Is an Appropriate Wheelchair Becoming out of Reach?

Feature Editor Introduction: Kristi L. Kirschner, MD

Never before has the world been more replete with technological aids for people with disabilities: high-performing prosthetics; accessible computer devices; environmental control units; wheelchairs that can recline, stand, and climb curbs; and laptop-sized ventilators to name just a few devices. Such tools can make the difference between people with physical disabilities living in their own homes, participating in their communities, and being engaged in the workforce versus being confined to an institution, or an inaccessible home and even to bed. Yet, just as Tantalus in Homer’s *Odyssey* stood immersed chest high in water beneath a tree laden with ripe fruit, he could neither quench his hunger nor thirst. As he would reach up to grasp, or bend down to drink, the fruit and water would move just out of reach. So it is for many people with disabilities when they gaze at all the available technologies [1]. Tantalizing, but unattainable.

Nowhere is the situation more frustrating than in the domain of wheelchairs. Access to liberating mobility equipment is changing—and often not for the good. The Medicare Affordability Act (2003) [2] and more recently The Patient Protection and Affordable Care Act [2], in an effort to save money, have instituted competitive bidding for Medicare wheelchair contracts. Rental equipment is now the rule rather than exception for wheelchairs covered under Medicare—a real problem when customization is needed. UsersFirst, a program of United Spinal Association, was created to advocate “for greater access to appropriate wheelchairs, mobility scooters and seating systems for people with disabilities” (www.usersfirst.org). This group is currently supporting an initiative, Save the Wheelchair campaign [3], “This year advocates will call for, among other issues, passage of *HR 492/S. 948*. Ensuring Access to Quality Complex Rehabilitation Technology Act of 2013, a bill to establish a benefit to ensure that persons with spinal cord injuries and disorders have access to complex rehab technology.”

As history has demonstrated, many other health insurers will adopt and follow Medicare guidelines. A number of state Medicaid programs are also delegating their health insurance responsibilities to for-profit managed care companies, many of which have little experience with disability and durable medical equipment (DME). Narrow networks are the rule rather than the exception, and the expertise of those charged with approving or denying approvals of wheelchairs may be quite limited.

Not surprisingly, in addition to the obvious group of people who have the most at stake—namely, wheelchair users—other stakeholders are concerned as well. The Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) (www.resna.org) is questioning the wisdom of the new rules and regulations of the Centers or Medicare and Medicaid Services (CMS). RESNA, as the premier professional organization dedicated to promoting the health and well-being of people with disabilities through increasing access to technology solutions, is questioning the value of competitive bidding, capped rentals, and other policies adopted purportedly to save costs but in reality serving to narrow rather than expand choices for people in need of DME.

With this backdrop and the fact that Illinois is experiencing significant budget cuts to state Medicaid, about a year ago a group of concerned stakeholders in Chicago began to meet to discuss the looming crises in DME. Access to the timely provision of appropriate wheelchairs and needed repairs was at the top of the list of DME concerns. Several members of this group of concerned stakeholders have been involved in helping to create a not-for-profit Medicaid health plan, the Community Care Alliance of Illinois (www.ccaillinois.com) and wanted to discuss the challenges of ensuring how the patient can continue to have access to such critical equipment in the midst of a transition to managed care. As the availability of these tools decreases, the cost to the patient will rise and the expertise of those charged with approving or denying approvals of wheelchairs may be quite limited.
care. The group reached out to the Small Business Program at DePaul University Masters in Business Administration for assistance in identifying solutions. The questions posed by the group were whether a new (ie, different) business model could preserve and enhance access to critical wheelchairs in the midst of cost cuts. For example, would a lend/lease system for high-end equipment help ensure access while addressing the budgetary crises in our state? The issues with which we have been grappling are not unique to Chicago or Illinois, but are happening across the country. At heart, these issues are arguably civil rights and social justice issues [4]. At the end of the day, access and participation are contingent upon having not only an accessible environment but the right equipment to navigate in it.

This topic will be presented in 2 parts. Part I, presented in this issue, will be a commentary from Jessica Pedersen, an OT, Assistive Technology Professional (ATP), and RESNA-certified Seating and Mobility Specialist (SMS or the second tier of RESNA certification) as well as Denise Harmon, a seasoned ATP representing the perspective of the vendor. For the next column, part II will be viewpoints from DME users, a small business analyst, and a PM&R physician.

The questions that I have asked our commentators to address include the following:

1. What do you believe are “best practice” policies for obtaining the appropriate wheelchair? How are the current rules and regulations of various payers facilitating and preventing this from happening?
2. What are the practical barriers (service and reimbursement wise) to ensuring access to best practice evaluations and quality equipment?
3. What are some potential solutions to the looming crisis?
4. How can we ensure that the people who depend upon the equipment maintain access without undue burden while fraud and abuse is prevented?

As always, I welcome your comments regarding this column, or suggestions for future columns.

REFERENCES

Commentary from Jessica Presperin Pedersen MBA, OTR/L, ATP/SMS:

As an OT with 35 years of experience, I have had a long-standing interest in the area of wheelchair mobility and seating.

The evolution of seating and positioning product choices and service delivery options have expanded multifold during my career. This expansion allows us to be in a position where individuals requiring mobility aides should be able to access experts who can determine mobility and seating needs and provide equipment conducive to the environments they need to access, allowing optimal participation. This equipment should be maintained and updated as needed.

RESNA published the Wheelchair Service Provision Guide, which provides recommendations for which professionals and steps are needed for successful outcomes in wheelchair and seating procurement. It can be downloaded at RESNA.org.

Process for Procuring a Wheelchair

RESNA outlines the steps to procurement. Basically they include the evaluation, equipment trial or simulation, equipment recommendation and justification, physician agreement and prescription, prior authorization if required by the third party payer, delivery and fitting of equipment, teaching and training in safety, simple maintenance, and use of equipment, follow-up for proper fit and usage, and necessary long-term upkeep and maintenance.

Professionals Involved in Wheelchair and Seating Procurement

RESNA strongly recommends a team evaluation that is client centered. The 2 professionals that should be involved throughout the procurement process are the seating therapist, usually an occupational or physical therapist, and a rehabilitation technology supplier who is the distributor of the recommended equipment. Both professionals should have continuing education in the area of wheelchairs and
seating. Ideally, they should be certified as an Assistive Technology Provider, (ATP) and a Seating and Mobility Specialist (SMS), which are regulated by RESNA. The ATP is a broad-based examination that recognizes the generalist in assistive technology. The SMS focuses specifically on seating, positioning, and mobility (for more information about these credentials, see www.resna.org).

To ensure that appropriately trained professionals are involved in all aspects of the evaluation, provision, and repair of seating equipment, it would be helpful to have a requirement by third-party payers that educated and credentialed therapists and suppliers be involved in the procurement process. Mandated proof of wheelchair and seating knowledge and skills in the form of an ATP or SMS credential or documented continuing education and competency would be 1 way of ensuring that.

It is also suggested that manufacturers sell their equipment to distributing suppliers who know the basics of seating and how their equipment needs to be measured for and fit. At this time, a few manufacturers have the integrity to stand by their equipment and sell only to qualified suppliers. It is bothersome to see high-end equipment such as power wheelchairs and pressure distributing cushions being sold online or by fly-by-night durable medical equipment (DME) companies that hire salespeople who have no instruction in how to measure for equipment, ensure that a proper cushion or seating equipment is provided for, or give safety and maintenance training. So often, the wheelchair is dropped off by a driver without the person being fit—or worse, sent in a box through a mail-type of delivery company not related to the distributor at all.

I have seen some of my home health patients who have received equipment that was ill fitting, missing a cushion, or could not be used, either because it did not fit through the doors inside their home or because they were never taught how to control the power wheelchair. Well-meaning suppliers and therapists can gravely err in issuing the wrong equipment. Medical equipment has significant risks and benefits. When the wrong equipment is dispensed, functional and medical complications can result, such as loss of ability to self-propel, development of expensive and debilitating pressure sores, pain, rotator cuff injuries, respiratory problems, scoliosis, or aspiration.

When I contacted the suppliers who distributed these wheelchairs, I learned that the salespersons were very well meaning but had no training in recommending and fitting a wheelchair other than how to fill out an order form. These salespersons often think that they are helping the person out by getting them a scooter or recliner wheelchair with elevating leg rests, and are often surprised that what they ordered does not fit, can cause harm, or cannot be used. If a manufacturer allows the equipment that they produce to be sold by uneducated and untrained individuals, this problem perpetuates, especially in an environment of competitive bidding.

Most third-party payers do not recognize the need for an evaluation with a seating specialist. In fact, in many states and federally, the therapist is not required to be involved in the equipment procurement process. As long as the patient’s physician (many of whom have little to no knowledge about seating and positioning) signs off on the prescription, the order can be processed. What many well-intentioned physicians do not realize is that by blindly signing a pre-generated prescription, they assume liability for adverse consequences. Sadly, as an expert witness, I have seen physicians trying to defend letters of medical necessity that they signed but did not compose.

Where Wheelchair and Seating Evaluations and Fittings are Performed

Wheelchair and seating evaluations and fittings can be performed at wheelchair and seating clinics, schools, nursing homes, residential facilities, inpatient and outpatient sites, and in the home. Optimally, the seating therapist and the rehabilitation technology supplier are present, as well as equipment to show and trial with the patient. The ideal setting is a designated wheelchair and seating clinic that has a mat to perform a hands-on evaluation, transfer assist equipment, evaluation tools such as pressure mapping systems, and wheelchairs, cushions, backs, and alternative wheelchair controls to trial. These clinics ultimately house skilled therapists and suppliers dedicated to the profession of wheelchairs and seating.

Sadly, the wheelchair and seating clinics appear to be decreasing in number rather than multiplying with the increase in products and awareness of the wheelchair procurement process. Many of these clinics struggle to break even, let alone try to turn a profit. Some medical facilities have chosen to close the clinics rather than operate at a loss. Recently, 1 of the wheelchair and seating clinics in Chicago closed, leaving only 1 dedicated seating clinic left in the city. The reasons for this are multifold. The therapist—productivity ratio in a seating clinic is usually 25%-30% less than productivity in a standard outpatient rehabilitation therapy clinic. This is often the result of the time that it takes to perform an evaluation, equipment trial, fitting, and mandated documentation, including any telephone follow-up required. An evaluation includes transferring a person onto a mat to assess physical and functional abilities related to seating, skin check, pressure mapping, and trial of equipment. A high-end power wheelchair with customized seating might cost as much as $27,000 or more, requiring specific recommendations to meet an individual’s needs—yet it is often expected that the decision be made within a 1-hour timeframe.

To maximize revenues, many clinics have split the hands-on evaluation of the person from the trial and simulation of equipment into 2 separate sessions. However, this is difficult if the individual is coming from a long distance. If the evaluation and trial of equipment cannot be broken into
2 sessions on separate days, the clinic often loses reimbursement because of the inability to charge for the time spent to complete the evaluation. The financial issues do not end there. A glut of documentation mandates from various third-party payers will increase the expense of non-reimbursed time, delay the time of procurement, and clog the system. If the equipment is denied, the therapist often writes an appeal, which is not reimbursed. The therapist is also not reimbursed for the time to research equipment options and to work with a supplier and the individual user to discuss pros and cons of choices.

More properly staffed and equipped wheelchair and seating clinics are needed throughout the United States to meet the needs of wheelchair users. Two things might help this to occur. First, third-party payers need to recognize the specialty evaluation and the time that it takes to provide it. The wheelchair and seating evaluation should be reimbursed accordingly, allowing for 2 hours of evaluation on the same day when needed because of complexity or distance traveled.

Second, third-party payer requirements for documentation need to be streamlined. Proper documentation for an insurer should focus on what is needed and why, providing the reader with a picture of the person to illustrate equipment need. Equipment recommendations should be specific with clear justification as to why it is needed. Electronic documentation with electronic signatures will allow instant sharing of information, is easily added to a person’s medical chart, and allows for tracking of which equipment is purchased and whether it is used successfully. The requirement for narrative letters of medical necessity is of questionable usefulness. The time that it takes to write these letters is not reimbursed. The formatting varies per writer, making it difficult for the reader (ie, third-party payer) to find the necessary reasoning for approving and paying for the equipment, and critical information may be missing.

In 2003, Jill Sparacio, OTR/L ATP/SMs, and I reformatted an evaluation designed by Michael Babinec, OTR/L ATP/SMs, and added the justification portion to the form. The state of Illinois approved this form and mandated its use by anyone seeking reimbursement for complex rehabilitation technology through Medicaid. The form leads the evaluators and readers through the process of information needed to make an equipment decision, provides specific formatting to identify what equipment is needed, and allows for explanation of why it is being recommended. Information regarding the equipment being replaced and necessary measurements are included. The documentation must be clear as to who is providing the information for the evaluation and recommendation. While the physician signature verifies the medical and functional findings of the patient, he/she should not be expected to know specifics of the equipment recommendations such as manufacturer and model. If the documentation specifying the equipment is only signed by the physician, the physician takes on full responsibility for the equipment recommendations. Most physicians will acknowledge that this is not their expertise and rely on the seating therapist’s input for equipment specifications. That should, therefore, be reflected in the documentation. This evaluation is currently in the process of being updated and electronically formatted. The evaluation form HFS 3701H can be downloaded at www.hfs.illinois.gov/assets/060806_3701h.pdf.

Recycling Equipment

There is a plethora of equipment that is in good condition, whether it was quickly outgrown or the user needed it for a short period of time, either needing something else due to medical changes or passing away long before the life of the equipment was reached. There have been many discussions about recycling equipment that is still useful. At this time, used equipment can be found on craigslist or eBay or at garage sales. Sometimes it is donated for re-use. Liability remains a huge concern as far as formally reissuing usable wheelchair bases to individuals. Third-party payers will often not pay for repairs on used reissued equipment. One of the goals of the stakeholder group that Dr. Kirschner refers to above is to investigate how loaner and recycling groups work in the United States, and to consider incorporating a program to offer refurbished and repaired equipment in the Chicago area for reuse.

Advocating for Policy Change

Reimbursement fee schedules for equipment or funding policies that provide little or no reimbursement for complex rehabilitation technology products often prevent individuals from having reasonable choices offered, or being able to receive the most optimal equipment. For example, third-party payer policies often require that a patient be unable to walk safely in their home to be able to access a wheelchair; yet, without such a device, the person is homebound and unable to participate in the community. Thus, it is common that a person who can walk 20-30 feet in their home will be denied wheeled mobility even though they cannot walk down the driveway and struggle when outside the home in grocery stores, buildings with long hallways, or a workplace or school setting. Getting a person who is at high risk for pressure sores a pressure-reducing wheelchair cushion or a customized back to support the trunk is becoming increasingly difficult as well. In the end, a narrow range of diagnoses often determine a patient’s eligibility, as opposed to medical and functional needs.

In the past 10 years, several professional and consumer organizations have been advocating to CMS and the U.S. Congress to make changes regarding policy for reimbursement of complex rehabilitation technology. I am active in the efforts of RESNA and the Clinical Task Force (www.clinicaltaskforce.us). Other organizations include the ITEM Coalition—Independence Through Enhancement of
Medicare and Medicaid, National Registry of Rehabilitation Technology Suppliers (NRRTS), United Spinal Association, National Coalition for Assistive and Rehab Technology (NCART), National Council on Independent Living, American Occupational Therapy Association (AOTA), and American Physical Therapy Association (APTA).

As Dr. Kirschner mentioned, there is a major effort to develop a separate benefit category for complex rehabilitation equipment. This will be similar to the separate category for orthotics, allowing people with disabilities who use high-end equipment to be considered differently from those using standard rental wheelchairs and manual mobility bases must be rented rather than purchased, resulting in difficulties in customizing the wheelchair cushions. This is a small percentage of people who use wheelchairs. The goal is to ensure that access to custom power wheelchairs, ultra-light-weight wheelchairs, customized tilt wheelchairs, and seating systems are covered under the Medicare program.

In closing, I would like to encourage rehabilitation physicians to advocate for the passage of the Complex Rehabilitation Technology bills now in Congress. S.948 and HR 942- Ensuring Access to Quality Complex Rehabilitation Technology Act of 2013 113th Congress (2013-2014). For more information about these bills, please see http://www.access2crt.org.

Commentary from Denise Harmon, CRTS/ATP:

Writing this commentary has been one of my most challenging tasks in some time. As an Assistive Technology Professional (ATP) in the complex rehabilitation technology arena, understanding the evolving policies, as well as the requirements (and often restrictions), of provision of appropriate wheelchairs can be at times overwhelming. What follows are my thoughts about the current landscape, challenges, and perhaps potential solutions. For the purposes of this article, the individual with disabilities and complex medical needs will be referred to as the “consumer.”

The best practice for obtaining an appropriate wheelchair has to be consumer centered and involve a team of professionals with advanced knowledge in complex rehabilitation technology (ie, seating and wheeled mobility). In addition to the consumer, the team should involve a clinician (either an occupational or physical therapist), credentialed rehabilitation technology supplier/ATP, and a physician. Ideally, the clinician would carry the ATP credential as well. Additional team members might include manufacturers, the consumer’s caregiver or spouse/significant other, a vocational counselor or human resources advisor, or other pertinent parties such as a school representative or social worker.

A wheelchair prescription is complex and involves 3 components: the wheelchair user, the wheelchair technology, and the environment or context of the user [1]. The initial assessment and provision requires the following: a) interview with the consumer that includes the person’s medical status/functional needs and goals, including anticipated vocational and transportation uses, as well as caregiver goals; b) physical assessment of the consumer; c) observation of consumer’s use of current wheeled mobility, if appropriate; d) knowledge and demonstration of products that will meet the consumer’s needs; e) consumer trials with appropriate wheeled mobility and seating options; f) physical inspection and measurements of the consumer’s home and school or work environment; g) application for funding and procurement; h) delivery, fitting, and adjustment of the prescribed seating and mobility as well as training in its use; and i) subsequent follow-up and adjustment as needed.

When any of these steps are missed or incomplete, the resultant wheelchair can be suboptimal, resulting in duplication of services, loss of work, injury, and abandonment of the wheelchair.

It is ironic that as seating and mobility technology have advanced, consumer access is becoming more difficult. Access may be thwarted by the lack of knowledgeable professionals, particularly in certain geographical areas, as well as by inadequate funding. The funding environment for rehabilitation technology has changed remarkably in recent years, and most of the changes have not expanded quality and consumer choice. One of the exceptions is the requirement by Medicare that an ATP be involved in the assessment and delivery process for complex wheelchairs. This requirement should be considered the most basic level of certification of the professionals who are assessing the needs of the consumers. Although private insurers and state Medicaid programs often follow Medicare policies, this is not necessarily the case. At this point, many state Medicaid programs and most private insurers have not adopted this quality standard.

With many other recent Medicare policies, industry stakeholders feel backed against the wall, and are unified in fighting against the current seemingly indiscriminate, and arbitrary “medical equipment” coverage policies, so as to protect consumer access. One particularly troubling policy has been Medicare’s requirement that K0004 manual and Group 2 Power Wheelchairs be provided, contingent to a competitive bidding policy [2]. The resultant effect has been to restrict consumer choice of supplier as well as wheelchair model and features that best suit the consumer’s medical and functional needs. A second Medicare requirement that is troubling is the requirement that “complex” tilt in space manual mobility bases must be rented rather than purchased, resulting in difficulties in customizing the wheelchair.
to the consumer’s needs. (A tilt in space manual mobility base is a wheelchair that changes an individual’s orientation in space relative to the ground, while maintaining seat-to-back and seat-to-legrest angle.)

Probably the most unjust policy is that any mobility base, power or manual wheelchair, will only be approved if it is required for mobility-related ADLs in the home. Functional necessity for manual or power mobility outside of the consumer’s home only are not considered. There is concern that state Medicaid programs and private insurers will soon adopt Medicare’s “in-the-home restriction,” which will again make access to appropriate wheeled mobility more difficult for those who require it to participate outside of their homes. It often feels like a quagmire when denials, cumbersome appeals processes, and delays in payment prevent consumers from accessing the appropriate equipment in the current funding environment. Former Users First Alliance Executive Director and staunch consumer advocate Ann Eubank once said: [CMS and] “the private insurance industry have conditioned us to strictly think ‘medical necessity.’ But people who use mobility equipment, Americans, think meaningful life equals function” (oral communication).

As business people, the complex rehabilitation companies (CRC) understand and respect budgetary restrictions and balance sheets. What we cannot abide by is the seeming smoke and mirrors of “balancing the budget” on the backs of the most vulnerable of our citizens. Instead of improving the process, what the most recent CMS policies and procedures have done is to confuse the environment and place undue administrative burdens on the clinicians, ATPs, and administrative support staff. Reimbursement levels for clinicians do not come close to covering the hours spent in evaluations, documentation, training, and fitting, let alone the continuing education and administrative costs required. Poor reimbursement to the clinician puts the team and consumer at risk.

The ATP and CRC are charged with navigating disparate coverage policies. At one time, a prior approval would guarantee appropriate coverage of the recommended mobility device. This is no longer the case. CRCs are increasingly seeing private insurers arbitrarily stating either that a prior approval is not required, or simply that when approving a complex rehabilitation technology product, they will not commit to a specific dollar amount. The result can be chaos. The ATP and CRC often choose to supply the consumer with a product, not knowing until the time of billing how they will be reimbursed. Often, insurers will approve a product and deny coverage at the point of claim. With many complex rehabilitation products, they have been noted to approve items that are Healthcare Common Procedure Code (HCPC) designated as “miscellaneous” (ie, an item as simple as headrest support hardware, or as complex as power elevating legrests), only to decide at claims adjudication how it will be paid—most often, at $0. In the end, it is the consumer who is often left with a very large co-pay.

The ATP/CRC, by default, are the “interpreters of policy coverage” for the consumer. Although the policy belongs to the consumer, most consumers do not have a detailed understanding of it. Not uncommonly, most private insurers’ prior approval letter will read “prior approval of this item will not guarantee payment.” When an insurer denies a line item or entire claim, this can have a negative impact on the consumer trust of the ATP/CRC. In addition, most recently, we are seeing private insurers approve only the mobility base code, and “bundle” all of the remaining HCPC codes, such as the joystick controller, seat cushion, and lateral trunk supports. This places an undue burden on the clinician, ATP, and administrative staff to revisit the prior approval request, and to provide additional documentation of the need for each of the individual line items.

Medicare reimbursement to the CRC is also problematic. Medicare can audit any claim up to 7 years. Medicare offers a prior approval process only for complex rehabilitation technology, relative to certain codes (specifically, power wheelchairs). For all other coded items (such as manual wheelchairs, and seating products), there is no prior approval process. The clinician and ATP prepare the appropriate documentation and supply the product once the CRC administrative staff have reviewed the paperwork to ensure that documentation meets coverage guidelines. In the past, this process ensured that the consumer received the needed equipment in a timely manner, but increasingly the supplier is at risk for nonpayment.

Medicare’s most recent contract with Recovery Audit Contractors (RAC) has wreaked havoc. RAC auditors are paid a percentage of what they deny; in other words, they are incentivized to deny claims. The CRC will undoubtedly appeal the denial. What this means is that millions of dollars in reimbursement are pending, well after the consumers have received the technology. Roughly 70% of the first level of appeals are approved, and 90% of second level of appeals are approved. However, if, by the second level of appeal, the CRC loses yet again, Medicare takes back the money from the claim, plus interest. At this point, the CRC will request that the claim go to a hearing with an administrative law judge (ALJ). It can take up to 2 years for the hearing to be scheduled on the docket. In fact, hundreds of thousands of orders are pending ALJ hearings nationally. Meanwhile, before that ALJ hearing, Medicare has denied the claim. If the consumer has need for repair, the CRC will be unable to provide it, as Medicare will deny the repair claim as well.

Often, by the time the ALJ reviews documents before the hearing, the CRC may receive a report that the judge has all he needs to approve the claim. The long-awaited hearing is then cancelled, and the payment to the CRC is re-instated.

One can understand, then, that at the end of the day, very little room remains for the stakeholders to work toward development of improved service delivery practices. In the year 2014, this is a travesty. In the end, advocacy and changes in policy are required. One important example of
pending legislation is Bill HR 492/S.948 “Ensuring Access to Quality Complex Rehabilitation Technology Act” [3]. Ultimately, the goal of the proposed Bill HR 492/S.948 is to improve access to quality complex rehabilitation technology while improving the quality of life for individuals with disabilities and complex medical needs. This legislation recognizes both the complex and highly customized nature of the technology required to meet the needs of the consumer, as well as the qualified professional involvement and services necessary to the provision of high-quality, effective mobility devices.

CMS and the federal government are fragmented and unwieldy. Local legislators, local businesses, and the general public need to hear consumers’ stories. For a long time, we have “protected” the consumer from the details of provision of product; we have taken on the fight on their behalf. In hindsight, this has not helped the process. There is a huge gap in consumer engagement and education regarding their individual policy coverage. Not all consumers are adept at understanding their policy coverage; thus advocacy via outside agencies is a must. Linking arms with consumer groups, as well as NRRTS, RESNA, and NCART, we can make a difference. Many people have used this quote—it is as appropriate to consumer access as anything else [4]:

“Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it’s the only thing that ever has.” —Margaret Mead

Additional Resources

Illinois HFS Seating Mobility Evaluation (http://www2.illinois.gov/hfs/sitecollectiondocuments/hfs3701h.pdf)


National Registry of Rehabilitation Technology Supplier (NRRTS) Directions Archives (http://www.nrrts.org/directions)


Users First (http://www.usersfirst.org/)

REFERENCES