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DIRECTIONS

VOL 2 » SPRING 2009

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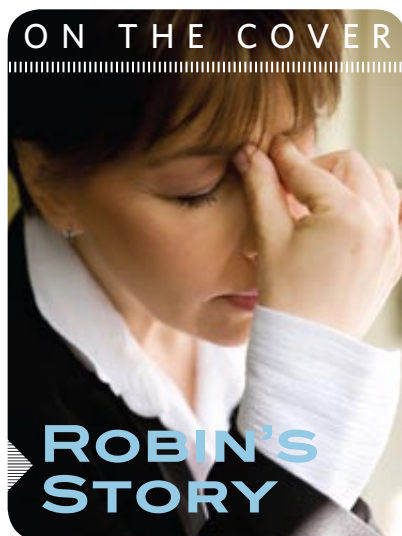
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ADVERTISERS' INDEX

Altimate Medical.....	37
Bodypoint, Inc.	32
BodyTech Northwest	14
Conduit Marketing.....	10
Convaid, Inc.	41
Freedom Designs, Inc.	11
HME Expo.....	27
Innovative Concepts	6
Invacare Corporation.....	21, 31
MK Battery.....	17
Motion Concepts.....	9
Permobil Inc.	Inside Back Cover
PinDot.....	15
Prairie Seating	47
Prime Engineering.....	25
PRM	33
Quantum Rehab.....	5
Ride Designs.....	36
Snug Seat.....	19
Stealth Products	7
Sunrise Medical	Inside Front Cover
The ROHO Group.....	Outside Back Cover
TiLite.....	29
U.S. Rehab	35
Varilite.....	13
Vista Medical	44
Wenzelite Rehab.....	46

ON THE COVER



ROBIN'S STORY



NRRTS & THE INDUSTRY

New Registrants	44
CRTS® Credentials	46
Former NRRTS Registrants	44
2009 TeleSeminar Series	
Eastern	48
Pacific	49
Charter Corporate Friends of NRRTS	50
Corporate Friends of NRRTS	50
Association Friends of NRRTS	50

FEATURES

FROM THE NRRTS' OFFICE

- 4 What Have You Done For Me Lately?

CFON FOCUS: MOTION CONCEPTS

- 8 Defeating the Disproportionate Weight Distribution Dilemma

LIFE ON WHEELS

- 12 The Valiant Struggle

CFON FOCUS: PERMOBIL

- 16 Medicaid and Medical Necessity

NOTES FROM THE FIELD

- 18 I Thought I was Going to be Cool When I Grew Up... What Happened?

LAW LIBRARY

- 30 Devil in the Details: How to Prevent Problems with Delivery Documentation

THE BOTTOM LINE

- 34 Repairs: How Do I Make Them Work for My Company?

ASSESSMENTS

- 38 Selecting the Appropriate Seat Cushion

CELA '09
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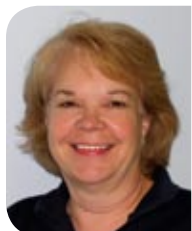
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NRRTS TELESEMINARS
2009
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[MORE INFO ON PAGE 48 & 49]



What Have You Done For Me Lately?



WEESIE WALKER, ATP, CRTS®

NRRTS President

BRANCH MANAGER, NATIONAL SEATING & MOBILITY

COVER STORY

Our cover story recounts the saga of one CRTS®' efforts to make a difference in the life of her patient. It is this level of compassion and commitment that defines

the professional rehabilitation technology supplier. Her efforts were above and beyond the call of duty but would not be needed if the government would more diligently regulate suppliers of power wheelchairs to our most vulnerable citizens with disabilities.

The kind of effort described in our cover story solves the problem for one individual but do not help to achieve systems change to impact hundreds of thousands of people. Policy change will only happen when people with disabilities and their advocates step-up and confront the mass marketers and their too-good-to-be-true claims of "free" wheelchairs. When things go wrong the consumer with disabilities must complain loudly to Medicare, Medicaid, Better Business Bureaus, local news outlets and anyone else who will listen.

Suppliers, therapists, physicians and other professionals working with these people need to facilitate this communication with the powers-that-be. Helping to make our clients' voices heard is one of the only ways to fix our broken system

TIME FLIES WHEN YOU ARE HAVING FUN!

Last month, ISS celebrated its 25th anniversary. It is hard to believe that a quarter of a century has passed since the first Symposium was held. At this year's conference, there were over 800

attendees. NRRTS collaborated with the University of Pittsburgh to offer a high quality educational experience. Michele Gunn, ATP, CRTS®, presented a live case study. Her client had received a 1-800-Powerchair about two years ago. Michele and her staff performed a mat evaluation, took measurements and did simulated seating. In the end, the client received a chair that offered her the needed function and positioning she requires. Her complete case study is the feature article of this edition of *DIRECTIONS*.

Gerry Dickerson, ATP, CRTS®, did a presentation with Darren Jernigan sharing little known facts about Medicaid, Medicare and private insurance. Kevin Phillips, ATP, CRTS®, did a presentation on getting complex rehab funded. The NRRTS booth was busy with inquiries and visits from registrants.

GEORGIA REHAB COUNCIL GATHERS MOMENTUM

The GRTC continues its mission to bring some sensibility to the Georgia Medicaid program. The biggest issue for suppliers is the proposed deletion of the K0108 code. The Council has been working to develop a list of codes that need to be opened in the system. Dr. Doran Edwards, MD is working with the council to determine the best system. Dr. Edwards was

...continued on page 6



Dr. Edwards working with Laura Cohen, Ph.D., PT, ATP and Sherrie Hess on selecting codes for Medicaid to open

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What Have You Done For Me Lately?

instrumental in developing the Level II HCPCS codes as medical director of SADMERC. NRRTS Registrants are working together to gather information as it is requested by Medicaid. If these efforts fail, suppliers will then begin enlisting the consumers who no longer have access to needed services to bring the issue to light. The lessons learned here will be beneficial as these problems arise in other states.

GEARING UP FOR CELA

As this article is going to press, NRRTS is gearing up for our most important event of the year—CELA. This year, our focus is to bring more consumers to the hill to share their individual stories of the importance of technology in their lives and the need to have access to qualified suppliers. Besides the educational offerings, the scheduled meetings with Representatives and Senators will be the high light of the conference. The

things we can learn in Washington will give us more experience in dealing with our state Medicaid programs.

ARE YOU A PROFESSIONAL?

- NCART represents the Rehab Technology Companies and the manufacturers.
- AAH represents the Oxygen and DME suppliers.
- RESNA is the educational and certification body for Rehab Technology.

NRRTS is the only organization whose sole mission is to support, promote and identify the Professional RTS. We work with and support all of the above organizations, but, our purpose is to gain recognition for the invaluable service provided by CRTS®, and RRTS™ in the provision of Complex Rehab. We take this mission very seriously.

We are committed to staying on top of legislative issues and sharing the information including the

implications to our profession. We are providing quality educational webinars and teleseminars that allow for continuing education without travel expense. Go to the NRRTS website for the complete listing of the scheduled sessions.

NRRTS publishes the leading magazine of our industry. (Okay, I might be a little bit prejudiced!) *DIRECTIONS* contains articles that are very informative and timely.

These are just few things NRRTS has done for you lately. As your all volunteer board works on more exciting ideas, just remember, we've got your back!

See you at CELA! **D**

ABOUT THE AUTHOR

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Defeating the Disproportionate Weight Distribution Dilemma



STEPHANIE TANGUAY, OTR, ATP
Clinical Education Specialist
MOTION CONCEPTS

STATISTICALLY, WE ARE ALL getting heavier—seriously. According to the National Health and Nutrition Examination Survey (NHANES) 2001–2004, the prevalence of obesity more than doubled among U.S. adults from 1960 to 2004—from 13.3 percent to 32.1 percent—with the majority of that increase occurring since 1980. Manufacturers should take note of these statistics and design with them in mind.

It is not just that we are becoming heavier as a population; incidence of

lymphedema is also increasing. Cellulites, lipedema and other vascular disease processes can cause massive increases in the size of limbs and other body parts. Often, these conditions cannot be “resolved,” but only managed. Most of these conditions result in a disproportionate distribution of weight, which limits ambulation and makes wheeled mobility prescription challenging.

This anterior

weight distribution results in forward instability of many wheeled mobility bases, both manual and power. For many of these consumers, manual wheelchair mobility is unrealistic. Lymphatic conditions present a unique set of circumstances, as 60 percent or more of a consumer’s body weight can be in his or her lower body. This makes positioning and support of the lower extremities problematic, and it severely alters the anterior stability and overall performance of most power wheelchairs.

Additionally, the suspension features, anterior anti-tip systems and shock-absorbing casters—which effectively improve ride and performance for consumers up to 300 pounds—are not designed for such anterior weight distributions. Lower extremity support and positioning is compromised in regard to accommodation for larger leg size as well as structural integrity of lower extremity support mechanisms.

I hear requests for and see case studies of mobility solutions for some of these consumers. More frequently, I hear and see the results of mobility devices provided for these consumers without successful outcomes. It makes me wonder if we all don’t need to do a better job of communicating. Rehab technology suppliers and clinicians should not presume that a published weight

capacity of 400 or 500 pounds for a power base would perform the same as it would if the consumer’s weight were evenly distributed primarily in the lower extremities or the abdominal and thoracic area.

The ISO/7176-1 static stability testing weight of the test subject and the weight distribution recommendations do not make account for disproportionate distribution of consumer weight. Some manufacturers can test for higher anterior (belly) weight or increased lower extremity weight on a system if they know for what specific situation the chair is being ordered. While it is impossible to test for every situation, scenario and diagnosis, it is critically important to communicate your client’s weight distribution information to the manufacturers.

Mobility device and power seating system manufacturers all ask for measurements as well as height and weight information for the consumer. We don’t always get it, but it is helpful. Think of this scenario: you are asked to provide a power mobility device for a person who is 5 foot 8 inches tall and weighs 380 pounds. That information alone suggests an image of body shape and weight distribution. Perhaps the request includes a seat width of 26 inches. The diagnosis of lower extremity

...continued on page 10

While it is impossible to test for every situation, scenario and diagnosis, it is critically important to communicate your client’s weight distribution information to the manufacturers.

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Defeating the Disproportionate Weight Distribution Dilemma

lymphedema could mean that more than 200 pounds of that person's body weight is in his or her lower extremities! As a RTS, the opportunity to see the person enables you to work effectively to meet each consumer's needs.

I often encourage RTSs and clinicians to take pictures of their clients. I adamantly believe the Chinese proverb: "A picture's meaning can express ten thousand words." Not only is this a great way to communicate the consumer's physical status to the funding source, but it can also allow manufacturers to see what you see in the field. Anterior view and lateral view photos, especially a full-seated lateral view photo that illustrates weight distribution, can assist manufacturers in working with

you to better address the mobility needs of your clients.

Providing this type of information to the manufacturers will enable them to make recommendations for optimal setup and use of their equipment. Perhaps it will impact how a seating system is mounted on a power base. Maybe it will lead to development of new equipment options. Certainly, it is always better to be proactive than reactive. I think we would all prefer the opportunity to work as a team to meet the needs of all the consumers who utilize and rely upon assistive technology devices. **D**

ABOUT THE AUTHOR

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Reference:

National Center for Health Statistics. *Chartbook on Trends in the Health of Americans. Health, United States, 2006*. Hyattsville, MD: Public Health Service. 2006



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The Valiant Struggle

JEFF ADAMS
Co-Founder
MARVEL WHEELCHAIRS

I GREW UP A pretty average kid; I loved doing just about any sport I could—baseball, swimming, riding my bike ... but most of all, I loved hockey. A bit of a cliché growing up in Canada, but it's the simple truth.

I remember so vividly how much happier I was with a hockey stick in my hand, skating on rinks and ponds or running around playing street hockey with the kids in my neighborhood, dreaming about being the captain who scored the goal that won the cup.

I was a bit of a miracle baby, having overcome cancer at a year old. I survived with the help of some brand-new chemotherapy treatments and radiation therapy, which was also pretty experimental in 1971. I survived at a time when many didn't.

When I was 9 years old, my world came crashing down. What we hadn't realized was the radiation therapy that saved my life had also caused tiny burns on my spine, and eight years after the treatment, one of them blistered and burst, causing a spinal cord injury in the lumbar region. I retained some movement

in my right leg, but mostly none in my left, and I had to start using a wheelchair every day.

It was an unexpected and very unwelcome change in my life.

I spent about a year in a rehab center, and when I got out, I realized there were going to be new kinds of barriers in my life. The first one had to do with getting back into my house—there were two stairs at the front. Once we figured that one out by putting a ramp in, the next barrier I had was getting back to doing all the things I loved to do—mostly sports.

I remember going out to play street hockey again for the first time, holding a hockey stick in one hand and pushing my wheelchair with the other. I didn't score too many goals. I felt as if a dream had died, as if a small part of me had died.

My little brother Kevin and my friends got together to try to figure things out. We knew I had to keep playing—even at that age we understood that getting back to being a part of the community was enormously important.

We decided we needed to change things up a bit, so we took the net and stuck it in the middle of the street, then took a stool and stuck it in the middle of the net. I sat on the stool and played goalie, and an amazing thing happened. I started to dream again.

Now instead of playing out and dreaming about being Darryl Sittler,

I played in net sitting on a stool and dreamed about being Mike Palmateer. Instead of dreaming about being the guy who scored the goal that won the cup, I dreamed about being the guy who stopped the puck to win that same prize.

I can remember sitting there, hearing "car!" ... one kid would drag the net out of the way and another would drag me, on my stool, out of the way. We got some interesting looks.

I played tennis, but instead of a bounce on each return, I got two bounces while my brother Kevin got one. I tried for three bounces, but he wouldn't go for that deal. He's a litigation lawyer now, so maybe that had something to do with me losing the argument.

The point is I changed everything, I modified everything, and my reality became completely different.

All of the modifications, all of the changes were to level the playing field so I could continue to compete, because competition is good for us. The equipment I used, the technology that was available to me, became a liberating thing, but was also limiting. I remember my dad cutting the push handles and brakes off of my E&J stainless-steel folder so I could make it go faster.

I kept on going, changing everything, modifying everything so I could play the sports that I loved. But as happy as I was, a small part

...continued on page 14

All of the modifications, all of the changes were to level the playing field so I could continue to compete, because competition is good for us.

A close-up, low-angle shot of several wheelchair wheels on a polished wooden floor. The wheels are arranged in a row, receding into the background. The focus is sharp on the wheels in the foreground, showing the spokes and the rubber tires. The background is slightly blurred, showing the lower legs and feet of people sitting in the wheelchairs, wearing blue pants.

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The Valiant Struggle

of me was frustrated at having to change everything all the time, at always being the one who needed the modifications, the accommodations, and the endless conversations and negotiations that came as a result.

When I was 13 years old, my life changed again in an unexpected way, but this time for the better.

I got the chance to try wheelchair basketball at Variety Village; my coach was a guy named Joe Millage. After the first practice, I was so excited about a game where I didn't have to modify anything that I asked him if my friends from school could come watch me play. He said they could, but that they had to play in wheelchairs. The Village had a couple of extra chairs and he told me that if any of my friends wanted to show up, that he'd bring them and they could borrow the chairs.

Reality changed again, but this time, it was my friends' reality that changed. This time, it was my

rules. This time, they had to modify the way they played, and it changed the way they saw me.

They got to play using the technology that defined me in so many ways, and they finally started to understand in a real way what it meant to use a wheelchair. Of course it didn't give them a complete awareness, but the door of understanding opened the tiniest crack, and it was enough.

Technology levelled the playing field; in fact, it did more than level the playing field. All of a sudden, for the first time since I had started using a wheelchair, I had a natural advantage in a physical way over my friends, because I understood how to make the wheelchair work better. It turned a stereotype on its head and made my brother and my friends think in a new way. It helped them understand me a little bit better, but it also helped them understand themselves a bit more, too.

Understanding each other lets us

redefine the way we see each other; it lets us celebrate diversity instead of living in fear of it, no matter what the root of that difference. Making that effort to understand the people around us is the starting point to having the courage to face up to the barriers in our lives, and to help encourage the people around us to challenge those barriers.

Every single one of us has something in our lives that's worthy of a valiant struggle. Sometimes those struggles are about overcoming our own barriers, and sometimes they're about helping others overcome theirs.

Regardless, they're always about having the courage to face up to a challenge. That courage, most of the time, boils down to how we react to the events of our lives, and the way we react to both the good and bad is something that defines us.

Gathering up the courage to react in the best way possible is an exercise that never fails to bring me closer to being the person I want to be.

That experience with technology had a profound effect on my life, which continues to this day. I'm incredibly proud to be one of the founders of Marvel Wheelchairs™, because the entire focus of the company is to provide the best wheelchair technology possible to people who need it so they can level the playing field of their own lives, and to hopefully help them approach their barriers with as much courage as possible. 

ABOUT THE AUTHOR

Jeff can be reached at jeff@marvelwheelchairs.com.

Jeff Adams is a Paralympian competing primarily in the 800m and 1500m track events. He co-founded Marvel Wheelchairs in 2007 and is very active in disability rights advocacy. He sat as chair of the Accessibility Advisory Counsel of Ontario, providing advice to the Minister of Citizenship for the province of Ontario on legislation addressing accessibility, which resulted in the Ontarians with a Disability Act, the first legislation of its kind in Canada.



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Medicaid and Medical Necessity



DARREN JERNIGAN
Director of Government Affairs
PERMOBIL, INC.

THE DEFINITION OF MEDICAL necessity is constantly under attack, and states are starting to become quite creative and resourceful when attempting to skirt around the definition to limit reimbursement. First, there is no federal statutory or regulatory definition of medical necessity. The closest the country has come to a definition was a Supreme Court ruling in 1973. In *Doe v. Bolton* (410 U.S. 179, 35 L. Ed. 2d 201, 93 S. Ct. 739), the

court ruled on factors related to health, allowing a physician to make his or her best medical judgment.

Under federal law, Medicaid beneficiaries are entitled to have payment made on their behalf if items and services are (1) included among the benefits covered by their state's Medicaid program and (2) "medically necessary" for the individual in

question. Many states, however, are starting to redefine the definition of medical necessity

using a little known 1115 waiver from the federal government.

Section 1115 of the Social Security Act provides for the Secretary of Health and Human Services broad authority to authorize experimental, pilot, research or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered or use innovative service delivery systems, but under the previous administration some states were allowed to use the waiver to limit services. Nine states have 1115 waivers: California, Colorado, Delaware, Illinois, Maine, New Mexico, Oregon, Tennessee and Utah.

In Maine, DME will be approved as long as equipment is not more costly than a medically appropriate and realistically feasible alternative pattern of care. Furthermore, aesthetic or deluxe models or equipment and aesthetic or deluxe features are not reimbursable.

In Tennessee, the definition of medical necessity was redefined and it now must meet four specific criteria. One of which includes meeting a requirement that the item or service be the "least costly" alternative course of diagnosis

or treatment for which there is adequate "clinical scientific evidence" of its safety and effectiveness. Thirteen states have medical necessity definitions that include a "convenience or deluxe" requirement, 11 states have definitions that include a "cost effective" requirement and one state has a definition that includes an "adequate" requirement. No state appears to apply all three requirements simultaneously, as the Tennessee standard does.

Notice the words being used: adequate, alternative, appropriate, deluxe, realistic and feasible. These words are subjective and open to interpretation by Medicaid and become indisputable by a physician when applying medical necessity. With states trying to save money and with Medicare approving these waivers, it becomes more imperative than ever for complex rehab to have its own benefit category.

Please contact me if you would like to learn more about your particular state and Medicaid in regard to medical necessity. 

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With states trying to save money and with Medicare approving these waivers, it becomes more imperative than ever for complex rehab to have its own benefit category.

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I Thought I was Going to be Cool When I Grew Up... What Happened?



JIM NOLAND, ATP, CRTS®

NRRTS Treasurer

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AS A KID I thought, someday, I am going to be cool. Being a rock star, president or policeman was on the top of the list. Medical equipment sales? What happened? I thought I was going to be cool!

I started as a physical therapy assistant in Southern California after getting out of the Army in 1991. I wanted to work at the best place so I could learn from the most talented people. I got a job with the spinal cord injury unit at Ranchos

Los Amigos Medical Center in Downey, Calif. Man was that a tough job.

I was terrible at first, but eventually I was allowed to help out in its seating clinic and learned from Anjali Weber and other great clinicians about seating

and function. Everything related to function. We had all of the latest wheelchairs and seating options to try out with our patients. Each clinician had to master advanced wheelchair mobility skills like wheelies, curbs, ramps—and even escalators!

We generally kept people in rehab for four months to a year or more back then, so we really bonded

with them and came to appreciate their recovery experiences. That job and those people formed my ideas about how seating and mobility is done and why it is so important to get it right.

After leaving Rancho I worked in different settings, somehow always managing to do seating and positioning with every client I saw. I just knew each person could be more comfortable or independent if I just experimented with his or her wheelchair or seating. I was addicted!

Then it happened. I was blown away by this amazing speaker who explained the stepping-stones of Jay. (Anyone remember that?) Sharon Pratt got me so excited about wheelchair seating that day I actually asked Whit Gill, the Sunrise representative, for a job. He helped me get one and I was required to learn everything from scratch about our industry. I had never heard of a buying group, secondary discount, etc. I was so green! Eventually I moved from Los Angeles and worked a territory for Sunrise in northeastern Ohio.

In 2001 I decided to take the plunge and become a RTS. I knew a bunch of them and I did a lot of seating in a clinical setting, so how hard could it be? Wow, was I wrong. Early on, my boss came to me and said, “Jim we do not have anyone to see pediatric clients. Will you do it?” I replied, “Sure I can do adults...why

not kids?” I had a lot to learn, and I didn’t even know it.

Later that same year, some therapists invited me to sit in on a myelo clinic to help give advice on wheelchairs. I was very excited and agreed to do it. When I got to my car I called my pediatric seating therapist girlfriend (now my lovely wife) and asked her about myelo. She explained it was spina bifida! We all have to learn sometime, so that weekend was Chinese take-out and a crash course in myelodysplasia.

Okay, so I got better. I learned everything from everyone I could. Courses, books, magazines and mentors were my steady diet in the early years. I adopted the practice of performing a mat evaluation on every client and used the clinical goal-based seating model I learned as a clinician. Over time my outcomes improved dramatically. (On a side note, has anyone ever looked at the work they used to do and cringed?)

I also spent a few years as a part time surveyor for ACHC and learned a lot about the hows and whys of running a healthy business. I met some excellent people who are committed to this work. Tom Henley and his staff served as a great example of a few people working together to make a big difference in their community. I decided after performing that survey that I would try to open my own place.

...continued on page 20

Courses, books, magazines and mentors were my steady diet in the early years.



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*I Thought I was
Going to be Cool
When I Grew Up...
What Happened?*

When I got married and moved to Erie, Pa., I partnered up with an existing pediatric-focused orthotic and prosthetic shop. We started a complex rehab practice, adding it to the existing business. (I think we should describe what we do as a professional practice.) I was not allowed to work with my wife due to conflict of interest, so I had to build my business by being creative and working my tail off.

The model that worked best for us was to invest in our community. Community education, good service and excellent outcomes eventually proved our practice and developed our reputation in Erie. My referral sources know if there is a new product, I will get one in and show it to them. They have come to expect me to bring them organized and up-to-date information on funding and resources for their clients. They know my staff will help anyone in the community to the best of our ability, even if we will not ultimately be the providing vendor. That model has worked for us on many levels. Fiscally, we learned it is always in our best interest to make decisions that benefit the community we serve. That is what led me to NRRTS.

I was hopping mad about the changes in Medicare and their impact on our livelihood. How could our industry let us down? Why did they not see it coming? So I asked to write an article for *DIRECTIONS* titled "What's the matter with NRRTS?" To my surprise the NRRTS board and staff actually let me do it.

As I thought about how mad I was and what I wanted to say, I became aware of how I contributed to the problem by not participating. So I changed my mind and wrote that

article not to complain, but to call people to action and to help NRRTS be better at responding to the needs of the RTS.

I ran for office and became the treasurer, and now I can be a strong advocate for the CRTS®. I want the board to adapt to the changing needs of the professional RTS; the board needs to find ways to provide a tangible benefit for each of its registrants and increase its roster to include all of us so we have a much stronger voice in the conversation about where our industry is going.

I figure if people put forth good ideas and give their best efforts toward our collective success, NRRTS will benefit and our industry as a whole will be better. I see that as the potential of NRRTS—the ability to better our industry and protect and preserve the role of the CRTS®.

We all could look at our dues money as a way to contribute to improving our situation. We could look for ways to help the board and ourselves. Sometimes that help is criticism and other times it is action. RTSs need to give both time and money to causes and organizations that are looking out for our professional livelihood.

I am surprised, now that I am on the board, of how little feedback we get from registrants. Few complaints or even ideas about where NRRTS should go are ever offered. We are listening! Few people are talking, though. Call Judy, Simon or Amy. Call me and let me know what you want done. Tell me where we are wrong and where you want us to focus our attention.

Being on the board is an honor and a privilege. Please consider putting your name in for

consideration. You will find what I have found—a great group of talented people who put their time and energy into their passions and livelihood.

What will I do after my time on the board is up? I think I will go back to working on being cool...we have to learn sometime!

Get involved and keep the faith! **D**

ABOUT THE AUTHOR

Jim may be reached at 814.838.0099 or jnoland@pirt.us.

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Robin's story



I first met Robin in April of 2004 at Quest North, a local day program that employs and provides services for persons with disabilities. Robin had cerebral palsy that affected all four extremities with athetoid patterns when she moved; her diagnosis did not impair her function cognitively. Though she couldn't speak, she communicated well with a voice-generating device that she accessed by direct selection.

Robin cannot walk, so she uses a power wheelchair for mobility. When I met her, she was using a group three style rear-wheel drive power chair with a rehab seat frame, commercial pressure relief seat cushion, back support, additional support components and a power tilt.

For the most part she was comfortable in the chair and well supported. She and other clients who share her diagnosis often have broken items on their wheelchairs due to tonal issues. This was also the case with Robin, who had a broken joystick, tilt switch and footrests. We made many repairs.

In January of 2006, Robin's support coordinator sent in a prescription for a new wheelchair. Her existing chair had been provided in 2000 by another local company that no longer worked with clients who had Medicare as their funding source.

We believed the existing chair was beyond its useful age, as it was more than five years old and it would be more cost effective to replace the chair than to make the needed repairs. Her seating needed to be addressed

and she had multiple broken items that included the tilt actuator motor and switch, joystick and drive motors.

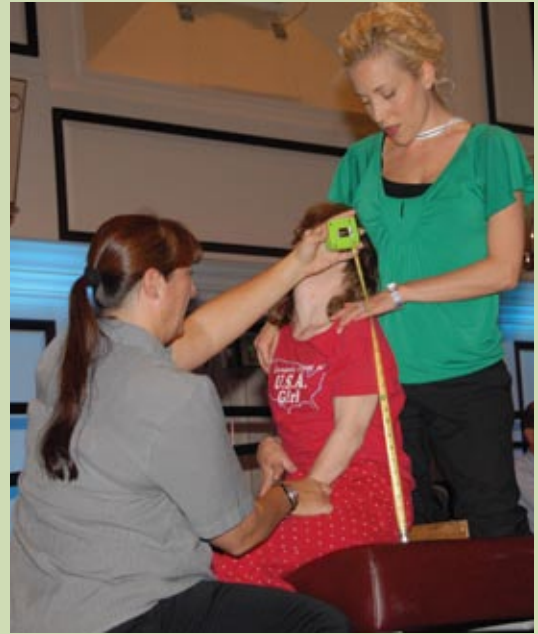
I explained the process of getting Robin a new chair to her support coordinator and made an appointment at our local seating clinic to get started. (Robin was not able to communicate via phone, so she often relied on other people for help with various tasks such as arranging transportation.) For Robin, "the process" turned out to be "the downfall" instead.

The previous October introduced Medicare's latest attempt—"the process"—to curb fraud and abuse in our industry. Due to "wheeler dealer" stories, our industry providers were being lumped together with people who were involved in illegal schemes with powered mobility.

To prevent some of this activity, The Centers for Medicare and Medicaid Services added a few more hoops for us to jump through and then they lit them on fire with the enforcement of their new face-to-face policy (i.e., "the process") for powered mobility.

The policy requires a client to meet with his or her doctor in person to clarify the need for a powered mobility device. In addition, new directives for documentation were added and

For Robin, “the process” turned out to be “the downfall” instead.



specialty evaluations from therapists were made mandatory for rehab wheelchair frames and powered seating.

There were also various timelines tied to how paperwork came in and out. This was said to be a protective measure so clients got what they needed in a timely fashion.

To this day, we still struggle with all these policy requirements. Going through the necessary steps—collecting information, processing it through the Advance Determination of Medicare Coverage, ordering equipment, fitting it and delivering it—takes three to four months if nothing goes wrong. And something always goes wrong.

I explained all this to Robin’s support coordinator and we were supposed to meet at a clinic the following week. I was there, but Robin did not show up to meet me. Robin had been having problems with her job coach and support coordinator, so she had new contact people. I tried to reschedule through them, but once again I did not see Robin at the clinic. I left messages with each contact before giving up when I never heard back. I had to hope that she would try to find me when things in her life calmed down.

In August of that same year, I got a call from Sunny, who ran the physical management program at Quest North, Robin’s day program. The facility was letting us come back in to take care of some clients’ needs; we set a date, as we had a large list of people to see.

Sunny and I met later that week and started going through our list. I could tell that she wanted to say something but was having a difficult time getting it out. When she got up the nerve, she said, “Michele, I need to talk with you about Robin’s new wheelchair.”

There was an eyebrow lift and head tilt that accompanied her statement, and not in a good way. My head tilted in the other direction and the words, “Robin’s new wheelchair?” were still hanging in the air when Robin rounded the corner. A feeling of gut-wrenching dread

...continued on page 26



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dropped my stomach into my feet when I saw her chair.

I looked at Robin and then back at Sunny. The look on Sunny's face was both questioning and accusing. The last time that we had been together working with Robin at Quest North, she thought I was supplying Robin's new chair, so she naturally assumed the resulting product was my doing.

Robin had been given a consumer-style group 2 power wheelchair with a captain's seat. This wheelchair was fine for many users, but should have never been recommended for Robin. She was falling over to the side and she was not able to maneuver very well when before she had been a good driver—and the chair was already broken. Her tone had caused the hinge of the bracket that holds the seat and back together to crack the wood on the seat.

We all spent awhile catching up and filling in the missing pieces of the puzzle. It seemed that Robin's new coordinator had said she knew it would not take as long as I had told her it would to get a new chair and that Robin did not need to go to any clinic to get a specialty evaluation; she knew someone who could bring a new chair out in a couple of weeks and Robin could even pick which color she wanted.

In the time that I lost touch with Robin, her power chair quit working altogether and she was stuck in her manual chair. I'm sure to Robin it must have sounded very appealing to get a new chair very quickly, but after she received it, she found that it didn't work out very well.

The company that supplied the chair sent their technician to Robin's home several times, but said that he

...continued on page 28



A feeling of gut-wrenching dread dropped my stomach into my feet when I saw her chair.





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had done everything he was able to do for her. Sunny and Robin asked what I could do to help her, and I had to explain that I was no longer her provider.

Robin was going to have to work with the company that supplied the chair unless she wanted to make them take the chair back and have them return the funding to Medicare so that we could start over. I gave them all of the information that I could to help them, and then I closed Robin's file.

How did this happen? Robin was not just someone who caught a slick ad while watching TV late at night and dialed an 800 number. She was my client, and I was unable to prevent her from receiving inappropriate equipment.

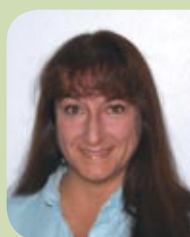
Two and a half years later, Robin was still using the same wheelchair. She was unable to return it, because the company that provided it went out of business shortly after we spoke.

Robin joined me with her therapist during a seminar that I presented at The International Seating Symposium on March 12. We completed an evaluation, two different seating simulations and a clinical trial. The results showed incredible improvements in her seating and functioning. They were so amazing, in fact, that companies from the complex rehab community, who have asked to remain anonymous, have donated the proper chair and seating system for Robin.

Robin is one of the lucky few. There are still hundreds of people with special needs who are making five-year mistakes every day because they are receiving the wrong information.

ABOUT THE AUTHOR

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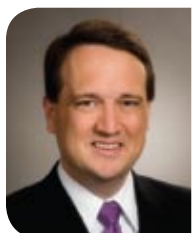
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Devil in the Details: How to Prevent Problems with Delivery Documentation



CLAY STRIBLING, ESQ.
Attorney
BROWN & FORTUNATO P.C.

A salesman can tell you, that it isn't always the boss that makes the key decisions in an organization. If a salesman cannot get the receptionist to let him see the decision makers, then there is no way a sale gets made. Alienate the gatekeeper, and you can pretty much write-off any future business from that company.

Similarly, one of the key cogs in the HME machine is the delivery technician.

Often underappreciated, a good delivery tech can do wonders for your business by creating good rapport with your customers, and helping your company obtain documentation needed to bill. Given

the importance of this role, HME suppliers should take care to train and monitor delivery drivers to be certain they are doing your company a service, and not undermining your success.

TRAINING

Delivery technicians play a pivotal role in educating your patients. Doesn't it make sense this important

employee should receive the same detailed and comprehensive training that other employees receive?

In many companies, management excludes delivery techs from key training by rationalizing that 'compliance training has to do with billing, sales and collections. These departments all play a key role in compliance, but the delivery tech has just as much to do with a company's compliance than any of these others. Many significant compliance issues are dealt with at delivery. Matters relating to HIPAA, patient collections, documentation, and compliance with the supplier standards all have serious ties to the delivery process. For this reason, companies should include delivery techs in all training provided to other employees. In addition, each company should conduct routine training geared specifically to delivery techs to be certain these employees understand their key role in the company.

DOCUMENTATION

Any supplier that has billed Medicare for products and/or services understands that collecting the correct documentation often means the difference between getting paid for a claim or getting denied. Failure to get the proper signature in the proper location can lead to denied claims, and in some extreme cases,

allegations of fraud or wrongdoing.

Given the significance of the delivery paperwork, there are several issues that delivery techs should watch for with any patient:

- All forms requiring patient signature should be signed and dated by the patient. Many times a patient will sign a form correctly, but fail to date where indicated. If a form requires patient signature and date, the patient must complete both. In addition, if a patient is unable to sign a form, the authorized representative signing on the patient's behalf must list his/her relationship to the patient and the reason the patient is unable to sign.
- Once the patient has signed a delivery document, it cannot be changed by the delivery tech or the company. Any subsequent changes to the document must be initialed by the patient and dated.
- All questions posed by the patient, or issues raised by the patient should be documented in the patient's record. If Medicare later asks a patient about the delivery process and the patient brings up issues not reflected in the notes, the auditor may doubt the accuracy of the company's documentation.
- Finally, and most importantly, review all documentation to verify

A good delivery tech can do wonders for your business by creating good rapport with your customers and helping your company obtain documentation needed to bill.

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*Devil in the Details:
How to Prevent
Problems with Delivery
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its accuracy once again at the time of delivery. Delivery techs should go over basic information with patients again such as physician name, product ordered, accessories provided, serial numbers and other relevant info one last time. These issues can certainly prevent a claim from being paid if not completed correctly.

Although each department within an HME supplier is important, the sheer number of key issues impacting the delivery process mandate that a supplier should spend company time and resources on this function. In addition to training, the supplier should routinely audit the information provided on delivery to be certain that delivery techs are collecting the appropriate information. Only by verifying that the delivery techs

have the information they need to assist can a supplier be comfortable that they will get paid (and keep the payments) for items delivered to beneficiaries. **D**

ABOUT THE AUTHOR

Clay Stribling, Esq. is an attorney with the Health Care Group at Brown & Fortunato, P.C., a law firm based in Amarillo, Texas. He represents pharmacies, infusion companies, home medical equipment companies and other health care providers throughout the United States. Mr. Stribling is Board Certified in Health Law by the Texas Board of Legal Specialization. He can be reached at 806.345.6346 or cstribling@bf-law.com.

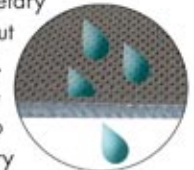
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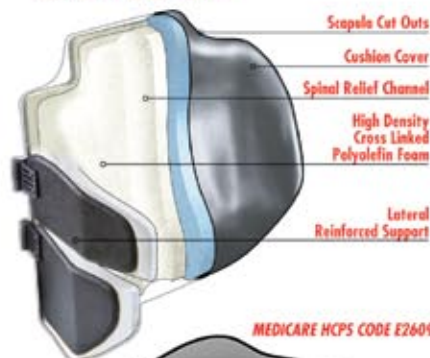
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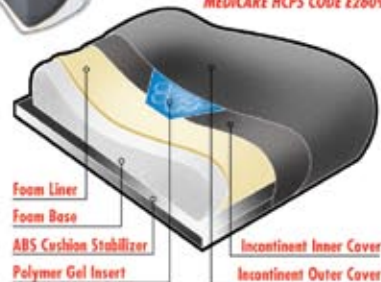
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Repairs: How Do I Make Them Work for My Company?



PEGGY WALKER, RN
Billing & Reimbursement Advisor
US REHAB

WHEN IT COMES TO repairs, the question I receive more often than any other is: "Where is it written?" or "Can you show me where I can find that in writing?" On Oct. 1, 2003, CMS restructured its paper-based manual system to create a web-based system, which combines all of the various instructions for CMS programs and contractors. This web-based system can be found at www.cms.hhs.gov/manuals.

We can find all reference notes related to repairs, maintenance, replacement and delivery in The Medicare Policy Manual (pub. 100.2,15,110.2). This manual states that payment may be made for repair, maintenance and replacement of "medically required" DME, including equipment that has been in use

since before the beneficiary enrolled in Part B of the program. So what are Medicare's definitions for repair, maintenance and replacement?

Repair means to fix or mend and to put the equipment back

in good condition after damage or wear. Repairs to beneficiary-owned equipment are covered when necessary to make them serviceable.

Remember the beneficiary must still meet the coverage criteria for that item. A new CMN/DIF and/or physician's order is not needed for repairs if the equipment was purchased by Medicare. However, if it was not purchased by Medicare, you'll need an order and must make sure the item meets Medicare criteria.

Maintenance is the routine periodic servicing, such as testing, cleaning, regulating and checking. Maintenance of beneficiary-owned equipment is not covered; the owner is expected to perform such routine maintenance. However, more extensive maintenance which, based on the manufacturer's recommendations, is to be performed by authorized technicians, is covered as a repair for medically necessary beneficiary-owned equipment.

Replacement refers to the provision of an identical or nearly identical item. Equipment owned by the beneficiary, or a capped rental item, may be replaced in cases of irreparable damage or loss. Irreparable damage refers to damage which results from a specific accident, theft or natural disaster (e.g. fire or flood). In these cases, a physician's order and/or a new CMN (when required) are needed to reaffirm the medical necessity of the item.

An item can also be replaced if:
a) it has been in continuous use by the patient on EITHER a rent or

purchase basis for the equipment's useful lifetime and b) the beneficiary elects to obtain a new piece of equipment. In either case, a new order is required. The reasonable useful lifetime of DME is determined through program instructions. In the absence of program instructions, carriers may determine the reasonable useful lifetime, but in no case can it be fewer than five years. Computation of the useful lifetime is based on when the equipment is delivered to the beneficiary, not the age of the equipment. Replacement due to wear is NOT COVERED during the reasonable useful lifetime of the equipment.

Now that we know the "rules," how do we get these services paid?

The current repair code for labor is E1340, with one unit equal to 15 minutes (this code changed April 1, 2009, to K0739). There is no fee schedule assigned to this code at this time. The last fee schedule, dated 2001, showed a range from \$9.60 to \$17.66 (AK), with a mean of \$11.29. When billing this code, you need to put a breakout narrative that states: "repairs to (name, make, model), purchased by (payer source) on (date purchased) took (time in minutes) to replace (item)." This needs to be abbreviated, but obvious enough that the reader can fully understand the information, particularly the name, make, model, the date of purchase and who purchased it. Remember to

*Repair means
to fix or mend
and to put
the equipment
back in good
condition after
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Repairs: How Do I Make Them Work for My Company?

always use the words “broken beyond repair” versus “worn out.”

The old RP modifier has been replaced with the RA and RB modifiers. The RA modifier is used when replacing the whole item due to expiration of its lifetime or loss due to accident, disaster or theft. The items you provide in order to repair a piece of equipment are billed with the NURBKX modifiers (for manual wheelchair accessories you also need to add the KE modifier if the accessory was included in round one of competitive bidding).

If you’re replacing items on both the right and left sides, use NURTRPKX (1 unit) then NULTRPKX (1 unit) to prevent having to use an overflow modifier (99). Note that this rule changes from day to day and may differ by jurisdiction, so if the claim is denied, use the overflow modifier NUKEKX99 and add RBRTLT in

the narrative field. When using any miscellaneous E1399 or K0108 code, or any NOC (“not otherwise classified”) code, always supply the name, make, model and MSRP so that payment can be established for it.

If the repair will require longer than 24 hours and you need to supply a loaner wheelchair, use code K0462. This is paid by the item you provide and is, for up to one month, a rental for loaner equipment while beneficiary-owned equipment is being repaired. You must note why the repair took longer than one day to complete.

Each supplier must decide what procedures he/she needs to change to make any type of profit on billing for repairs. I always suggest if you did not provide the original item, it’s best to bill non-assigned. Research your allowable and the units you have to bill, and make sure you have everything you need to make

an informed decision. I know in the past many providers have not researched their options, but now is the time to do it.

Also keep in mind that CASH is the best HCPCs code there is. There is nothing wrong with asking for payment up front on a non-assigned claim. When does someone like Sears just bill you for something after the fact? Never! They ask you for a credit card up front. That’s what we need to be doing, too.

What about a service charge? The new repair labor and replacement policy that took effect on April 1, 2009, specifically states you cannot bill service fees to the beneficiary. After this date, you can bill the patient a service charge for repairs ONLY if you are billing non-assigned. In these cases, you need to make sure you have a service fee schedule and explain this up front to the beneficiary.

The new repair policy also limits the allowed units of service for certain repairs. The number of allowed units for these repairs is very restrictive at this time and we are working throughout the industry to change this. In all cases, remember that payment for delivery of DME, whether rented or purchased, is generally included in the fee schedule allowance for the item and cannot be billed.

It’s important to use the VRU (automated voice response unit) to check for beneficiary history of items purchased or rented in your jurisdiction. You also need to make sure the beneficiary qualifies for the item being repaired. A beneficiary may have more than one item in his or her home, and Medicare will only pay for repairs for the chair on record. **D**

ABOUT THE AUTHOR
Peggy may be reached at
803.754.2090 or
peggy.walker@vgm.com.

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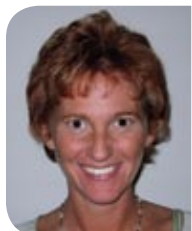
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Selecting The Appropriate Seat Cushion: How Much Do We Or Should We Consider The Science?



SHARON PRATT, PT
Director of Education, Seating
SUNRISE MEDICAL

SEAT CUSHIONS HAVE EVOLVED, and it seems that the process involved in selecting clinically appropriate seat cushions for our wheelchair-seated clients has switched gears somewhat from a purely artistic approach to perhaps a more evidence-based or science-based thought process. This is a welcome change in our industry and one we can all embrace.

Regardless of what funding source we're accessing, we have to be accountable with our documentation of the assessment, goal forming and product selection process. When it comes to product selection, the challenge we face is that clinicians and RTSs have significantly different levels of technical knowledge, and there is little or no real evidence that any product is more effective than or superior to another product. What we do know is that:

- Humans vary in shape and load.
- Materials used in seating work differently.
- Cushions react to shape and load.
- Each interaction between cushion and human is unique.



foam compresses under load and the force experienced by the body is one of reaction.



The most common materials used in seat cushion design include foams, elastomers, fluids and gels. Each of these materials accommodates body loads and shapes with different mechanisms and forces. The mechanism in play with foam is compression;

With fluids such as Jay fluid, the mechanism is displacement; fluid displaces under load and forces are hydrostatic.

Manufacturers take these various material constructs—foams, air, elastomers or combinations of these—and apply design techniques such as segmentation, firmness layering and pre-contouring.

Tension has to be factored in at all levels of design. The outcome is a product design that meets client needs and the goals as established by the clinicians. These goals could be categorized as:

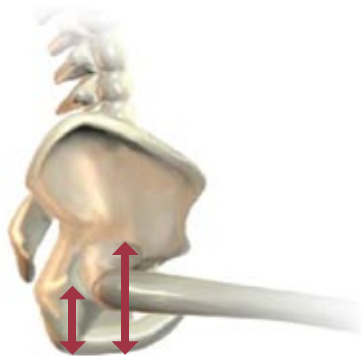
- Primary
 - Redistribution of load
 - Stability
 - Positioning
- Secondary
 - Heat and moisture dissipation
 - Impact and vibration dampening

How does this information translate into desirable clinical outcomes and client satisfaction? I believe it is of utmost importance for us to think through a series of steps when faced with the task of selecting the appropriate cushion selection.

Step 1 is the clinical evaluation, from which we glean information pertaining to postural presentation and tolerances for correction; stability needs; skin integrity and risk for decubitus ulcers; anatomical dimensions and overall body dimensions; functional status; continence status; as well as maintenance ability, just to name a few.

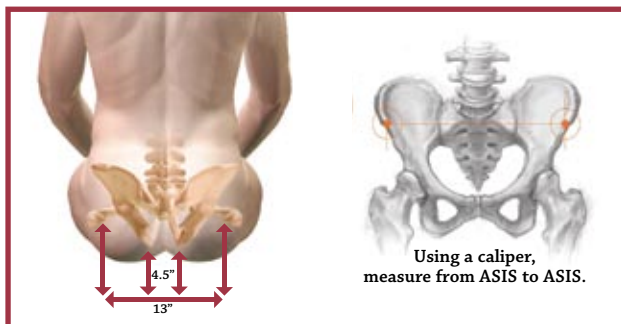
Step 2 is the identification of goals. Example: For this client to be able to function from a seated position, he/she needs lateral stability, skin protection due to past history and correction of a flexible pelvic obliquity and posterior pelvic tilt.

Step 3 is the translation of clinical findings and goals to equipment parameters. For example, if the goal is lateral stability, should we not be thinking about the material and product design? Will one get more stability from sitting on a container filled with fluid or from sitting on foam? Does the density of the foam matter? Does it matter where the body is taking the load? Does it matter what the shape relationship is between the body and the cushion? I believe all of these factors matter.



Some important adult anatomical considerations: The height difference between the ischials and the undersurface of the trochanters is approximately 2 inches.

The distance between the ischials in a male is approximately 4–4.5 inches, and in a female it is 4.5–6 inches. Is this important? Yes, if we care where the ischials are in relation to the cushion. The width between the undersurface of the trochanters is also a very valuable dimension. Why? If we want to provide lateral stability, it might be important to have the cushion provide stability beneath the trochanters. To ensure this happens, it would help if the cushion's pelvic contour width matched that of the anatomical width of the undersurface of the trochanters. (I have yet to find a pelvis measuring wider than 13 inches from undersurface of trochanter to undersurface of trochanter.)



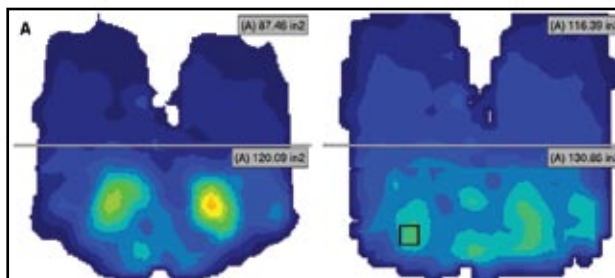
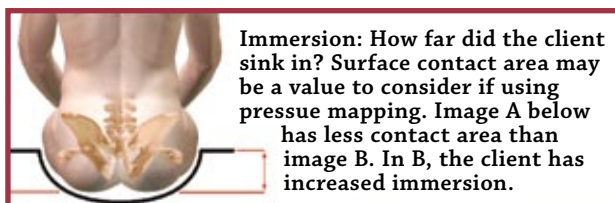
How does one measure these widths easily? I've found a direct relationship between the distance between the ASISs and this undersurface of trochanter-to-trochanter distance. So, with a caliper, it's very easy to point to the ASISs and capture the measurement. This translates nicely to the desired pelvic contour width of the cushion.

With these facts in mind, now we can consider the

product design and use of materials. If lateral stability is one of the goals for the client, now I know that the cushion needs to be designed such that the ischials can sink into the material at least 2 inches without bottoming out, and the pre-contouring needs to respect the anatomical dimensions of the trochanters. The cover and the materials beneath the cover need to have minimal tension so as to allow this optimal immersion of the ischials. If using a fluid material beneath the pelvis, segmentation becomes an important factor. This may reduce the flow of the fluid from one side to another, enhancing stability.

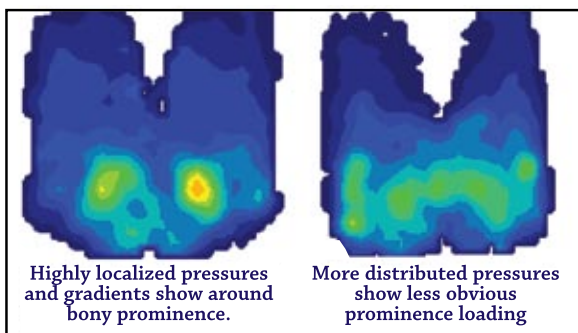
If skin protection is an identified goal, we need to think about immersion without bottoming out as well as envelopment and magnitude. This means that we want the ischials to sink in and we want an optimal shape relationship with the client's shape so there is an overall reduction in the magnitude of pressure. Generally, the greatest shape relationship can be achieved with fluids that have in the design low surface tension and a volume that permits the appropriate depth of immersion. Others use the intimacy of custom molding to achieve this shape relationship.

Step 4 is trial and outcome measurement. If pressure mapping is a tool being used to assist with the evaluation and outcome measurement, surface contact area is a good value to look at to see immersion.

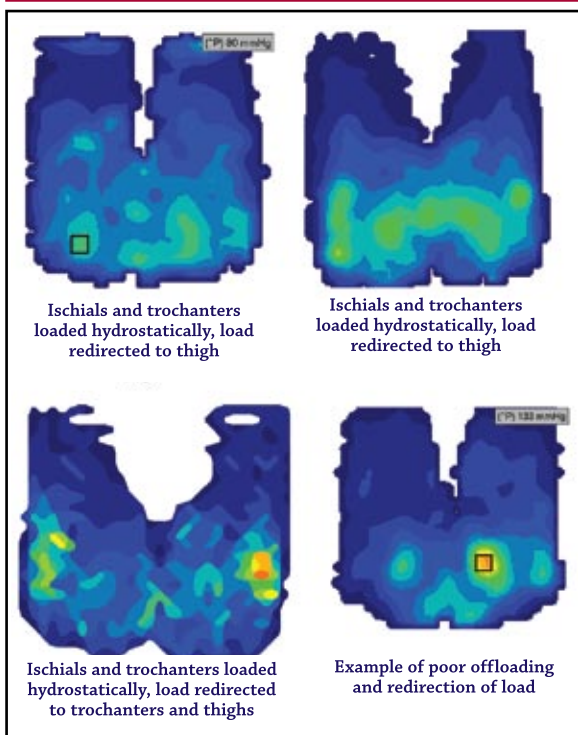


Envelopment is the intimacy of the shape formed with the clients' shape. Variances in high and low pressure values may help with seeing envelopment.

Selecting The Appropriate Seat Cushion: How Much Do We Or Should We Consider The Science?



Magnitude is how well a cushion has distributed pressure. One could look at peak pressures and average pressures to determine magnitude. The goal is usually to have the lowest pressures possible in the areas that are most sensitive to load bearing.



In the absence of pressure mapping, we have our hands, eyes and client feedback as our tools to gain this information. Under the goal of skin protection, we're also considering shear reduction as well as moisture and heat management.

Questions to reflect upon are: Can the client move in his or her cushion with minimum resistance to ischial excursion? If not, they may be experiencing increased shear forces. What materials are offered in the cushion and cover to address moisture and heat dissipation? What clothing is worn next to the body and how does that impact moisture and heat dissipation?

In summary, I would like to share a checklist that I use to help me look at all cushions with a critical eye:

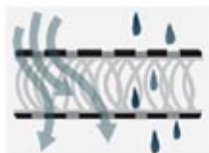
- Check cover material and tension.
- What materials are used?
 - Think about mechanisms and forces.
- What design techniques are present?
 - Are there segmentation, density/firmness layering and/or pre-contouring?
- What is the contouring or shaping capability in the pelvic loading area?
 - What's the potential for immersion?
 - What's the load distribution method?
 - Is there potential for the trochanters to be loaded?
 - What's the potential for lateral stability and forward stability?
- Positioning: What are the possibilities?

I recall like it was yesterday the days when I used to ask for the cushion to fit my client's chair without giving much or any thought to fitting the cushion to the pelvis first and then to the chair. I based a lot of my selection processes on what I had previous success with as well as what I thought was comfortable for my client.

I'm glad to say that GONE are those days. I'm delighted and embrace the changes that I see within my own clinical best practices as well as in the practices of others. The decisions can be made upon a foundation of science and evidence, and this is a very exciting evolution. **D**

ABOUT THE AUTHOR

Sharon may be reached at 888.333.2572, Ext 4669 or sharon.pratt@sunmed.com.



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CELA'09

COMPLEX REHAB EDUCATION AND LEGISLATIVE FORUM

APRIL 20-23, 2009

Presented By:



In association with:



Monday, April 20, 2009

7:00pm

Welcome Reception & NRRTS Open Meeting

Location: Carroll Room at Sheraton, Baltimore City

Tuesday, April 21, 2009

7:00am

Breakfast and Orientation to Capitol Hill visits

Location: Liberty Ballroom at Sheraton, Baltimore City

8:00am

Buses depart for Capitol Hill

Location: Sheraton, Baltimore City

5:00pm

Buses depart Capitol Hill

Location: Capitol Hill

6:00pm to 7:00pm

Decompression Wine & Cheese Reception

Location: Lounge Room at Sheraton, Baltimore City

Wednesday, April 22, 2009

7:00am to 8:30am

Breakfast and Capitol Hill Visit Debriefing

Location: Room 307 of the Baltimore Convention Center

8:45am to 9:30am

Saying No - a survival skill for Complex Rehab Providers and Therapists

Surviving and continuing to provide quality seating and wheeled mobility services in the face of continuing regulation and funding cuts often seems like an impossible task. The key for both suppliers and therapists is learning how and when to say "no."

Presenter: Gerry Dickerson, CRTS®, Director of Rehab Technology, Medstar, Inc.

Location: Room 307 of the Baltimore Convention Center

9:30am to 11:00 am

Doing More With Less -Making Appropriate Seating and Wheeled Mobility Clinical Decisions in the Face of Funding Cuts - Part 1 - Manual Wheelchairs and Seating

The reality of our industry and profession is that there will be less reimbursement for what we provide but the clients' needs will remain the same. What strategies can we use to meet these needs? How will manufacturers provide alternatives that work within the emerging funding structure? How can we manage the expectations of the client and those of the referral source?

Moderator: Joni McGhee, OTR, Clinical Coordinator, TIRR/Memorial Hermann

Presenters: Foster Davis, Freedom Designs; Tom Whelan, Global Vice-president, Seating, Sunrise Medical; Tina Roesler, MSPT, ABDA, Director of Sales & Education, TiLite

Location: Room 307 of the Baltimore Convention Center

11:00am to 12:30pm

Doing More With Less -Making Appropriate Seating and Wheeled Mobility Clinical Decisions in the Face of Funding Cuts - Part 2 - Power Wheelchairs and Seating

The reality of our industry and profession is that there will be less reimbursement for what we provide but the clients' needs will remain the same. What strategies can we use to meet these needs? How will manufacturers provide alternatives that work within the emerging funding structure? How can we manage the expectations of the client and those of the referral source?

Moderator: Joni McGhee, OTR, Clinical Coordinator, TIRR/Memorial Hermann

Presenters: Mike Babinec, OTR/L, ABDA, Product Manager: Power Wheelchair Electronics, Invacare Corporation; Julie Piriano, PT, ATP, Director, Rehab Industry Affairs, Quantum Rehab; Ann Eubank, OTR/L, Director of Education, Permobil

Location: Room 307 of the Baltimore Convention Center

CELA 2009 SCHEDULE OF EVENTS

Thursday, April 23, 2009

8:00am to 9:00am

Looking Back - Lessons for the Future

The presentation will ask and answer questions like "What, if anything, did we as a Complex Rehab industry and profession do wrong to get us where we are today?" "What do we have to do individually and as an industry to get back on course?"

Presenter: Hymie Pogir, Vice President of Product Planning, National Seating and Mobility

Location: Room 345 of the Baltimore Convention Center

9:15am to 10:45am

Powered Mobility Training for Children with Complex Needs

Powered mobility training for individuals who have never experienced independent mobility cannot continue to utilize strategies used in the past. How chairs are configured, the electronics programmed, the seating developed and the environment planned are all critical to successful use. These strategies will be shared with real case studies.

Presenter: Karen Kangas, OTR/L, Seating and Positioning Specialist in private practice in Shamokin, PA

Location: Room 345 of the Baltimore Convention Center

Fixed Postures? Flexible Opinions

Many postures described as "fixed" are actually very flexible. Unfortunately they are flexible in the direction of further deterioration, not towards improvement. This presentation will challenge participants to improve their evaluation and documentation skills to more accurately describe what has traditionally been labeled as fixed postures. Strategies to optimize flexible components of posture through seating and alternative positioning devices will be presented.

Presenter: Tom Hetzel, PT, ATP, CEO, Ride Designs/Aspen Seating

Location: Room 347 of the Baltimore Convention Center

11:00am to 12:30pm

Bariatric Seating - Challenges, Techniques and Technology

Participants in this session will be able to identify the scope and problems associated with obesity and bariatrics, identify the causes and dynamics of bariatric clients medical management, demonstrate various safety issues associated with the bariatric client, describe the solutions for choosing appropriate equipment and caring for the bariatric client's skin, understand the challenges faced in seating and wheeled mobility and will discuss the multidisciplinary team efforts to plan the bariatric client's care.

Presenter: Pat Meeker, MS, PT, CWS, The ROHO Group

Location: Room 345 of the Baltimore Convention Center

Stable, Not Static - Dynamic Seating to Improve Movement and Function

To some, dynamic seating is the design and fabrication of equipment that will withstand the strong movement patterns of many wheelchair users. To others, the provision of dynamic seating is focused on seating that allows or restores natural postural movement while maintaining comfort and stability. This presentation will focus on seating that allows or restores natural postural movement.

Presenter: Allen Siekman, Siekman Consulting

Location: Room 347 of the Baltimore Convention Center

THANKS TO THE FOLLOWING SPONSORS OF CELA 2009!

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SUPPORTER:



CONTRIBUTOR:



NEW REGISTRANTS

Congratulations to the newest NRRTS Registrants!

(January 24, 2009 through March 31, 2009)

Roy C. Brown, ATP, RRTS®

Prescription Medical Equipment & Supplies, Inc.

1019 Dalworth Dr

Mesquite, TX 75149

Telephone: 972-288-2332

Fax: 972-288-2321

Registration Date: 2/19/2009

Sarah Cook, RRTS®

Cook Medical Supply

162 Hwy 13 South

Morton, MS 39117

Telephone: 601-732-6334

Fax: 601-732-7124

Registration Date: 3/24/2009

David J. Mignacca, Sr., RRTS®

Comprehensive Home Medical Equipment, Inc.

1150 Oaklawn Ave

Cranston, RI 02920

Telephone: 401-463-9400

Toll Free: 800-850-3693

Fax: 401-463-9402

Registration Date: 3/30/2009

Kathryn Samay, RRTS®

Ultimate Mobility

1158 Main St

Worcester, MA 01603

Telephone: 508-363-1227, x.120

Toll Free: 888-675-1777 x.120

Fax: 508-363-1228

Registration Date: 3/20/2009

FORMER NRRTS REGISTRANTS

The NRRTS Board determined RRTSTM and CRTS® should know who has maintained his/her registration in NRRTS, and who has not. Names included are from January 24, 2009 through March 31, 2009. For an up-to-date verification on Registrants, visit www.NRRTS.org, updated daily.

Lydia Aceves, ATP

Jeffrey W. Andersen

Jason Berges

Brian James Clark, ATP

Richard B. Cooper, ATP

Rafael Gutierrez, ATP

Craig Hanner

Rick Liston, ATP

Mike Madej

Doyle Mann, ATP, CRTS®

Kerry Marschand, ATP

Jeffrey Martin

Clint Moore, ATP

Ines Roberto Reyes, ATP

Eric Sale

David J. Schultz

Steven R. Secrease, ATP

Alan James Smith, ATP

Scott D. Smith

Anthony J. Soria, Jr.

J. Christopher Williams

Sacramento, CA

Redding, CA

Phoenix, AZ

Waterloo, IA

Irving, TX

Sacramento, CA

Des Moines, IA

St. Louis, MO

Jacksonville, NC

Tampa, FL

South Bend, IN

Jamestown, ND

Mesa, AZ

Uvalde, TX

Alsip, IL

Peoria, IL

Little Rock, AR

Syracuse, NY

Sandusky, MI

Alsip, IL

Ft. Worth, TX



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RAP 2000 - Looking Back to the Future

MARCH 18 AND 19, 1999 were landmark dates for the Rehab Technology industry and profession. They marked the first time that 20 major stakeholders in Rehab Technology met to discuss the professional future of our industry. This Rehab Accreditation Project meeting was co-sponsored by the National Association of Medical Equipment Services Rehab Council (now American Association for Homecare-Rehab and Assistive Technology Council); the National Registry of Rehabilitation Technology Suppliers; National Seating and Mobility; U.S. Rehab, and the MED Group National Rehab Network.

Was this a case of being careful of what you wish for because you just might get it?

See for yourself. Here is the RAP 2000 Executive Summary. The entire report is available at www.nrrts.org.

Rap 2000 Executive Summary

Individualized products and services provided to clients by highly-trained and credentialed members of the Rehab Technology profession have long been overshadowed by the more general business of durable medical equipment, a much larger segment of the multi-million dollar business of home medical equipment. As such, Rehab Technology Companies have faced health care accreditation standards that are poorly suited to their specialty area.

Accrediting organizations fail to recognize the unique practices and concerns of the Rehab Technology industry in favor of the more popular practices of respiratory therapy, infusion therapy and home health care.

It is the goal of members of the Rehab Technology community that these unique Rehab practices and concerns be recognized with the development of appropriate accreditation standards that address specific practices of this area of health care. Ultimately, with such accreditation standards in place, managed care organizations and clients needing these services will be better prepared to determine which providers are qualified Rehab Technology Companies that can best meet their Rehab Technology product and service needs.

To reach this goal, five major Rehab Technology industry organizations and a number of independent companies, representing more than 2,000 Rehab Technology Companies, unveiled the results of a two-day consensus conference. Accreditation guidelines were established for measuring the standards of practice associated with the field of Rehab Technology. The Rehab Technology community has been asked to comment, providing feedback that will ultimately result in the

crystallization and adoption of and adherence to these much-needed formal accreditation standards.

The consensus conference was sponsored jointly and attended by representatives from these and other major Rehab industry organizations: the National Association of Medical Equipment Services Rehab Section; the National Registry of Rehabilitation Technology Suppliers; National Seating and Mobility, Inc.; U.S. Rehab; the MED Group National Rehab Network; as well as representatives of independent Rehab Technology Companies.

The consensus statement outlines standards for Rehab Technology Companies and serves as a basis for measuring acceptable levels of performance and quality within the Rehab Technology field. In the business of HME/DME vs. the business of Rehab Technology, significant differences were outlined in the following areas:

- **Personnel:** Levels of staff training and credentialing.
- **Evaluation Process:** When, where and how client evaluations are conducted.
- **Physical Plant:** Inventory and service needs based on the type of equipment and level of technology provided.
- **Fitting/Delivery/Follow-up:** Fitting the technology to the client, client education, quality assurance and customer satisfaction.
- **Service/Repair:** Inventory management, warranty tracking, defined service policy, manufacturer product support.
- **Patient Advocacy:** Assist client with funding process, payer negotiations, and complex claims processing.
- **Outcomes:** Measurement of point-in-time progress for client.

Summary

The Consensus Conference provided a forum for Rehab Technology industry members to delineate a set of standards and measurement tools to clearly identify Rehab Technology Companies; benefit the industry as a whole and help it move into the 21st century; and most critically, to serve people with disabilities who use Rehab Technology products and services. It is the goal of the group to establish this set of requirements as the standard by which all Rehab Technology Companies should be measured.

The ultimate goal is the development of an accreditation program that clearly differentiates the Rehab Technology process from the of HME/DME products.

CRTS® CREDENTIALS

Congratulations to NRRTS Registrants recently awarded the CRTS® credential. A CRTS® receives a lapel pin signifying CRTS® or Certified Rehabilitation Technology Supplier® status and guidelines about the correct use of the credential. Names listed are from January 24, 2009 through March 31, 2009.

John Ken Bagot, III, ATP, CRTS®
Mr. Wheelchair, Inc.
Jefferson, LA

Terry L. Bergman, ATP, CRTS®
GSH Home Med Care, Inc.
Palmyra, PA

Wayne Carroll, ATP, CRTS®
Mobility Medical, Inc.
Flowood, MS

Jerry E. Cormier, ATP, CRTS®
Rehab Specialties
Pharr, TX

Jeffery E. Fought, ATP, CRTS®
Chesapeake Rehab Equipment, Inc.
Camp Hill, PA

Laura Frey, ATP, CRTS®
Mobility Solutions, Inc.
Odessa, FL

Michele A. Froehlich, ATP, CRTS®
R & R Discount Medical, Inc.
Kalamazoo, MI

Jed Golding, ATP, CRTS®
Ability Medical Supply, Inc.
Sunrise, FL

Bennie G. Jones, ATP, CRTS®
Rehab In Motion, Inc.
San Antonio, TX

Joseph L. Kelley, ATP, CRTS®
Kwik Kare, Inc.
Ocean Springs, MS

Justin Look, ATP, CRTS®
ALL-U-MED, Inc.
Temple, TX

Leigh Ann Matthews, ATP, CRTS®
Complete Care, Inc.
Ft. Payne, AL

David Lee McGraw, ATP, CRTS®
Mountaineer Home Medical
Morgantown, WV

Valerie A. Pagan, ATP, CRTS®
A & O Surgical Supply, Inc.
Bronx, NY

William D. Pierce, ATP, CRTS®
National Seating & Mobility, Inc.
Niantic, CT

Paul S. Protzman, ATP, CRTS®
Bee Mobile, Inc.
Chula Vista, CA

Ellen Russell, ATP, CRTS®
Matheny Rehab
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All Others	\$35

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Long distance charges may apply and .2 CEUs have been applied for.

Cancellation Policy: No refunds will be provided.

EASTERN TIME ZONE

Thursday, May 21, 2009 • 5:00pm to 7:00pm Eastern **SETTING UP AN OPTIMALLY CONFIGURED MANUAL WHEELCHAIR**

Dr. Mark Schmeler, OTR/L, ATP & Kendra Betz, MSPT, ATP

Advancements in manual wheelchair technology provide people with disabilities the opportunity for improved function while minimizing known risks of upper limb pain and injury. However, with a wide range of wheelchair technologies available, practitioners and suppliers are often challenged in recommending optimal equipment for their clients and carry the burden of justifying lightweight custom manual wheelchairs to funding sources. Mark is an Instructor and Director of the Continuing Education Program in the Department of Rehabilitation Science & Technology at the University of Pittsburgh. Kendra is a Physical Therapist and RESNA certified Assistive Technology Practitioner (ATP) who has worked for the Veterans Health Administration (VA) since 1993 specializing in Spinal Cord Injury, wheelchairs and seating, and adaptive sports.

Thursday, June 16, 2009 • 5:00pm to 7:00pm Eastern **EARLY INTERVENTION**

Delia "Dee Dee" Freney, OTR/L, ATP

This presentation will take a clinical look at seating and mobility for the birth to 3 year old population. Many babies and young children have been identified with neurological and orthopedic diagnoses that have seating challenges. Supported positioning is important for weight bearing as well as sitting for fine motor, feeding, respiration as well as a factor in sensory experiences and exploration. Present size and future growth for seating and mobility pediatric equipment for this population has been a challenge for both the clinician and the rehab manufacturer. The focus of this presentation will be the application of positioning devices with clinical case studies to discuss the problems this young population faces. Dee Dee has been an Occupational Therapist in practice since 1978.

Thursday, July 16, 2009 • 5:00pm to 7:00pm Eastern **HOW TO GET HIGH TECH COMPLEX REHAB FUNDED** **Kevin Phillips, ATP, CRTS®**

You can't get that funded! Have you heard that lately? An entire generation of participants in the healthcare system...clinicians, suppliers, and clients have been hoodwinked into believing that complex assistive technology just can't get paid for. Clinicians and Suppliers may feel that funding needs to dictate the evaluation process. As a result, there is a trend to recommend suboptimal and inadequate solutions because they're easier to get funded. Well, it's just not true. In fact, good funding for high end, functional and creative AT solutions is alive and well. This course will review some of the keys to a successful equipment request, and review several examples of successful interventions.

Thursday, August 20, 2009 • 5:00pm to 7:00pm Eastern **AVOIDING LEGAL PITFALLS: TYPES OF RELATIONSHIPS YOU CAN AND CANNOT HAVE WITH PHYSICIANS AND OTHER REFERRAL SOURCES** **Denise Fletcher, Attorney**

September 17, 2009 • 5:00pm to 7:00pm Eastern
TBD



NRRTS TELESEMINARS 2009

.2 CEUs FOR EACH TELESEMINAR HAVE BEEN APPLIED FOR

The University of Pittsburgh is certifying the educational contact hours of this program and by doing so is in no way endorsing any specific content, company or product. The information presented in this program may represent only a sample of appropriate interventions. Each person should claim only those hours of credit that he or she actually spent in the educational activity.

This unique educational opportunity is designed with three criteria in mind: to provide quality continuing education in seating and wheeled mobility, to meet the annual CEU requirement for ATS and ATP renewal, and to provide this programming in an extremely, cost-effective manner - as low as \$75 per CEU.

The TeleSeminars' faculty members are among the most well-known and talented people in our industry and profession. They will present state of the art information and answer questions from participants. Prior to each TeleSeminar the presenter's Power Point presentation and other course material will be uploaded to a special section of the NRRTS website (www.nrrts.org). Registered participants may download and print these or follow along during the TeleSeminar.

Audience: ATSS, ATPs, physical therapists, occupational therapists (intermediate to advanced)

PACIFIC TIME ZONE

Thursday, April 30, 2009 • 5:00pm to 7:00pm Pacific
**KEEPING UP: AN OVERVIEW AND COMPARISON OF
NEW POWER WHEELCHAIR ELECTRONICS**
Michelle Lange, OTR, ABDA, ATP

Participants will have the opportunity to increase their knowledge about power mobility and develop a better understanding about what to provide their client population. Specific issues to be discussed include the comparison and contrast of the four new power wheelchair electronics packages. Michelle evaluates children and adults in the areas of positioning, mobility, access to communication devices and computers, and electronic aids to daily living. She is a frequent author and speaker.

Tuesday, May 26, 2009 • 5:00pm to 7:00pm Pacific
PROVIDING PELVIC CONTROL
Allen Siekman, Siekman Consulting

Control of the pelvis in seating is complicated by the desire to provide a stable base of support and postural stability. This presentation will explore methods and devices helping to control pelvis and trunk location and allow functional controlled movement. Allen Siekman has 30 years clinical experience as a seating specialist, designer and educator, specializing in the design and provision of seating equipment for children and adults with moderate to severe physical challenges. He has been a popular instructor at the annual RESNA National Conference the International Seating Symposium, and presents workshops and seminars on Wheelchair Seating to varied audiences worldwide. He works on several ISO standards groups serving as Chair of the RESNA/ISO Wheelchair Seating Standards Working Group, and is an active participant in the research and development of standards for support surfaces.

Thursday, June 18, 2009 • 5:00pm to 7:00pm Pacific
WASHINGTON UPDATE
Gary Gilberti

This presentation will review what has happened in the last 12-18 months and the opportunities available in the next 12 months. Questions that will be answered include. What strategies can be employed in DC for the benefit of complex rehab? And what can NRRTS, NCART, etc. do? Gary is president of NCART and president of Chesapeake Rehab Equipment in Baltimore, MD.

Thursday, July 23, 2009 • 5:00pm to 7:00pm Pacific
**STANDING: ADVANCED PRINCIPLES,
PRACTICES AND CLINICAL APPLICATIONS**
Ginny Paleg, PT

This exciting course moves expert rehab providers to the next level. Bone density, bowel, bladder, spasticity and range of motion benefits of passive and dynamic standing (including vibration) programs will be highlighted. This session will conclude with a rousing session on funding that will leave you shouting "show me the money." Ginny Paleg is a pediatric PT from Silver Spring, MD. She works in a 0-3 (Early Intervention) program for Montgomery County Public Schools. She serves children in their homes and daycare centers. She is the Reimbursement Chair and listserve monitor for the pediatric section of the APTA. She is on the editorial board of Rehab Management and PT Products Magazines, and is on the consumer advisory board of VTech toys.

Thursday, August 13, 2009 • 5:00pm to 7:00pm Pacific
PRESSURE MAPPING
Sharon Pratt, PT

This session will provide a review of what clinical best practices are in place around the world to date. Their pitfalls and strengths will be discussed and demonstrated. A suggested baseline protocol for effective clinical use of pressure mapping will be reviewed. When selecting a seat cushion, what does immersion, envelopment and magnitude mean and how can pressure mapping be used as a tool to assist with measuring these outcomes? Sharon Pratt, PT, is Director of Education, Seating for Sunrise Medical.

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