding battle is and will always be waged in the halls of our nation's capital. NRRTS Registrants and other industry professionals who climb the Hill each year at CELA are essential, but it is the self-advocates who are the real game changers.

"We need as many voices as we can get talking to politicians, but when you put a person in a wheelchair in front of a legislator it changes everything. It's sometimes hard to get someone to advocate for themselves, but it's just so powerful and does make a difference," Jolicoeur said.

Even with all the changes and ever growing frustrations, Jolicoeur continues to be dedicated to those who aren't always equipped to help themselves. Without knowing it, Jolicoeur has established a wonderful legacy for his two young daughters, Hope and Zoe. A legacy of caring for others that was planted then grew and grew, as Jolicoeur rode tractors and baled hay in Michigan's idyllic farm country. He has lived a life rooted in compassion and concern for people with disability and their families. His kindness will not be forgotten.

Jolicoeur is a charming, humble man whose teenage years were filled with more questions than answers. Today, most who know him would agree the answers he worked so hard to find have made the folks back in North Branch very proud, especially those at the steak house.

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Separate Benefit for COMPLEX REHAB Technology Update

Written by **Don Clayback**

PURSUING SEPARATE RECOGNITION FOR CRT AT THE STATE LEVEL

WITH THE INTRODUCTION OF THE "ENSURING Access to Quality Complex Rehabilitation Technology Act" (H.R. 4378) in Congress, we are making progress in getting recognition for Complex Rehab Technology (CRT) within the Medicare program. However, to ensure national adequate access to CRT for people with disabilities this "separate recognition" in coverage and payment is also critical at the state Medicaid level. CRT stakeholders in some states are beginning to take up this challenge.

Every state is different, so an initiative to create separate recognition for CRT and the related regulatory and/or legislative language must be tailored to a particular state's regulations and statutes. While the work to date on the federal level can be helpful, a state initiative must be "state specific." In order to be most effective, time must be taken at the start to develop a thoughtful plan outlining the strategies and action steps. This involves identifying current and potential CRT access issues that need to be addressed within the state.

As part of the planning process, the involvement of all CRT stakeholders (consumers, clinicians, suppliers, and manufacturers) is important. Their inclusion early on will engage them in the process and lay the foundation for support for the needed discussions with legislators and policy makers.

In developing a plan and materials to secure state CRT recognition, the following objectives and information should be considered:

1) Establish CRT safeguards for medicaid beneficiaries and the state:

- Only suppliers that are accredited as CRT suppliers can provide CRT products.
- An accredited CRT supplier must meet the quality standards established for durable medical equipment suppliers under the Medicare program.
- An accredited CRT supplier must have at least one qualified W-2 employed CRT professional for each location to analyze the needs and capacities of qualified individuals, assist in selecting appropriate covered CRT items for such needs and capacities, and provide training in the use of the selected covered CRT items. The term "qualified CRT professional" means an individual who is certified by the Rehabilitation Engineering and Assistive Technology Society of North America as an assistive technology professional (ATP).

d. An accredited CRT supplier must have the capability to provide service and repair for all CRT products it sells.

2) Formally define Complex Rehab Technology in statute:

- CRT is individually-configured products that: (i) are designed for qualified individuals to meet their specific and unique medical, physical and functional needs and capacities for basic activities of daily living and instrumental activities of daily living; (ii) are primarily used to serve a medical purpose; and (iii) generally are not useful to a person in the absence of illness or injury. CRT requires services including, but not limited to, evaluating the individual's needs and capacities and configuring, fitting, programming, adjusting or adapting that particular technology.
- The term "individually-configured" means when a device has a combination of features, adjustments or modifications specific to an individual that a qualified accredited supplier provides by measuring, fitting, programming, adjusting, or adapting the device, as appropriate, so the device is consistent with an assessment or evaluation of the individual by an appropriate clinician and consistent with the individual's medical condition, physical and functional needs and capacities, body size, period of need, and intended use.
- The term "qualified individual" means an individual with certain physical and functional needs and capacities and certain medical conditions that shall include, but are not limited to, the following congenital disorders, progressive or degenerative neuromuscular diseases, and injuries or trauma which result in significant physical or functional needs and capacities: spinal cord injury, traumatic brain injury, cerebral palsy, muscular dystrophy, spina bifida, osteogenesis imperfecta, arthrogryposis, amyotrophic lateral sclerosis, multiple sclerosis, demyelinating disease, myelopathy, myopathy, progressive muscular atrophy, anterior horn cell disease, post-polio syndrome, cerebellar degeneration, dystonia, Huntington's disease, spinocerebellar disease, and certain types of amputation, and paralysis or paresis that result in significant physical or functional needs and capacities.

SAVE THE DATE

NATIONAL CRT LEADERSHIP & ADVOCACY CONFERENCE

Including CELA 2013 and the 2013 Medicaid Summit

Hyatt Regency Crystal City - Arlington, Virginia
April 30 – May 2, 2013
Presented by NCART and NRRTS

The mission of protecting and improving access to Complex Rehab Technology (CRT) continues to be a priority for CRT suppliers and manufacturers. To provide a forum for CRT education, networking, and advocacy the National Coalition for Assistive and Rehab Technology (NCART) and the National Registry of Rehabilitation Technology Suppliers (NRRTS) will be holding a "National CRT Leadership and Advocacy Conference" in **ARLINGTON, VIRGINIA ON APRIL 30 THROUGH MAY 2, 2013.**

The theme of the three day conference is
"PROMOTING THE FUTURE OF CRT."

In today's world, information is critical and time is limited. With this in mind, the conference will combine three events into one program:

CRT Leadership Day- A first time event, this segment will consists of business presentations and breakout sessions for the management teams of suppliers and manufacturers. All information will be CRT specific. The day will be capped by an industry reception for networking and fundraising.

The National Medicaid Summit- Medicaid funding is critical to CRT access. In its third year, this segment will cover the latest Medicaid trends, issues, and advocacy strategies relating to CRT coverage and payment.

CELA- The historic cornerstone of advocating in Washington, this segment will focus on federal advocacy. The orientation, state delegation meetings, and visits to Members of Congress will allow consumers, clinicians, suppliers, and manufacturers to come together and deliver the CRT message.

The goal of the conference is to allow CRT stakeholders to come together in one place for high value education, networking, and advocacy. If you are a CRT supplier or manufacturer you'll want to have your company represented all three days! If you are a consumer advocate or a clinician you'll want to join us for days two and three. Program details and registration information will be announced in the coming months. **For additional information contact Don Clayback, NCART Executive Director, at 716-839-9728 or dclayback@ncart.us or contact Simon Margolis, NRRTS Executive Director, at 763-494-6774 or smargolis@nrrts.org.**

3) Identify and segregate CRT HCPCS Codes:

- There are two groups of HCPCS codes that include CRT products. There are "pure" codes which contain exclusively CRT products and there are "mixed" codes containing both CRT and standard products. A listing of these codes can be found in the Educational Area at http://www.ncart.us.

4) Identify Coverage Policies that may need change or implementation:

- Are there any issues with application of the Medicare In-The-Home Restriction?
- Are there any coverage limitations based on age?
- Are there any CRT products not covered?
- Other coverage issues?

5) Identify Payment Policies that may need change or implementation:

- Are the service costs of providing CRT recognized in establishing payment? The services provided by the CRT supplier include: home accessibility and transportation survey; technology assessment; equipment demonstration/trial/simulation; product feature matching to identified medical, physical, and functional needs; system configuration; purchasing and assembly; fitting and adjusting; programming; and product related training and follow-up.
- Is payment provided for temporary rental equipment when a Medicaid beneficiary's CRT item is being repaired?
- Is there an annual review of CRT codes and fee amounts for appropriate adjustments as needed?

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Complex Rehab Technology Update...

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- Is CRT exempted from any competitive bidding actions?
- Other payment issues?

6) Consider implications of Managed Care Organizations:

- Given the increasing role Managed Care Organizations play in covering Medicaid beneficiaries, provisions must be made to incorporate these changes and policies into the MCO's coverage and payment of CRT.

7) Identify Other Required Changes:

- Based on the input from concerned stakeholders and others, identify other changes that would improve or protect access that should be included in the initiative.

Are you ready to get rolling? For state associations and others that are considering the pursuit of separate state CRT recognition, NCART is available to assist with input and guidance. There have been a variety of tools and documents created to help in the process. Related information such as position papers and starting legislative language can be found in the Educational Area at *http://www.ncart.us*.

Getting back to the Medicare arena, we must continue to gather momentum and push to get H.R. 4378 passed. Members of Congress will not sign on to the bill unless they hear from you and others in your district. So please invest the time to contact them. You can e-mail your representatives and access a variety of advocacy material at *http://www.access2crt.org*.

Thanks for your active advocacy at both the federal and state levels and for getting others engaged in our efforts.

CONTACT
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> *Visit www.ncart.us for more information.*

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When NRRTS is Successful, Consumers Have MORE OPPORTUNITY for *Success*

Written By **Ann Eubank, LMSW, OTR/L, ATP, CAPS**

RECENTLY, USERSFIRST PARTICIPATED IN the Independence Expo in Orlando, Fla. It is a consumer show attracting approximately 900 very engaged attendees. The UsersFirst booth draws people who are trying to get a wheelchair that works, and who most of the time, are frustrated with the system and the process. It was a pleasure sharing the UsersFirst booth with NRRTS president, Michele Gunn. Gunn's knowledge of the process and ability to communicate with consumers was invaluable.

As we worked in tandem answering consumer questions, offering guidance on the process and asking consumers to sign the H.R. 4378 petition, the conversation evolved into an enlightening experience for us both. Gunn asked that UsersFirst write this article, because she wanted us to educate the industry on UsersFirst and how it works.

Here are excerpts from the discussions Gunn and I had during our day in the booth: how UsersFirst works, what we do, and why UsersFirst and NRRTS should work more closely together.

Most consumers engage with UsersFirst because they have read about it in a magazine or online, or were referred by a supplier or a peer. As we all are too well aware, the process is complicated and fragmented. Every insurance company has different rules, and the rules change at a moment's notice. Consumers, many times, just want to replace what they currently are using and when they do, they discover their mobility device is no longer covered.

WHO WE ARE:

UsersFirst is an empowerment model – not a business model, not a moneymaking model – we are service driven, consumer run and non-profit. That means we create change through community and peer-support. We do not make calls to insurance companies for consumers; we guide them in the steps and the consumer must do the work. We do provide support to help consumers navigate the process. With five people on staff, including two social workers, one nurse and wheelchair users, we are available to answer any question related to disability or locate resources to assist.

Gunn and I discussed the difference in marketing from a consumer non-profit point of view versus a business model. Membership is free. Our messaging is worded to reach the consumer. It is vital our movement be sustainable. Sustainable means our members feel there is value to being a member and therefore want to stay connected. Gunn stated this is similar to NRRTS. If the NRRTS Registrant does not perceive value, he or she will not renew. NRRTS offers peer-support providing connection, information and an opportunity to take action politically. UsersFirst offers connection, support, information and action related to limiting policies.

The UsersFirst mission complements the NRRTS mission, to provide the best service and products to people with disabilities. Our goal is to affect positive change for people with disabilities. As our membership grows, we have more influence from a policy standpoint. We are more alike than different.

WHAT WE DO:

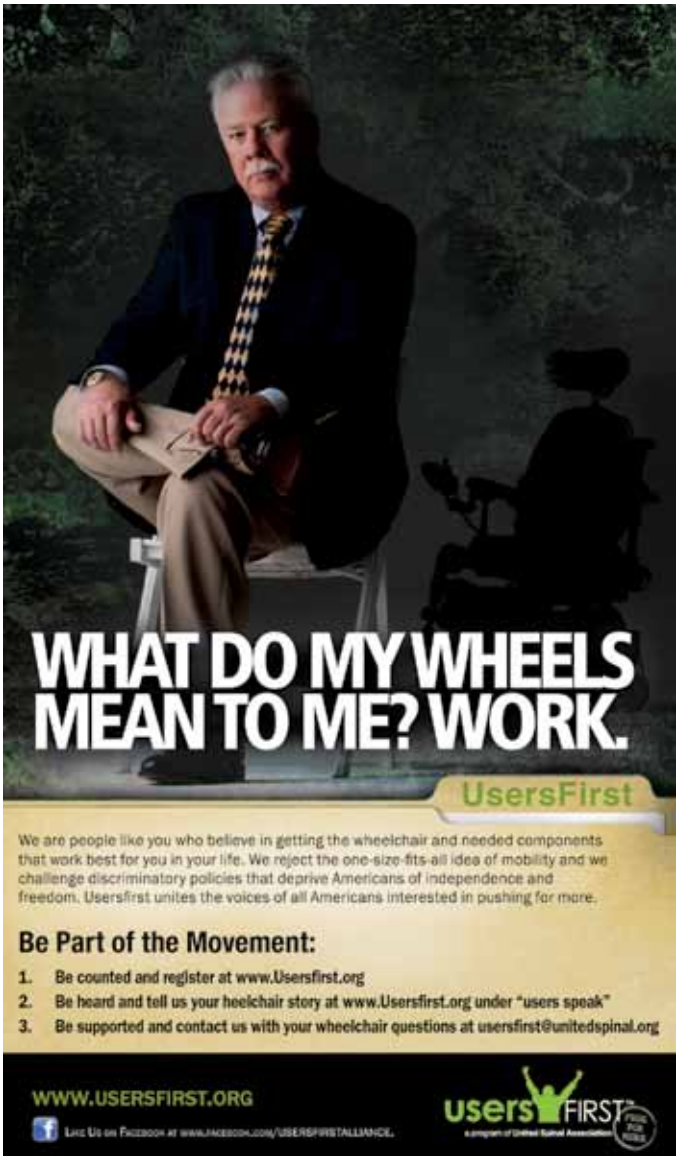
- We provide guidance using the UsersFirst Mobility Map located at http://www.usersfirst.org. This map is interactive where the consumer can contact UsersFirst at any time. The Mobility Map was developed in collaboration with a few NRRTS board members and prominent clinicians. Its intent was to help guide consumers through the entire service delivery process of wheeled mobility and to help suppliers in their communication with consumers. For example, there is a section on the denial/appeal process. Consumers trust the site because a consumer non-profit sponsors it, just like suppliers trust a supplier site.

UsersFirst is an empowerment model – not a business model, not a moneymaking model – we are service driven, consumer run and non-profit.

- UsersFirst and NSCIA answer more than 550 consumer calls each month. We work with consumers daily to find resources within their communities.
- UsersFirst reaches out to suppliers who are

willing to provide funding advice for individual cases. We receive detailed questions about funding and the NRRTS community has been very helpful.

• UsersFirst facilitates numerous consumer support groups throughout the country. We call these groups "grasstops" – people who have identified themselves as advocates.



• We have access to approximately 44,000 members, 30 chapters and about 100 hospital memberships.

• Consumer messaging: UsersFirst encourages consumers to work with the supplier. UsersFirst is interested in the policy affecting the situation and educates the consumer toward the policy that limits their access.

• Because we are trained social workers, we encourage empowerment. Empowerment means the consumer does the work. UsersFirst provides the support and space for consumers to become empowered on their own – for them to find their own voice.

• UsersFirst was created to improve access to wheelchairs.

Fun story from the booth: Gunn said she was very interested in how UsersFirst interacted with consumers. As Gunn listened to UsersFirst explain CRT to consumers, she remembered the lengthy process to establish a term that would represent the complexity of the equipment which they provide – complex rehab technology. It is a strong term and absolutely needed to separate non-adjustable, commodity type wheelchairs from complex rehab. By the end of the day Gunn was using UsersFirst consumer language, "Your adjustable, customized wheelchair is called CRT, and will you sign a petition so policy makers know your chair is different than the ones in the airport?"

In conclusion, when NRRTS is successful, UsersFirst /NSCIA members have the opportunity to be more independent and successful with everything they do in their lives. A consumer's wheelchair might not be the first thing on his/her mind at every moment. Family, work and everyday life is most important, but life is not possible without the right wheelchair. Thank you for partnering with us.

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LESSONS Learned

Written by **Wendy Koesters, PT, ATP**

I THINK ANYONE INVOLVED IN ASSISTIVE technology can admit there are never -lessons to be learned to best meet our client's needs and goals. The following cases have taught me things to take into consideration when I don't have a cut and dry client. Wait...when was the last time I had that?

Most of the clients referred to our interdisciplinary clinic have a high number of co-morbidities and have been referred for our expertise when they have medically declined or their chairs are in a state of disrepair. Now, they are completely dependent upon the new technology we assist in prescribing and need it as quickly as possible.

The client's expectations for this equipment being the "fix" to all of their mobility and independence issues cannot always be achieved. In my practice, I am constantly evolving my evaluation to fitting process to best educate clients on their options and the impact of these choices on daily tasks. Then as a team, we can implement the optimal equipment for the client in the most time and cost productive manner.

What are better questions to ask to fine tune into their needs?

What are the best ways to trial options on the seating system?

How is the best way to implement and train on the use of this equipment in the following scenarios?

I want this exact chair in my new system.

Consider Tim, a husband, father and full-time employee at a large university with incomplete paraplegia. His office is set up exactly to his needs to access via his wheelchair. An inch difference in height seat to floor, dump and even length of frame adversely affected his access to his office as well as community wheelchair skills.

The supplier and I learned a small difference in his rigid frame was not acceptable to him when an alternate frame style from TiLite was received due to his old frame style no longer being in production. We had to go back to the drawing board and order a new frame. He was frustrated, of course, with waiting on the initial length of time dictated by insurance to receive the wheelchair and then the added time to make the decisions on his options and order a new frame.

This case taught me to take specific measures of old systems and include the client, therapist and vendor to go line-by-line through the K005 order form. Had we reviewed the CAD drawing (can be requested from the manufacturer), made adjustments to best replicate the client's old system and included the client in the decision making process, his frustration and vendor/ manufacturer financial hit on ordering a new frame could have been avoided. Frame styles change and the above is the only way I know to best match apples-to-apples or in this case frame-to-frame.

A client has serious co-morbities that affect decisions on options for the seating system, but the client's lack of understanding versus coping with medical decline causes a disconnect in my medical versus their opinion on needs.

I always introduce my responsibility as a physical therapist at seating clinic as an educator on options for seating and mobility with an understanding of their current needs, as well anticipation of their needs up to five years in future. My best attempt to make this estimate is with their current diagnosis, functional level presented, and any change in function reported in the last six to 12 months. I introduce the supplier as a teammate with a better understanding on the reimbursement from insurance or estimation of self-pay cost of these options needed. I have many clients who are not ready to make significant changes I recommend to assist with current needs, much less listen about my prediction into future needs. Here are two such cases and their results.

Michelle is a stay-at-home mom and wife who enjoys working on vehicle repairs requiring frequent chair to floor transfers. She has had multiple wound flap surgeries for Grade IV wounds with osteomyelitis of sacrum, bilateral ischials and greater trochanters. She presented to her original evaluation with a folding K0005 with sling seat and back plus Roho cushion. Her chair was literally falling apart, and she was adamant her Roho cushion did not work for her active

How is the best way to implement and train on the use of this equipment in the following scenarios?

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Lessons Learned

(continued from page 28)

lifestyle for stability or durability. She presented with a flexible pelvic obliquity, hyper lordotic posture, mild flexibility with her scoliosis, signs of shoulder impingement and pain, lack of trunk tone, and non-healing ischial sores.

The infected wound along with GI issues resulted in low energy and discomfort with sitting in her current seating set-up. She was having difficulty propelling her current chair over gravel, the six inch step into her home and steep driveway. Michelle's goals for mobility outside of the home and independence with floor transfers did not fit with my recommendations for wheelchair type or seating options.

Similarly, another client, Rose, and her caregiver daughter's goals did not meet my recommendations for options to meet her medical needs in regard to seating. Rose has a degenerative musculoskeletal disorder and chronic sacral wound. She has had multiple falls and surgeries resulting in decline in endurance for sitting balance stability as well as ADL independence. In the past six months, she went from living alone to being dependent on her daughter for all self-care and transfers. Her folding K003 manual wheelchair, sling seat and back, and foam cushion is only tolerated for up to one or two hours with added pillow support to assist with comfort, as well as balance with her hyper lordotic posture and loss of balance to right. Her goals for comfort and foot propulsion (not even five to ten feet consistently completed on tile surface) and her caregiver/daughter's goal for ease of transport in and out of car and pushing within home/community could be met with options offered to them.

Both of these clients with their medical co-morbities, wounds, and decline in self-propulsion would have benefited from a power wheelchair with power tilt for independence and increased frequency of pressure relief, balance assist, and energy conservation. Neither client due to transportation nor home set-up would or could consider power mobility.

Michelle was fitted with a custom back support but due to restriction in movement. She abandoned this technology. The end result was a solid back support, gel plus foam cushion modified for relief at her greater tuberosities, education on advanced wheelchair skills and intervention for shoulder pain. In review of this case, this client's goals for functional independence outweighed her goal for wound healing and prevention. Following this case, I now request the vendor, as able, to provide a solid back on their current manual frame as a transition from a sling to a custom back support. Other clients with this transition have been more open to the support and benefits when transitioning sling, solid, to custom support.

Rose's goals were also different than my therapeutic/medical benefits with the chair. I had the confidence to firmly educate on not pursuing a replica of her current frame, but holding onto a new order until her needs changed. It is not in the best interest of the client to utilize their funding for equipment that will serve them for only a very short period of time and serve no increase in function, comfort or wound healing over prior equipment. Also, the therapist has to consider the financial loss to supplier if inappropriate equipment is recommended and client abandons.

The moral of the story with both of these cases is trial, trial and trial. In Michelle's case, her chronicity and severity of wounds clouded my ability to realize her highest priorities. But with a longer in home trial of a solid back support, she may have been able to give us this feedback sooner rather than too late. With Rose, the feedback she gave of intolerance to the restriction of movement felt during a trial of shape capture for

> The therapist can work with clients on these trials and utilize the vendor for assistance with equipment access and set-up as a consultant service for optimal use of vendor and therapist productivity.

custom mold led to trials of off-the-shelf solid backs to her determination that a sling back with pillow support was the only way she would utilize a chair. The therapist can work with clients on these trials and utilize the vendor for assistance with equipment access and set-up as a consultant service for optimal use of vendor and therapist productivity.

Client is a "marginal" propeller and is pursuing an entirely new manual seating system.

Smart wheel assessment, Kirby's checklist for wheelchair skills, client's report of functional mobility in home and community plus assessment of arm joint and muscular integrity are all good screening tools to check a client's success with propulsion.

My definition for "marginal" propeller are those that are at that breaking point of decrease in independence if one further factor goes awry: wound, further ROM loss in arm, declining balance support, or maybe even an illness that causes a further strength loss. I have had some assessment to implementation processes with such clients who have been very challenging, lengthy, and difficult at reaching the client's end goal of improvement in home/community access.

When Tabitha was presented to our clinic with a thoracic spinal cord injury and unilateral hand de-gloving injury more than 20 years ago, she was having a tough time.

The client has a recurrent wound at sacrum and ischials, pain in shoulders and neck, multiple medical co-morbidities causing decrease in strength with propulsion in community in past year, further exaggeration of posterior pelvic tilt and scoliosis, and new van with ramp versus lift due to funding issues. I thought with completing a K0005 order form with the client with a slightly shorter frame and supportive back and pressure relieving cushion vs. current rigid long frame, foam cushion and sling back that the majority of her problem list would be solved. She had never been to a clinic before or been educated on all of her options. The next six plus months post implementation of her chair found one issue after another to solve: comfort in back and neck, discomfort with cushion, declined independence over outdoor terrain, tipping forward and backward, and inability to independently propel up and down van ramp.

Needless to say, Tabitha wasn't happy and I was frustrated at myself. We changed too many things too quickly and weren't able to accurately target interventions due to so many factors involved. A wheelchair skills test if completed at initial evaluation would have targeted her baseline skill level because Tabitha did not have an understanding that her skill level currently could not be similar to that of two years ago prior to medical decline, that her 12 degree ramp to her van was not a realistic goal with her lack of trunk control and hand function with pneumatic tires, or that postural assist for wound healing could not be achieved without some compromise and altering of technique for reaching/ADL strategies.

I used what I learned with Tabitha to carryover to Claire, a teacher with Frederick's ataxia and severe skeletal deformity of legs, pelvis, spine and shoulders. Significant trials of wheelchair options for high to low tech trialed to best fit my medical opinion to client's functional goals. The end result was not what I had envisioned as a first route, but it met her functional needs and she expressed understanding of each change: cushion, back support, with transition to power in future when she determined necessary – not I, as the clinician, deemed mandatory. But utilizing objective measures to have clinical, as well as client's, true understanding of skill level pre and post new equipment was beneficial to work as a team with Claire, whereas in Tabitha's case where it seemed as though there was a divide between therapist/vendor medical goals and client's more functional based goals.

So, thank goodness I am continuing to learn new things that can best assist serving my client's needs. Having a true understanding of a client's desires and goals cannot always be achieved within a 90 minute evaluation, but takes follow-up, education, more education, plus a listening ear and watchful eye of the client for best outcome. Waiting to utilize funds until the client is ready to take that step or is forced to take that step is the client's choice, not mine. The above clients have definitely taught me valuable lessons to utilize in the future that I hope you can use in your practice as well.

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Demystifying the Wheelchair Seating and Mobility Medical JUSTIFICATION Letter

Written By **Jill Monger PT, MS, ATP**

I HAVE BEEN TOLD, TIME AND TIME AGAIN, "Clinicians just do not know how to write a strong justification letter to assure seating and wheeled mobility products can be provided." This complaint comes primarily from suppliers, insurance reviewers and even some clinicians themselves. It's really not that difficult. A comprehensive evaluation and assessment including a list of technology needs and a justification for each item or feature on the list is what is needed. This clinician-generated document takes care of one critical part of the documentation requirement. Also needed are pertinent supplemental medical records from the physician including the physician's history and physical, annual examination, recent office visit notes, and pertinent tests and measures related to the mobility impairment.

COMMON CLINICIAN MYTHS

Myth #1: Not enough time

One barrier, from a clinician's perspective, is that there is "not enough time" to complete the specialty evaluation and documentation. First, if clinicians have time to work on transfers and dressing, they have time to ensure patients will have the appropriate technology to function throughout life once they are dressed and in their wheelchairs. Let's be honest: people spend much more time actually functioning in their wheelchairs than transferring in and out of them. Do clinicians really think the wheelchair assessment and justification process is less important than other therapeutic interventions such as strengthening, ROM and functional skills training? Of course not.

Myth #2: A separate letter of medical necessity is required

It is not necessary to generate a separate letter of medical necessity. Duplicate and redundant work is not needed. Instead, clinicians can leverage the work they have already done. Clinicians are required to perform an initial evaluation on every new patient. If the clinician has been treating your patient for some time, you might suggest the clinician utilize the initial evaluation as a starting point and prepare a supplemental wheelchair assessment as an addendum. The initial evaluation, by definition, should include the pertinent medical and surgical history, social history, review of systems, physical and functional examination, including a summary of current equipment and a plan of care, including goals and interventions. Don't forget to include this initial evaluation as an attachment to the equipment submission packet.

Myth #3: I do not get paid to do the wheelchair assessment

If the comprehensive PT or OT evaluation (CPT billing code - 97501 or 97003) is current, the clinician can use the wheelchair management billing code (CPT 97542) to bill for the wheelchair assessment. The wheelchair assessment by definition should include a more specific mat evaluation to identify postural and motor function needs, and a more detailed description of activities of daily living from the wheelchair, transfers, environmental and transportation factors, as well as other related functional and performance details. The assistive technology code (CPT code 97755) is another billing option for only the most complex patients requiring integration of multiple technologies. The wheelchair management code (97542) is appropriate for billing for the majority of cases – most basic and intermediate level assessments.

Myth #4: Wheelchair assessments are too complex

The complexity of the wheelchair assessment and fitting process typically falls into one of three categories: Basic, Intermediate and Complex. The majority of Medicare beneficiaries will have only Basic or Intermediate level needs and will not require an extensive evaluation process. Children and individuals with complex needs will require a more extensive process. In some cases, the treating PT or OT may recognize his/her professional limitations and select to refer the patient to a clinical colleague who specializes in seating and wheeled mobility. This is always an appropriate option when patients' needs exceed a clinician's expertise. Regardless of the complexity of the evaluation performed, it is the clinician's responsibility to provide the data necessary for a third party to make a determination of medical necessity and appropriateness for the items requested.

> This clinician-generated document takes care of one critical part of the documentation requirement.

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Manufactured in the U.S.A.
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... Justification Letter

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> Using the team approach, the supplier can help the clinician who is unfamiliar with specific technology recognize his/her expertise by asking focused questions regarding seating and mobility related problems and objectives.

Myth #5: Wheelchair skills training is not covered

Fitting and training may require additional sessions beyond the initial wheelchair assessment and can take two hours or more. Wheelchair skills training is a covered service as long as it is part of the established plan of care outlined in the evaluation. A clinician only needs to document the goals, intensity, duration and plan. Wheelchair skills training, unfortunately, is frequently underutilized leaving patients to learn and problem solve on their own.

RTS OPPORTUNITIES FOR CLINICIAN TRAINING

Product Options and Features

Another barrier for many clinicians is the idea that they do not know enough about specific technology and, therefore, do not feel qualified to justify it. All clinicians do, however, have expertise in determining patient problems and potentials, goals, and prognosis and know how to develop a therapeutic plan of care. Using the information from the initial evaluation and the wheelchair assessment, the PT or OT can determine seating and mobility related problems such as medical issues, postural deformities/ limitations, and functional limitations. Here is where suppliers come in. Using the team approach, the supplier can help the clinician who is unfamiliar with specific technology recognize his/her expertise by asking focused questions regarding seating and mobility related problems and objectives. This team-oriented discussion should lead to decisions regarding technology features that can help meet each of the patient's objectives. This approach will allow the PT or OT to be able to set technology-related goals for each of the problems identified during the evaluation process. This is what clinicians are trained to do! You – the supplier – can help the clinician to determine which features and products, in the universe of technologies, can best meet the identified goals. The clinician can justify the features by describing the patient problem, specifying the required equipment feature and the corresponding clinical rationale, providing the solid documentation needed.

DME Policy

Most clinicians are very familiar with the Local Coverage Determinations (LCDs) for their clinical services. However, many clinicians are unfamiliar and unaware of the LCDs related to durable medical equipment. This is the supplier's area of expertise. It is extremely helpful for suppliers to educate clinicians regarding insurance guidelines such as the CMS LCDs. In fact, consider providing clinicians with actual copies of the LCDs!

These policies give very specific criteria as to what constitutes justification for a given feature. This information will help clinicians to understand how their clinical evaluation can be used to support the justification process.

CLINICIAN TASK FORCE ACTIVITIES

The CTF is working to educate clinicians and policy makers regarding the elements of clinical documentation required to demonstrate medical necessity and appropriateness. To build the capacity of the clinical work force and ensure qualified PTs and OTs are available to fill the public need, the CTF is working with APTA and AOTA to define clinical practice guidelines related to seating and wheeled mobility services (Guide to PT Practice, AOTA Knowledge and Skills Paper). The CTF is in the process of developing extensive comments to CMS as the agency embarks on creating an E Clinical Template for PMD for physicians. Members of the CTF regularly seek out opportunities to present to clinicians at various local and national conferences to begin to elevate the level of knowledge and assist in helping PTs and OTs develop their expertise in the area of seating and wheeled mobility.

IN CLOSING

Suppliers are critical members of the interdisciplinary team. Sharing your expertise with your clinical teammate in the form of information, resources, discussions and problem solving is an important professional skill that helps elevate the level of practice and the quality of services for those we serve. While the process of creating the clinical documentation to justify seating and wheeled mobility can seem daunting to the general PT or OT, it's really not that difficult, and more importantly, their patients are depending on them to do so! It is high time to "JUST DO IT"!

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What is the SEATING & MOBILITY SPECIALIST (SMS) Certification?

Written By **Carmen DiGiovine, PhD, ATP/SMS, RET**

DIRECTIONS has invited RESNA to begin submitting a regular column in each issue. Please enjoy reading our newest column.

- THANK YOU, RESNA!

MANY CERTIFIED ASSISTIVE TECHNOLOGY

Professionals (ATPs) contacting RESNA have questions about the Seating & Mobility Specialist (SMS) certification. Most of the questions boil down to this sentiment: "What is it and why do I need it?"

The SMS certification recognizes and identifies rehabilitation professionals with advanced knowledge and experience in the field of seating and mobility. RESNA established the program to provide formal recognition for ATPs with advanced clinical knowledge, experience and skills in this area of practice, and to assist consumers and the health care community in identifying these professionals.

Right now there is no regulation or requirement for professionals in the seating and mobility field to obtain the SMS certification. For most, this is purely a matter of professional pride. However, speaking from personal experience, I can attest that the SMS has heightened my credibility at The Ohio State University and the Wexner Medical Center where I work. The RESNA name has significant brand recognition among my peers and identifies me as a leader in the profession. I experience this on a regular basis as leaders use the RESNA name and ATP/SMS credential when describing the professionals working at the Assistive Technology Center. Finally, and most importantly, I'm able to easily convey to consumers that they are getting the highest quality services by working with a professional who has earned the ATP/SMS certification.

ELIGIBILITY REQUIREMENTS

Eligible candidates must have an ATP certification in good standing; at least 1,000 hours of direct, in-person, consumer service delivery experience in seating and mobility at any time during the career; and demonstrate initiative in two professional service categories within the past five years.

There are seven professional service categories from which any two can be chosen: continuing education, presentations/formal instruction, mentoring/supervision, client service delivery, advocacy, leadership and publication. The RESNA website has several examples listed for each category. For example, in the continuing education category, the requirement is one CEU in seating and mobility courses. The CRTS designation in good standing from NRRTS also fulfills this requirement. Other examples of fulfilling the professional service category requirement include things such as serving as a reviewer for a peer-reviewed journal or publication (publication), giving a

> The SMS certification recognizes and identifies rehabilitation professionals with advanced knowledge and experience in the field of seating and mobility.

(continued on page 40)

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... Specialist (SMS) Certification

(continued from page 38)

> If you plan on making the seating and mobility field your career, then it really pays to invest in yourself and achieve the SMS certification.

formal presentation at a conference (presentation/formal instruction), or training a staff person in the field for at least four hours (mentoring/supervision).

The service categories historically tend to be the most concerning part of the application for applicants. Based on my experience, it is a rather simple process. Just remember you only need to complete two of the seven categories. In short, if you have your ATP certification and you've been working in direct client services in seating and mobility long enough to be recognized as a leader either through participating in conferences, mentoring or supervising staff, or some other activity, you are likely eligible.

HOW TO APPLY

Download the SMS exam application from the RESNA website. With the completed application, you will also submit documentation of two professional service categories and a work verification form signed by your supervisor. Send the application and the supporting documents to the RESNA office along with the $250 exam fee. Once approved, the office will send you an e-mail confirmation with your testing code. You can then schedule your exam at any of the hundreds of Prometric computer-based testing centers located across the United States, Canada, and even internationally. You have up to one year to take the exam once approved, but I would encourage you to take the exam as soon as possible and keep the momentum going.

WHAT THE EXAM INCLUDES

The SMS exam has 165 questions and includes photographs and videos. The exam covers performing an assessment; funding resources, coverage and payment; implementing an intervention; outcomes assessment and follow up; and professional behavior. It is a rigorous exam, but it is designed to reflect current expertise and best practices in the field. Check the RESNA website at *http://www.resna.org/certification* to see the full SMS exam description.

The RESNA website also lists several books and articles that are useful for exam preparation, as well as web resources from other organizations.

MAINTAINING CERTIFICATION

Once you achieve your SMS certification, both your SMS and ATP certifications will be placed on the same renewal schedule, so there is only one renewal to worry about every two years. There is no additional continuing education requirement as long as 50 percent of the education applies to both certifications.

If you plan on making the seating and mobility field your career, then it really pays to invest in yourself and achieve the SMS certification. This advanced certification sets professionals apart as dedicated experts, and recognizes lifelong learning spent developing seating and mobility knowledge, skills and expertise. Insurers, health plans, government agencies and others can use the SMS and the ATP to identify and select qualified professionals to care for complex seating and mobility needs. Plus, there is the satisfaction and the confidence which comes from knowing you have set the bar high for yourself and have achieved that level of professional expertise.

If you have questions about the SMS certification and are attending Medtrade in Atlanta this October, please stop by the RESNA booth and talk to Eric Nepomuceno, RESNA's Certification and Education Manager, or e-mail certification@resna.org . Thank you to Simon Margolis and NRRTS for inviting RESNA to submit a regular column to Directions magazine. We are excited about the opportunity and look forward to engaging more deeply with NRRTS members, many of whom are also RESNA members.

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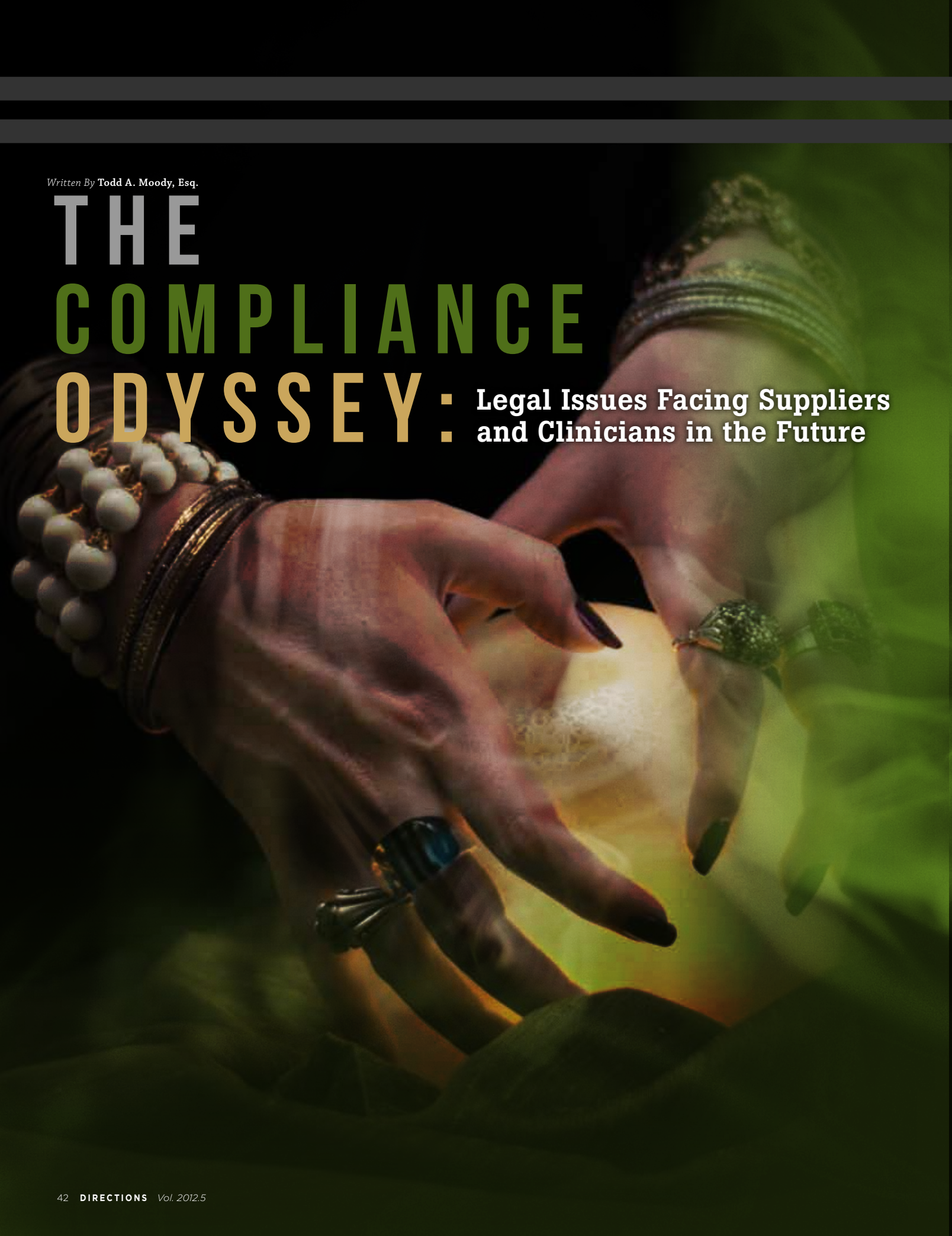
Written By **Todd A. Moody, Esq.**

THE COMPLIANCE ODYSSEY: Legal Issues Facing Suppliers and Clinicians in the Future



In Homer's epic tale, *The Odyssey,* Odysseus desires to finally return home to his wife and son in Ithaca after the 10-year Trojan War and seven years of captivity on the goddess Calypso's island. Knowing of Odysseus's desire to make it home to his wife and son, and using her knowledge of potential obstacles, the goddess Athena intervenes on multiple occasions, and in a variety of ways, to protect and guide Odysseus home. It would certainly be nice if we all had an "Athena" to ensure the steps we and those around us take will ultimately lead to our safe arrival at our destination. For suppliers and clinicians, the destination of compliance is an ever-moving target, and the path is mired by pitfalls and obstacles. Unfortunately, there is no Athena in our industry to point out with certainty the legal issues that will be most important in the future, but this article will attempt to point out a few legal issues I suspect suppliers and clinicians will face going forward.

PATIENT PROTECTION & AFFORDABLE CARE ACT

We are all aware now of the Senate Reform Bill, H.R. 3590, entitled the "Patient Protection and Affordable Care Act" (PPACA), which was signed into law by President Obama in 2010. Now that the United States Supreme Court has looked at the law and upheld its key provisions, we know it is here at least for the time being. The following are a few key provisions suppliers and clinicians should understand for the future.

SECTION 3022

Accountable Care Organizations. This section created the Medicare Shared Savings Program, which allows the Centers for Medicare and Medicaid Services (CMS) to contract with Accountable Care Organizations (ACOs) beginning January 1, 2012. On October 20, 2011, the Department of Health and Human Services (DHHS) released final regulations providing additional guidance on the implementation of the Medicare Shared Savings Program. An ACO is a group of health care providers that agree to be accountable for the quality, cost and overall care of beneficiaries who are assigned to the ACO. ACOs are designed to improve coordination of patient care among physicians and other providers by providing a financial incentive to the ACOs to minimize expenses.

Among other requirements, an ACO must (i) have a formal legal structure (e.g., corporation or LLC), (ii) have a sufficient number of primary care professionals for the number of assigned beneficiaries (there will be at least 5,000 beneficiaries assigned to each ACO), (iii) enter into an agreement to participate in the program for at least three years, and (iv) meet certain quality standards. The quality standards relate to four areas affecting patient care, including patient and caregiver experience of care, care coordination, preventative health, and at-risk populations.

The ACO participants will bill and receive the traditional fee-for-service amount from Medicare. However, to encourage savings, CMS will set a benchmark amount for the ACO, and the ACO is entitled to share in any shared savings if the actual expenditures of the ACO come in under the benchmark. CMS initially offers ACOs a one-sided and a two-sided risk model. Under the one-sided model, the ACO will share in the savings in the first two years of the contract and share in the savings and losses the third year of the contract. Under the two-sided model, the ACO will share in the savings and losses all three years, but the ACO will be eligible to share a much higher percentage of any savings than under the one-sided model. After an ACO's first three year term, the one-sided model will be the only option.

The only providers that can form ACOs are hospitals, physicians, similar professionals (such as nurse practitioners and physician assistants), Federally Qualified Health Centers, Rural Health Clinics, and certain Critical Access Hospitals. The DHHS secretary has authority to add to this list of providers. Suppliers and providers not listed above may not independently form an ACO, but they may participate in an ACO formed by one or more of the providers listed above. Suppliers and providers that are not participants in an ACO should still become familiar with ACOs as ACO participants may be large referral sources. The presence and importance of ACOs is likely to only increase.

ACOs are designed to improve coordination of patient care among physicians and other providers by providing a financial incentive to the ACOs to minimize expenses.

Suppliers and providers that are not participants in an ACO should still become familiar with ACOs as ACO participants may be large referral sources.

SECTION 6401

COMPLIANCE PROGRAMS. By a date determined by the secretary, certain providers will be required to establish a compliance program. Such compliance programs must contain core elements which will be established by the secretary in consultation with the OIG.

There is no specific implementation timeline for DHHS to establish the core elements. CMS has, however, solicited comments from the public as recently as February 2, 2011, on issues pertaining to implementation of the core elements. Based on previously-published compliance program guidance by the OIG, the HME and home health industries can fairly and accurately predict the core elements the OIG will expect to be included in compliance programs.

Existing OIG compliance guidelines list seven required elements of an effective compliance program: written policies and procedures; designation of a compliance officer and compliance committee; conduct of effective training and education; development of effective lines of communication; enforcement of disciplinary standards; auditing and monitoring; and response to offenses and corrective action. In order to be deemed "effective," the compliance program must be something more than a set of documents that simply restate these seven elements. These seven basic elements must be specifically implemented by the provider and be designed to address past, existing and future activities of the provider.

Once DHHS issues regulations, and a deadline, for compliance programs, it will be important for providers to "buy into" the importance of compliance. As the OIG said when it first issued its guidance: "Compliance efforts are designed to establish a culture … that promotes prevention, detection and instances of resolution of conduct that do not conform to federal and state law … [T]he compliance program should effectively articulate and demonstrate the [provider's] commitment to ethical conduct. Benchmarks that demonstrate implementation and achievements are essential to any effective compliance program. Eventually, a compliance program should be part of the fabric of routine … operations." The OIG warned that merely purchasing compliance policies is not enough: "Implementing an effective compliance program requires a substantial commitment of time, energy and resources by senior management and by the [provider's] governing body. Superficial programs that simply have the appearance of compliance without being wholeheartedly adopted and implemented … or … that are hastily constructed and implemented without appropriate on-going monitoring will likely be ineffective and could expose the [provider] to greater liability than no program at all."

The HME and home health industries can fairly and accurately predict the core elements the OIG will expect to be included in compliance programs.

These seven basic elements must be specifically implemented by the provider and be designed to address past, existing and future activities of the provider.

Benchmarks that demonstrate implementation and achievements are essential to any effective compliance program.

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REPORTING AND RETURNING OVERPAYMENTS.

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ANTI-KICKBACK STATUTE AND FALSE CLAIMS ACT.

A claim that includes items or services resulting from a violation of the Medicare/Medicaid anti-kickback statute constitutes a false or fraudulent claim under the Civil False Claims Act (31 USC § 3729). Because of this link, suppliers and clinicians must be on the alert for potential kickback violations due to the possibility of qui tam actions, otherwise known as whistleblower suits, arising as a result of those kickbacks.

AUDITS AND REVIEWS

For some time now, a veritable alphabet soup of Medicare contractors (e.g., NSC, DME MAC, CERT, RAC, ZPIC) have been performing post-payment audits and prepayment reviews of claims. Still, these are two of the biggest challenges facing suppliers and clinicians. There is abundant contractor abuse in how the audits, reviews and investigations are being conducted. AAHomecare and industry stakeholders are working with CMS to correct these abuses. Nevertheless, audits, reviews and investigations will be a permanent part of the landscape.

Why is there such an increase in audits, reviews and investigations? They are money makers for the government. For every dollar expended by the government to chase a recoupment, the government recovers many more dollars. There is an increase in utilization of HME; this is to be expected in light of the "graying of America." Generally speaking, HME is expensive. This, by itself, will capture the government's attention. Contractor auditors are becoming more sophisticated in reviewing HME claims. It is a priority of CMS to uncover and prevent fraud in the Medicare fee-for-service program. Health care providers (not just HME providers) have become the new boogey man to the government. The boogey men used to be "Big Oil" … then "Big Tobacco" … then "Big Pharma" … and now "fraudulent health care providers." Recovering money from fraudulent health care providers makes for an easy sound bite for politicians. Health care providers are "low hanging fruit" for recoupment actions by the government.

So what does the provider do? It would be nice if the provider could wave a magic wand. Unfortunately, such a wand does not exist. The steps the provider must take to reduce the chances of having its cash flow cut off are the following: (i) implement a formal corporate compliance program; (ii) conduct regular self-audits of patient files; (iii) have an outside consultant come in at least once a year to audit patient files; (iv) have a competent health care attorney review the provider's marketing practices and relationships with referral sources to determine if there are any kickback/Stark problems; and (v) be detail-oriented (to a point of almost being paranoid) regarding completeness and accuracy of patient files.

Compliance has always been important, but it is even more so now. For suppliers and clinicians to stay in the game, they

Compliance has always been important, but it is even more so now. For suppliers and clinicians to stay in the game, they need to stay abreast of the legal landscape in which they are operating.

need to stay abreast of the legal landscape in which they are operating. With Medicare struggling to care for its 48 million beneficiaries through $549 billion in expenditures in 2011, the futures of Medicare and businesses which depend on it are not clear. This is especially true with the tsunami of 75 million baby boomers who are now or will soon be flooding this already struggling system. The opportunity for suppliers and clinicians to continue serving these beneficiaries will depend on knowledge of, and compliance with, theses and other important laws.

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These written materials are not intended to be legal advice or legal opinion on any specific facts or circumstances. The contents are intended for general information purposes only. The law pertaining to these issues may have changed since these written materials were submitted. The reader should consult his or her own attorney for legal advice.

Written By **Michelle L. Lange, OTR, ABDA, ATP/SMS**

STROLLERS VS. MANUAL WHEELCHAIRS

Clinical Indicators

When evaluating a client for a non-powered mobility base, either a stroller or a manual wheelchair may be recommended. So how do you determine which is most appropriate? This article will address some of the clinical indicators for each of these mobility bases. Many funding sources, seeking to save costs, are questioning the medical necessity of manual wheelchairs, as strollers are usually a less costly alternative. As professionals who frequently must write documentation justifying this equipment, it is important to explain why a particular category of mobility base is being recommended.

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WHEN IS A MANUAL WHEELCHAIR APPROPRIATE?

THE TILITE TWIST OFFERS AN EXTREMELY LIGHT WEIGHT SELF-PROPULSION OPTION FOR YOUNG CHILDREN

In general, a manual wheelchair is recommended instead of an adaptive stroller for the following reasons:

Frame growth: Manual wheelchairs provide more frame growth than adaptive strollers. For a growing client, this means a manual wheelchair can be used longer than a stroller.

Frame adjustment: Manual wheelchairs provide more frame adjustment. Frame adjustments are an important part of addressing postural needs. For example, many manual wheelchair frames include an adjustable seat to back angle to achieve the optimal position for trunk and head control. This is often unavailable in an adaptive stroller.

Fixed tilt: Manual wheelchairs can be adjusted so the seat is parallel to the floor or slightly tilted posteriorly. Many adaptive strollers place the client in a significant fixed posterior tilt. A fixed tilt may assist trunk and head control by allowing gravity to do the work. However, clients who spend a great deal of time tilted rearward may lose active head and trunk control, have more limited visual range and may be at increased risk of aspiration.

Seating: Adaptive strollers typically use the same manufacturer's seating options. On the other hand, manual wheelchairs can accommodate a variety of manufacturers' seating systems and components, depending on the client need. Adaptive stroller seating systems are less aggressive and do not offer as much adjustment as seating systems available for use in a manual wheelchair. In general, adaptive strollers are best used for clients with minimal to moderate positional needs and manual wheelchairs are best used for clients with moderate to maximum positional needs.

Independent propulsion or potential to self-propel: Adaptive strollers are dependent mobility bases. A caregiver is required for propulsion and the client has no ability to move through space. A manual wheelchair can be set-up to be a dependent mobility base (using smaller rear wheels, for example) or a base which provides for self-propulsion. If a client is able to self-propel, even with limited functionality, they can benefit from independent movement through space. Benefits include improved cognition, vision and visual perceptual skills, socialization and participation and reduced learned helplessness. If a client demonstrates potential to self-propel, even with limited functionality, over the expected lifetime of the frame, a manual wheelchair is an appropriate option. If an adaptive stroller is recommended when self-propulsion is anticipated, it may need to be replaced with a manual wheelchair prematurely.

Age appropriateness: Our culture equates a stroller with an infant or young child. Placing a child in an adaptive stroller for several years is not age appropriate for many clients (often a funding source will require that a base is five years old before considering replacement). People interact differently with a child in a stroller, tend to expect less and may not see the child as a capable person.

Haley & Devon

HALEY IS A 3 YEAR OLD GIRL with the diagnosis of spina bifida. She is non-ambulatory and her parents either carry her or place her in a standard toddler stroller. Her therapists are anxious to provide her with more independence in her mobility. Haley tried a manual wheelchair designed for very small children. This unique configuration places the "pushing" wheel in the front for easier propulsion for clients with short arms. She was able to propel this wheelchair base throughout the clinic with good control and was quite motivated to explore her environment. When this manual wheelchair and seating system were submitted for funding, the funding source denied the request, stating a stroller would be more appropriate and less costly. Additional documentation was submitted supporting the importance of independent mobility for cognitive and visual skill development and for building trunk and upper extremity strength. The therapist also pointed out Haley's condition would

SOME ADAPTIVE STROLLERS INCLUDE MODERATE POSTURAL SUPPORT

require lifetime mobility assistance and delaying a manual wheelchair would not eliminate the need. Finally, the therapist also mentioned providing a dependent mobility base to a client who is capable of independent mobility is unethical. Funding for a manual wheelchair was successful.

DEVON IS AN 8 YEAR OLD BOY with the diagnosis of cerebral palsy. He has been using an adaptive stroller since the age of 5, but has outgrown it. His therapists are now recommending a manual wheelchair. Devon does not have the ability to propel a manual wheelchair though he is using a gait trainer in therapy. He will be receiving a power wheelchair in the near future. The recommended manual wheelchair includes a manual tilt and custom seating system to meet his postural needs. The funding source has denied this request, asking why a replacement stroller is not more appropriate. The therapists submitted additional information explaining a manual wheelchair will provide more growth for Devon than a stroller and so will not need to be replaced as quickly making it more cost effective. A stroller is also not as age appropriate for an 8 year old who would most likely use a new stroller until age 13 if the base provided enough growth. Devon requires a tilt for postural control and fatigue. This is included in many strollers, however, Devon also needs to come forward out of the tilt for functional activities. Many adaptive strollers with tilt would not provide adequate forward tilt position. Finally, Devon requires moderate positional support for orthopedic symmetry (i.e. to prevent his spine from collapsing into a curvature), stability for function and to control muscle tone. The evaluating team believed his positional needs would be better addressed in a custom linear seating system in a manual wheelchair with the needed frame adjustments. Although Devon will be receiving a power wheelchair, this will be used primarily at school and he requires a more supportive seating system than a stroller would provide during those out of school hours. A manual wheelchair was approved.

WHEN IS A STROLLER APPROPRIATE?

THIS TILT IN SPACE MANUAL WHEELCHAIR CAN COME TO A FULLY UPRIGHT POSITION AND SUPPORT ANY LEVEL OF POSITIONING NEEDS. THIS IS SOMETIMES AN APPROPRIATE OPTION FOR A CHILD WHO IS UNABLE TO SELF-PROPEL.

Adaptive strollers, also referred to as dependent. mobility bases, are available for nearly all sized clients. Strollers are available for neonates through adults. Frame adjustments and seating options vary significantly. An adaptive stroller may be recommended instead of a manual wheelchair for the following reasons:

Limited use for seating: A client may not require adaptive seating throughout the day. The client may be able to sit on a couch or floor independently and only require a seating system when in a mobility base or for limited activities.

Limited use for mobility: A client may be independently mobile (ambulatory or using assistance such as a walker) and only require a stroller for long distances and/or when fatigued.

Limited positional needs: A client may have limited positional needs and not require the support provided by a more aggressive seating system or need frame adjustments found on manual wheelchairs.

Small child: Adaptive strollers are available in smaller sizes than manual wheelchairs for very young children, even neonates. A stroller is also more age-appropriate for a young child.

Medical issues: Some adaptive strollers offer a rear facing position which allows a caregiver to monitor a small child who has medical issues. Oxygen and vent support is also on option on some adaptive strollers, as well as on many manual wheelchairs.

Height adjustment: Some adaptive strollers include an integrated or separate base which allows height adjustment so the client can be placed closer to floor level or higher at table height. This is designed so a younger child can be positioned at a peer level for play and at table height for feeding and other activities.

Parental Preference: Some parents prefer an adaptive stroller over a manual wheelchair, particularly for younger children, as it may be more acceptable and less stigmatizing.

As a back-up to a manual wheelchair: Adaptive strollers generally weigh less than manual wheelchairs and often are easier to fold and fold more compactly. As a result, adaptive strollers are usually easier to transport and carry into inaccessible locations. If a family does not have an accessible vehicle or home, a stroller may be a reasonable option. If the client has moderate to maximum positional needs and/or the ability or potential to self-propel, a manual wheelchair may still be needed. This wheelchair may be primarily used in one location, such as the home or at school and the adaptive stroller used for transportation by the family.

Sam & Alexi

SAM IS NOW 6 MONTHS OLD. He received his adaptive stroller upon discharge from the NICU. His adaptive stroller was available in an infant's size and included many features he required. The stroller included tilt and recline which was important as Sam cannot yet sit up and is sometimes tilted or reclined to meet his medical needs. The entire seat can be placed in the rear facing position, so the caregiver can watch him while pushing the stroller to monitor his medical condition. This stroller base can also support Sam's ventilator and oxygen. When at home, the seating system is removed and placed on an indoor hi-low base. Sam is sometimes placed at a lower height so he can participate when his parents are playing with his 3 year old sister on the living room floor. He is placed at the higher position when Mom works on his feeding program at the kitchen table.

ALEXI IS A 16 YEAR OLD young man who is 10 years post TBI. He uses a tilt in space manual wheelchair with a moderately aggressive seating system. He is not able to push the manual wheelchair and has not been successful in using a power wheelchair, due to cognitive and visual limitations. The home has a ramp so the wheelchair can get in and out of the house. Alexi takes an accessible bus to school. His mom has an accessible van, but prefers to put Alexi in a stroller for quick trips, as it is easier for her to manage this lighter base. She also uses a stroller if the van is unavailable, as she cannot fit the manual wheelchair in her car. The family also travels frequently and prefers to bring the stroller as it folds, is lighter weight and because they are fearful the manual wheelchair will be damaged on an airplane. Alexi is not positioned optimally in the stroller and is stuck in a fixed tilt. For short periods of time, this is not problematic. This therapist would prefer Alexi use his manual wheelchair during quick trips and travel, but I don't have to take care of him 24/7 either. Part of being family centered is meeting the client's needs and respecting family preferences.

PART OF BEING FAMILY CENTERED IS MEETING THE CLIENT'S NEEDS AND RESPECTING FAMILY PREFERENCES.

The above are guidelines; however, a comprehensive evaluation is still required to identify all client needs and to match those needs with the most appropriate equipment options to increase the likelihood of a successful outcome. These guidelines may be helpful, however, in justifying one category of equipment over another to funding sources. I hope you find this information helpful in your own documentation.

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Toll Free: 800-319-1438
Fax: 423-386-2129
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David Lucero, RRTS®
National Seating & Mobility, Inc.
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Fresno, CA 93727
Telephone: 559-252-4396 x.206
Fax: 559-252-4507
Registration Date: 8/3/2012

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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 July 11 through Sept. 10, 2012. For an up-to-date verification on Registrants, visit *www.nrrts.org,* updated daily.

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