THE OFFICIAL PUBLICATION OF THE NATIONAL REGISTRY OF REHABILITATION TECHNOLOGY SUPPLIERS | VOLUME I | WINTER 2008

DIRECTIONS

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advertisers' INDEX

Altimate Medical 25
Bodypoint, Inc. 28
BodyTech Northwest 37
Convaid, Inc. 17
Freedom Designs, Inc. 9
Innovative Concepts 13
Invacare Corporation 33
MK Battery 5
Mobility Management Magazine 22
Motion Concepts 19
New Mobility 12
Permobil Inc. ..... Inside Back Cover
Prairie Seating 11
PRM 31
Quantum Rehab 15
Ride Designs 32
Snug Seat 39
Stealth Products 21
Sunrise Medical 45
The A.R.T. Group ..... Inside Front Cover
The MED Group 40
The ROHO Group ..... Outside Back Cover
TiLite 7
U.S. Rehab 23
Varilite 35
Vista Medical 29
Wenzelite Rehab 41

HAS YOUR MAILING OR EMAIL ADDRESS CHANGED?

Please help us keep our records current by providing your updated information to Amy Odom at aodom@nrrts.org.

EMAIL ADDRESSES ARE NOT PUBLISHED OR SHARED.

26

ON THE COVER

Coding: A Foundation for Change?

Manual Wheelchair Codes-Another Storm Brewing for Rehab?

NRRTS & THE INDUSTRY

New Registrants 41
Former NRRTS Registrants 41
CELA '08 42
2008 TeleSeminar Series 43
Charter Corporate Friends of NRRTS 46
Corporate Friends of NRRTS 46
Association Friends of NRRTS 46
ATS Credentials 46
Scott Alexander Obituary 46

FEATURES

FROM THE NRRTS' OFFICE
4 NRRTS Update

CORPORATE FRIEND OF NRRTS FOCUS
TI LITE
6 A Long, Hard Look

TALKING POINTS
10 Business Unusual

LIFE ON WHEELS
14 The Crossroad: A Veteran's Story

CORPORATE FRIEND OF NRRTS FOCUS
CONVAID
16 The Information Highway is a Two Way Street

NOTES FROM THE FIELD
20 RTSs Can and Will Make a Difference

CORPORATE FRIEND OF NRRTS FOCUS
ALTIMATE MEDICAL
24 Taking a Stand on the Importance of Standing

LAW LIBRARY
30 Overview of the 2008 OIG Work Plan

THE BOTTOM LINE
34 Frequently Asked Questions in Rehab Reimbursement

ASSESSMENTS
36 Dynamic Seating: Long Overdue and Now a Possibility

CORPORATE FRIEND OF NRRTS FOCUS
THE MED GROUP
38 Making Winning Rehab-Equipment Providers

NRRTS update

SIMON MARGOLIS
Executive Director
NRRTS

2007 WAS A HECK OF A YEAR!

If you and your company are reeling from a lack of focus given our turbulent time, you're certainly not alone. The changes in our industry have created an unforgiving environment for many formerly strong companies and service delivery practices. Smart people adapt with new strategies and a re-doubled focus on results.

It is important for us to remember that, to many people, tight times and new strategies serve more to distract than to inspire. Uncertainty does that. The result: many people start to drift just at a time when a heightened focus is needed the most.

> *"The definition of insanity is doing the same thing over and over and expecting different results."*
> *Benjamin Franklin*

So how can we be certain our efforts are focused on the results that matter -- and away from the activities that don't? For ages we have used "goal setting" as a way to get us going in the right direction. But given today's pace, this practice, in its traditional form, is not enough.

The good news is there's something we can do to keep ourselves focused. The first step is to simply recognize the way we've done things in the past are not going to work in the new environment.

Our focus is fading fast when we see:

Tunnel vision – We become so engrossed in our own activities that we ignore the need to be part of the solution to the root problem.

Activity traps – We throw ourselves into our jobs, working ungodly hours. Yet, even as we attempt to get everything done, we don't seem to get out from under the work. Furious activity does not equal achievement.

Danglers – We bend, and even break our own or our company's rules in a well meaning attempt to provide the same level of service we used to – even though we're aware of the negative impact on our ability to serve all our clients in the long run.

Gaps – In sandlot baseball, sometimes several kids will greet a fly ball with screams that, "I've got it! I've got it!" When it drops down between them all, it's not long before the finger pointing starts. When mistakes are made during difficult times, identifying who dropped the ball becomes very important – when the focus should be on solving the problem.

Even in a time of chaos, lost focus can be regained setting realistic goals for ourselves helps. Humans are goal-oriented by nature. But each of us needs to develop updates to our traditional methods of operation that truly match the reality of our current professional, clinical and business environment.

The solution to many of these problems can only be addressed by binding together with other people who are sitting in same rocking boat. The way out of the situation lies in each person impacted by the current state of affairs to take personal responsibility for being part of the solution rather than a spectator complaining from the sidelines.

NRRTS provides the vehicle for these types of activities. It requires very little of our already stretched time budget to do things that will have a positive impact. We can become agents of change. Three simple steps: (1) Visit the NRRTS website, www.nrts.org, weekly; (2) Respond to the e-mails you receive from NRRTS and participate in the requested activities; and (3) Continue to educate your clients and referral sources about who is responsible for the current state of affairs and think carefully about solving problems that you didn't create. D

ABOUT THE AUTHOR:
Simon Margolis can be reached at smargolis@nrrts.org or 763.559.8153.

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A Long, Hard Look

JOSH ANDERSON
Vice President of Marketing
TiLite

WHEN ASKED TO WRITE AN article for NRRTS, I pondered a multitude of topics. Do I talk about the materials and design of mobility equipment; the importance of wheel position for efficient propulsion and upper extremity joint health? After all, the NRRTS registrants and Friends of NRRTS who read this publication should understand and care about these issues. But then I received this email from my friend Bob:

"So much for the idea of 'If the chair is just a bit too wide and heavy it won't make a difference'."

"My everyday chair is 14" wide- always has been. Nine weeks ago when I broke my leg, I was fitted for a brace...the brace does allow my knee to bend and I can transfer into an every day chair."

"...the brace is so wide that I had to use a 17" wide chair... Combine this with the fact the frame weighs almost 30 pounds... and in only nine weeks my shoulders have gone from 'fine but a bit tender' to totally trashed...my fingers and thumbs are going numb, and I am having trouble sleeping at night because my arms go numb."

"So much for the idea of 'If the chair is just a bit too wide and heavy it won't make a difference'."

Bob's email got me thinking. Although I am no expert on the topic, I decided that Bob's story illustrated the likely scenarios we could see if competitive bidding is put into place for Complex Rehab equipment and if Medicare's "in the home" coverage policy continues to expand. The details we have learned about design and configuration seemed irrelevant when it appears that we may be reverting to the days of 50-pound non-adjustable manual wheelchairs. While Bob's situation is thankfully temporary, it is a great testament to the importance of properly fit equipment and the functional impact improper equipment will have on our customers. These two Medicare policies (competitive bidding and "in the home") threaten to turn Complex Rehab equipment into a commodity item, which will force providers to make tough financial decisions and limit the users' access to appropriate equipment. For NRRTS registrants and the customers they serve, this is a frightening proposition.

Being a manual chair user for the past 22 years, I can lend a unique perspective. I am an incomplete C5-6 quadriplegic who uses a manual wheelchair for mobility. To further complicate things, I'm 6' 9" inches tall. At the time I was initially in rehabilitation, my height and injury level proved to be a challenge to the provider and therapists. They would have to work together to completely rebuild a demo chair for me. During this process the provider realized that no manufacturer made extension tubes to accommodate my lower leg length and that he would have to order backrest extension tubes (since they were longer), cut the push handles off (because no push handles weren't an option) and mount the footrest to them to get the proper length. In the end, the provider spent two days configuring and adjusting this demo chair to fit me. Once this lengthy process was complete, the provider ordered my first definitive chair, which also took two days and multiple visits to setup properly. My first chair was state-of-the art for its time and allowed me to achieve my independence. Just as important, I felt empowered not disabled! I believe the successful outcome can be attributed to three things:

Level of expertise - My therapist and provider had in-depth knowledge of my unique requirements and existing rehab technology and worked together to create the best possible mobility device for my needs.

Technology - My chair was made of lightweight aluminum, adjustable so that it could accommodate my needs, and came in multiple sizes, which guaranteed a better fit than a "standard" chair.

CONTINUED ON page 8

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CONTINUED FROM page 6

Service - The provider devoted at least four days to my specific chair including the time it took to customize a demo chair, order the new chair, customize the new chair, delivery and setup.

Ironically, all three of these components are threatened by competitive bidding:

Level of competency - Although new rules dictate that power chair evals be completed by an ATS in conjunction with a qualified health care professional, we know there is a shortage of ATS and CRTS credentialed suppliers. This will only get worse when considering the financial constraints of competitive bidding. Emphasis on the most appropriate product becomes a distant second to the cheapest product during the bid process and level of skill will diminish.

Technology - A competitive bidding environment will create enormous pressure for providers to provide the least expensive equipment. And providers who participate in competitive bidding will be prohibited from providing better, more expensive equipment to their non-Medicare customers. No consideration is given to performance, fit, durability, or weight. Manufacturers who build the best possible mobility and develop new technologies will not be rewarded; instead manufacturers who build the cheapest product that satisfies the minimum requirements will thrive. Providers who want to supply the user with the best possible mobility will simply never get the bid. My first wheelchair in 1986 weighed 28 lbs and offered a variety of configurations to approximate my seating needs. My current wheelchair weighs 19 lbs (a 32% weight reduction) and is custom built to my exact measurements. The transition to lighter weight, more custom fit mobility has greatly impacted my functional ability and allows me to be completely independent. Competitive bidding takes function and independence out of the equation. Also, I didn't mention, that independent research studies show that ultra-light wheelchair frames are more durable, making them more cost effective in the long run.

> *Competitive bidding creates liability not fiscal responsibility.*

Service - An independent study funded by NCART and presented to Congress found that 50.5% of the cost related to complex rehab equipment is service-related. Therefore, to compete effectively in a competitive bidding environment, providers will need to reduce the service component of their cost structure as well as the equipment component. Competitive bidding will translate to minimum service, because the provider simply will not be able to afford to take the time. Even the best equipment, when it is not properly set up, will perform poorly and can be dangerous for the user.

We all know the pitfalls of competitive bidding, but I take it very personally. Even though I don't rely on CMS for my equipment, most private insurance companies and other funding sources look to Medicare fee schedules and coverage policy for guidance. As CMS establishes lower prices through competitive bidding, it will base its fee schedules on these lower prices. Therefore, these lower prices will become the basis for almost every funding source's prices. Therefore, unless we are successful in achieving a Complex Rehab carve-out, the prices established by CMS using competitive bidding will become a reality in all funding sectors. And then there is CMS' "in the home" standard for determining what equipment is appropriate. As CMS publishes coverage policies that determine particular products are never medically necessary "in the home," it becomes impossible for Medicare beneficiaries to obtain these products unless they pay out of pocket to upgrade, which many cannot afford to do. Then the private insurers and state Medicaid programs base their coverage policies on CMS, and suddenly no one can obtain the proper equipment.

The ability of our customers to access appropriate equipment should be a right, not a fight. The long-term impact of improperly fitted wheelchairs can lead to shoulder damage, greater fatigue and skin related issues that will cost CMS (and the beneficiaries) much more than a few million dollars. Competitive bidding creates liability, not fiscal responsibility.

A wheelchair user can be considered an asset or a liability to the community. With the right equipment, a person in a wheelchair can integrate back into society, contribute to the work force, and live a productive life. Competitive bidding for Complex Rehab leads us down the path of the treating these individuals as commodities. While our industry is working diligently on behalf of our customers, we must involve the users themselves to see real change; and unfortunately, most are not even aware this is taking place. It is our responsibility, as NRRTS registrants and Friends of NRRTS, to spread the word to consumers about the changes that are coming and advocate with them for change, before it is too late. D

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Business Unusual

BOB GOUY
CEO
UNITED SEATING AND MOBILITY

A NEW YEAR BEGINS and the world of complex mobility rests on the cusp of a new era. If you are to believe what a lot of people are saying now, the future might look pretty dim. Don't believe everything you hear. Yes, times are difficult but the future has yet to be decided. We will persevere as an industry and continue to be a valued member of the healthcare delivery system. However, make no mistake; this does not mean business as usual. It is inevitable the delivery model and the role of the RTS will evolve over the next few years but new opportunities await; they are just hidden within the change and turmoil that exists today. It's important to pay attention and seize these opportunities by adjusting to the changes as, or before they happen. Be proactive and lead by example whenever you can. When you do everything in your power to positively impact those you work with, you are actually leading change instead of reacting to it.

For our industry to thrive, we have to do the right thing always without question.

For our industry to thrive, we will all need a little inspiration along with the support and involvement of our clients, manufacturers, clinicians, and each of you individually. We have to work as a team to educate and inform our payers of the opportunities we provide our clients and their beneficiaries. With this in mind I would like to share with you what I believe to be the key elements for success through the next couple of years.

Trust is a simple word with incredible power. It is a hard thing to gain and extremely fragile, but when it exists is the key that opens the door to opportunity. Recently, our company completed two transactions with two separate companies resulting in two completely different experiences.

One party took advantage of what it saw as a loophole for no other reason than to dodge a commitment. Trust with that company has been destroyed, and it will be a long time, if ever, that we would consider working with it.

The party in the other transaction went out of its way to be accommodating and acted in the most professional manner. It gained our trust and it would be an easy decision to work with it again. Do you do the right thing when you find a loophole? I wonder if we were to measure the trust the payers, clients and clinicians have in us if we, as an industry, would rank very high? I'm sure you all understand the power of trust and I know many of you have very trusting relationships, but overall I believe we have a long way to go. Trust has to come full circle with everyone involved in the process.

As a RTS, you understand clients generally don't trust you implicitly until you prove yourself. You also understand the responsibility that is assumed once this trust is established. This same scenario is true with our payers. Do you ever wonder why they demand case managers and others be involved and that such detailed justifications be given? It's because they do not fully trust us. For our industry to thrive, we have to do the right thing always without question. This means always providing what is medically necessary and appropriate, within the limitations of reimbursement. It is critical your commitment include consideration for who is paying the bill and how your decisions impact your company's ability to remain solvent and support the clients we serve.

We all have to work toward consistency in our pricing and service. While all of healthcare struggles with pricing methodology, it is important to develop a strategy that makes sense and is consistent. Whenever payers create additional burdens, make sure to have a conversation with them explaining how it affects your company, but ultimately their clients. Make sure you truly understand your cost and represent the facts. They will listen

CONTINUED ON page 12

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CONTINUED FROM page 10

if you speak to them and not at them. You can and should be having these dialogs and conversation because it will go a long way toward establishing a trusting relationship.

Also, I believe that clinicians have a duty to understand the funding limitations that exist. Everyone has a responsibility to provide the level of product necessary for our clients' success but it is essential to understand how destructive it is to provide free "upgrades" to clients when they do not qualify or have coverage for that product. I do not believe reimbursement will ever stabilize if this continues. When there is disregard for funding limitations during an evaluation, there is disregard for the client. Providers must maintain a rational financial return in order to fully service and support their clients. This is not the same as an access issue caused by lack of funding. When this is the case, it is everyone's responsibility, including the client, to get involved. Obviously, the pressure on reimbursement is affecting change in this regard. Consistency is critical to our ability to gain the trust and cooperation needed from the payer. So, the next time you as a supplier are tempted to surrender to arm twisting and end up providing more than a client qualifies for, take a few extra minutes to explain how harmful this can be and do what is right.

When there is disregard for funding limitations during an evaluation, there is disregard for the client.

Manufacturers must continue to work closely with suppliers to deliver products and services that are client focused and meet reimbursement criteria. They will have to continue to develop and enforce strict standards for their provider networks and establish criteria that allow them to effectively manage their markets. The days of selling to anyone who wants to become a provider are over. Anything less creates false competition and an over saturation of the market resulting in a financially weak supply chain. This inevitably contributes to unscrupulous behaviors as people become desperate for revenue. As a professional RTS, it is your job to only support those companies supporting this model.

I would like to add a caveat– it is there should always be a product in the market that over performs, has features that are more style than substance, and exists if nothing more than for being cool. Our

clients should have the right to buy whatever they want. We just can't expect private insurers, Medicaid or Medicare to pay for them. We must work to differentiate this product, and we should support our clients' rights to access this product and pay the difference over a more utilitarian choice. Even this strategy requires open and honest dialogue because many payers are actually afraid that unscrupulous suppliers will take advantage and so they place unreasonable restrictions on upgrading product.

Being a professional Registrant of NRRTS means you have an obligation to always act in a way that supports your credential. This means when you are faced with an ethical decision, you make the right choice, every time. Frequently take stock of your skills and if necessary spend time educating yourself beyond what is required. Take it to the next level. Be proud of what you do. You have worked hard and been given a wonderful opportunity to make a big difference in someone's life. Use every opportunity you have with clients, clinicians, manufacturers, and payers to prove your professionalism. Get involved politically. It is absolutely essential regardless of how frustrating it can seem at times. Remember by acting in a professional manner while keeping your clients' best interest in mind is what will differentiate those of you who are inspired by what you do from those who are simply doing a job.

We cannot continue to do business as usual. It is time for a new era in complex mobility. Trust and professionalism are our keys to success. We know as an industry that we provide a tremendous value at a very low cost, and if we work hard to always do the right thing, we will further establish ourselves as a trusted partner in the healthcare delivery chain. Let's work together in the coming years to make this industry a shining example of how healthcare can and should be delivered.

I hope you are inspired by your career. If you are lucky in life, it can come from work, a hobby or your family and friends, as long as you remain open to it. Luckily I've been surrounded by people who have inspired me throughout my life including my sons, Phillip and Kevin. Phillip's courage and commitment and Kevin's joy and compassion, both leaders in their own way, are always looking to do "business unusual."

Find your inspiration and lead the way; your clients are depending on you. D

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The Crossroad: A Veteran's Story

BRYAN ANDERSON
Spokesperson
Quantum Rehab

IT'S NOT DIFFICULT FOR ME to pinpoint the moment my life hit a crossroad.

I was in Walter Reed Medical Center for months of therapy after losing both of my legs and my left hand to an improvised explosive device (IED) in Iraq, just outside of Baghdad. I was learning to walk with prosthetic legs, to use different prosthetic arms for different tasks and to use a power wheelchair in situations where prosthetics weren't a possibility. In short, I was learning how to live my day-to-day life with a body that was suddenly very different from the one I used to have.

I'm different physically, but who I am as a person hasn't changed.

The thing you need to understand about me is I'm a pretty easygoing guy. I like to make people laugh and I like to have a good time, and I can usually find the humor or at least the best part of just about any situation. But my recovery was long, painful and difficult, and some of those days at Walter Reed were pretty dark. Some of those days, it was just about impossible to see beyond the pain and how different everything was going to be from that point forward.

For me, that was the crossroad. That was the moment when I had to decide the quality of the rest of my life. Was I going to get on with my life and get back in the game, or would I just exist until I died? So I did the only thing I could do: I started living.

I'm different physically, but who I am as a person hasn't changed, and I still like to have fun. Once I got out of Walter Reed, I wanted to find out how much I could still do. The answer? I can do anything I want. I've been water skiing, jet skiing and rock climbing. I made a 110-mile bike ride from Gettysburg to Washington D.C. I've gone to the National Wheelchair Games in Alaska.

And along the way, I also got a fair amount of media coverage. There are only a few triple amputees from the war out there, so that meant I was a bit of a celebrity. Things really took off early this year, when I was on the cover of Esquire Magazine. I'm not exactly the type of guy who one would expect to even read about in Esquire, but there I was on the cover. More recently, I was featured on an HBO documentary called "Alive Day," which profiled wounded veterans from Iraq, starting on the days we were injured and survived.

Overall, I seem to be in demand! I'm doing more and more wheelchair games, media events and speaking engagements, and I have a really hectic travel schedule. And the fact is, most of these opportunities have come my way as a direct result of my injuries. I'm just trying to have as much fun as I can in the process. That's not to say I'm glad that I got hurt, or that getting injured in war is a good thing. It's not. It's just my reality. And I'm definitely not trying to say something corny like, "If life gives you lemons, make lemonade." I swear, if someone ever said that to me, I'd probably smack him with my good hand!

I guess I'm just saying that I reached a crossroad and picked a direction. And wherever that road takes me, I'm going to enjoy the ride. D

ABOUT THE AUTHOR:
Bryan Anderson is an Iraq war veteran and national spokesperson for Quantum Rehab, a division of Pride Mobility Products Corporation. He participates in a variety of sports and recreational activities and is currently touring numerous rehab facilities. Bryan can be reached at banderson@pridemobility.com.

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The Information Highway is a Two-Way Street

SUE JOHNSON
Director of Sales & Marketing
CONVAID

NO ONE CAN DENY the Internet has brought about tremendous changes in our industry over the past few years. We are now able to provide tremendous information to customers via websites, so our customers come to us better informed. And in addition, the Internet levels the playing field for all companies, because regardless of size, each company has the opportunity to have an informational websites for a relatively low cost.

Anyone can take advantage of the "information highway," otherwise known as the Internet!

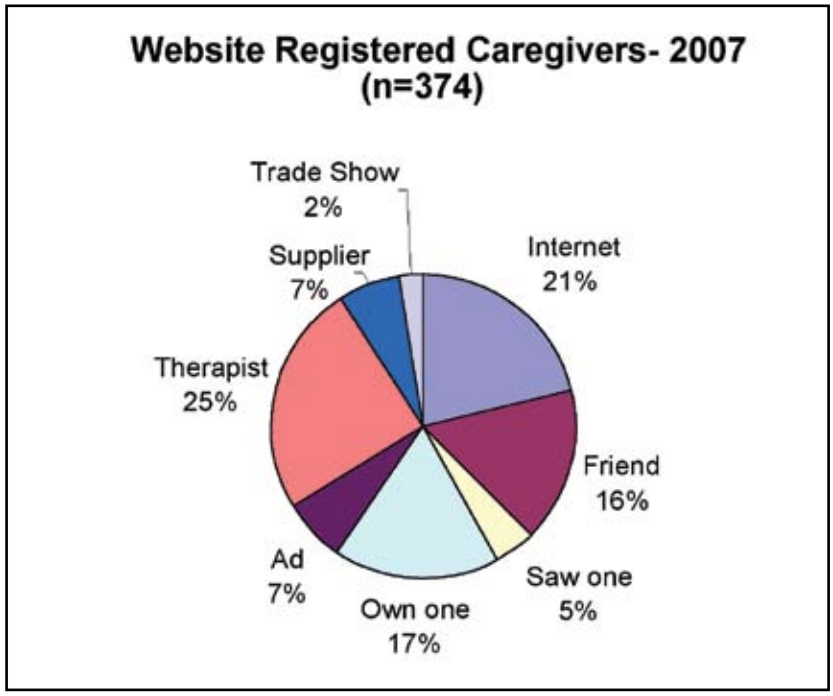
The purpose of this article is not to advocate Internet sales of rehab equipment or direct sales by manufacturers. This article is intended to inform you of ways to create a website for your company that will be a valuable tool for both you and your customer—a website that is easy to use, provides information about your products and services, and in return, gives you valuable feedback about your customers.

The two-way street

Visitors of your website can communicate with you through user forums, brochure requests and requests for other information. Following is an example of how my company's website allows us to collect valuable marketing information from visitors.

Retail pricing is not listed prominently on our website. Instead, we have a "log in for price lists" link on the homepage; visitors must register to get pricing. Registering is simple and doesn't require phone numbers or addresses. Rather, it asks for a name, e-mail address, state and visitor type (i.e. supplier, clinician, end-user/caregiver/parent or other). Different questions are asked depending upon the visitor type, because we want to collect different information from each group concerning what types of information for which they are looking.

We believe most end-users/parents/caregivers who register for price lists are relatively interested browsers. They most likely have a particular model in mind and will go to their therapists or suppliers with an order form in hand.



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CONTINUED FROM page 16

The Information Highway is a Two-Way Street

We sampled 374 of the visitors in the end-user/caregiver/parent group to find out how they discovered us:

End-User/caregiver/parent question: Where did you find out about our company?

What did we learn from this? First of all, it is obvious the data is skewed toward Internet users. But keeping this in mind, the data led us to some conclusions and confirmed some of the information we already knew:

Word of mouth is our best referral source. Branding is important. The categories of "Friend (or relative)," "Saw One" and "Own One" represent 38 percent of the total. This means that quality of product and service must be our number one priority.

Therapists play the most significant role in referring consumers to our company.

Therapists play the most significant role in referring consumers to our company.

Consumers are spending considerable time on the Internet gathering information, so it is important to keep our website current.

Advertising and trade shows play a much smaller role than we realized.

We need to do more with our suppliers. As we all know, increasing margins is not an option as we are all stretched as thin as possible with rising costs and tight Medicare/Medicaid budgets. So we need to work with suppliers in creative ways to reach our potential customers. Example: working with suppliers on regional manufacturer-sponsored educational seminars for therapists, which will provide opportunities for networking and product display during breaks.

Our website gathers vast amounts of valuable information. Brochure requests provide leads, which include names, addresses, phone numbers, e-mail addresses and often-important questions about our products, which are referred to our Customer Service Team. We always ask if and how the person wants to be contacted by a company representative, and we adhere to that request. About half respond "no," because they don't want to be bombarded with phone calls, e-mails or and junk mail. However, even if therapists from schools and other facilities don't want to be contacted individually by a customer service rep, their facilities might be included in the invitation to an educational seminar or might be added to our list of referral sources to visit. Many of our website visitors are from schools that have been buying from catalogs because they have not developed working relationships with the suppliers in their area. Many are asking for referrals to their local suppliers.

Website statistics

Most website hosting companies offer a user interface for reporting pertinent information about your website in several categories of interest.

- The platform your visitors use: Many visitors are still on dialup and have slow computers that lock up if they try to open a Flash site, a large PDF or a video. Keep files, photos and videos small. Don't get too fancy with technologies that can make the website load slowly. Match your website's technology with the low end of your visitors' platforms. If you can, look at the with both a Windows and a Mac browser to make sure nothing looks or acts weird.
- Files downloaded: What files are downloaded most frequently on your website? Keep them current. Remove old files so visitors don't inadvertently get old information from stored bookmarks.
- Pages frequently visited: You can place an ad for a new product, information about a special event or other important details in a "hot area" of your website.
- Hits and unique visitors: Hits count the clicks within your website, but don't tell you how many visitors are coming to your website. The number of unique visitors is more valuable information.
- Exit points: Where are people leaving your website? You may have unintentionally provided exit points by allowing links to take people away from your website and onto another. You can set up the links to outside resources so they open up new pages within your own site, so when the visitor finishes viewing that resource, he or she will still be on your website.

Anyone can take advantage of the "information highway," otherwise known as the Internet!

You do not have to be a computer geek to design a good website. The Internet is an affordable, easy-to-use marketing tool, which can be used to obtain and access valuable information ...valuable information that helps you work smarter, not harder. D

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RTSs Can and Will Make a Difference

LESLIE RIGG, MS, ATS, CRTS®
Co-owner
ATS WHEELCHAIR AND MEDICAL
Vice President
NRRTS

I AM OFTEN ASKED HOW I got started in this industry. It is not as if I went off to college with the grand idea that I wanted to be a RTS. Somehow, it just happened. I am actually a speech pathologist by education, having received my Certificate of Clinical Competence from Central Missouri State University in 1982.

I worked as a speech therapist in a variety environments—from hospitals to group homes—and finally landed at Idaho State School and Hospital in Nampa. While there, I worked with my current business partner and fellow CRTS®, Robert Krogh, in fabricating communication devices for my nonverbal clients. I wanted functional communication devices that would attach to their wheelchairs and not get lost. This often required a prerequisite of working with clients in their wheelchairs to achieve a functional seated posture. We experimented with pillow positioning, cut and paste foam and early foam-in-place.

Ask not what your organization, registry or profession can do for you. Ask what you can do for your organization, registry or profession.

In the late 80s, I left the State School and began working as an itinerant speech therapist for group homes and day treatment centers in the area. I saw that many of the more severe and profoundly challenged individuals were being discharged to homes and personal-care providers. I also noticed that no one at that time (besides Robert) was interested in the seating and positioning needs of these individuals. I thought we could do a great job in the community by taking care of these needs. I talked Robert into quitting, and thus ATS Wheelchair and Medical was born.

This just happened to be at the end of the "golden age," and the implementation of the "six-point plan" was not far in the future. It was a good time for learning; I loved the clients and the challenges. It was also a time when you could simply send in a quote, get an approval and provide the equipment. We all know things are more difficult now, but the rewards are the same.

As a CRTS® and co-owner of ATS, my day is filled not only with evaluations and equipment fittings, but also with the day-to-day tasks of running a company. That means making sure we keep up with our accreditation and compliance requirements, reviewing budgets, taking care of personnel issues and tending to anything else that requires my attention. And that "anything else" just so happened to include a call to serve on the NRRTS board.

I have been a RTS long enough to know a new profession needs leaders to establish direction. So, when I was asked to be on the board, I was flattered. I must confess, I looked around and thought, "Are you talking to me? I am just a small supplier in little old Boise, Idaho. What do I have to offer?" I thought of a lot of excuses, like I am too busy, I really don't know much and on and on. But, I knew I had to accept. I had to give my time and energy to an organization I believed in, an organization that was dedicated to bringing my work to a professional level.

I have served on the NRRTS board as Review Chair for four years and currently serve as Vice President. My time as a review chair gave me insight as to who my fellow professionals were and who wanted to be part of this profession. It opened my eyes to the need for standards of practice, ethics and education for individuals wanting to be RTSs. As Vice President, my focus is helping Review Chairs with applications and renewals to ensure consistency and to help with questions and concerns.

CONTINUED ON page 22

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CONTINUED FROM page 20

RTSs Can and Will Make a Difference

I am proud to serve on the board at this time of turmoil and uncertainty. There is a lot of talk now about ATS versus CRTS®, versus NRRTS registration. I would like to be optimistic; the services a RTS provides will always be needed, and even greater skill and expertise will be needed as technology improves and expands. We WILL be recognized for the skills and services we provide. How long that will take and what it will look like depends on the passion and commitment of the RTSs as a group. It will depend on how vocal we are and how urgently we request the assistance of our consumers. It will depend upon how well we educate the community and our congressmen on the benefits of the services we provide. It will depend upon how urgently we demand changes that support the specialty of complex rehab.

We all know things are more difficult now, but the rewards are the same!

Sometimes I spend so much time listening to complaints, I wish there were more offerings of solutions. So, I will close with the following thoughts:

Ask not what your organization, registry or profession can do for you. Ask what you can do for your organization, registry or profession.

You must be the change you wish to see in your profession.

Just Do It! (Nike) D

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Taking a Stand on the Importance of Standing

ANDY HICKS
Eastern Regional Manager
ALTIMATE MEDICAL

WE ARE IN THE business of helping people maintain their independence and continue to live in their homes or the environment of their choice. Despite the bad press our industry has been getting lately, we should all be proud of this mission. We do this by providing a large selection of sophisticated devices that primarily aim to improve mobility or increase independence in activities of daily living (ADL). Standing systems also help to maintain independence, but do so by fostering good health for people who are non-ambulatory. By promoting health and reducing the risk of medical problems, standing systems increase the likelihood that people will maintain their independence and continue to live in their homes. This is part of our mission: to help our clients maintain their health and their independence. And if we succeed, then our clients stay and continue to work with us.

The standing device is often neglected, because the perceived or real challenges in funding.

How therapeutic is standing—what does the research say? Most of the research on the therapeutic benefits of standing has been focused on maintaining bone-mineral density and healthy bones. Recent data presented at the American Academy of Cerebral Palsy and Developmental Medicine meeting in 2006 stated that 7.5–10 hours of standing per week will maintain bone density for children with cerebral palsy. This research is in general agreement with previous studies and suggests that one–two hours per day of standing can maintain bone density in non-ambulatory individuals and reduce the risk of fractures.

Prevention of bone fractures is understandably very important,

CONTINUED ON page 28

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CODING:

A FOUNDATION FOR CHANGE?

THE IMPETUS FOR MUCH of the change our industry has endured has been based on modifications to HCPCS coding. Coding change presents opportunities to modify more than the number used to identify a product on a claim form. In fact, the change that accompanied power wheelchair coding modification is an extreme example of the amount of change that can result from code modification. Massive change occurred in this product category that impacted coverage, pricing and ultimately the level of technology individuals can obtain.

Now the industry awaits changes to HCPCS coding for manual wheelchairs. It is the type of waiting that infers holding one's breath. While efforts to modify this code set were on a steady track last summer, this initiative appears to have reached a standstill. To understand what might have changed the direction of CMS, you have to consider what would prompt the modification of this code set at all.

Fraud does not appear to play a role in this product category. If fraud isn't an issue, a sense of urgency around changing these HCPCS codes may not exist for CMS. Another reason that CMS would consider modifying a code set if access is being denied is as a direct result of inadequate coding. While there may be access issues related to manual wheelchairs, it isn't clear that it is the direct result of inadequate coding.

For some people, the inability to find a real impetus for change might bring a common adage to mind: "If it isn't broken don't fix it." There are good reasons to avoid change that isn't absolutely necessary. After all, we have certainly seen the collateral damage from massive and simultaneous change. In the case of manual wheelchair codes, the codes inadequately define current technology and the result is that individuals with complex disabilities may not have access to technology that would promote the highest level of function. However, there is no guarantee that changes to the code set would solve that problem. Access is also impacted by the level of reimbursement for the single code (K0005) that represents a broad range of complex-rehab manual wheelchairs. Moreover, don't forget the "in the home" restriction. As long as CMS limits coverage only to technology necessary for functionality inside the beneficiaries' homes, there will be trouble accessing highly functional technology.

However, the degree of access problems could potentially increase if manual wheelchairs are included in the competitive bidding program for Medicare. This is most likely the impetus for code modification for CMS. Broad and inadequately defined codes alone are not likely to drive CMS to implement more revisions in the area of mobility products. It is more likely the combination of inadequately defined codes and competitive bidding that caused CMS to consider modifying the manual wheelchair code set. Therefore, the timing of any modification to these codes is likely to coincide with plans to include these products in the competitive-bidding program.

The current manual-wheelchair code set isn't ideal. But, are there sufficient issues to justify an overhaul? Consider the majority of manual wheelchairs provided to Medicare beneficiaries are those billed under K0001–K0004. There has been very little innovation in these categories that impact the consumer. Most of the technological

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change has been focused on the needs of the supplier, i.e. merging of standard and hemi-height technology for inventory management and increased parts commonality to reduce inventory requirements for replacement parts. So, is there value in revising the codes for these products if the technology hasn't changed? Actually, one could argue, and there are some studies that suggest, that no one who is self-propelling should be using standard manual-wheelchair technology at all. This technology does not allow for the proper alignment of the wheels for propulsion, resulting in potentially harmful stress on the upper body.

One important technological change that took place many years ago was the addition of the angle-adjustable caster housing to high-strength, lightweight wheelchairs (K0004). This technological change allowed small but meaningful changes in seat angle while maintaining the proper alignment of the caster to the ground to facilitate propulsion. This technology is not called out in any of the code characteristics, and as a result, chairs that have this capacity are grouped with chairs that don't. However, CMS could argue that this technology is accessible today; maybe it's not routinely provided under the K0004 code, but a beneficiary could access this technology through an upgrade using an ABN.

So, if that is the extent of technological change in the area of manual wheelchairs frequently provided to Medicare beneficiaries, one might wonder why, even with competitive bidding, CMS would change the codes at all. The opportunity that revised coding offers is only apparent when this category of products is analyzed as a whole. Code modification could provide an opportunity to fine-tune coverage for standard mobility and promote access to lighter-weight and better-performing products for elderly and chronically ill beneficiaries. The cost to Medicare for this change would be minimal, and yet it would provide a positive outcome for those consumers.

Possibly the most important opportunity that would result from revising manual wheelchair codes would be the ability to address the broad range of technology currently coded as K0005—ultra lightweight manual wheelchair. Currently, this code only requires that the chair weigh less than 30 pounds, have rear axle adjustability and a lifetime warranty. There are no requirements identified for seat angle, seat-to-back angle and back-height adjustment; no minimum requirements for rear-axle adjustment; no distinction for chairs that weigh 29 pounds from those that weigh 18 and I could go on and on to further illustrate why the K0005 contains an inappropriately broad range of technology.

Once it is clear that the greatest opportunity for positive change is at the level of complex rehab, it would be tempting to think that there is no value in the initiative. After all, Medicare isn't the primary insurer for most complex rehab. This might explain why CMS isn't rushing to implement changes for this code set. Not only will the coding changes require analysis of payment for these codes, it will also require the development of a revised LCD. This involves a great deal of effort and regulatory process for CMS and its contractors.

However, for the rehab industry, and more importantly, for the consumers, appropriate refinement of the code set is important for ensuring access to this technology through other insurers. The higher-functioning products are more routinely covered by Medicaid, private insurance, workers' comp, voc rehab and the VA, and with few exceptions, they all utilize HCPCS codes for billing. Without codes to distinguish the levels of technology, it is impossible to develop distinct coverage and difficult to establish different levels of reimbursement. Most Medicaid programs apply a "least costly alternative" mandate that is difficult to monitor without different codes to represent the different levels of technology. How can an insurer justify paying a higher amount without codes to define the distinct technological or functional differences?

So, shouldn't the industry, clinicians and consumer advocates be lobbying for change regarding manual wheelchair coding? Understanding the answer to this question will help you understand why the initiative is stalled. I have explained why CMS may not be moving forward at this point, but I have not explained why the industry isn't screaming about it. The answer is simple: the experience over the past two years regarding power wheelchairs has been painful and it has illustrated how Medicare can negatively influence other payers. It is clear that CMS will instruct its contractors to develop policies that are appropriate for Medicare beneficiaries and within the scope of "in the home". It is also clear that other insurers follow in the footsteps of Medicare. Regardless of the fact that the Medicaid mandate is different from that of Medicare and that the patient populations and needs may be different, it is simply easier to adopt Medicare policies.

The comfort and predictability of the current code set, coverage policies and reimbursement for manual wheelchairs can be easy to accept when one considers the potential problems associated with massive change. While change offers the opportunity to improve coverage and reimbursement, and to increase access to improved function for people with disabilities, it also brings the risk that access could be reduced and reimbursement could be cut; all of these were the result of the revised power-mobility codes. Moreover, the changes spread like kudzu to other insurers. These are the reasons that all stakeholders will work hard to influence decision makers if CMS decides to move forward with manual-wheelchair coding, but not put forth a lot of effort to force change. Unfortunately, the outcome is too unpredictable and the risk of a negative outcome too high.

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CONTINUED FROM page 24

but what may be more important is preventing the loss of range of motion, which studies indicate can be achieved by standing for shorter intervals than what is needed to maintain BMD. As has been noted for years by therapists, people who live in wheelchairs take the form of a wheelchair. If a person is gaining more flexion in the joints and becoming fixed in the lower extremities, what does this mean for this person's transfers, hygiene, positioning and the consequences of pressure wounds when bed positioning is limited? If a person with full ROM goes from sitting to standing, the whole body moves out of flexion and into extension. If he or she stands erect, this should create a lordotic curve in the back, which in turn creates cervical extension, making it easier to bring the head back and tilt it up. This is especially true if standing has begun at an early age or at the onset of the disability, and if the opportunity to stand is provided on a regular basis. Also, how many of the people you work with have a therapist, nurse or a dedicated family member to help them with exercises to maintain their range of motion? Most likely, the answer is very few. Today's standing systems are an efficient and low-cost way to provide long-term therapy that can reduce costs by preventing medical problems and help people continue to live independently.

> *Standing systems reduce spasticity.*

Standing systems also reduce spasticity. Swedish researchers Knutson and Odeen found that standing 40 minutes per day not only improved ROM, but also helped manage spasticity. They observed that standing provided a stretch to the gastrocnemius-soleus muscles that minimized the spastic restraint 26 percent to 32 percent, depending on the flexion of the feet. What is most encouraging is that they found the effects can be maintained for several hours after standing. These studies have prompted the Swedish government to provide standers with the intent to reduce the prescriptions of antispasmodic medications and to reduce the request for heel cord and other corrective surgeries. Reduction of spasticity could help with functional

activities, such as ambulation, and could help prevent deformities, which in turn lessens the likelihood of corrective surgery. The secondary benefits are almost more important to the individual and caregiver, and can include a reduction in pain and better-quality sleeping patterns.

Funding is the elephant in the room for providing standing systems in the USA, as Medicare does not pay for standers except by individual consideration. State Medicaid programs and private insurance providers each have different DME policies on standing systems, making it difficult to navigate the requirements and paperwork for reimbursement. Fortunately, most funding sources will pay for standers when a clear letter of justification is provided, describing the treatment goals and how standing will accomplish the goals for the person. For example, writing in the justification letter that "the stander is requested so the client can maintain ROM for assisted standing pivot transfers" is often successful for getting reimbursement.

Unfortunately, when a standing device is approved, the payment is sometimes inadequate. There are no quick, simple fixes to these issues, but it is important that we stick together as manufacturers, therapists and suppliers to find solutions to provide all complex rehab, including standing systems, for each individual as the need arises. We must also continue to support peer-reviewed research on the medical benefits of standing, which will provide a compelling rationale for funding sources. The standing device is often neglected because of the perceived or real challenges in funding. However, funding can be found for standing systems, and they should be promoted on behalf of our clients because of the importance for lifelong health, independence and quality of life. D

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Overview of the 2008 OIG Work Plan

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FOR MOST OF THE country, October, November and December meant preparing for the holidays, watching the leaves change in the fall and preparing to make New Year's resolutions. For rehab and HME suppliers, however, the fourth quarter brought the OIG work plan and force suppliers to consider what segments of their operation might be under scrutiny from the OIG in the upcoming calendar year. The 2008 work plan contains many provisions of interest to rehab and HME suppliers.

The OIG is going to be involved in scrutinizing power wheelchair claims, which should cause suppliers to increase efforts to be certain that documentation passes muster.

Of particular interest to rehab suppliers are two provisions specifically addressing power wheelchairs. According to the work plan, the OIG will review documentation supporting claims for power wheelchairs paid for by Medicare and will determine whether Medicare beneficiaries received the required face-to-face examinations from the referring practitioners prior to receipt of previous wheelchairs.

This level of scrutiny should come as no surprise to suppliers of power wheelchairs. Many suppliers already experienced payer audits and probe reviews to determine they are in compliance with the current local coverage determination for their products. However, the OIG is also going to be involved in scrutinizing power wheelchair claims, which should cause suppliers to increase their efforts to be certain that documentation passes muster.

In addition to reviewing documentation to verify the face-to-face examination has occurred, the OIG will also be comparing invoice prices for power wheelchairs to the Medicare fee schedule in order to address pricing variations. According to its own internal data from 2004, the OIG found the reimbursement rate paid by Medicare for power wheelchairs exceeded the price suppliers paid by 242%. In November of 2006, CMS adjusted the Medicare fee schedule to decrease this margin. The work plan makes it clear CMS will again be examining the profit margin realized by suppliers in the provision of these products. Based on the data collected in 2008, power-wheelchair suppliers might experience another price adjustment in the near future.

In addition to these provisions specifically aimed at suppliers of power wheelchairs, there are other provisions that might impact rehab and HME suppliers in the 2008 work plan. Among the issues addressed are:

- The OIG will be conducting a review of the extent of Part B services provided to nursing-home residents, even if those stays are not paid under Medicare's Part A SNF benefit. Services provided during a Part A SNF stay are billed to Medicare directly by the SNF and Part B services are included in this benefit. The OIG will focus its investigation on durable medical equipment and enteral nutrition therapy provided. Previous OIG reports found that $210,000,000.00 was potentially inappropriately paid to DME for beneficiaries residing in nursing homes. DME and rehab suppliers should be careful to verify all services and products provided to residents of nursing homes meet all eligibility requirements and that all documentation is in place prior to submitting a claim since these claims will be subject to enhanced scrutiny during 2008.
- The OIG will take a close look in 2008 at DME services and products furnished to beneficiaries receiving home-health services. According to the OIG, it believes there are indications of unnecessary DME being ordered for beneficiaries currently receiving home-health services. For this reason, HME

CONTINUED ON page 32

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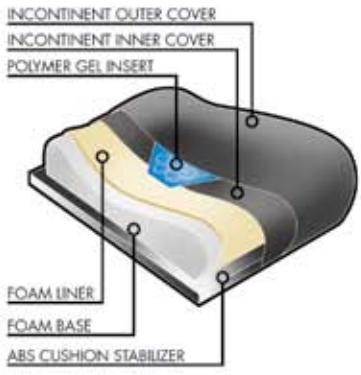

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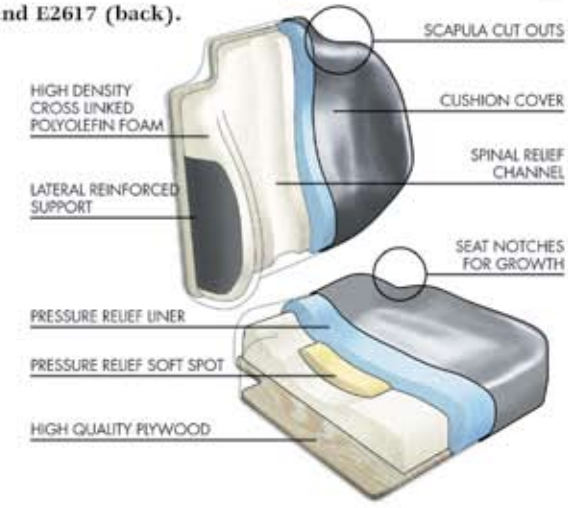

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CONTINUED FROM page 30

Overview of the 2008 OIG Work Plan

suppliers and rehab providers should take specific care and diligence in the documentation and medical necessity for items provided to patients who are receiving home-health benefits, since these claims will also be subject to additional scrutiny in 2008.

- Suppliers who provide products and submit claims containing modifiers will be subject to enhanced scrutiny during 2008. CMS' review found suppliers had little or no documentation to support many claims and also that suppliers may be using modifiers inappropriately. Those suppliers who are using modifiers on their claims, particularly the KX modifier, must be certain all documentation necessary to support the claim is obtained prior to submitting the claim for payment.
- The OIG plans to closely review all claims submitted by South Florida providers for DME and supplies. Most suppliers are aware of the scope of potentially fraudulent activities conducted by many South Florida suppliers. For this reason, suppliers in South Florida should take particular care in obtaining documentation and submitting claims since it is certain all of their claims will be subject to an enhanced level of scrutiny.
- The OIG is going to review whether CMS has inappropriately made payments to suspended or excluded DME suppliers. It can be anticipated that CMS, the payment contractors, the program safeguard contractors, and the National Supplier Clearinghouse ("NSC") will be aggressively revoking supplier numbers for noncompliant companies and suspending payments for companies engaged in practices the payment contractors believe are problematic. CMS will be closely monitoring this process and the OIG will be investigating to determine whether or not payments are being made to companies that are suspended or whose supplier billing privileges have been revoked.
- The OIG will be reviewing Medicare payments for DMEs to determine the adequacy of medical records and other supporting documentation used by the Comprehensive Error Rate Testing (CERT) program. Any supplier who has undergone a CERT audit could be subject to additional investigation from the OIG to determine basic issues such as medical necessity and adequacy of the documentation for products provided.

As always, the OIG work plan is important as a road map for enforcement priorities during the upcoming year. For each of the areas listed above, it is important that suppliers review their internal policies and procedures and take specific care to be certain that they are in compliance with all CMS, payment contractor, program-safeguard contractor and NSC guidelines. Given the high level of turmoil in the industry today, suppliers should do everything in their power to prepare for those issues that they know will be under scrutiny during the upcoming calendar year. D

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Frequently Asked Questions in Rehab Reimbursement

JIM STEPHENSON
Rehab Reimbursement Specialist
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WHAT'S THE LATEST ON the ATP/ATS requirement, effective April 1, 2008?

The requirement that patients receiving rehab power wheelchairs on or after April 1, 2008 be evaluated by a RESNA-certified Assistive Technology Practitioner was recently removed from the power-mobility device (PMD) local-coverage determination (LCD); the following language was removed from the policy:

> *The supplier's requirement to employ a certified ATS or ATP may be met through a contractual arrangement.*

The specialty evaluation for patients receiving a Group 2 single power option or multiple power option PWC, any Group 3 or Group 4 PWC, or a push rim activated power assist device for a manual wheelchair must be performed by a RESNA-certified Assistive Technology Practitioner (ATP) specializing in wheelchairs or a physician who is board-certified in Physical Medicine and Rehabilitation.

The following requirement, which is in the current LCD will remain in its place:

Patients receiving a Group 2 single power option or multiple power option PWC, any Group 3 or Group 4 PWC, or a push rim activated power assist device for a manual wheelchair must have a "specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features.

The following language will be retained and will go into effect for rehab-power wheelchairs with dates of service on or after April 1, 2008:

A Group 2 single power option or multiple power option PWC, any Group 3 or Group 4 PWC, or a push rim activated power assist device for a manual wheelchair must be provided by a supplier that employs a RESNA-certified Assistive Technology Supplier (ATS) or Assistive Technology Practitioner (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

The supplier's requirement to employ a certified ATS or ATP may be met through a contract arrangement.

Why are my PMD claims getting denied?

Recent publications by CMS have shown an astounding number of PMD claims are being denied. CMS pointed out the following as the primary reasons that PMD claims are being rejected:

- The physician order did not have all of the required seven elements.

These elements include:

1. Patient's name
2. Date of face-to-face exam
3. Diagnosis/conditions that support the claim for PMD
4. Description of the equipment required
5. Expected length of need
6. Physician signature
7. Date of physician signature
8. The documentation did not state that a reason for the physician visit was for a mobility examination.

When a patient visits his/her physician for a face-to-face examination, one of the primary reasons for the visit must be for a mobility evaluation (i.e. "Mrs. Smith is present today for a mobility evaluation").

- Functional limitations were not addressed in the face-to-face evaluation.

The National Coverage Determination (NCD) provides a series of nine questions that should be addressed when evaluating a patient for use of mobility-assistive equipment (MAE). These questions address the patient's ability or inability to use various types of MAE, including canes and walkers all the way up to power wheelchairs, to

perform mobility-related activities of daily living (MRADLs) such as toileting, grooming, bathing and feeding. Functional or mobility limitations sufficient to impair the patient's participation in MRADLs needs to be documented to prove medical necessity for the appropriate type of equipment to resolve the patient's limitations.

- Letters of medical necessity and/or supplier-created evaluation forms were submitted without supporting documentation from the patient's medical record.

The physician must provide documentation to support the need for a PMD. The physician shall document the medical necessity in a detailed narrative note in his/her charts in the same format that they use for other entries. Supporting documentation can come directly from the face-to-face examination or from pertinent parts of the patient's medical record. The medical record includes information from the physician, hospital, nursing home or home-health agency. Many suppliers have created physician forms that have not been approved by CMS. Even if the physician completes this type of form and puts it in his/her chart, this supplier-generated form is not a substitute for the comprehensive medical record.

- There is no date stamp or equivalent to verify supplier receipt of the physician order and documentation within 45 days.

Suppliers must date stamp the script and supporting documentation to prove receipt within the required 45 days. This date stamp can be in the form of a manual date stamp or it may be achieved via the date stamp that prints out on a fax transmission. D

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Dynamic Seating: Long Overdue and Now a Possibility

CATHY MULHOLLAND
Director
PACIFIC REHAB

A CHILD'S SEATING SYSTEM should provide proper positioning and postural support, but not limit the child's ability to move and play an active role in his or her own habilitation. A dynamic seating system can help a child build strength, increase the active range of motion, provide pressure relief, increase circulation and encourage active communication.

"Dynamic seating" is an interactive program that will include the initial results of a clinical study, case histories and the therapeutic rationale to support the utilization of a dynamic, active seating system.

A dynamic seating system should provide proper positioning and postural support.

An active seating system can aide in the development of motor skills. Children, who are non-ambulatory and have not developed anti-gravity postural musculature to maintain their bodies in a variety of postures, consistently have poor to fair muscle strength. It is not reasonable to expect these children to strengthen if they do not have the ability to move. How does one develop head and trunk control without opportunity? Whether a child extends due to atypical tone, agitation or merely to stretch and relieve pressure, it is very difficult to align the pelvis during extension; the child eventually returns from active extension into sacral sitting or misalignment. A seating system that moves with the child helps eliminate the need for continual repositioning, however, anatomically placed pivot points must be a component of the system to minimize shear and displacement during this movement.

An active seating system can benefit a child with poor respiratory tidal volume. Through extension, the child has the opportunity to stretch intercostals, and through movement, develop strength in musculature which permits active rib flare, depth of inspiration and in some cases improved oxygen saturation.

Many children will develop pressure issues related to shear as well as prolonged pressure. A seating system that allows for movement while minimizing shear can improve comfort and reduce the potential for skin/tissue injury.

These children need to communicate. Interaction with others, exploration and communication all require movement. The ability to "animate" with changing postures during communication, move towards the people they are interacting with or away from those who they do not wish to interact with, all require movement. In addition, we are "neurologically designed" to lean forward when our attention is required, whereas leaning backwards is our "neurologically relaxed" posture.

Children who need support to sit properly oftentimes feel trapped when they are surrounded with rigid postural supports, resulting in a battle between the child and the seating system. The rigid seating system, by nature of the hardware, usually wins. A dynamic system works with these children, not against them.

Presentation of the Clinical Study, "The Effects of Dynamic Seating on Spasticity and Joint Function in Children with Disabilities" (Dr, Michael Hahn, University of Montana)

A research grant was recently awarded to Dr. Hahn from the Thrasher Research Fund to pursue basic and clinical research into the potential impact of our novel wheelchair design on functional mobility in children with cerebral palsy. The clinical measures used in this study include the Gross Motor Function Measure (GMFM), the Pediatric Evaluation

of Disability Inventory (PEDI), the Modified Ashworth Scale and standard measures of passive and active range of motion (ROM). The GMFM is a standardized measure that evaluates gross motor function in lying/rolling, sitting, crawling/kneeling, standing and walking. The GMFM yields a percentage score (with 100% representing full, normal function) and a disability classification level (one–five, with level five representing the most disabled).

The PEDI is an adaptive-assessment instrument that provides clear links between assessed functional capabilities and a defined goal. It was developed to measure both fine and gross motor skills based on parent observation (through a structured interview). This device assesses both performance and capability of performing activities of daily living (ADLs) in the categories of self-care, mobility and social function.

The Modified Ashworth Scale is a common measure of muscle tonicity in response to passive stretch. Tonicity is scored on a scale from zero–five, with five representing the most hypertonic condition. This scale is inherently subjective; the measure's reliability has therefore been enhanced in the current study by ensuring that one single therapist administers the test with each child. The ROM measures are assessed by the same therapist, using hand-held goniometers.

The expected outcomes of the study are:

1) increased range of motion and functional mobility in the hip, knee and ankle joints,
2) decreased muscle spasticity and
3) enhancement of independent daily function.

The success of these outcomes will greatly influence the child's interaction with the surrounding environment, maintaining neuromuscular function and providing enhanced mobility for coordinated development. This research will bring great benefits for children with CP, and children with other neuromuscular conditions should also benefit from the findings of this initial study. Upon completion of the initial funding period, a subsequent project will be proposed to broaden the target population to include children in under-represented areas within the United States and in developing countries. D

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Making Winning Rehab-Equipment Providers through Relationships, Cost Strategies and Collaboration

DAVID JONES
Director of the National Rehab Network
THE MED GROUP

SUCCESSFUL REHAB-equipment providers in today's changing climate must operate using best-business practices to improve operational efficiencies.

Providing consumers with a wide range of the most cutting-edge technology can be a challenge, because everything has to be tested in a convenient location where the patient will be assisted throughout the process by appropriately trained and courteous professionals. This process has been the basic protocol of the rehab-equipment professional. However, following this premise will not ensure your business' success. Being able to provide the highest level of service is extremely important, but it must be considered in concert with profitability. Many rehab-equipment professionals realize their ability to continually provide winning customer (referral, consumer and payer) satisfaction depends on the strength of the company the professional represents.

Successful rehab-equipment businesses have respected relationships with referral sources, consumers and payers.

Listed below are a few key attributes of winning rehab-equipment businesses.

- First and foremost, successful rehab-equipment businesses have respected relationships with referral sources, consumers and payers. The customers are the lifeblood of any rehab-equipment provider, as these resources are the revenue streams for the company. Focus is placed on becoming a trusted advisor based on knowledge and conscientious service. These organizations champion their education, experience and credentials, and their focus is on keeping their skills current on the clinical, funding, governmental and technological segments of their profession. They are a primary educator and resource for many of their referral sources, consumers and payers. It is important for the customer to understand the rehab-equipment provider's commitment to his or her vocation, and ultimately, to the customer.
- Implement strategies to lower the cost of product acquisition. Many successful companies are finding there is strength in numbers and they are on board with group-purchasing organizations (GPO) to leverage the collective power of the larger group. Utilizing a formulary that offers a comparative starting point and parameters on a wide variety of products based on features and margin is also a strategy to consider. In addition, the manufacturer's operating costs as they relate to the supplier—such as fax or electronic communications and ordering, local representative costs and requirements—are also analyzed. Rehab-equipment providers appreciate quality and reliability in manufacturing partner's products, the ability to "single invoice" with a wider variety of manufacturers and the overall ease of partnering with successful manufacturers.
- Winning rehab-equipment businesses continually look for ways to become more efficient, streamline processes and lower operating costs. All aspects of the business are analyzed—intake, evaluation, demo, product selection, funding, delivery and billing. Initiatives include consolidating much of the process through scheduled internal or facility clinics, which allows for more details accomplished with less staff and in less time. The continued education of physicians, therapists and clients regarding their responsibilities in this extremely regulated process also helps streamline and increase efficiencies. Additional strategies include electronic billing opportunities, Global Positioning Systems (GPS) to route and track

CONTINUED ON page 40

x:panda™

A unique seating system that offers unparalleled dynamic movement and growth for even the most challenging conditions.

The x:panda is a multi-adjustable seat with a dynamic back, making it possible for a child to extend and push back against relatively light resistance which recovers into the desired seating position. The back can be angled to place a child in an open or closed hip angle, and locked into place for feeding and other activities where a static back is required.

The x:panda is available in three sizes, each providing seat depth, width, and back height adjustment. Combine the x:panda with our Tiger, Serval, Combi, Cougar, and High Low Indoor or Outdoor frame for superior mobility.

x:panda™ by R82

Main Features:

Suitable for children from 6" to 14" in seat width
Dynamic back – maintains pelvic positioning
Dynamic movement – adjusts to fit most users
Individually adjustable leg abduction
Patented recline adjustment
Innovative stylish design

Snug Seat Inc.
12801 E. Independence Blvd.
P. O. Box 1739
Matthews NC 28106
Tel 1 800 336 7684

SNUG SEAT®
Web: www.snugseat.com

CONTINUED FROM page 38

Making Winning Rehab-Equipment Providers through Relationships, Cost Strategies and Collaboration

drivers and advanced manufacturer representative communication to coordinate "just in time" demo product availability.

- Winning rehab businesses all visualize the future of the industry and understand that the "writing is on the wall" regarding the need for system collaboration and integration. Working toward the transfer and integration of pertinent communication and data between provider, payer and manufacturer is a key to improving efficiency, accuracy and timeliness. This much needed integration will allow for data and communications to be cataloged in a more accessible space, creating operating efficiencies through all facets of an organization. The rehab-equipment provider requires the tools that are already in place via separate provider, manufacturer and payer channels to be integrated in a seamless, yet unobtrusive way. As the industry works to accomplish this paramount task, it is also evident the rehab equipment-provider community is sharing information and insight with peers as never before. This collaboration and ability to come together and speak with a clear and unified voice will drive systems integration to levels the industry requires.

Benjamin Franklin once advised Americans to "Remember that time is money." Such an adage couldn't be more pertinent in today's rehab-equipment industry. Successful rehab-equipment providers can balance high-end experience and customer service with the understanding that they must be more efficient and continually lower operating costs.

While this may just be the tip of the iceberg, these proven attributes are the foundation to which winning rehab-equipment providers adhere. Take the time to critically assess how your business manages relationships, cost strategies, efficiencies and collaborative efforts. This gives you a great opportunity to build your own best business practices going into 2008 and beyond. D

ABOUT THE AUTHOR:
David Jones can be reached at djones@medgroup.com or303.653.4611.

Congratulations to the newest NRRTS Registrants!

(November 7, 2007 through January 7, 2008)

Benjamin Douglas Burton, RRTS™
Medical Mobility, Inc
316 Bluebird Rd
Goodletsville, TN 37072
Office: 615-851-1400
Toll Free: 800-441-1708
Fax: 615-851-9447
Registration Date: 11/14/2007

Lee Kerns, RRTS™
Tri-State Medical & Bariatric Solutions
10496 Loveland-Madeira Rd
Loveland, OH 45140
Office: 513-794-0340
Fax: 513-794-0341
Registration Date: 11/20/2007

Robert G. Miller, RRTS™
Bachs Home Health Care
136 Main St
Hackettstown, NJ 07840
Office: 908-813-3003
Toll Free: 800-813-3002
Fax: 908-813-3002
Registration Date: 1/4/2008

Darryl E. Muraski, RRTS™
Bach's Home Health Care Supply
136 Main St.
Hackettstown, NJ 07840
Office: 908-813-3003
Toll Free: 800-813-3002
Fax: 908-813-3002
Registration Date: 11/27/2007

FORMER NRRTS REGISTRANTS

The NRRTS Board determined RRTS™ and CRTS® should know who has maintained his/her registration in NRRTS and who has not. Names included are from 11/6/2007 through 1/7/2008. For an up-to-date verification on Registrants, visit www.nrrts.org, updated daily.

Joseph J. Clark	Keizer, OR
Janet L. Clarke, RN, ATS	St. Louis, MO
Russ Entrekin	Blackwood, NJ
Roger D. Henke, Jr., ATS	Lafayette, LA
Mitchell R. Hillier	Madison, WI
Carey Jinright, ATS	Montgomery, AL
Bennie G. Jones	San Antonio, TX
Prak Kim	Torrance, CA
Colter D. Kirkham	Pocatello, ID
Jerry L. McClure	Stockbridge, GA
Debra J. McFarlin	Amarillo, TX
Edward O'Brien	Traverse City, MI
Kevin T. O'Grady	Biloxi, MS
Ron Roberts	Lenexa, KS
Christine Rohrkemper	Campbell, CA
James R. Simpson	Bluebell, PA
Gerald Ward, ATS	San Antonio, TX
Paul Wilkie	Kansas City, MO
John M. Willis	Jonesboro, AR

CELA '08

Continuing Education and Legislative Advocacy Conference

April 23-25, 2008

Have you ever wanted to tell your Congress person or Senator how you feel about the work they do, or don't do, on your behalf?

Are you frustrated by what seems to be arbitrary decisions made on Capitol Hill and at CMS?

Do you want to influence legislation that impacts you, your clients and our entire industry and profession?

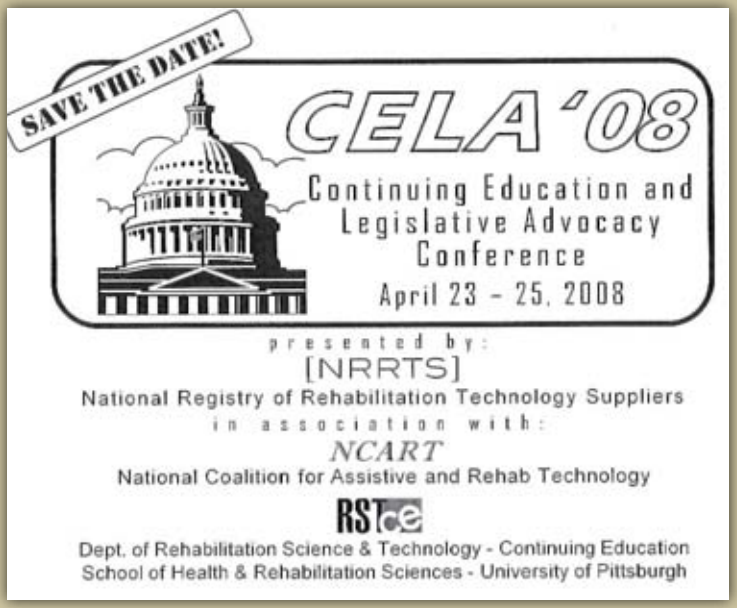
If so, CELA '08 is the unique opportunity for you to do two things during one event:

Meet your Continuing Education Requirements for NRRTS and for RESNA credentialing without "breaking the bank."

Visit with your Senators and Congress people, and/or their staff, in their offices on Capitol Hill.

Experienced NCART staff will be scheduling Capitol Hill visits for all pre-registered CELA '08 attendees, as well as preparing a Capitol Hill Visit Primer and leading an orientation session on the evening before the Hill visits.

CELA '08 is an exceptional, cost-effective opportunity to get your required CEUs/CECs and to be an agent of positive change for our industry and profession.



10 CECs/1.0 CEUs have been applied for.

ON-LINE REGISTRATION WILL BEGIN IN MID JANUARY 2008.

Conference Information

Location
Holiday Inn Washington Dulles International Airport
45425 Holiday Drive, Dulles, Virginia 20166
Phone: (703) 471-7411
Room rates - $129 per night single/double.
Complimentary airport shuttle is available. Round-trip airfares to Washington Dulles International Airport are some of the lowest in the country.

Registration Fees
NRRTS Registrants: $125
Friends of NRRTS & NCART Members: $175
All others: $250
Registration Fee includes all course materials; Opening Reception; continental breakfasts; transportation to/from Capitol Hill; and appointment scheduling with your Members of Congress.

PROGRAM

Wednesday, April 23, 2008

11:00am - 1:00pm
Registration

1:00pm - 1:10pm
Welcome - Weesie Walker, CRTS®
NRRTS President

1:10pm - 1:40pm
Consumer's Perspective (TBD)

1:40pm - 3:00pm
Keynote Address
Dr. Mark Schmeler

3:00pm - 4:30pm and
4:30pm - 6:00pm
Break-out Sessions

Standing: Principles and Practices
Ginny Paleg, Andy Hicks

Destructive Postural Tendencies
Tom Hetzel

6:30pm - 7:30pm
Welcome Reception
Hors D'oeuvres and Open Bar

7:30pm - 9:00pm
Orientation and Training for Capitol Hill Visits
Sharon Hildebrandt

Thursday, April 24, 2008

8:00am - 9:00am
Continental Breakfast

9:00am
Buses Depart Hotel for Capitol Hill

10:00am - 4:30pm
Capitol Hill Visits

5:00pm
Buses Depart Capitol Hill for Hotel

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CONTRIBUTED BY

Motion Concepts Ti

AS OF JAN. 15TH 2008

Friday, April 25, 2008

7:00am - 7:30am
Continental Breakfast

7:30am - 8:00am
Capitol Hill DeBriefing
Sharon Hildebrandt

8:00am - 9:00am
Medical Rationale for Tilt, Recline and Elevating Legrests
Dr. Brad Dicianno

9:15am - 11:00am
Break-out Sessions

Bariatric Seating
Patrick Meeker

Powered Mobility from Cognitive to Technology to Clinical Application
Ann Eubank, Kevin Phillips, Teresa Plummer

11:00am - 11:30am
Lunch

11:30am - 12:30pm
Selene Faer Dalton-Kumins

[NRRTS] 2008 TeleSeminar Series

.2 CEUs FOR EACH TELESEMINAR HAVE BEEN APPLIED FOR

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

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

TeleSeminar Series Registration Fees

NRRTS Registrants	$75
Friends of NRRTS	$100
All Others	$150

Individual TeleSeminar Registration Fees

NRRTS Registrants	$20
Friends of NRRTS	$25
All Others	$35

Register on-line at www.nrrts.org or by phone at (800) 976-7787.
Long distance charges may apply.
Cancellation Policy: No refunds will be provided.

Thursday, February 21, 2008 • 5:00pm to 7:00pm Eastern Time

PROVIDING PELVIC CONTROL

Allen Siekman, Siekman Consulting

AUDIENCE: ATSs, ATPs, physical therapists, occupational therapists (intermediate to advanced)

Control of the pelvis in wheelchair seating is an ongoing challenge. It is complicated by the conflicting desire to provide a stable base of support and postural stability. There is growing evidence that providing pelvic stability can be achieved while also allowing dynamic, functional pelvic movement. This presentation will explore methods and devices that help control pelvis and trunk location while allowing functional controlled movement.

Allen Siekman has 30 years clinical experience as a seating specialist, designer and educator, specializing in the design and provision of seating equipment for children and adults with moderate to severe physical challenges. He served as the Head of the Seating and Mobility department at the Rehabilitation Engineering Center at Children's Hospital at Stanford in Palo Alto, California for 14 years. He was the Marketing and Product Manager for the seating product division of Invacare Corporation for six years. After seven years, Mr. Siekman left his position as the Director of Seating and Design at Beneficial Designs Inc. to start his own design, consulting and testing firm. He is currently involved in many professional endeavors related to wheelchair seating.

Thursday, March 20, 2008 • 5:00pm to 7:00pm Eastern Time

PRESSURE MAPPING WHEN, WHO AND HOW TO GET PAID FOR IT

Sharon Pratt, PT, Sunrise Medical

AUDIENCE: ATSs, ATPs, physical therapists, occupational therapists (intermediate to advanced)

This session will review clinical best practices in the use of interface pressure mapping from around the world, as they exist today. Their pitfalls and strengths will be discussed. The presentation will explore the real world concerns of funding this evaluation modality.

Sharon Pratt has specialized in the field of seating and mobility for over 20 years. Graduating from Trinity College, Dublin, Ireland as a Physical Therapist, Sharon has experienced many aspects of the seating and mobility service delivery model. She has given over 400 presentations on seating and positioning to physical and occupational therapists, nurses and case managers, worldwide. In Toronto, Canada, she managed her own clinical practice, and then managed the seating and mobility devices category as the senior policy coordinator for the Ontario government's Assistive Devices Program. Joining Sunrise Medical in 1996, she developed and managed the education department and lectured extensively on seating to varied audiences worldwide. In 1999, she became the global product manager for Jay seating products.

Tuesday, April 1, 2008 • 5:00pm to 7:00pm Eastern Time

THERE'S MORE TO POWER SEATING THAN "TILT OR RECLINE?"

Stephanie Tanguay, OTR, ATP, ATS, Motion Concepts

AUDIENCE: ATSs, ATPs, physical therapists, occupational therapists (intermediate to advanced)

The ability to design a mobility device specifically for maximizing function is the art that seems to be forgotten in the shadows of codes and margins. This session will utilize case studies to illustrate how much more our industry has to offer the power mobility user.

Stephanie Tanguay's career has focused on seating and mobility for more than eighteen years. She worked as an Occupational Therapist for thirteen years and as a Rehab Technology Supplier for almost seven. She has both ATP and ATS Certifications. Stephanie is currently the Clinical Education Specialist for Motion Concepts.

Thursday, May 29, 2008 • 5:00pm to 7:00pm Eastern Time

THE MEDICAL BENEFITS OF TILT

Jane Fontein, OT, PDG

AUDIENCE: ATSs, ATPs, physical therapists, occupational therapists (intermediate to advanced)

What are the medical benefits of tilt? The session will include a review of studies about tilt-in-space wheelchairs. Case studies demonstrating benefits will spur discussion from the audience about their experiences with tilt.

Jane Fontein has been an Occupational therapist for over 20 years, working in a variety of areas including long-term care and rehab, and as a manufacturer, educator and supplier. She worked at GF Strong Rehab Centre on the spinal cord unit and coordinated the outpatient-seating program. For several years Jane provided education seminars and in-services across North America for wheelchair cushion manufacturers. She has spoken at the International Seating Symposium on several occasions as well as RESNA and the Canadian Seating and Mobility Conference. Jane is the Clinical Specialist for PDG, providing education seminars across North America.

Thursday, June 26, 2008 • 5:00pm to 7:00pm Eastern Time

HOW IS REHAB FARING IN WASHINGTON?

Rita Hostak, Vice President for Government Affairs, Sunrise Medical

AUDIENCE: ATSs, ATPs, physical therapists, occupational therapists (intermediate to advanced)

Discover exactly what is happening concerning Complex Rehab and Assistive Technology in Washington, DC and what you can and need to do about it.

Rita Hostak is Vice President of Government Relations for Sunrise Medical. She has been with Sunrise since 1982. She has twenty-three years of experience in the home healthcare industry ranging from sales and sales management to government relations. She has twelve years of experience involving the regulatory and legislative side of reimbursement. Rita is the current president of the National Coalition for Assistive and Rehab Technology (NCART), serves on the Regulatory Committee at the American Association for Homecare and is the co-chair of the CMS Program Advisory and Oversight Committee regarding competitive bidding.

Now more than ever...
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When buying a back, most people expect it to work without complication: the shell fits just right, the hardware mounts easily, contouring matches exactly, and moving the back on and off the chair is effortless. For most products, this is the ideal not the reality... until the **J3 Back**. Never before have the creative minds behind Jay spent more time studying the subtleties of fitting the back to the chair and the user to the back. Their result: The **J3 Back**. The most comprehensive combination of adjustable hardware, individual shell sizes and positioning capabilities ever assembled. **Introducing J3™...**

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

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Snug Seat nothing compares to a smile!
TherAdapt
U.S. Rehab
Whitmyer Biomechanix

CFONS

AEL Adaptive Engineering Lab — A Seating Company That Cares
AltimateMedical Standing People, Changing Lives
A.R.T. Group Artistry in Rehab Technology
ATG Rehab
Bodypoint
Convaid Advanced Seating & Mobility
FMS Frank Mobility Systems, Inc.
Metalcraft
Motion Concepts
Otto Bock HealthCare
Prairie Seating Corporation Custom Contoured Cushions
Prime Engineering
PRM The Power of Precision
Quantum Rehab Innovative Rehab Solutions — A Division of Pride Mobility Products Corp
Ride
rifton
Stealth Products
Ti Life
United Seating & Mobility
Varilite

AFONS

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GAMES
NEART
NEMED

ATS CREDENTIALS

Congratulations to NRRTS Registrants who earned the ATS credential. Depending upon their registration date, they will be awarded CRTS® upon completion and approval of the renewal following fulfillment of required registration.

Louise E. Barcus, OTR, ATS, CRTS®
Mobility Therapy
Grover Beach, CA

Dawn C. Havrilla, ATS, CRTS®
Health Aid of Ohio, Inc.
Cleveland, OH

Thomas H. Linder, Jr., ATS, CRTS®
Bay State Medical, Inc.
Hanover, MD

Donald Bradley Moore, ATS, CRTS®
A&A Home Health Equipment, Inc.
Monroe, LA

Ines Roberto Reyes, ATS, CRTS®
MRR Reyes Medical Equipment, Inc.
Uvalde, TX

Christopher J. Russell, ATS, CRTS®
National Seating & Mobility, Inc.
San Diego, CA

Ernie Sibrian, ATS, CRTS®
ATG Designing Mobility, Inc.
Cerritos, CA

Dwaine A. Smith, ATS, CRTS®
Degen Berglund, Inc.
La Crosse, WI

Philip C. Wegman, ATS, CRTS®
Halls Medical
Centralia, WA

SCOTT ALEXANDER, ATS, CRTS®, age 38, of Huntsville, Alabama, passed away on October 31, 2007. He is survived by his wife, Miscal and daughter, Hannah. Scott was a NRRTS Registrant from 2002 until his death. He earned his ATS in 2004 and his CRTS® in 2005.

Scott was dedicated to his work and enjoyed helping his patients achieve their highest level of mobility.

NRRTS extends its condolences to Scott's family, friends, clients and coworkers.

Friends,

Come, 2,4 legged and 4 "wheeled" Sometimes - Friends, you can always trust - They'll never leave you stranded, In the dust - Faithful, reliable, unbreakable as steel - No different than the bond between me and

My Permobil

K300 PS Jr	
MAXIMUM SPEED	5 MPH
BATTERY CAPACITY	Group 34
GROUND CLEARANCE	3"
BASE LENGTH	34.5"
MINIMUM WIDTH	24.25"
SEAT TO FLOOR HEIGHT	16.5"
GRADIENT CAPACITY	10° Up 6° Dn
USER WEIGHT CAPACITY	165 LBS
SEAT WIDTH	11" to 16"
SEAT DEPTH	10" to 18"
POWER SEAT ELEVATOR	YES

AJ PRESCOTT *Permobil user since 2007*

Prose by Ekula Saq – Permobil user since 2001

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