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18 Insidious Change: Medicare’s 20-Year Impact on Complex Rehab Technology

Rita Stanley examines how two decades of Medicare policy changes — many of them subtle — have altered the access landscape for today’s beneficiaries.

22 Justify It: Seat Elevation

Seat elevation can make the world a more accessible place for wheelchair users, and can facilitate the safe performance of a number of mobility-related activities of daily living. Why then are funding sources lagging in recognizing the many benefits of this positioning opportunity?

26 Vision & Mobility

What does a client’s eyesight have to do with seating & mobility success? As it turns out — a lot! Many mobility-related injuries and conditions can also impact vision. Here’s how vision can be affected, and how the seating & mobility team can answer those challenges.
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editor’s note

Forewarned, Forearmed

There is a famous adage about a frog and a pot of water. If you heat the water to boiling and throw the frog into it, the frog will recognize the danger and will leap from the pot. But if you put the frog into the pot while the water is at room temperature and then gradually heat the water to boiling, the frog won’t leap out. It won’t realize the danger creeping up on it, so it stays in the pot and does nothing to save itself.

While biologists disagree on whether this account is literally true, its metaphor is sobering: It can be difficult to notice danger when it creeps up on you.

That’s true in everyday life as well. This month, Rita Stanley, VP of government relations for Sunrise Medical, gives a real-life example using Medicare funding for complex rehab technology (CRT), and how policy changes have hurt CRT reimbursement over a period of years.

As Rita points out, the shifts aren’t always cataclysmic or headline making. In fact, they’ve often been the opposite: incremental changes in policy interpretations that lead to gradual but ongoing shifts in reimbursement. In the end, Rita’s work suggests something much more dangerous than even long-term payment reductions. It suggests that a slow leeching of funding can result in policy-makers’ failure to see and uphold the critical value in CRT. It suggests that when technology and related services are slowly devalued, not all at once but through dollars-and-cents erosion over the years, legislators and funding sources have a harder time continuing to perceive those things as critically important to beneficiaries.

Turn to page 18 to check out Rita’s article.

I think the frog-in-boiling-water metaphor makes a lot of sense, but I also believe that the opposite can be true. When you’re fighting every day on the front lines to get your clients into the best seating & mobility solutions that you also have to justify to payors, it can be tough to find time to see the bigger picture.

One example is a greater understanding of how factors such as vision can impact a successful seating & mobility system (page 26). Eyesight may not have been one of the top factors to consider during seating & mobility evaluations in the past, but deeper insight into how injuries or illness can impact vision can be one more tool for today’s clinicians and ATPs.

And since this is the issue that will be distributed in our booth at the International Seating Symposium (ISS) in Nashville, of course we have a huge new technology preview starting on page 30. There are products here that would surely have sounded nothing to save itself.

So have a blast learning and catching up with colleagues at the ISS. And come see Mobility Management in booth B05. ●
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ROVI & Motion Concepts’ X3
Collaboration Ready to Debut

It’s one of the more intriguing partnerships in recent years.
ROVI, the new rehab division of Shoprider, a scooter and consumer power chair manufacturer.
Motion Concepts, the innovative manufacturer whose power positioning products often begin as one-off creations for the most complex needs.
Together, they’re bringing to market the X3, a Group 3 power wheelchair whose configuration — the two batteries line up end to end instead of side by side — results in a chair width of just 23.25” and improved balance and stability, says industry veteran Brad Peterson, VP of sales & education for Motion Concepts.

A Collaborative Effort
ROVI’s president is Cody Verrett, an industry veteran with plenty of rehab power chair design and manufacturing experience, and a former colleague of Peterson’s. As Verrett began developing a new power chair design, he reached out to Motion Concepts.

In a conversation with Mobility Management, Peterson said, “It was a collaborative effort from the start, but Cody definitely came to the table with his vision, his ideas and what he thought was going to make a successful power base. He knew what had been successful and what hadn’t been successful with any power base in the last 10 to 15 years.”
The idea of working with a power chair manufacturer from the beginning of the process was intriguing, Peterson said.
“We were flattered because I think one of the reasons he wanted to work with us was he recognized our skill set. He recognized how we do power positioning and how important it is, not just having a good base, but having a really integral, high-performing product. We started working together from day one, from a blank sheet of paper, literally, to what you have today.”

What ROVI and Motion Concepts have today is a new power base that Peterson calls “elegantly simple,” combined with the power positioning options that clinicians and ATPs have come to expect from Motion Concepts: up to 55° center-of-gravity tilt, 170° recline with extended shear reduction, up to 12° seat elevation, and seat-to-floor heights as low as 17” with 12” of seat elevation.

Distribution Through Motion Concepts
The X3 will be available exclusively through Motion Concepts, whose reps — both independent reps and territory business managers from Invacare Corp., parent company of Motion Concepts — will take orders and handle demo requests. Demo chairs were being built in January, with a goal of having them in the field in March.
“The X3 is going to be a Motion Concepts product, and it will be available with a full range of Motion Concepts power positioning products,” Peterson said.

While he added that he understands clinicians’ and ATPs’ reluctance to order new products, Peterson noted of the X3, “It’s Motion electronics, it’s PG Drives controls, it’s ElectroCraft motors, so pretty much everything on it except the suspension and the metal is a proven product that everyone in this industry has used. We wanted people to feel comfortable right from the get-go.”

Its width is the most immediately noticeable feature of the X3, but Peterson said this svelte figure doesn’t come at the expense of performance.

“Having the narrowest, widest, lowest, anything-ist, is a nice marketing story, but invariably having something means you’re sacrificing something else,” he said. “What’s nice about the X3 is you have the narrowest chair out there, a full-size rehab chair, but Group 34 batteries so it has a full-range battery setup in the base. It’s not like you’re sacrificing the size of your gas tank to get something narrow.”

He added, “The orientation of the batteries and how they’re located geometrically over the drive wheels and what that does to the weight distribution of the system — it gives us a very stable base, forward and rearward, that really climbs quite well.”

At press time, the X3’s base had been submitted for PDAC coding — K0848, 849, 856 and 861 — and Peterson said he anticipated being able to start taking orders around mid April. Already, he said, Motion Concepts was preparing “to have power positioning systems ready to marry up to power bases when they start to arrive.”

Up till now, Motion Concepts has been an aftermarket player, which Peterson acknowledged has lengthened the delivery timeline for its customers. Now, combining Motion Concepts’ power positioning with a power base that the company was instrumental in designing and will also distribute will shorten those delivery times.
“We all know the efficiency, the evaluation-to-delivery times are tantamount to price and function in the industry right now,” he said. “People want it quickly. A quote I heard [about the X3] was ‘I love it. It’s simple, it’s stable, it drives great…but what I like most about it is it’s going to make it easier to get Motion Concepts.’
“We’ve always been working with something that someone else has handed us. With this, we had an open-minded organization say, ‘Hey, do you want to work on this with us? And how do we make it better and different?’ That to us was really exciting.”
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Matthew Monaghan Is New Invacare President/CEO

Invacare Corp. has named Matthew E. Monaghan its new president/CEO.

A Jan. 22 news release from the manufacturer said Monaghan would take over April 1. He succeeds Interim President/CEO Robert K. Gudbranson, who last year replaced now-retired Gerald Blouch. Gudbranson will continue as Invacare’s senior VP/CFO.

The announcement said Monaghan most recently comes from Zimmer, a Warsaw, Ind., company serving the musculoskeletal healthcare segment. Zimmer specializes in joint replacement technology, and Monaghan is senior VP and general manager of Zimmer’s global hips business segment.

Monaghan was responsible for more than $1.3 billion in revenue and the division’s product development, engineering, clinical studies, quality, regulatory affairs and marketing functions, Invacare said.

C. Martin Harris, M.D., MBA, interim chair of Invacare’s board of directors, said, “I am pleased to welcome Matt as Invacare’s next president and CEO. Our board conducted a thorough and comprehensive search over the past six months and unanimously concluded that Matt is best suited to lead Invacare through this critical time and into its next phase of growth and development.”

Invacare Corp. has been under a U.S. Food & Drug Administration consent decree since December 2012, and wheelchair production at two of the company’s facilities in its Elyria, Ohio, hometown has been sharply curtailed during that time.

Harris pointed out, “In addition to his medical device background, [Monaghan] has proven turnaround experience, which will be critical to Invacare as it works through its short-term challenges. We are fortunate to have someone with Matt’s broad cross-functional experience, and the board looks forward to the results of partnering with the senior management team under Matt’s experience and leadership.”

In the announcement, Monaghan said, “I am honored to have been selected to lead Invacare at a time of unprecedented opportunity for the company. I look forward to working closely with Invacare’s board of directors, executive team and talented and hard-working associates to continue to turn around this business, innovate, and resume the company’s historical market leadership position.”
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SEE US AT ISS BOOTH 115
“Setting the Standard”
New APTA Special Interest Group Focuses on Seating & Mobility

A new Special Interest Group (SIG) of the American Physical Therapy Association (APTA) is focusing on seating & mobility. The official name of the new group, which is within APTA’s neurology section, is Assistive Technology/Seating & Wheeled Mobility (AT/SWM).

The group’s mission and objectives reads in part, “To enable Neurology Section Members to increase knowledge, improve evidence-based practice, and foster the development of new practitioners in this specialized area of practice. This SIG will also empower members to serve clients with neurological conditions at the highest level and to perform research activities to grow the evidence related to the efficacy of Assistive Technology/Seating & Wheeled Mobility.”

In explaining the need for the new SIG, APTA noted that clients with conditions including spinal cord injury, multiple sclerosis, muscular dystrophy and cerebral vascular accident often need assistive technology, but that formerly, no APTA group “focused on developing knowledge and fostering evidence-based practice in the evaluation, prescription and training of individuals to effectively use AT/SWM.”

APTA points out that the aging U.S. population as well as longer life expectancies for people with disabilities will result in increased need for assistive technology products.

In a related news release, ROHO Inc. said the new group “fills a void.” ROHO Clinical Applications Manager Tricia Garven, PT, ATP, was one of the key professionals contributing to the creation of the SIG.

“At ROHO, we believe we all have a stake to improve outcomes for anyone at risk for deep tissue injury,” Garven said in the company’s announcement. “We have a long-standing commitment to what we call ‘the science of safe seating.’ Working with and helping educate professionals in the area of AT/SWM is further evidence of that commitment.”

The SIG is seeking new members; to qualify, professionals must be an APTA member and a member of the neurology section.
The all new X3 Power Base is the perfect complement to Motion Concepts’ full line of innovative power positioning products! Available exclusively through Motion Concepts, the innovative and exciting X3 boasts the narrowest wheelbase in the industry and all the function and durability you have come to expect from Motion Concepts.

See us at ISS, Booth #224
Permobil Names New Senior VP of North American Sales

Todd Walling is Permobil’s new senior VP of sales for North America, the power chair manufacturer has announced.

Following last spring’s acquisition of TiLite, Walling will be “managing and setting strategic goals” for both the Permobil and TiLite sales forces, the announcement added.

Walling, who began his healthcare career with Cardinal Health in 1999, worked in contract administration and served as rehab product manager for The MED Group before joining Permobil in 2007. He has been Permobil’s key accounts manager and area sales manager.

Larry Jackson, Permobil’s president of North American operations, said of Walling, “We are excited to promote Todd to this new role. He has proven himself to be a good leader and strategic thinker.”

In a January conversation with Mobility Management about his first priorities in the current dynamic environment, Walling said, “I will continue building a seamless and dedicated sales force for both brands, but making sure that the market sees Permobil and TiLite as one and not two different companies. When our salespeople are out there educating people on Permobil, they will also bring TiLite into the conversation. I will be focused on building our sales team into being the ultimate resource for the dealers, clinicians and end users.”

Now that sales reps will handle not just complex rehab power chairs, but also TiLite’s ultralightweight manual chairs, Walling said a strong clinical background will be more important than ever.

“That’s been a big part of our development program,” he noted. “We’ve been looking for salespeople that have ATP and clinical experience. That’s always been one of our advantages in the market. My goal will be expanding our sales force in certain areas of the country and with these additions, obviously sales management, education and training will be my top priority.”

Walling said TiLite’s Jim Black and Terry Mulkey “have been doing an excellent job educating our sales force, clinicians and our dealer network on the concept of TiFit” — defined as “the art of building the ergonomics of the wheelchair around you, the rider.”

“Though he acknowledged that work remains to be done, Walling added, “The transition has been a lot easier than we expected because most of our dealers are already in the manual wheelchair business.”

As for what ATPs and clinicians can anticipate as complex rehab show season gets underway, Walling said, “We’re ecstatic about the upcoming International Seating Symposium (ISS) here in Nashville coming up in February. And we’ll be introducing several new products. Not to steal from Apple, but this will change everything.”

Permobil’s plans for 2015 include the Virtual Seating Coach’s first software production release, as well as showing in the United States the new power chair seen by REHACARE attendees in October.

But Walling said even if ATPs and clinicians are familiar with the Virtual Seating Coach, announced at the 2014 ISS, and were at REHACARE 2014, the 2015 ISS will hold surprises from Permobil.

“You haven’t seen all of it yet,” Walling said. “There’ll be features which have never been offered in powered seating, and the industry will see more innovation to the popular Corpus seating system.

“Going forward, seating & positioning skills and education are going to be our number-one priority. We’ve always felt it’s all about the seating, and then the base comes secondary. What separates Permobil from our competition, we believe, are all our Corpus seating advantages. These are specific, unique features that Permobil offers.”

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ROVI Names Anselmi as Director of Education

Industry veteran  Eli Anselmi is the new director of education for ROVI, the complex rehab technology division of Shoprider.

The announcement came as ROVI prepares to launch the X3 (see page 8), a Group 3 power chair with an all-new design that's capable of complex seating & positioning functions.

"We are thrilled to have someone of Eli’s caliber join our organization at such an early stage," said ROVI President Cody Verrett. "We look forward to the depth of experience he adds to our team. The timing for Eli to join our company is perfect, as we are on final approach to market launch, and his presentation skills and product application knowledge are truly outstanding."

Anselmi’s responsibilities will include creating and distributing product education materials. He’ll also work closely with ROVI leadership on future product development.

In its news announcement, ROVI (rovimobility.com) said it is "completely dedicated to developing innovative power mobility systems for adults and children requiring complex seating applications and advanced drive controls." 

National CRT Conference Changes Dates

Get out your calendar: There's a new set of dates for this year's National CRT Conference.

In a Jan. 22 bulletin to members, NCART Executive Director Don Clayback said the conference will now take place April 21-23 to ensure that as many members of Congress as possible would be in Washington, D.C., while the event was happening.

In the new schedule, Leadership Day is Tues., April 21. The theme of the day will be CRT presentations aimed at providers and manufacturers, capped off by a "CRT United" reception in the evening.

Wed., April 22, is Advocacy Day, with stakeholders participating in funding and advocacy sessions. At the end of the day, a Congressional session will prepare attendees for their Capitol Hill meetings the following day.

On Thurs., April 23, attendees visit Senate and House offices to meet with members of Congress and their staffs. At a 5 p.m. debriefing reception, attendees can share their experiences with fellow advocates.

In explaining the change in dates, Clayback said, "We became aware that although the Senate will be in session on our original dates, the House will be back in their districts and not in session. So in the
Ottobock Introduces New Marketing Director & Manager

Ottobock has two new faces in its marketing department. In January news announcements, the manufacturer of seating, mobility, prosthetic and orthotic technology named Rod McCrimmon its new director of marketing, and Cali Solorio its new marketing manager.

McCrimmon will be responsible for the marketing team managing Ottobock’s prosthetics, orthotics, bracing and mobility products, the company said. McCrimmon most recently served as director of integrated lab marketing for St. Jude Medical. He’s also served in marketing roles for Stereotaxis and GE Healthcare.

“Rod’s significant experience in the medical device industry makes him an excellent fit for his new position,” said Scott Schneider, Ottobock’s chief marketing officer for North America. “His proven commitment to the patient and his demonstrated ability to successfully market breakthrough technology on a global platform is impressive, and we look forward to his contributions.”

Solorio’s most recent experience was with Inova Labs, where she served as a senior marketing manager. She’s also been director of marketing for ICAP Patent Brokerage and the marketing coordinator for Ocean Tomo.

At Ottobock, she’ll support new product intros and the orthopedic rehab and product lifecycle management divisions.

“The diversity in Cali’s professional background in the areas of marketing, advertising and public relations make her an exceptional fit for her new position,” McCrimmon said. “Her experience in both domestic and global initiatives is also especially valuable as we add and expand marketing roles at Ottobock, and we look forward to her impact on company growth and performance.”

interest of maximizing our time in Washington, we had to make the difficult decision to move our conference to these new dates.”

The event includes CELA 2015 and the 2015 Medicaid Summit, and the meeting will remain at the Hyatt Regency Crystal City in Arlington, Va.

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I have been working in the durable medical equipment (DME) and complex rehabilitation technology (CRT) industry since 1982. For the first half of my career, there was a steady climb in innovation. Technology developed in basements and garages seemed to almost seamlessly transition to manufacturing facilities and supplier networks, making it available to the people who needed them. CRT in many ways leveled the playing field for people with disabilities, at home, work, school and in their communities.

Technology kept pace with advances in rights for people with disabilities and allowed people to take advantage of opportunities to work, go to school and live full and satisfying lives.

Unfortunately, anyone who has been involved in providing CRT in the last 10 years has witnessed significant changes in access. It didn’t happen all at once; it has been insidious.

A few years ago, I started trying to keep track of the various changes that have impacted access to CRT. Some of the changes were significant, like the dramatic changes in coding, coverage and payment for power mobility devices in 2006. Some appeared to be minor, like the elimination of the ability to bill for non-standard handrims at initial issue of a manual wheelchair. But it is the cumulative effect of years of change that has truly altered access.

Starting with a Clean Slate

A desire to expose and explain the cumulative effect is what motivated me to write ‘Medicare and Complex Rehabilitation Technology: A 20-Year Review, The Impact of Medicare Legislation and Regulation on Complex Rehabilitation Technology Access and Innovation,’ which was published in the January-March 2015 edition of Topics of Geriatric Rehabilitation.

As I researched the myriad changes to ensure I captured as many as I could and that the facts regarding each were accurate, I was stunned. When you consider the convoluted documentation requirements and face-to-face requirements, and add them to the coding, coverage, and payment changes, it is a wonder any CRT is provided.

Something must change, and it must happen quickly. We will not be able to undo 20 years of policies, rules and legislation overnight. However, I do believe the separate benefit category initiative, being led by the National Coalition for Assistive and Rehab Technology with support from a stakeholder steering committee, is the industry’s best opportunity to start with a clean slate. Starting with a clean slate is our best hope of improving access, and improving the lives of people with disabilities.

To know what must change, we must understand the root cause of our current reimbursement pain. It is important to acknowledge that very few policy makers or legislators know the history. Without an understanding of the cumulative effect of changes, and an understanding of why the current level of funding is inadequate, it is difficult for decision makers to believe that another reduction, small or large, has the potential to block access to CRT and close more CRT businesses around the country.
To develop a good understanding of why we are where we are, I routinely use the analogy of a three-legged stool to describe reimbursement: coding, coverage and payment. If any one of these three elements of funding is inadequate or inappropriate, access will be reduced or denied.

The Three Legs of the Stool
Coding is one of the most complicated components of funding. The Health Insurance Portability and Accountability Act of 1996 mandated the use of the Healthcare Common Procedure Coding System (HCPCS) for all payors. This was not fully implemented until 2003, when the use of local codes (codes that were unique to them and not part of a national code set) by non-Medicare payers was eliminated. Non-Medicare payors routinely created local codes for items such as pediatric or bariatric equipment, custom equipment, or for items that they covered, but Medicare did not.

Industry groups worked alongside Medicaid staffs to develop requests for new HCPCS codes and submitted applications requesting new codes for items that had previously been assigned to local codes. The results from these efforts are a big part of the pain we feel today. In many situations, CMS chose to classify technology into existing codes and to change code descriptors to state, “any type” resulting in very complex technology being assigned to the

Chart 1: Impact of Policy and Coding Decisions on Reimbursement

<table>
<thead>
<tr>
<th>Initial HCPCS Code</th>
<th>Descriiption/Definition</th>
<th>Fee Schedule Date</th>
<th>Fee Schedule Amount</th>
<th>Current HCPCS Code</th>
<th>Status</th>
<th>2014 Fee Schedule Amount</th>
<th>Impact based on last available fee schedule</th>
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<tbody>
<tr>
<td>K0005</td>
<td>Ultralightweight Adult Wheelchair</td>
<td>2003</td>
<td>$ 61.81</td>
<td>E0467</td>
<td>billed replacement only</td>
<td>$ 123.81</td>
<td></td>
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<tr>
<td>K0053</td>
<td>Seat depths 15.1/2, 7/8 for high strength lightweight and ultralightweight manual wheelchairs</td>
<td>2003</td>
<td>$ 99.79</td>
<td>billed replacement only</td>
<td>$ 195.10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K0054</td>
<td>Seat widths 1811, 12, 13, 15, 17, 19 for high strength lightweight and ultralightweight manual wheelchairs</td>
<td>2003</td>
<td>$ 104.64</td>
<td>billed replacement only</td>
<td>$ 194.54</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K0056</td>
<td>Seat height less than 37 in. equal to or greater than 32 for high strength lightweight or ultralightweight manual wheelchairs</td>
<td>2003</td>
<td>$ 99.79</td>
<td>billed replacement only</td>
<td>$ 195.10</td>
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<td></td>
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<tr>
<td>K0051</td>
<td>Fixed loop with ankle strap, each</td>
<td>2003</td>
<td>$ 25.59</td>
<td>billed replacement only</td>
<td>$ 10.29</td>
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<td></td>
</tr>
<tr>
<td>E8192</td>
<td>Pressure Equalizing Cushion</td>
<td>2004</td>
<td>$ 387.07</td>
<td>billed replacement only</td>
<td>$ 165.77</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total: $ 5,208.24
Impact: 25.18% reduction in reimbursement
Reimbursement Series

Access to Complex Rehabilitation Technology

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Description</th>
<th>Fee Schedule</th>
<th>Example 1 DME</th>
<th>Example 2 CRT</th>
<th>Example 3 CRT</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0950</td>
<td>WHEELCHAIR ACCESSORY, TRAY, EACH</td>
<td>FLOOR $83.28 KE $96.63</td>
<td>Wood, plastic, Acrylic</td>
<td>MSRP $98 - $210</td>
<td>MSRP $399 (Large)</td>
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<td></td>
<td></td>
<td>CEILING $97.98 KE $113.68</td>
<td></td>
<td></td>
<td>MSRP $374 - $430 (Hardware)</td>
</tr>
<tr>
<td>E0955</td>
<td>WHEELCHAIR ACCESSORY, HEADREST, CUSHIONED, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH</td>
<td>FLOOR $161.98 KE $187.94</td>
<td>Whitmyer® Single Pad Headrest</td>
<td>MSRP $205 - $450</td>
<td>MSRP $5355 - $675</td>
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<tr>
<td></td>
<td></td>
<td>CEILING $190.57 KE $221.10</td>
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<td></td>
<td>MSRP $415 - $715</td>
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<tr>
<td>E0995</td>
<td>WHEELCHAIR ACCESSORY, CALF REST/PAD, EACH</td>
<td>FLOOR $24.35 KE $28.26</td>
<td>Calf Rest Pad</td>
<td>MSRP $36</td>
<td>MSRP $130</td>
</tr>
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<td>CEILING $28.65 KE $33.25</td>
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<td>MSRP $400</td>
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<tr>
<td>E0978</td>
<td>WHEELCHAIR ACCESSORY, POSITIONING BELT/SAFETY BELT/PELVIC STRAP, EACH</td>
<td>FLOOR $34.35 KE $39.70</td>
<td>Pelvic Belt</td>
<td>MSRP $25 - $85</td>
<td>MSRP $87 - $92</td>
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<td>CEILING $40.23 KE $46.71</td>
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<td>MSRP $112 - $116</td>
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<td>E0951</td>
<td>HEEL LOOP/HOLDER, ANY TYPE, WITH OR WITHOUT ANKLE STRAP, EACH</td>
<td>FLOOR $15.21 KE $17.65</td>
<td>Heel Loop</td>
<td>MSRP $30</td>
<td>MSRP $130 - $138</td>
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<td>E0960</td>
<td>WHEELCHAIR ACCESSORY, SHOULDER HARNESS/STRAPS OR CHEST STRAP</td>
<td>FLOOR $72.89 KE $84.57</td>
<td>Chest Belt</td>
<td>MSRP $64 (Non-padded)</td>
<td>MSRP $130</td>
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<td>CEILING $85.75 KE $99.49</td>
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same code as a standard item of DME. The pictorial chart (page 20) illustrates the impact of coding.

It is very rare for a payor to develop its own fee schedule. The Medicare fee schedule is the basis for almost every payor. And it is rare to find a payor that pays at the full Medicare fee schedule; it is usually some discount off of Medicare. If 100 percent of the fee schedule prevents access, it is unreasonable to think that 20 percent less will have a better result. Without getting into the complexity of the formula Medicare uses to develop the fee schedule for each new HCPCS code, I will just say that when you combine dissimilar technologies and use the median price of those items to determine the payment amount, the reimbursement will be too low for the more complex items, and potentially it will be too high for the least-featured items.

What is harder for the average person to see is the change in reimbursement that resulted from years of legislation mandating reductions or freezes in the CPI-Update factors used to adjust the Medicare fee schedule each year. Between 1999 and 2014, the cumulative impact reduced the Medicare fee schedule by more than 20 percent.

Policy change that results in cuts in reimbursement is the most insidious. During my research, I identified seven items commonly provided with ultralightweight manual wheelchairs where policy and coding changes reduced or eliminated payment. The total impact for all items was a 25- percent reduction in reimbursement (see chart 1, page 19).

The full picture isn’t complete, though, until you consider how product selection has changed. Unfortunately, even many clinicians are resigned to the fact that their patients cannot have the technology that they need. These changes that have happened little by little have slowly but definitely changed what consumers are provided. Most important of all is that few consumers are aware that they may have received something different, something that could improve their function only a few years ago. So while their needs are not totally met and the technology they receive may not allow them to do all the things they need and desire to do, they do get something. And the something they get is most likely in the same HCPCS code as the technology they truly need, but the fee schedule amount does not allow access to it. The loss in access is invisible to payors if the technologies are classified in the same HCPCS code.

My goal for the article in Topics of Geriatric Rehabilitation was to document years of change that have led to where we are today. My goal for this article is to encourage everyone to work alongside consumers and clinicians to fight for improved access. I believe understanding the facts is the first step. Then we must shine a light on access problems that exist and acknowledge that changes in access have been insidious. It will require all-stakeholder involvement to obtain the change that is needed to ensure that we can return to improving people’s lives through innovation and provision of CRT.
Of the different positioning functions that complex rehab technology wheelchairs can offer — including tilt, recline and elevating legrests — seat elevation is probably the one that gets the biggest rise (no pun intended) out of the ATPs and clinicians who have to justify it to funding sources. While seat elevation can offer a number of benefits, especially to seating & mobility clients who spend long periods in their wheelchairs, convincing payors to reimburse for it can be difficult.

*Mobility Management* asked Julie Piriano, PT, ATP/SMS, director of rehab industry affairs for Quantum Rehab, for her take on the benefits of seat elevation and why rehab professionals so often find themselves at odds with funding sources.

Q: What benefits can seat elevation offer in the areas of activities of daily living, transfers and the creation of more accessible situations and environments? Why do you believe these are important points for funding sources to consider?

**Julie Piriano:** Power seat elevation is often cited as medically necessary for an individual to be able to transfer independently to/from the chair. However, power wheelchairs provide the wheelchair rider with 360° of mobility in a two-dimensional plane. We live in a three-dimensional world, and access to the vertical environment is extremely limited from the seated position — whether that is the retrieval of medications and grooming items stored in a medicine cabinet, being able to reach into the refrigerator/freezer and then safely cook a meal in the microwave or at the stove top, or pulling clothing out of the top dresser drawer and off the rod in the closet to dress. As a result, the ability to fully participate in life’s basic activities of daily living either requires the assistance of another to do things they could otherwise perform independently, or it causes significant overuse injuries as the upper extremities are required to perform functions in an over-head/shoulder position.

The ability to adjust the height of the seat allows the user to improve the biomechanical advantage of reach at the shoulders, elbows and wrists to access things such as light switches, thermostats and faucets as well.

In addition, an individual’s vertical height in the standard seated position significantly limits their line of sight, requires excess cervical extension to communicate with an individual who is standing, and...
contributes to neck and upper-back pain. In an elevated position they are safer drivers, can see and hear others better, and are often more productive at work and school.

Q: Many payors seem to view seat elevation as a luxury or a lifestyle feature rather than as a clinically significant functional positioning option. Why do you disagree?

JP: A power seat elevator may be helpful to an individual with compromised mobility to come to stand and “do something” once they get from point A to point B, similar to a lift chair — and therefore is viewed as a convenience item by some payors.

However, there is nothing luxurious or convenient about being a person with a permanent disability who cannot stand, reach or function in their environment without the use of power adjustable seat height technology. This distinction needs to be reviewed on a case-by-case basis by all payors, as there is a serious injustice occurring in the disability community.

Q: Are any funding sources paying for seat elevation? If so, what sorts of justification and documentation have successfully been used? What kinds of details are important for clinicians and ATPs to include?

JP: Veterans Affairs (VA) has a written list of indications for the provision of power wheelchairs with an elevating or descending seat that include verification that:
- Criteria for power mobility have been met.
- Functional goals have been identified that can be achieved by changes in vertical position.
- Vocational goals have been identified that can be achieved by changes in vertical position.
- Communication goals have been identified that can be achieved by changes in vertical position.
- Patient desires elevation capability and understands/accepts limitations of using a chair with this capability.

The VA also provides guidance with regard to the general contraindications that clinicians should consider before recommending this technology. Those contraindications include:
- Inadequate cognitive function, judgment, vision, motor coordination or the presence of a sufficiently serious spatial neglect, to preclude safe operation of the device.
- If there is a history of active seizures in the last six months, clearance should be obtained from a neurologist that the patient’s seizures do not prohibit safe use of a motorized device.
- A documented history of reckless behavior that threatens physical harm to self and/or others, such as that due to drug-/alcohol-impaired functional abilities.
- Frequent failure of prior prescribed wheeled mobility devices suggesting a pattern of misuse, abuse or neglect.
- Home/community environment will not support use of motorized device.
- Fails training with device(s). Every effort should be made to resolve deficiencies and should include consideration of retraining and equipment alterations and modifications.

Many of the state Medicaid programs will also consider funding power adjustable seat height when the clinician and supplier/ATP paint the picture as to why the individual requires this feature. Texas,
Minnesota and North Carolina all have some degree of written coverage criteria for the E2300 HCPCS code, but outside of that, 43 states will individually consider the request to financially support the provision of this technology, especially when they are able to understand the impact of seat elevation on the individual.

For example, measuring the wheelchair user’s vertical reach at the standard sitting height and at an elevated height, and relating it to what the person is able to do in that heightened position, helps paint the picture for the reviewer. If this increased function reduces the need for some or all of the personal care assistance previously required by the individual, this further supports the need for this feature.

In addition, state Medicaid programs must consider community mobility as part of the overall settings of use for power wheelchair users.

**Q:** The discussion over funding for seat elevation has been going on for years. Do you foresee any significant change in payors’ willingness to fund seat elevation in the near future?

**JP:** There is a misconception that “nobody pays for” power seat elevation because Medicare has deemed it not reasonable and necessary, and a number of commercial payors have written policies that “follow Medicare guidelines.” While it may be easy to fall back on an assumption that a particular third-party payor won’t cover it, if the power wheelchair user would benefit from the technology, it is a disservice to them if the clinician or supplier does not document the need for the device and submit it for prior approval.

If the third-party payor denies the request, it is important to understand the reason for the denial in planning your next steps. Do they cite a written policy that specifically states they do not cover power seat elevation? If not, did the submitted documentation clearly outline what the individual was able to do with the seat elevated vs. the standard seat height?

The only way we are going to change the perception that this technology “is never paid for” is to show why the beneficiary “needs to have” the device as opposed to the reviewer being left with the impression that it would be “nice to have.”

From a Medicare perspective, the key to moving power adjustable seat height technology to a covered benefit, alongside power tilt and power recline, is to attain separate recognition of complex rehab technology and differentiate its use for individuals with permanent disabilities and complex medical needs from the typical Medicare beneficiary.

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**Editor’s Note:** The Rehabilitation Engineering & Assistive Technology Society of North America (RESNA) has a position paper on seat elevation. Find it here: resna.org/sites/default/files/legacy/resources/position-papers/RESNAPositionontheApplicationofSeatElevatingDevices.pdf

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Medicare’s national competitive bidding program has once again encroached on complex rehab technology (CRT).

In a Feb. 4 bulletin to members and stakeholders, Don Clayback, executive director of NCART, said the Centers for Medicare & Medicaid Services (CMS) intends to use competitive bidding pricing to set allowable prices for CRT wheelchair accessories. Competitive bidding information would come from bids for standard wheelchair accessories.

Clayback explained that November final rule CMS 1614-F — about how pricing gleaned from competitive bidding would be used to set DME pricing in areas not under competitive bidding — left out key information about CRT, and that NCART therefore “followed up with CMS in writing and in person.”

Clayback said, “We received some very disturbing answers in a Frequently Asked Questions published by CMS in December. The FAQ indicates that effective Jan. 1, 2016, CMS intends to use competitive bidding pricing information obtained from bids for standard wheelchair accessories to reduce the payment amounts for complex rehab wheelchair accessories. If this policy is not rescinded, effective Jan. 1, 2016, when these codes are used on complex rehab wheelchairs, they will be paid at lower competitive bidding-determined payment amounts instead of the traditional fee schedule amounts under the current policy.”

Such pricing would reduce access CRT consumers’ access to the technology they need to meet clinical and functional needs, Clayback said. He added that CMS’s latest pricing plan directly violates the 2008 Medicare Improvements for Patients & Providers Act, “which specifically exempted wheelchair accessories used with complex rehab power wheelchairs from the competitive bidding program. It also goes against subsequent Medicare policy developed following the legislation, which provides the same payment policy for wheelchair accessories used with complex rehab manual wheelchairs.”

At press time, Clayback said CMS had not released an official list of impacted CRT codes. But he emphasized CMS’s plans should be rescinded based on the following:

● It’s in violation of Congressional legislation (MIPPA 2008).

● It’s contrary to subsequently developed Medicare policies created by CMS following the legislation that provides for accessories used on both complex rehab manual and power wheelchairs to be paid at traditional fee schedule amounts.

● It’s using information obtained through competitive bidding that relates to standard wheelchair accessories and inappropriately applying it to complex rehab wheelchair accessories that were not part of competitive bidding.

● Since many other payors follow Medicare policies, the fallout will also impact access for people with disabilities who are covered by Medicaid and other health insurance plans.

Clayback said NCART will continue to communicate with CMS directly, but has also asked members of Congress to intervene.

Breaking News: CMS to Use Competitive Bidding Prices to Set CRT Accessory Allowables

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Watch where you’re going! From infancy (as we toddle toward stairs) through childhood (as we chase the dog through the kitchen) into adulthood (as we weave through a Starbucks while carrying a Mocha Light Frappuccino), we’re told to look out while we’re moving.

But this natural warning can have a different meaning to people who are blind or visually impaired — and vision can add a complex wrinkle to the equation for members of a seating & mobility team. Like able-bodied people, wheelchair users experience vision loss. But the causes and potential solutions can be very different from what other healthcare professionals encounter.

How Common Is Visual Impairment?
It’s understandable, given the myriad of topics to discuss, if a client’s vision is not a primary consideration of a mobility assessment.

But seating & mobility clients can have vision impairments that significantly impact the way they use their wheelchairs.

Angie Kiger, M.Ed., CTRS, ATP/SMS, marketing channel & education manager for Sunrise Medical, says ATPs and clinicians should be prepared to encounter a number of different types of vision impairments when working with clients.

“The American Federation for the Blind quotes a statistic: that up to 40 percent of the brain is utilized to receive, interpret and translate information into visual images,” Kiger explains. “So it’s not surprising that a lot of diagnoses that we work with — traumatic brain injury (TBI), cerebral palsy (CP), any sort of brain injury — would have vision affected also.”

“Vision impairments are largely under diagnosed,” says Magdalena Love, OTR, ATP, clinical education specialist for Permobil. “If a client doesn’t have a dog or a cane, oftentimes we don’t assume they have visual impairments. However, due to the nature of the visual system spanning across many parts of the brain, oftentimes there are visual impairments with neurological conditions. Some research estimates that following a TBI, up to 80 percent of individuals experience some sort of visual disturbance. This resolves itself oftentimes, but about 30 percent of individuals experience lasting visual impairments that need to be addressed.”

These impairments differ from the issues we think of when we generically discuss problems with eyesight, such as nearsightedness. “Common visual issues addressed following TBI/stroke include diplopia (double vision), visual field cut, visual inattention/neglect, and various visual processing disorders,” Love says.
"I would see cortical visual impairment with my clients with cerebral palsy," Kiger says. Adding to that challenge: "The hardest part for individuals with cerebral palsy is that a lot of them are non-verbal," she notes, which means they aren't always able to explain to the seating & mobility team what they can and cannot see.

**Vision Impairments with Different Causes**

Vision is a complex topic, in part because multiple bodily systems are involved.

"I like to split the visual system up into three parts," Love says. "I think of them almost like parts of a computer. The first part is input, like your keyboard or your mouse. And then you get the throughput, the actual workings of the computer, the hard drive and the software. Then you've got your output, whatever you see on your screen.

"The vision system is kind of like that, so I think of vision disorders in that sense. There could be some input problems — let's say you've got myopia (nearsightedness) or hyperopia (farsightedness), which are some of the normal things that we could need glasses for. That is an input problem; the shape of the eye is malformed, so when light goes through the lens, it's either behind or in front of the lens. But when we talk about brain injury or someone who has not had a chance to develop a normal visual system, there can be a lot more issues."

Love adds that she doesn't usually focus on visual acuity— aka, clarity of vision — during the evaluation “because that can be easily addressed with a single referral. But [when I] do a brief acuity screening, that can tell me. *Wait a minute: something's atypical. I should refer out.* It could be just that the eye is misformed and [the client has] hyperopia or age-related presbyopia, which is what happens when we need reading glasses around [age] 40 or 45."

"The real challenge, Love says, is that vision problems aren't always detected when the client is in a rehab facility. "They're not found out until somebody really goes out into the community. Because if you think about your routine in the morning — brushing your teeth, getting yourself dressed — you can do those things in complete darkness. So a lot of times those scores in in-patient rehab don't catch vision problems if people don't need a cane to get around. Then they get home, and they have a power chair, and now — they're running into walls or having trouble finding curb cuts or things like that that weren't caught in in-patient rehab."

**Detecting Potential Vision Impairments**

Love acknowledges, "In today's clinics, there simply is not enough time to complete a comprehensive visual assessment for every person who is getting a seating and mobility evaluation."

Still, she says ATPs and clinicians can do basic screenings.

"Asking clients to complete a 'functional acuity' test identifying print objects at both near and far distances can be helpful," she says. "I also liked to do some sort of scanning test, such as identifying how many exit signs, fire hydrants, posters, etc., are in the room. If the individual is unable to easily complete these tests, it will cue me to dig deeper or refer them to an optometrist who specializes in visual development — College of Optometrists in Vision Development (COVD) certification, ideally — for a more complete evaluation."

Kiger starts observing a new client even before they formally meet.

"I would walk into the therapy room or the waiting room at the hospital, and I wouldn't necessarily introduce myself, especially if the child was looking at the TV," she says. "Sometimes, the kid would be looking off to the corner, but actually smiling and engaging with the TV. So that tipped off to me that there's something going on with vision. You have to be careful, because they might be completely visually impaired and just reacting to sound. But clearly, there's something going on."

She also looks for cues in how the client positions himself.

"Why are they constantly turning their head in one direction? Why are they looking up or looking down? If someone is constantly fighting to get into a certain position, are they visually attending to something that you don't notice because you're looking head on at it? They're seeing maybe a glimpse of color — maybe they have a visual field neglect."

**Strategies for Raising Success Rates**

While many vision impairments may not be resolvable, Kiger says there can be ways to help clients compensate.

"I've done little things in their environment, especially if it's a long-term care facility or at school," she notes. "I find out what colors or what areas they see the best. If you have somebody who has a left-side field neglect — they can turn to see, but you've got to remind them to turn their head and look in that direction — I'll take duct tape or painter's tape in a bright color that I know they react to and put that on that side of the wheelchair. I've lined the left footplate with it so it triggers 'Oh, I've got to remember to look at this' for the client."

"And at home, can you take painter's tape and make a line down the hallway so they're able to highlight where the different boundaries are?"

If the client uses vision aids, Kiger wants those aids present at the evaluation. "This might sound completely basic, but when doing an evaluation, especially on someone who is non-verbal, ask the caregivers if they have glasses. If they do, bring them to the evaluation. I've been at evaluations when we start asking about hearing and vision, and it's 'Oh, yeah, they wear glasses at school.' Great, do you have them? 'No, we didn't bring them, they're at school.'"

Asked how ATPs and clinicians can raise the chances that clients with vision impairments will be successful wheelchair operators, Love says, "The most under-utilized technology: training! Specific mobility training has shown to improve success with mobility goals in both children and adults following stroke."

In fact, in very young children, vision impairments may be due to lack of independent mobility experience.

"The visual system does not fully develop without independent mobility," she explains. "This is vital for children especially. The very visual and motor skills that are required to be ‘safe’ at power mobility driving actually develop through having access to independent mobility."

Those skills don't develop nearly as well if the child has to rely totally on dependent mobility.
Vision & Mobility

“The brain is more actively involved in navigation tasks when you are independently doing it yourself,” Love says. “When it comes to kids, depth perception, what steps actually mean, what any obstacles actually mean — none of that stuff is normally ingrained in us. It’s an experience-driven brain development.

“There have been studies — Karen Adolph is the PT who headed them — about ‘fake’ cliffs. Toddlers who just started crawling would be on one side [of the cliff] and the moms would be on the other side, saying, ‘Come on, Baby, come here.’ And the kids would just waltz right over it and not even register that there was a cliff. Then they’d bring them back just a little bit later, when they’d had more experience with crawling, and now these kids were hesitating at that cliff edge: ‘Wait a minute, that is a drop-off. It’s not safe for me to go.’”

Research has proven, Love says, that visual skills and independent mobility go hand in hand.

“If kids don’t have access to navigating their environments and connecting the visual information with safety and mobility, those skills just won’t develop,” she says. “If you get these kids who’ve been in [dependent mobility] chairs for years and then you put them in a power chair and you see they’re not safe, they’re running into walls, it’s not necessarily because they don’t have the potential to be safe. They just haven’t had the chance to explore their environment and learn: ‘Hey, this is what a wall does, this is what a step does, this is how I turn and navigate through a doorway.’”

The same can apply to stroke patients striving to regain function.

“We’ve put a lot of our stroke clients into these low, hemi-height chairs, but it’s not functional,” Love says. “They can’t go over high-pile carpet, they can’t get over thresholds, and a lot of times it’s so exhausting that their [spouses] just push them around wherever they go. And [the patients] don’t actually need to use their visual systems. You’ve got these clients with field cuts that are continually running into walls. With some very specific training you can see improvement even with individuals following stroke with visual impairment. The research is showing that.”

The take-away seems to be that vision impairment should not prevent a client from having the opportunity to be independently mobile. With proper help and training — such as from an Orientation & Mobility specialist (see sidebar), even a client with significant vision limitations might learn to be an independent wheelchair user.

Kiger recalls an assistive technology supplier telling her about one of the first clients he ever worked with: a man who needed his power chair adjusted, and just happened to be blind.

“He was asking [the client], ‘Can you see this color on the LED screen?’ The man said no; he was completely blind. The supplier said his knee-jerk reaction was Oh my gosh, you’re driving a power chair?

“But the client drove the chair better than anyone he’s ever seen in his life.”

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American Foundation for the Blind
AFB’s Web site devotes a section to vision impairment that’s tied to brain injury, commonly referred to as cortical visual impairment or cerebral visual impairment, the organization says.

Cliff or Step?
Read “Posture-Specific Learning at the Edge of a Drop-Off” by Kari S. Kretch and Karen E. Adolph, New York University, to learn about how infants’ vision and perception evolve as they experience independent mobility.
psych.nyu.edu/adolph/publications/KretchAdolphInPress_CliffStep.pdf

North American Neuro-Ophthalmologist Society (NANOS)
NANOS says its members specialize in visual problems related to the nervous system. This Web site can help to locate local neuro-ophthalmologists, which can be a challenge. This specialty, like seating & mobility, seems to be a small one.
nanosweb.org

Orientation & Mobility Specialty
According to VisionAware, this specialty was created after World War II to help soldiers blinded in battle. Among the breakthroughs was a longer, lighter-weight cane to facilitate independent travel. O&M specialists teach clients “orientation” skills (where you are, where you want to go) and “mobility” skills (safe, efficient movement from place to place).
visionaware.org/info/everyday-living/essential-skills/an-introduction-to-orientation-and-mobility-skills/123

Visual Field Neglect
This page from the Optometrists Network describes hemianopsia — aka, hemi field loss — in which patients with brain injury lose their side vision to the left or right. Visual field neglect is a further complication: Patients with hemianopsia aren’t aware of the field loss and don’t compensate accordingly...but prompting and training can help.
braininjuries.org/hemianopsia_field_loss.html

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Booth 1009

Acta-Relief Back
The all-new Acta-Relief back integrates the flexible, adjustable BOA closure system that allows the back to offset the center of pressure and better remove pressure points from the spine. The BOA system facilitates equal, stable pressure distribution in an off-the-shelf back design. In 16", 18" and 20" widths.
Comfort Company
(800) 564-9248
comfortcompany.com
Booth 606

Trekker Chair
Lightweight and easy to use, the Trekker has 180° reversible seating so the child can face forward or toward the caregiver. Adjustable recline opens the seat-to-back angle from 80° to 170° in 10° increments. -5° to 45° tilt is available as an option. In sizes 12 and 14 for kids up to 110 lbs. Transit option is available.
Convaid
(888) CONVAID
convaid.com
Booth 112
**Trekker Gait Trainers**

Available in three sizes, the Trekker is height adjustable and can be used in anterior or posterior position. Tool-free accessories mount onto the frame as needed. Junior and Youth sizes fold for transport. Accessories include adjustable forearm platforms, hand loops and trunk support.

Drive Medical  
(877) 224-0946  
drivemedical.com  
Booth 214

**SunMate FRG**

These orthopedic cushions contain a non-halogenated, fire-retardant additive that allows the foam to burn with low-toxicity emissions and still pass fire safety standards. The cushions have eight support levels from extra soft to hard, and come in standard and custom sizes. Waterproof covers or coatings are optional.

Dynamic Systems  
(855) SUNMATE  
sunmatecushions.com  
Booth 117

**NXT**

Freedom Designs’ tilt-in-space wheelchairs offer portability and durability with positioning support. The Future Fit program provides parts to grow the folding or rigid NXT once during the frame’s lifetime. Freedom also offers the Lower Extremity Accommodation Frame and the Multi-Axis Positioning System footrest for legs and feet.

Freedom Designs  
(800) 331-8551  
freedomdesigns.com  
Booth 224

**GRIP Lap Board**

Wheelchair users can transport food, beverages and personal items on this board, which features a non-tacky, non-slip surface on both sides. The board can be carried by hand or can rest in the wheelchair user’s lap. The board is available in sizes 11x14” (black, yellow or blue) or 8x18” (black).

GRIP Solutions  
(800) 401-1074  
mygripsolutions.com  
Booth 88

**Frontier V6**

The all-terrain features of the Frontier provide off-road capabilities outdoors, while the mid-wheel-drive configuration maneuvers well indoors. High-speed and aggressive terrain package has longer stabilizing front and rear bogie arms for maximum performance. With a weight capacity of 400 lbs. and a 6.4 mph top speed.

Innovation In Motion  
(877) 327-0681  
mobility-usa.com  
Booth 127

**X-Fer Rail**

Because transfers can need to happen anywhere, the X-Fer Rail is portable and lightweight, folding to just 16.25” and fitting into a backpack or briefcase. The open seating design limits the amount of contact to help reduce the risk of friction-based injuries. Weights less than 1 lb., but supports up to 250 lbs.

Maddak Inc.  
(800) 443-4926  
maddak.com  
Booth 605

**Matrix Easy Fit**

Get the benefits of custom molds with the adjustability and flexibility of component seating. Matrix Easy Fit dynamic seating is designed to provide continuous postural realignment and shock absorption, and it also grows and adjusts to meet changing needs. The system can be fitted and delivered the same day.

Matrix Seating USA  
(800) 986-9319  
matrixseatingusa.com  
Booth 831

**Gel Batteries**

Manufactured in the United States, MK Battery’s gel batteries are designed to the highest quality standards to provide longer lifespans and lower overall cost per cycle. That translates to a better overall value for both providers and the consumers who need dependable and durable power every day.

MK Battery  
(800) 372-9253  
mkbattery.com  
Booth 121
ROVI X3
With an impressively narrow base design that also results in stability and maneuverability, the X3 power chair is a new collaboration between ROVI and the seating experts at Motion Concepts. The X3 has been submitted for K0848, 849, 856 and 861 Group 3 codes, with the goal of officially launching and taking orders in April.
Motion Concepts/ROVI
(888) 833-6818
motionconcepts.com
Booths 224 & 804

Terra Flair
This stable chair with unique anatomical support and air inserts for skin protection is the newest member of the Terra line. It has ROHO adjustable dry flotation inserts, plus Rest Suspension foam for a stable ride and optimal skin protection. Register to win a BodyTrak pressure mapping system in the Ottobock ISS booth.
Ottobock Healthcare
(800) 328-4058
ottobockusmobility.com
Booth 416

Ergonomic Handrims
Out-Front’s handrim choices include the Natural-Fit, Surge and Q-Grip, which vary in coating surfaces, ergonomics and functionality. Use the Handrim Feature Finder at out-front.com/handrims to choose according to clients’ abilities and preferences.
Out-Front
(480) 833-1834
out-front.com
Booth 914

Custom-Molded Seating
A precise mold of a client is the start of Prairie Seating’s custom-molded process, which provides cushions to the exact specifications the client needs. Cushions can be given a vinyl cover or a removable cover. Additional features include mounting pans, extra depth and side supports.
Prairie Seating Corp.
(800) 588-0071
prairieseating.com
Booth 900

Superstand HLT
The newest generation of Superstand takes the versatile system to new heights, with a horizontal, high-loading transfer surface for more convenient, safer transfers. The 30” loading height eliminates awkward, uncomfortable bending and stretching for caregivers. The folding frame can be configured for prone, supine, upright or multi-positions.
Prime Engineering
(800) 827-8263
primeengineering.com
Booth 229

K300 PS Junior
With a 165-lb. user weight capacity, the K300 PS Junior has growth built right in. Seat widths are available 11”-16”, and seat depths from 10” to 18”. Armrests are adjustable, and the K300 offers seat elevation and optional power or manual tilt (45°) functions, plus programmable R-net controls. To ensure kids can keep up with pals, the base comes with a 5-mph top speed, with an upgrade to 6.5 mph available.
Permobil
(800) 736-0925
permobil.com
Booth 824

Q6 Edge HD
Quantum Rehab describes this heavy-duty power chair as “real-world ready” thanks to ultra-high torque 4-pole motors, Mid-Wheel 6 Drive Design ATX Suspension and Group 24 batteries. The Q6 Edge HD accepts a range of rehab seating, including TRU-Balance Power Positioning, and has a weight capacity of 450 lbs.
Quantum Rehab
(866) 800-2002
quantumrehab.com
Booth 524

Molift Smart 150
Easily wheeled and transported wherever it’s needed, the Molift Smart 150 has a lifting range of 10.6” to 66.1” to lift clients even from low locations, such as the floor. Its unique construction distributes weight evenly, while a compact footprint maneuvers well even in small spaces. It folds/unfolds easily without tools.
Snug Seat
(800) 336-7684
snugseat.com
Booth 500
Explore new products, experience the fun!

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- Vital Services
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- Info-packed Workshops

www.AbilitiesExpo.com
Register online for priority access

Los Angeles - March 6-8, 2015
Los Angeles Convention Center

New York Metro - May 1-3, 2015
New Jersey Convention & Expo Center

Chicago - June 12-14, 2015
Schaumburg Convention Center

Houston - July 31-Aug. 2, 2015
NRG Center (Formerly Reliant Center)

Boston - Sept. 18-20, 2015
Boston Convention/Exhibition Center

DC Metro - Dec. 4-6, 2015
Dulles Expo Center
i-Fit
Composed of high-quality materials, the i-Fit line of positioning accessories allow dynamic and structured support to attention to the smallest of details in fit, finish, sizing, features and clinical benefits. The i-Fit series is available in sizes from pediatric to adults.

Stealth Products
(800) 965-9229
stealthproducts.com
Booth 533

Zippie X’CAPE
With a weight as low as 19 lbs., the X’CAPE lets kids spend less energy on propulsion, so they have more left to learn, play and explore. XLOCK technology enables the X’CAPE to fold, while preserving rigid-frame-like performance. Available with fixed-frame option or swing-in/out hangers. Seat widths/depths start at 8”.

Sunrise Medical
(800) 333-4000
sunrisemedical.com
Booth 204

Free Form Seating
Custom-fit a backrest that can adapt to a client’s postural needs. Free Form Seating allows the ATP to contour a shell exactly as needed. Adjusts for weight loss/gain, growth, or a need for more/less support. With a breathable, washable cover. Available in three pre-shaped sizes or full sheets to assemble into any shape.

Symmetric Designs
(800) 537-1724
symmetric-designs.com
Booth 209

Communication Device Mounts
Help clients to keep phones and tablets within reach with these mounts that attach to a wheelchair’s frame, armrest, channel or tray. Mounts are available for various frame tubing sizes and to fit a range of popular smartphone and tablet sizes.

Therafin Corp.
(800) 843-7234
therafin.com
Booth 412

advertisers’ index

Company Name | Page # | Company Name | Page #
--- | --- | --- | ---
Abilities Expo | 33 | Ottobock HealthCare | 2
Adaptive Engineering Lab | 24 | Out-Front | 12
AmySystems | 9 | Permobil/TiLite | 36
Blue Chip Medical Products | 11 | Prairie Seating | 16
Freedom Designs | 7 | Pride Mobility Products | 3
HurryCane | 15 | Quantum Rehab | 3
Icon Wheelchairs | 21 | Prime Engineering | 25
Invacare Corp | 5 | ROVI Mobility Products | 29
Mobility Ventures MV-1 | 35 | Snug Seat | 28
Motion Concepts | 13 | Symmetric Designs | 14
National Seating & Mobility (NSM) | 19 | Wenzelite Re/hab/Drive Medical | 17
Numotion | 10 | iss marketplace

Company Name | Page # | Company Name | Page #
--- | --- | --- | ---
Adaptive Engineering Lab | 30 | MXK Battery | 31
AmySystems | 30 | Motion Concepts/ROVI | 31
Aquila Corp | 30 | Ottobock HealthCare | 32
Blue Chip Medical Products | 30 | Out-Front | 32
Clarke Health Care Products | 30 | Permobil | 32
Columbia Medical | 30 | Prairie Seating | 32
Comfort Company | 30 | Prime Engineering | 32
Convaid | 30 | Quantum Rehab | 32
Drive Medical | 31 | Snug Seat | 32
Dynamic Systems | 31 | Stealth Products | 33
Freedom Designs | 31 | Sunrise Medical | 33
GRIP Solutions | 31 | Symmetric Designs | 33
Innovation In Motion | 31 | Therafin Corp | 33
Maddak Inc | 31 | TiLite | 33
Matrix Seating USA | 31 | VARILITE | 33

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TX Series 2
Dual-tube frame geometry reduces flex to give the TX Series 2 a rigid-frame like ride, while the innovative design of its titanium frame gives the TX impressive durability. The extremely compact geometry makes the TX easy to transport, and the dual-tube aesthetic creates smooth, clean lines throughout.

TiLite
(800) 545-2266
tilit.com
Booth 810

JUNIOR Series
JUNIOR cushions and backs were created especially for children and use anthropometric data to produce lightweight, streamlined products for active kids and families. The Air-Foam Floatation seat cushion is 10x10". Back supports with pediatric VarLock hardware are available in mid or deep sizes in 10" size for 9" to 11" chairs.

VARILITE
(800) 827-4548
varilite.com
Booth 506

iss marketplace
Revolutionizing Accessible Transportation.

Built from the ground up and not a conversion, MV-1 is designed to withstand the demands of round-the-clock operations. MV-1 is ADA compliant, FMVSS certified with no exceptions or exemptions and the only purpose-built mobility vehicle that meets the “Buy America” act. Contact Mobility Ventures to learn why more transit authorities are switching to MV-1.
The Aero X Series 2 brings great value through stellar quality, reliability, and innovation:
- Superior rolling dynamics provide rigid-like performance
- Modularity for convenient configurability in the field
- Redesigned cross-brace geometry for easy, narrow folding
- Patented Speedloader front caster housing and two caster position options

The Aero X Series 2 reminds us all that value can be achieved without compromise.

See us at ISS, Booth #824