THE OFFICIAL NEWSLETTER OF THE NATIONAL REGISTRY OF REHABILITATION TECHNOLOGY SUPPLIERS

NRRTS news

inside

VOLUME 3 SUMMER 2007

from the nrrts' office | SIMON MARGOLIS

INDUSTRY UPDATE

NRRTS and NCART are working feverishly to gain support in the House of Representatives for HR 2231, the Medicare Access to Complex Rehabilitation and Assistive Technology Act of 2007, which can exempt rehab from national competitive bidding. We are also working on getting a companion bill passed in the Senate. A number of NRRTS Registrants and Friends of NRRTS have set up meetings with their Representatives and/or Senators. Others have called and e-mailed their legislators asking them to support the rehab exemption. Our industry, profession and the clients we serve certainly thank you for those efforts.

We particularly need consumers to contact their Legislators now.

It's hard to imagine why many more people haven't gotten involved. A large number of NRRTS Registrants work in the MSAs that have been selected for the first round of bidding. The second round of bidding, coming up just around the corner, will involve hundreds of additional RRTS™s and CRTS®s.

Each and every one of you reading *NRRTS News* needs to support NRRTS' and NCART's efforts to exempt complex rehab from competitive bidding. Not to do so is to put the clients you work with in the hands of the lowest bidder. Consumers need to understand the quality of the products and services they receive will inevitably decline as low bidders cut costs by providing less effective products, fewer services and poor follow-up care.

We particularly need consumers to contact their Legislators now. Please direct them to www.complexrehab.org for information about what they can do so they might gain a better understanding of the issues at hand and how they impact the industry.

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rehab forum

THERAPIST AND VENDORS AS COLLABORATIVE PARTNERS

THERESA F. BERNER, MOT, OTR/L, ATP

Being an occupational therapist has always given me a sense of accomplishment, because I'm able to see people overcome adversity and gain their independence back. I have always been intrigued by the ability of an individual to persevere and accomplish goals others may not see as achievable. When I was in school, I had the privilege of working with several people with spinal cord injuries; I was able to see how connected they became to their equipment and how their chairs allowed them interaction in a world that was constantly putting barriers in front of them. When I had the opportunity to work on an inpatient unit with people who had spinal cord injuries and assist with the development of a seating clinic, I jumped at the opportunity to put my experience to practice.

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DESIGN MARK HARTSFIELD, HARTSFIELD DESIGN

PRINTER PARKS PRINTING

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WE NEED TO BE HEARD

BY PAUL BERGANTINO
President
ATG Rehab

As a RTS, you have a significant impact on the lives of people every day. Your work is important! You are helping individuals become more comfortable, functional and independent. You bring hope and possibilities to people who might be feeling hopeless and powerless. As you are working with consumers, your focus is naturally on making sure they get the equipment to maximize their ability to live as independently and as comfortably as possible. You have received extensive training to make this happen. But, what about your role as it relates to the broader picture of our industry? Let's take a look at the big picture for a moment and think about other possibilities where you can have an impact, starting with the bottom line.

As a RTS, you have a significant impact on the lives of people every day.

Last year, the National Coalition of Assistive Rehab Technology (NCART) hired a research-consulting group to conduct a study on the rehab industry. The outcome showed the average profitability of a rehab company is 2%. The study found the average rehab company's results to be:

Sales	100%
Cost of goods	51%
Labor	33%
Other operating expenses	14%
Total cost	98%
Pretax "profits" (before taxes & depreciation)	2%

Keep in mind the 2% profit figure is an average; some companies may be doing a little better, some worse. Now imagine having to discount off this bottom line. You may be asking "how?" This is the question custom rehab companies are trying to answer on a regular basis. As low as the current profit margin is, payers are continuing to cut our reimbursement. How will a custom rehab company be able to survive if competitive bidding or a new managed-care contract reduces reimbursement even more? How will consumers be able to access the providers and obtain the products and services they need?

It wasn't always like this. There used to be a time when companies had the ability to subsidize really low reimbursement from certain payers as a result of more favorable reimbursement from those who valued the products and services we provided. Those days are long gone. All payers: Medicare, Medicaid and private insurances have been chipping away at reimbursement over the years. This has led to many custom rehab companies going out of business in recent years. We cannot continue to subsidize or accept additional discounts for our products. The services that must accompany the delivery and continued maintenance of these products cannot be reduced and must be preserved. Additional cuts will place the few existing companies at risk of being pushed out of business. If we (you) are not here, who will take care of the patient? An HME dealer? Pharmacy? Non-credentialed company? We take pride in the impact we have on our patients and the ability of our RTSs to turn dreams into realities.

The erosion of reimbursement has occurred in spite of industry attempts to raise our standards. The ATS certification will soon be a requirement for you as it already is with many payers; accreditation is a requirement for rehab providers with many payers, and it is expected to be a new requirement for CMS. As a result of extensive lobbying over the past year, CMS and Congress are beginning to understand what complex rehab is all about. We have worked hard for years at improving our companies and services, yet we have not been effective in getting payors to recognize the value and pay for the services we provide. Where is the value of raising the bar if we continue to be on the reimbursement-cutting block? If a tree falls in a forest with no one to hear it, does it make a sound?

Johann Wolfgang von Goethe said, "Knowing is not enough; we must apply. Willing is not enough; we must do." In spite of our challenges, I am confident we will succeed as long as we remain focused on what matters most and take action. So, how does this all relate to a RTS? You are part of the solution. Here are a few simple things you can do to help:

1. Understand the issues impacting the company you work for and the rehab industry as a whole. Learn more about national competitive bidding and the effect it will have on your company and your ability as a RTS to ensure access to quality equipment. Ask your company for information on these issues or go to www.complexrehab.org. In fact, I encourage you to take a few minutes to view this web site. You will find all the information you need and a link to follow that will show you how to take action. Share

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WE NEED TO BE HEARD

this web site with your clients, caregivers, clinicians etc.

2. We are specialists. We provide solutions, not just equipment. We need to make sure government and private payers recognize and pay for our services. Take action this year by contacting your member of Congress and asking him/her to sign on to H.R. 2231, The Medicare Access to Complex Rehabilitation and Assistive Technology Act of 2007. You'll find all the information you need on the above web site.

3. Make a commitment to remain informed about the issues affecting you and your company, and educate one person each day.

You have access to an audience that will be directly affected by congressional changes. Educate your patients, referrals and payers on issues negatively affecting our industry, and ask them to take action. Imagine the impact this would have if every RTS made this commitment each year. You can be the conduit for legislative action. You can help your patients find and use their voices.

It only takes one touch every day. The impact you have on the client is only the beginning of the endless possibilities you have for continuing to shine a light on the industry in which you work. You are connected to the bottom line more than you realize. Take action today and let's make sure we are heard. ■

Paul Bergantino can be reached at pbergantino@atgi.nu or 860-667-5933 x.101.

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INDUSTRY UPDATE

In fact, I encourage you to visit this site yourselves. Send e-mail to or call your Legislator. Let's not leave anything on the field as we fight to maintain the integrity of the process and the profession we have worked 15 years to develop. ■

Simon Margolis can be reached at smargolis@nrrts.org or 763-559-8153.

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I GREW UP

AUTUMN GRANT

I received a diagnosis of muscular dystrophy at the age of 10—the ultimate result of a referral to a specialist for a scoliosis evaluation. At the age of 10, words like muscle degeneration meant nothing; all I heard was the word "wheelchair." Of course, after my initial diagnosis, the speculation was I would not need to use a wheelchair until I reached my 30s or 40s; being the optimist I was even then, I figured I would never have to worry about it, because a cure would be found by then.

I probably should have started using a wheelchair in high school, but I refused because I did not want to be different.

Immediately after my diagnosis, I had very few noticeable symptoms, but I was able to "pass" as a person without a disability. I walked on my toes, did not run as fast as other children and climbed stairs very slowly, but was always able to blame it on a knee injury. I kept my disability a secret and only my closest friends knew what was going on. Despite constant falls, struggling to get out of chairs and no longer having the ability to climb stairs, I still thought I was "passing," and that no one knew there was something wrong.

I probably should have started using a wheelchair in high school, but I refused because I did not want to be different. I continued with the same attitude, even into college; I actually had a friend who went to campus with me everyday to help me get in and out of seats and to help me make it up the steep hills. My falls were also becoming a more serious issue, and I have five overlapping scars on my chin to prove it. I began to withdraw, because I could not keep up with friends anymore. Even though I did not use a wheelchair, I was different and people knew it. I could not "pass" anymore.

Because I realized I was not going to be able to bring a friend with me to work each day and that she also had a life, I reluctantly began using a scooter when I got my first job. I soon became aware the scooter was not making me different; it was actually allowing me to be more like my friends and co-workers. I no longer had to worry about fatigue; I could keep up with friends and family and participate in activities I had withdrawn from before. While I originally thought a wheelchair would cause me to give up aspects of my life, it actually allowed me to gain new aspects of my life—mainly independence.

It has now been 12 years since I used that first scooter, and now it is no longer an option—I must use a wheelchair for mobility. For many people without disabilities, it is difficult to understand how a person who needs help getting out of bed in morning and who needs assistance transferring to the shower could think of himself/herself as independent. Apparently, independence means something different to everyone. For me, it means being able to do my job without assistance; if I have to go across campus for a meeting, I can do that. It also means if I run out of milk, I can drive to the store in wheelchair-accessible van. It means if my dog needs to go outside, I can let him out and watch protectively over him from the backyard.

Last April, when I competed in the Ms. Wheelchair Massachusetts pageant, there was a reporter doing a story on the event. Because I was busy with the pageant, the reporter began talking to my father first. During the conversation, my dad mentioned I had refused to use a wheelchair or scooter much longer than I should have. When the reporter got around to talking to me, the question was asked, "How do you go from refusing to use a wheelchair when you obviously needed one to competing in the Ms. Wheelchair Massachusetts pageant?" My answer: "I grew up."

I recently had a student in my office who has a physical disability as I did in college. She is still able to walk with assistance and at the cost of fatigue and falling. During our meeting, her parents mentioned that they were buying her a scooter to take with her to college. I knew the look on her face; it was the look I had on my face during a similar college visit 15 years earlier. It was the look of "you can buy it, but I am not going to use it because I do not want to be different." I took this time to recognize myself in the young woman sitting in front of me, and gave her the advice I wish someone had given me at that age. I told her I had been in a similar situation and had wasted so much energy just trying to fit in, and denied myself what I really needed—that she may look at the a wheelchair as taking something away from her, but truly it adds so much to life. For me, it was some semblance of independence. Of course, there are places that I cannot go, but in all honesty, I could not go there before I started using my chair, either. ■

Autumn Grant can be reached at mswheelchairmass06@yahoo.com.

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LEVERAGING ALLIANCES TO AUGMENT YOUR MARKETING DOLLARS

WILL SIEMBOR
Marketing Manager
Home Care Services and Wheelchair Seating Service
University of Michigan Health System

In today's crowded and ever-changing market, we're all searching for the most economical methods for capturing additional clients. We all find ourselves pondering ways to stand out in this extremely competitive landscape, especially given the limited dollars we can allocate for marketing.

At times during my career, I was forced into implementing a "five loaves" marketing strategy due to a miniscule budget. The challenge was to find creative, inexpensive ways to fill the pipeline with qualified prospects without skimping on professionally designed marketing collateral.

By the way, you can only make a first impression once, so make sure your brochure and web site (usually the first points of client contact) reflect a polished, professional and well-established organization. And no, you can't save money by creating the brochure and web site yourself. It'll cost you more in the long run, because of business lost due to bad first impressions. There's no substitute for a professional graphic designer who understands your business and marketing objectives.

You truly can accomplish a lot for a little when it comes to spending marketing dollars, but you have to be focused and diligent. Forget about reaching everyone; this isn't a popularity contest, so don't worry if 99.9% of the population never hears about you or your or offerings. Focus—then focus some more—on keeping a constant flow of new and qualified clients coming through the door each month.

The best way I've found to get quality leads quickly and cheaply is to form an alliance with one or more established (and/or well-funded) partners. Besides generating leads, this type of relationship will provide you with instant credibility—something that could take years and cost thousands

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LEVERAGING ALLIANCES

to do on your own. Many established organizations don't mind working with smaller companies if the established company can fill one of their own needs at the local level or provide marketing value that's complementary to them.

Why would a large, established company want to align with you? Off the top of my head I can think of three good reasons.

1.) You're there; they're not. The classic model of a small company filling a need for a large company is what we all know of as a VAR (value-added reseller) relationship. Having many knowledgeable local sales and support reps on the street is a major benefit to any company—especially when they're not on the payroll. I'm sure you're well aware of the value a relationship such as this can provide for you, especially if they're an industry leader and/or have a hot product.

2.) They don't want to bother with it. You may have a skill or product set that's considered such a small niche that the larger companies may not want to be bothered with those types of leads. By positioning yourself as the expert within that niche market and proving to the larger company you'll follow up on the leads in a professional manner, they may pass all those leads to you. Don't rule out approaching a competitor with this type of arrangement—it doesn't hurt to ask. I've had many arrangements in the past where I concurrently partnered with a company on one opportunity and competed with them on others.

3.) The sum of the whole. One of the trends in the health-care industry today is the creation of interdisciplinary clinics that offer a team approach to patient care. We're getting high marks for clinics we have organized this way. During a single appointment, a team consisting of a physical medicine and rehabilitation physician, a physical therapist and a CRTS will evaluate a patient visiting our Collaborative Wheelchair Clinic. The team will together determine the best course of care, thus eliminating any miscommunication between specialists. Plus, the single visit speeds up the order process for the recommended chair. There may be clinics in your area you can team with to form an interdisciplinary clinic that is held a few times a month. Sure, it's an investment in time, but you'll be guaranteed 100% of the clinic's referrals.

All three of the above business relationships will provide some new client leads for you. That's a good start, but don't stop there—ask for more. Many other tools can be requested from your partner that will benefit the both of you. Here are some examples:

Participation in Regional Trade Events
Most large companies set aside funding for participating in a number of trade events each year. These events can be difficult for even a large company to staff since they usually run multiple days (many times spanning over a weekend). When you throw in the cost of travel, hotel and food for four–six people, it adds up quickly. Many times, the company sponsoring the booth will ask for help from local allies. By spending time performing booth duty, you'll not only have access to the new leads coming in, but you'll also be strengthening the relationship with your partner (all on his/her dime).

Professional Referral
Get written permission allowing you to use your partner's name in your marketing collateral and presentations. Also ask to have your name, contact information and/or logo displayed on his/her web site and other collateral.

Access to Contact Lists
Established companies have lists of all kinds: existing customers, trade-show leads and normal phone-in or web site generated leads. You can ask for access to these lists. Most likely, a company won't hand them over to you, but may be willing to mail your prepared marketing piece to the list(s) on your behalf.

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LEVERAGING ALLIANCES

Articles in the Local Press
Leverage existing press releases written by one of the companies with which you're aligned. I've talked public relations groups into slightly modifying releases to include me as the "local expert" or "local supplier." Local and regional papers are always looking for interesting and uplifting health-related stories. Don't hesitate to contact your local newspaper editors when you have a press release based on a positive patient story and/or new technologies.

Shared Marketing Funds
At the very least, a strong partner is usually willing to share the costs of marketing projects that benefit both of you. Sometimes it's a big percentage, and sometimes it's not. I've had partners pick up the entire newspaper-advertising tab, and the only cost I incurred was a small fee to have the boilerplate ad modified to include my contact information. I've also split the cost of booth space, collateral, luncheons and many other lead-generating activities.

Even if you don't have strong alliances formed yet, there are still many low-cost marketing activities you can do yourself. By far, my most efficient lead generator for niche supplies and services these past few years has been pay-per-click (PPC) advertising.

After reading an article stating that the majority of individuals use the Internet to seek out medical information for himself/herself or family, I became interested in learning how to entice those individuals to come my way. Through some trial and error, I set up some Google AdWords advertising campaigns. My Google ads only show up if a person does a Google search on one of my defined keywords. When he/she does enter one of my keywords, my ad will appear (usually on the right side of the screen). I am charged only if a person '"clicks" on the ad, which sends him/her to my Web site.

This is a great tool to generate focused leads for an economical price. Down the road, I'll gladly write an article entirely on pay-per-click advertising if there's enough interest.

One final thought on leveraging alliances: don't get caught up in a bunch of legal paperwork as you forge your relationships. Many times joint marketing projects can be agreed to with a simple handshake to get things going. There'll be plenty of time down the road to complete the paperwork, if it's necessary at all. ■

Will Siembor can be reached at 734.615.0278 or wsiembor@med.umich.edu..

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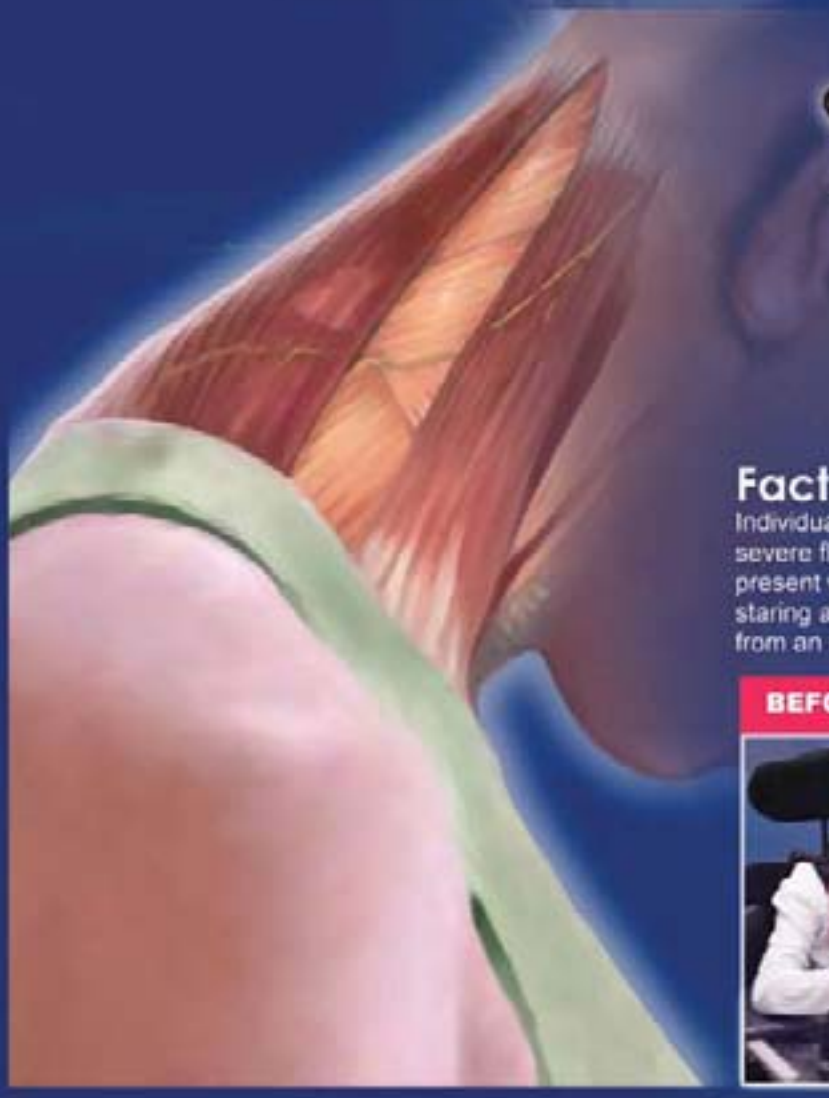

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REFLECTIONS

JOHN ZONA, ATS, CRTS®
Fallon Clinic
NRRTS At-Large Board Member

I got started in this aspect of the industry in 1982, when I made a solid seat for a manual wheelchair, put the cushion on the solid seat and saw how much better my client was sitting — I found the sling seat was not made for long-term sitting. I met one of the first rehab specialist physicians in 1983—a physiatrist. He told me rehab medicine and equipment was in its infancy, and he thought I had an aptitude for advancement. I worked with him for many years, and we collaborated on many custom wheelchairs. I found I enjoyed this kind of work and decided to specialize in assistive technology and specialized seating. I took courses at the University of Tennessee at Memphis in its rehab-engineering department, and while there, I took as many manufacturer courses as I could. Because there were not many manufacturers at this time, I researched and explored seating possibilities each time I would encounter a different diagnosis.

I joined NRRTS because it is the only group (registry) for me, as a seating specialist working for a rehab and respiratory supply company. Over the years, many colleagues had asked me to run for the board, but I felt I did not have the time to help the organization. A couple of years ago, at the International Seating Symposium in Vancouver, some colleagues (competitors) asked me to run again. I decided to do it, because I finally felt I had time to give back to the industry. I have also taken a job as the only seating specialist working for a rehab

Our profession has taken a great leap forward since CMS began requiring a certification to do "complex rehab."

company owned by a large group of physicians, and I do all their "custom mobility."

I feel the NRRTS board is very important, because it is a volunteer board of rehab and seating specialists who want the best for our industry. Anyone who feels they have leadership skills and knowledge of our industry should consider running for the NRRTS board. The obstacles, if any, are putting in the time to help NRRTS grow.

In my personal life, I am married with two wonderful daughters. The oldest just graduated from college in Boston and the youngest a freshman in Providence.

My workday consists of getting to my office between 6:30 and 7:00 a.m. I first answer my e-mail and voicemail from the previous day, and then evaluate clients, deliver custom wheelchairs/rehab equipment to clients or go to my wheelchair clinics.

Our profession has taken a great leap forward since CMS began requiring a certification to do "complex rehab," with NRRTS having the most advanced certification: CRTS®. The next step is collaboration between NRRTS and RESNA for a joint specialty-advanced certification in seating, positioning and assistive technology.

I have many personal experiences that make this profession so rewarding. One that stands out is a very intelligent, non-verbal, spastic quad, CP male client. His name is Darryl, and I have done his wheelchairs since he was in the first grade. He has recently graduated from college at the top of his class. He has done this with the help of an augmentive communication device for speech and a powered wheelchair that he prefers to drive with a chin control for mobility. In his senior year of college, he wrote a 30-page letter (book) to his parents thanking them for not putting him in an institution. He proceeded to tell them about all the personal care attendants who did and did not do their jobs and about all the relatives he heard say that he should be institutionalized. About me, he wrote I always knew he was intelligent as a child and I always talked to him rather than just talking to his parents—he valued that immensely. I saw his father after he wrote this letter, and he told me how much Darryl valued my opinions and valued my realization that he was just like me—only he couldn't walk and couldn't talk. Darryl now has a great job writing owners' manuals and other how-to books. These kinds of friends and (clients) keep me motivated to do the best for the disabled population.

This is a very rewarding profession that NRRTS will bring to the forefront of our industry. ■

John Zona is an At-Large Board Member for NRRTS. He can be reached at john.zona@fallon-clinic.com or 508-407-7711.

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THERAPIST AND VENDORS

The next 14 years was filled with the opportunity to work with vendors who took the time to teach me skills that were not captured in the classroom. They showed me equipment selection and fine-tune adjustments that would allow my patients to sit more comfortably. They took order forms and explained how to incorporate choices and options into my clinical vision of what my patients could do. These vendors explained reimbursement to me and helped me understand the guidelines insurance companies use to approve equipment. I then met the manufacturers of these products and began learning about the research and development of the products. Each of these manufacturers taught me how intricate and specific their products were, so that I could further my understanding of each of them.

We had a seating clinic that formed a partnership with area vendors who provided a service to the community. People would come to us with lists of things they could not do and places they could not go. Through careful consideration of needs as well as evaluation of their abilities, we would offer them a chance to have access to equipment that could improve their mobility. In addition to the patients, our team consisted of rehabilitation physicians, occupational therapists, physical therapists and carefully selected vendors. I then began understanding that we each had a role in the process. We had developed a careful partnership.

The physicians offer a comprehensive medical exam that provides us with direction for justification and an explanation of physiological presentation. Therapists can provide the mat assessment of kinesiology, explaining individuals' abilities. This can offer simulation and hands-on demonstration of optimal positioning. The vendor can then begin offering selection of products that can meet needs. Some therapists are more knowledgeable on products and some vendors have the background of a therapist. It is this interaction that begins the strengthening of the partnership. Having an open mind of what equipment matches the consumers' ability allows the therapist and vendor to problem solve choices for equipment. It is this interaction that must occur for the therapist and vendor to help each other learn, grow and think outside of the box.

I challenge everyone to form collaborative partnerships and work together to strengthen our mission.

Throughout the years of our clinic, the clinicians developed more knowledge and became less dependent on the vendors; we began presenting at conferences and sharing our knowledge outside of our clinic. As we reached further from our clinic, it was evident that the model we had at Ohio State University was not the norm. I learned that there were vendors who were not honest, therapists that were dictatorial and manufacturers who misrepresented their products. I heard therapists' complaints of vendors and vendors' frustrations with therapists.

Then came the challenges with reimbursement. All of a sudden, there were therapists dictating equipment, regardless of funding, and vendors limiting choices based on inconsistent criteria. The more I heard of these interactions, the more cornered I became for the consumers who we all had in common. It was these consumers who created our jobs. The people coming to us for opportunities to continue their independence were caught in whirlwind of finger-pointing and rationale on whose fault it was that they couldn't get the best equipment to overcome the adversity of their mobility limitations.

It doesn't take long for a bad experience to break down trust. We need to keep open communication, be willing to challenge each other and show respect for the piece of the puzzle we each have. Therapists need to respect the funding and vendors need to be willing to take risks.

I feel that with the experiences many of our patients have been though that resulted in the loss of their mobility, the least we can do is to put forth our best effort to help them make an equipment selection that works best for them with the resources they have at that time. We all would like to offer the top-shelf equipment, but the reality is that not everyone has premium coverage. We need to fight for the best reimbursement and engage consumers to be advocates. We need to hold each other accountable and be willing to accept that we all have more to learn.

I challenge everyone to form collaborative partnerships and work together to strengthen our mission. I would like to thank each and every vendor, suppler, technician, manufacturer, engineer, therapist and physician who took the time to teach me something about the area in which they were experts. It is through a combination of all these interactions that I have a stronger foundation to offer suggestions to the next person who needs assistance with their mobility. ■

Theresa Berner can be reached at 614.293.3847 or Theresa.Berner@osumc.edu.

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HOW TO AVOID THE APOCALYPSE

JOHN GALLAGHER
VP Government Relations
The VGM Group

As most readers know, in the next several months the Durable Medical Equipment (DME) Industry is facing a crucial juncture. Two Thousand and Seven (2007) is shaping up to be a pivotal make or break year. The industry is facing the proverbial "Four Horsemen of the Apocalypse." The four horsemen mentioned in the Bible are traditionally named Pestilence, War, Famine, and Death. However, the Industry is facing; National Competitive Bidding, Cap on Oxygen, Impact on Complex Rehab, and elimination of small to mid-sized independent providers.

Many in the industry denied the Apocalypse was real or that it would affect them.

Many in the industry denied the Apocalypse was real or that it would affect them. We now understand this thought process to be flawed. In this article, I hope to discuss the three critical issues before the industry and how we can ensure we thwart the effort to eliminate providers.

We have three bills in the house and two in the senate that can be used to beat the Apocalypse, and let's look at how they will benefit the provider:

– Competitive bidding - H.R. 1845 and S. 1428
– Oxygen - 36 month forced transfer of ownership - H.R. 621 and S. 1484 - Fixing bad policy
– Complex Rehab - H.R. 2231- Protecting those who need us most

COMPETITIVE BIDDING – HR 1845 (HOBSON TANNER) - HOW DOES IT HELP?

- CMS has the authority to expand nationwide in 2010
- Requires Quality Standards to be implemented prior to implementation of NCB
- Defines significant savings as 10% or more from Jan. 1, 2006 Fee Schedule (only products where a 10% savings can be expected would be bid- products which have already received reimbursement cuts/ reductions should be exempt)
- Allows any qualified business to continue to provide DME at the competitive bidding rate (Any Willing Provider Provision)
- Restores the appeals process for DME providers
- Exempts rural areas including MSA with less than 500,000 people and urban areas with low population density
- Comparability study must be performed before an allowable rate from an MSA can be applied to other areas of the country
- Requires CMS to perform an analysis on the initial 10 MSA in regards to beneficiary access and the affects on the DME provider community
- Congress must authorize the expansion of competitive bidding beyond the initial 10 MSA

CONTINUED ON PAGE 23


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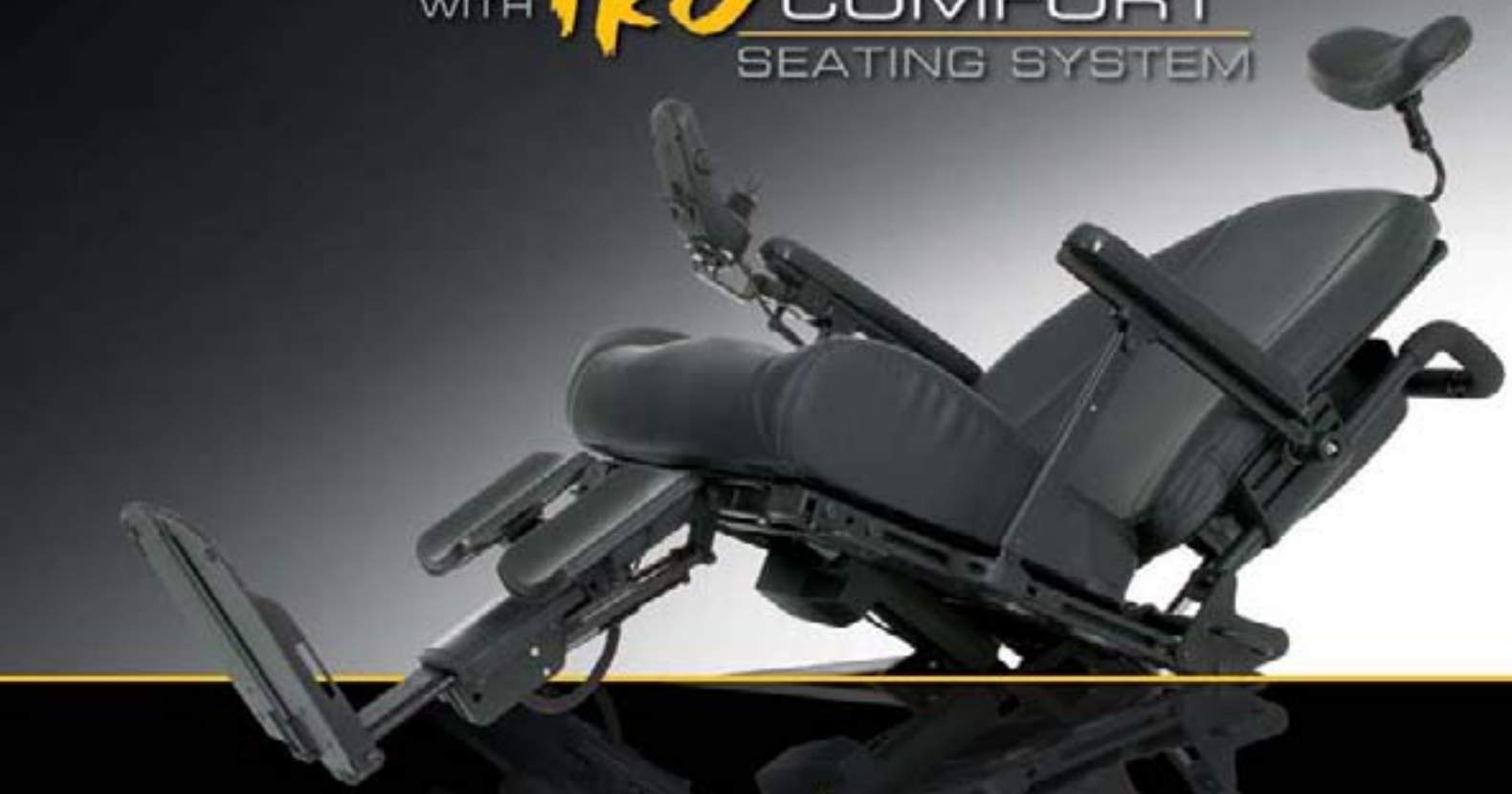

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AVOID THE APOCALYPSE

S. 1428 - HOW DOES IT HELP

- Differences between H.R. 1845 and S. 1428
  - The any willing provider provision only applies to companies with less than $6.5 million in sales- Small Business Only
  - No analysis is required of the 10 initial MSA's
  - CMS can expand competitive bidding without specific authorization from Congress
- Differences in the House version and Senate version will have to be worked out in the conference committee

H.R. 621 AND S. 1484 - SAVING OUR PATIENTS FROM BAD POLICY

- H.R. 621- Introduced by Representative Tom Price (R-GA) who is a Physician
- S. 1484 - Introduced by Senator Pat Roberts (R-KS)
- H.R. 621 and S. 1484 will rescind the 36 month cap on home oxygen equipment and services
- Presidents budget proposal would have capped oxygen equipment and services at 13 months- potential savings $6 billion

HR 2231 - PROTECTING THE PEOPLE WHO NEED US MOST

- HR 2231 - Introduced by Congressman Tom Allen (D-ME)- presently has 6 co-sponsors and is supported by NCART
- H.R. 2231 would exempt complex rehab equipment from the competitive bidding program
- Complex Rehab equipment and services are service and training intensive. The Complex Rehab client requires a lot of additional services that are not reimbursable but are supplied by Rehab providers at no cost
- The utilization numbers published by CMS indicate that 5,904 complex rehab chairs are purchased by Medicare per year. Cost savings are not enough to justify inclusion in CB
- HR 2231- Six co-sponsors to date

This effort to thwart the Apocalypse that is National Competitive Bidding is very time sensitive.

TIME SENSITIVE

This effort to thwart the Apocalypse that is National Competitive Bidding is very time sensitive. Rep. Tanner (D-TN), lead sponsor of H.R. 1845, would like to attach this bill to the "must pass" legislation known as the SCHIP (State Children Health Insurance Program) that is expected to be introduced in the weeks ahead. H.R. 2231 is in desperate need of your help, due to the low number of co-sponsors and the lack of a Senate companion bill. We need everybody to call your individual Congressional Representatives who have not co-sponsored any of these bills. Phone your Representative's offices and request that your member of congress agree to co-sponsor each of the HR bills listed above. Contact your Senators and ask that they agree to co-sponsor each of the S. bills listed above. If you are unsure how to contact your members of Congress/Senate, go to www.vgm.com and click on the DCLINK logo.

We can defeat the "four horseman," but it requires the effort of each and every provider. Have you made an effort today? ■

John Gallagher can be reached at John.Gallagher@vgm.com or 319-235-7100.

Good Resting Posture

DESTRUCTIVE POSTURAL TENDENCIES: IDENTIFICATION AND TREATMENT

Introduction

When one considers the progression of postural deformity, pain and dysfunction among wheelchair users aging with disability, it might be helpful to recognize the able-bodied population visit doctors for attention to back pain and related problems more frequently than for any other complaint except the common cold. Thus, the goal of reducing pain, deformity and dysfunction among people who can only sit is a huge challenge.

Identification of Destructive Postural Tendencies

Identification of destructive postural tendencies is key to supporting long-term health in sitting. A tough question may be, "which posture or task is the greatest priority?"

When sitting in a wheelchair, one is typically resting, propelling or involved in a fine motor task such as keyboarding, eating or playing poker. These tasks can be categorized as either resting, gross motor functional or fine motor functional. Which posture is of greatest importance? Do the sums. Which task does the typical wheelchair user find him/herself using the most? A large majority of wheelchair users find themselves resting and/or involved in fine motor activities the majority of the time.

Establish what tasks are being accomplished, for how long and in what setting, and you are well on your way to developing an appropriate order of goals for the sitter you are serving. This exercise will influence the entire process of evaluation through intervention.
Use of this exercise has revealed to me a common order with broad application across virtually all populations, and it serves as a compass to guide intervention:

1. Support non-destructive resting postures. When people relax in their wheelchairs, they should rest into their supports with their best possible posture, and without sliding out of their chairs.

2. Ensure support is provided so fine motor activities can be done without loss of alignment and stability at the core, i.e., thighs, pelvis and lumbar spine. Once the resting posture is proven well supported, observe clients attempting fine motor tasks such as keyboarding, eating or combing their hair. Do they lose that nice alignment demonstrated when resting? If so, your work is not done.

3. Do not block transitions into gross motor functional postures. Many gross motor tasks such as propelling, reaching and lifting require different postures. Gross motor tasks may result in loss of that nice postural alignment seen in goals one and two above. This doesn't necessarily mean a seating system is not working well. It may simply mean people need to reposition themselves once they get where they need to be.

Certainly there are exceptions to these goals and their priority, such as Paralympics and professional athletes, but the majority of wheelchair users' tasks will most likely fall in this order.

Assessment

A clinician should focus the assessment toward determining flexibility. The supine assessment typically allows the clinician to control for any neurological condition and reduce the impact of gravity, affording the most accurate range-of-motion (ROM)

assessment possible. If a client has normal ROM, does this mean the client can "sit up straight?" Probably not, as this question can only be addressed in sitting.

Move the client into sitting and establish where, within the available ROM assessed in supine, the person can be most comfortably supported toward a non-destructive resting posture. Establish where and how the person needs to be supported to accomplish this goal.

Simulation

Once you have established a general idea of how the client can be supported, it is time to gather equipment and configure a simulation. Everything done to this point and every evaluation finding will impact the seating and mobility prescription in at least one of the four following general parameters:


Gross Motor

- Angles: Angular relationships of postural supports relative to anatomical angles.
- Shapes: Contours and shapes of supports relative to the unique shape of the sitter.
- Materials: Materials are selected with skin care, postural control, "breathability," durability and maintenance in mind.
- Orientation to:
    - Gravity for stabilization of posture into supports.
    - Mechanism of mobility, i.e., upper extremities, one arm and one leg, joystick, head controls, etc.
    - Environment of use, including transportation when appropriate.

These four categories can be remembered through the acronym AMOS: angles, materials, orientation and shapes.

Measure the results of the simulation against the specific goals originally outlined:

- Support non-destructive resting postures.
    - If possible, encourage the sitter to relax, and observe postural change. A positive result would show an improvement in postural alignment and no sliding of the hips forward on the seat.
- Ensure sufficient support is provided so fine motor functional activities can be performed without loss of alignment and stability at the core, i.e., thighs, pelvis and lumbar spine.
    - Does participation in fine motor activities result in loss of core stability or postural alignment?
- Do not block transitions into gross motor functional postures.
    - Can the sitter complete gross motor activities and then restore him/herself into the non-destructive resting posture? It is nearly inevitable the stresses of manual propulsion—be it with bilateral upper extremities, lower extremities or one arm and/or one leg—will result in a change in the postural alignment of the sitter. The important thing is to determine if the sitter can propel and then reposition him/herself back into the supports once he/she gets where he/she needs to be.

Use the objective results of the simulation to make alterations to it as necessary until a good seating and mobility prescription can be established.

Summary of the Process

1. Identify the destructive tendency in sitting and determine and prioritize preliminary goals.


Fine Motor

2. Establish flexibility in supine.
3. Establish "correctability" in sitting, i.e., influence the client's posture in sitting toward his/her best possible posture.
4. Determine preliminary seating objectives and parameters using AMOS as a guideline.
5. Gather appropriate equipment for simulation of the selected parameters.
6. Measure effectiveness of the simulation and adjust parameters and goals appropriately.
7. Prescribe final equipment.
8. Fit the equipment.
9. Fully educate the client and care providers on use and care of the equipment.
10. Schedule a follow-up visit or call to ensure long-term effectiveness and outcomes.

Conclusion

A consistent approach to wheelchair seating and mobility has been presented. Consistency in approach, methods of evaluation and intervention is the easiest way to apply science to the often subjective and artsy elements of wheelchair seating. Well-organized goals are the compass to guide you through the process. Identification of the destructive postural tendencies will help you be more focused and directed through the assessment and in the measurement of outcomes. And remember: it is not just the wheelchair that influences one's long-term sitting health.

The full, unedited version of this paper can be downloaded at http://www.ridedesigns.com/education.html.

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CONFRONTING COMPETITIVE BIDDING: POTENTIAL LEGISLATIVE AND JUDICIAL RELIEF

DENISE M. FLETCHER, ESQ.
Attorney
Brown & Fortunato, P.C.

Since being signed into law on December 8, 2003, the Medicare Modernization Act has caused many sleepless nights for suppliers. This is particularly true for small suppliers. Of major concern have been the provisions related to competitive bidding. On April 2, 2007, CMS announced the final rule on competitive bidding and the initial ten competitive bidding areas and the products subject to the competitive bidding program. The final rule provides for a 60-day window in which suppliers can submit bids. Originally set to close on July 13, 2007, the deadline has been extended to July 20, 2007.

Several of the goals of competitive bidding are to decrease fraud and lower the expense of Medicare claims for durable medical equipment ("DME"). While these are important goals, it was not necessary for CMS to take the extreme approach it has with competitive bidding to accomplish these goals. The MMA also implemented a mandatory accreditation provision, which will go a long way in addressing fraud in the industry. The mandatory accreditation provisions require bidding suppliers to be accredited by August 31, 2007. In addition, CMS will require all suppliers to be accredited to obtain or keep a supplier number. At this time, CMS has not released a deadline for non-competitive bid suppliers to be accredited but suppliers should begin that process to ensure they can meet any CMS deadlines. As for the goal of decreasing the cost to the Medicare program for DME, recent years have seen significant changes in reimbursement. These changes have greatly reduced the profit margins for suppliers. As a result of these changes, the competitive bidding program is unlikely to see the returns CMS expects to achieve.

The basic premise of a competitive bidding program favors large suppliers, and as a result will hurt small suppliers.

Competitive bidding has not come without its problems. The basic premise of a competitive bidding program favors large suppliers, and as a result, will hurt small suppliers. CMS included several provisions in the final rule that were designed to ensure small suppliers were allowed the opportunity to participate in competitive bidding. These provisions include the ability to form networks and a provision that would allow additional contracts to be awarded if the target number of small suppliers is not awarded contracts. These provisions realistically do very little to ensure small suppliers a place in the industry after competitive bidding is fully implemented.

The one positive that has come out of competitive bidding is the industry

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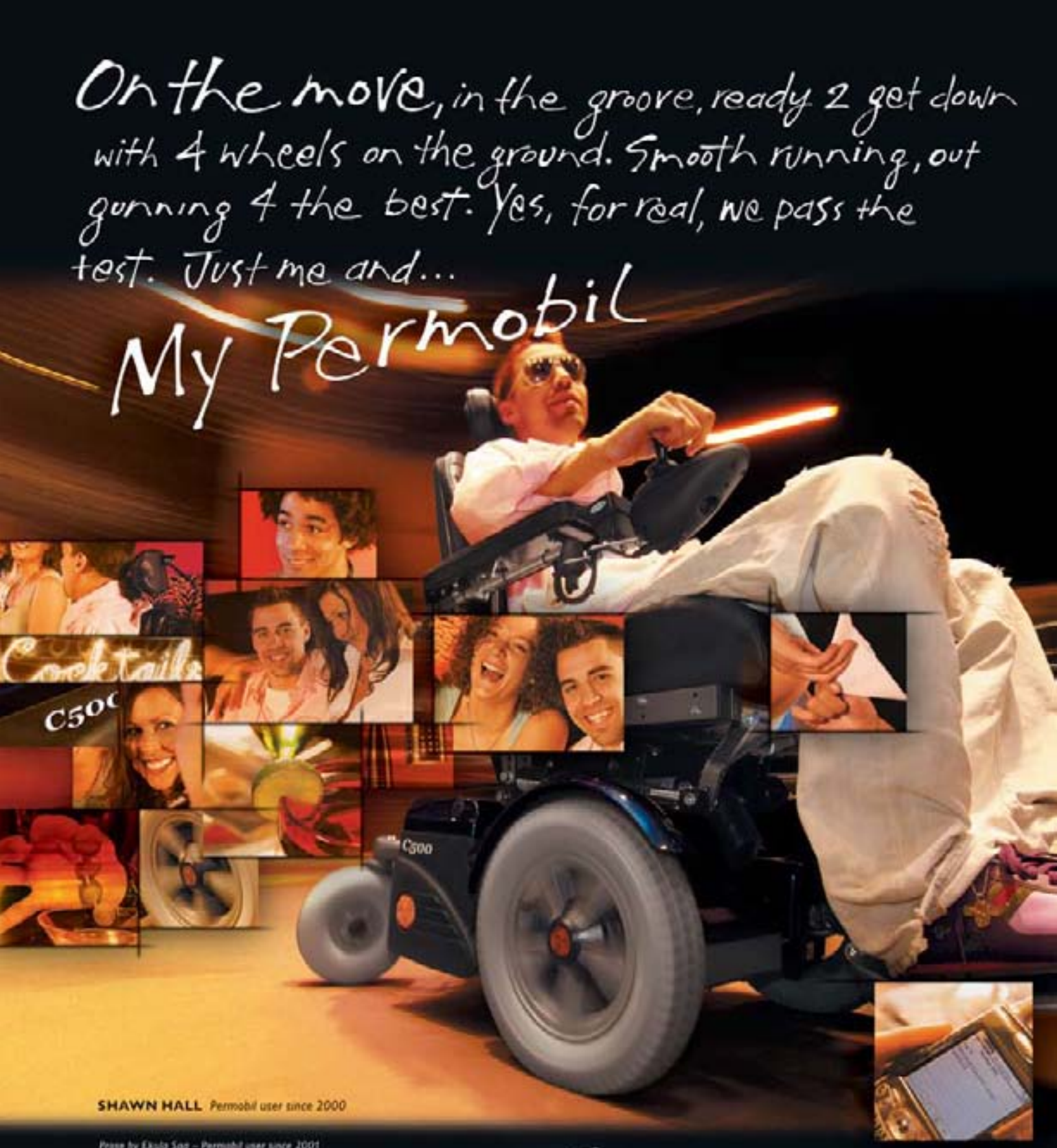

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CONFRONTING COMPETITIVE BIDDING

has become more cohesive in its efforts repeal the competitive bidding provisions of the MMA. The industry has been successful in having legislation introduced that would greatly lessen the effects of competitive bidding. This legislation is commonly known as the Hobson-Tanner bill, and if passed, would allow any supplier, that submitted a bid and is willing to accept the contract price, to participate and continue to provide products and supplies to Medicare beneficiaries. This bill was originally limited to small suppliers, but when it was reintroduced into the House on March 29, 2007, this limitation was removed. Senator Kent Conrad and Orin Hatch introduced a Senate companion bill on May 17, 2007. The Senate bill is slightly different in that the Senate bill would be limited to small suppliers. The differences in the bill would be worked out between the Senate and the House before being sent to the President for signature.

In addition to the legislative efforts to overturn competitive bidding, a lawsuit has been filed challenging the constitutionality of competitive bidding.

In addition to the legislative efforts to overturn competitive bidding, a lawsuit has been filed challenging the constitutionality of competitive bidding. The lawsuit was filed on June 12, 2007, in the Northern District of Texas. The plaintiffs include three Medicare beneficiaries with special needs who will most likely be forced to switch to low-cost providers who win contractors and three companies that qualify as small suppliers.

The three Medicare beneficiaries who are Plaintiffs have very special needs. For example, one of the beneficiaries is Gregory Hewitt, who is a C5 quadriplegic. Mr. Hewitt is currently able to function independently but only due to the custom equipment and quality care provided to him by his current DME supplier. The lawsuit alleges that beneficiaries like Mr. Hewitt are in imminent risk of harm because the high likelihood that small providers they rely upon will not receive bids and will be forced to obtain items for contract suppliers that will provide items at cut-rate prices without the care component that these beneficiaries are accustomed to receiving.

The complaint asks for relief based on violations of the equal protection and due process clauses of the United States Constitution.

The suppliers Plaintiffs are small DME companies with very few employees. These companies will have a difficult or impossible time competing in the competitive bid system. In fact, even if awarded a bid, these companies may be forced to provide medical equipment at prices that will likely be lower than they can afford. The end result is these companies will be forced out of the industry.

The complaint asks for relief based on violations of the equal protection and due process clauses of the United States Constitution. Under the equal protection clause, a classification must be reasonable, not arbitrary, and must rest upon some ground of difference having a fair and substantial relation to the object of the legislation, so that all persons similarly circumstanced will be treated alike. The complaint argues that Section 302 of the MMA has resulted in class legislation. The legislation discriminates against some of the Medicare beneficiaries and small DME providers. The complaint further alleges that there is no legitimate relationship between the competitive bidding provisions of the MMA and the legitimate state interest. As a result, the competitive acquisition program contradicts the underlying purpose of the entire Medicare program to ensure the weakest members of our society receive quality medical care.

The second cause of action alleges a violation of the due process. The competitive acquisition program disregards the property interest of Medicare beneficiaries such as those involved in the lawsuit. By eliminating any real choice of providers, the Medicare beneficiaries are left with the choice between low bidders, which may or may not supply quality products and quality service that the disabled and elderly require. Medicare beneficiaries, as a result, will be denied the specialized care they require and have been denied their substantive due process rights.

The complaint alleges the Plaintiffs will suffer imminent harm and irreparable injury. Because the complaint alleges there is no adequate remedy at law, it seeks the granting of an injunction and a request CMS be enjoined from future implementation of competitive bidding.

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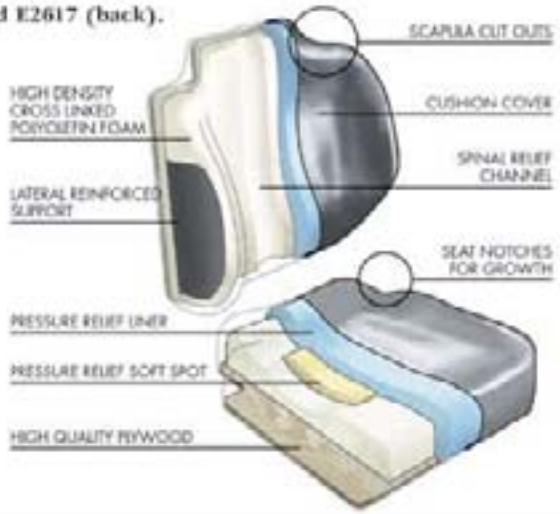

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DOES MY PATIENT QUALIFY? A GUIDE TO POWER WHEELCHAIR COVERAGE

JIM STEPHENSON
CMC, Rehab Reimbursement Specialist
Invacare Corp.

The creation of new power wheelchair codes and coverage guidelines has left many in our industry scratching their heads when it comes to deciphering whether a patient qualifies for a power wheelchair or not. However, qualification is just the first step in the process. Once you have established the guidelines have been met, you then have to figure out which type of chair you can provide. The following information should assist you in making those decisions.

Basic Coverage Criteria

- Patient has a mobility limitation that impairs his/her ability to perform one or more MRADLs.
- The limitation cannot be resolved with a cane or walker.
- Patient doesn't have sufficient UE function to operate a MWC in the home.

Rule Out Scooter/POV

- The patient cannot transfer to and from a POV, operate the tiller on a POV or maintain stability and position while operating a POV; or
- The patient's mental and physical capabilities are insufficient to operate a POV in the home; or
- The patient's home does not provide adequate access, space or surfaces to operate a POV in the home.

Power-Wheelchair Coverage Criteria

- The patient has the mental and physical capabilities to safely operate the power wheelchair provided; or
- The patient has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing and able to safely operate the power wheelchair provided; and
- The patient's weight is less than or equal to the weight capacity of the power wheelchair that is provided; and
- The patient's home provides adequate access, maneuvering space and surfaces for the operation of the power wheelchair that is provided; and

CONTINUED ON PAGE 32

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continued from page 30

POWER WHEELCHAIR COVERAGE

- Use of a power wheelchair will significantly improve the patient's ability to participate in MRADLs and the patient will use it in the home; and
- The patient has not expressed an unwillingness to use a power wheelchair in the home.

Additional Coverage Criteria for Specific Power Wheelchairs

All Group 3 or Group 4 Wheelchairs (K0848–K0886)

- The patient's mobility limitation is due to a neurological condition, myopathy or congenital skeletal deformity; and
- The patient has had a specialty evaluation performed by a PT/OT or physician who documents the medical necessity for the wheelchair and its special features.

All Single-Power Option Wheelchairs (K0835–K0840; K0856–K0860; K0877–K0880)

- The patient requires a drive control interface other than a hand or chin-operated standard proportional joystick; or
- The patient meets coverage criteria for a power tilt or recline-seating system and the system is being used on the wheelchair; and
- The patient has had a specialty evaluation performed by a PT/OT or physician who documents the medical necessity for the wheelchair and its special features.

All Multiple-Power Option Wheelchairs (K0841–K0843; K0861–K0862; K0884–K0886)

- The patient meets coverage criteria for a power tilt and recline-seating system and the system is being used on the wheelchair; or
- The patient uses a ventilator mounted on the wheelchair; and
- The patient has had a specialty evaluation performed by a PT/OT or physician who documents the medical necessity for the wheelchair and its special features.

The current LCD shows coverage criteria for power tilt, recline or tilt and recline are the same.

Power Seating Coverage

A power tilt (E1002), recline (E1003–E1005) or tilt and recline (E1006E1008), with or without power-elevating legrests (E1009–E1010), is covered if 1 and 2 are met and if one of criterion 3, 4 or 5 are met:

1. The patient meets all the coverage criteria for a power wheelchair; and
2. A specialty evaluation is completed by a licensed/certified medical professional, such as a PT/OT or physician, to assess the patient's seating and positioning needs; and
3. The patient is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or
4. The patient utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; or
5. The power-seating system is needed to manage increased tone or spasticity.

Coverage criteria for power mobility devices are based on a stepwise progression of medical necessity.

The current LCD shows coverage criteria for power tilt, recline or tilt and recline are the same. However, be certain to identify separately the medical necessity for each function in your documentation.

KX Modifier

- KX modifier states all specified required documentation is on file with the provider.
- KX modifier may be used for power-mobility devices and all accessories if one of the following conditions are met:

1. If all coverage criteria specified have been met for the product provided.
2. If there is an affirmative Advanced Determination of Medicare Coverage (ADMC) for the product provided.
3. If a Group 4 PWC is provided and all coverage criteria for a comparable Group 3 PWC have been met.

For which group does my patient qualify?

This dilemma seems to create significant confusion. The question then becomes what diagnoses qualify for the different groups? There is no official list that guarantees coverage for any of the groups, but there are diagnoses that line up more with certain groups than others.

Group 1 is for light duty and is designed for intermittent use indoors—generally two hours or less per day. These chairs do not accommodate seating or positioning items.

Group 2 is for basic daily mobility and is designed for use indoors—generally eight–10 hours per day or longer. These chairs are capable of accommodating seating and positioning items. Diagnoses that may qualify under Group 2 include: COPD, congestive heart failure, diabetes, osteoarthritis, amputation, weakness and fatigue.

Group 3 is for complex rehab and is designed for indoor use by patients with complex disabilities (neurological condition, myopathy or congenital skeletal deformity). Diagnoses that may meet these criteria include: MS, ALS, spinal cord injury, muscular dystrophy, CP, spina bifida, scoliosis, traumatic brain injury, spinal muscular atrophy, osteogenesis imperfecta and CVA. A comprehensive list of neurological

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continued from page 32

POWER WHEELCHAIR COVERAGE

conditions can be found on the National Institute of Neurological Disorders and Stroke Web site at: **www.ninds.nih.gov.**

Group 4 is for complex high activity and is designed for outdoor use by patients with complex disabilities. Group 4 is not covered by Medicare, but will be downcoded to the level for which the patient qualifies.

Downcoding

Coverage criteria for power-mobility devices are based on a stepwise progression of medical necessity. If coverage criteria for the device that is provided are not met and there is another device that meets the patient's medical needs, payment will be based on the allowance for the least costly medically appropriate alternative.

Some types of PMDs will never be paid in full.

Determinations of least costly alternative takes into account patient weight, seating needs and the need for other special features (i.e., power-seating systems, alternative-drive controls and ventilators).

Some types of PMDs will never be paid in full, but will always be either paid as a least costly alternative (if coverage criteria are met) or denied (if coverage criteria for a PMD are not met). In those situations, the first-level least costly alternative determination will be made by an automated system edit.

Jim Stephenson, CMC, Rehab Reimbursement Specialist for Invacare Corporation, can be reached at (800) 333-6900, ext. 6350 or jstephenson@invacare.com.

ETHICS

Ethics Chair, Rich Salm, CRTS®, Director, diligently investigates each complaint submitted. If deemed prudent the NRRTS attorney is consulted. The Complaint Process is alive and well, another safe guard of NRRTS!

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FEDERAL INITIATIVES ON REUSE OF ASSISTIVE TECHNOLOGY

JOHN H. HAGER
Assistant Secretary
Office of Special Education and Rehabilitative Services
U.S. Department of Education

Since my appointment as Assistant Secretary of the Office of Special Education and Rehabilitative Services (OSERS) at the U.S. Department of Education three years ago, I have worked to focus OSERS' programs on raising standards and closing achievement gaps; promoting accountability and raising expectations; and ensuring individuals with disabilities are not left behind—in school, in employment, in life.

We are always thinking of new, innovative and groundbreaking ways of promoting and ensuring the success of all Americans. Expanding access to, utilization of and reuse of assistiåve technology (AT), which includes durable medical equipment, is one way of leveling the playing field for people with disabilities. It provides access to the general curriculum for students with disabilities and expands employment opportunities for adults with disabilities.

We are always thinking of new, innovative and groundbreaking ways of promoting and ensuring the success of all Americans.

Focus on the reuse of AT at the federal level came with the passage of the 2004 amendments to the Assistive Technology Act (AT Act). The AT Act authorizes annual grant funds to every state for activities that increase access to and ensure acquisition of AT for individuals with disabilities. One such activity is the reuse of AT, and almost 100 reuse programs—from online exchanges to computer refurbishment to redistribution of durable medical equipment—are being funded by states using their AT Act grants.

Reuse programs are not limited to

CONTINUED ON PAGE 38

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SNUG SEAT®
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FEDERAL INITIATIVES

those supported under the AT Act. Citizens in nearly every state who see AT that, could be reused go to waste while those who need AT go without, have started grassroots organizations. Some grassroots AT reuse programs have been around for decades and operate out of warehouses; others can be found functioning informally out of church basements. Regardless of size, they all share a common goal: ensuring people who otherwise cannot afford AT get the devices and help they need.

OSERS shares that same goal and has undertaken an initiative to promote and support appropriate, effective reuse at the state and local levels. The best solutions to challenges often come from communities rather than bureaucracies, and device recycling is a prime example of this. This initiative is not about creating a federal bureaucracy around reuse or investing in a system that forces individuals with disabilities to accept reused equipment when they do not want it. Rather, it is about promoting reuse as an available and safe option for those who cannot afford AT or otherwise do not have access to AT.

Last year, OSERS sponsored a national conference that brought together AT reuse programs, representatives of the AT industry and other stakeholders from across the nation. Participants had the opportunity to teach and learn the challenges and opportunities of AT reuse from one another. The conference generated both information and enthusiasm, which were taken back to states and communities.

To keep the momentum going after the national conference, OSERS provided $2 million to support competitive grants for state agencies and non-profit organizations to establish new or expand existing AT reuse programs. From more than 50 applicants, 12 competed successfully and received grants supporting diverse, substantive and creative plans for meeting the AT needs of their communities through reuse. Information on each of these grantees is available from the Pass It On Center, the national AT device reuse technical assistance and coordination center sponsored by OSERS. The Pass It On Center is at the Georgia Department of Labor, and information about it can be found at: www.passitoncenter.org.

The Pass It On Center works with anyone in the AT and disability communities who desires to become involved in AT reuse.

This Pass It On Center works with anyone in the AT and disability communities who desires to become involved in AT reuse. The Pass It On Center has gathered stakeholders, including representatives of the AT industry, to form a national task force on AT reuse. This task force will work with and advise the Pass It On Center on issues of national significance related to AT reuse.

One of the center's first tasks is to develop a directory and classification of reuse programs around the nation. Once the directory is complete, it will help consumers who are looking for used AT and will provide a venue at which reuse programs can network. The Pass It On Center will use this network to disseminate tips, tools and strategies for reuse programs to ensure reuse is safe and results in positive outcomes for consumers.

The Pass It On Center will provide reuse programs with information about issues such as liability; sanitization; federal and state laws; and regulations related to reuse; useful life of devices; working with AT manufacturers and suppliers; successful policies, practices and procedures; quality indicators; and the role of AT reuse in disaster response. The Pass It On Center will support not just more reuse, but also better and effective reuse activities.

As the activities described above shine a national spotlight on state and local reuse programs, OSERS learns more about these programs and how they work. What has been discovered so far is just the tip of the iceberg. There is a long way to go to understand and realize the full potential and impact of these programs. As OSERS moves forward to promote access to, utilization of and reuse of AT, we will support, inform and guide other similar efforts under way. In communities across America, we must be able to use and reuse AT in ways that are safe, environmentally friendly and respectful of the AT industry. We remain focused on better outcomes for those we serve.

John H. Hager can be reached at 202-245-6496 or osers.oas@ed.gov.

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NRRTS ANNOUNCES JUDY DEXTER AS ASSOCIATE EXECUTIVE DIRECTOR

This past June, NRRTS was pleased to welcome Judy Dexter as Associate Executive Director. With extensive professional experience in areas such as administration, customer service, procurement, training and education, Judy brings with her the expertise and leadership required for this public role.

Judy spent 31 years with Quest Communications, held a position with the city/county of Broomfield and then transitioned to Aspen Seating/ Ride Designs in 2003 where her responsibilities included managing outreach programs, customer service and sales support.

NRRTS Executive Director Simon Margolis said of her arrival, "NRRTS is honored to have Judy on board. She has the industry experience and expertise to manage the organization and help lead NRRTS through the opportunities facing our industry and profession."

In her new role at NRRTS, Judy will be responsible for operating procedures, Registrant processing, financial and budget management, meeting and tradeshow coordination as well as various legal, corporate and administrative duties.

"I am tremendously excited to continue working with the NRRTS Registrants I met through Aspen Seating/Ride Designs, to learn more about the rehab industry and to further the future goals of NRRTS," said Judy.

Judy is married with seven—yes, seven—grown children. She enjoys nature and gardening at her ranch in Southern Colorado. Please join us in extending her a warm welcome.

Judy Dexter, NRRTS Associate Executive Director

Judy can be reached at jdexter@nrrts.org.

2007 NRRTS ELECTION

The results are final! Two hundred twenty (220) NRRTS Registrants or approximately a 25% response approved the slate of officers. Three individuals voted against the slate. The following were elected.

President
Weesie Walker, CRTS®

Vice President
Leslie Rigg, MS, CRTS®

Secretary
Mike Osborn, CRTS®, ROF

Review Chair for DMERC B
Kathy Fallon, ATS, CRTS®

Review Chair for DMERC C
Rick Liston, CRTS®

At-Large Board
Rich Salm, ATS, CRTS®
Mary Beth Kinney, CRTS®

The individuals will take office in August 2007. Thanks to these individuals for agreeing to serve on the NRRTS board.

GOODBYE, JUDY!

Judy Vance is officially retiring from NRRTS on August 25, 2007. NRRTS will definitely miss Judy, but we wish her the best!

Judy, employed by NRRTS since 1994, has been our mother and our friend. She's always been there for us no matter what. She's sacrificed; listened, worked hard and always did so with a smile on her face.

As a token of appreciation, Judy was presented with a quilt of special sentiments. Barbara Odom, Amy Odom's mother-in-law, made the quilt. Thanks to Barbara for making the quilt and to those who contributed a square.

Judy, and her husband, Tom, are relocating from Lago Vista, Texas, to Houston, Texas, and plan to spend their retirement enjoying their three grown children and spoiling their four grandchildren.

Thank you, Judy, for your service! We love you and good luck!

Judy embodies the compassion and commitment to our industry that the rest of us strive to achieve.

Tom Borcherding,
Executive Vice President, Global Sales,
The ROHO Group

When I started Mobility Management Magazine in March of 2002, Judy was there for the magazine, helping to get the word out in those early days. On behalf of NRRTS she richly contributed to Mobility Management's efforts to serve the rehab industry. Judy is dedicated to all things rehab, and I will always been grateful for her support.

Karen Cavallo, Publisher, Mobility Management Magazine

Judy Vance and NRRTS was a great match from the start. Judy has provided the dedication and a member service orientation that allowed NRRTS to grow and prosper during her tenure.

Don Clayback
Vice President of Networks for
The MED Group

Judy is an incredible woman whose name will always come to mind when NRRTS is said. She is the person who could answer any question about NRRTS, its history, its value and its registrants. She is already greatly missed! I wish her and Tommy good health, lots of happiness and all the best in their retirement.

Kathy Fallon, ATS, CRTS®
NRRTS Review Chair for DMERC B

In the crazy industry that NRRTS resides, the only constant we could depend on has been Judy Vance. She has both held our hands and kicked our tails when needed. No matter how bad a day, her voice could cheer me on the other end of the line. Judy, you will be missed more than you know. I wish you all the best as you retire.

Michele Gunn, ATP, CRTS®
NRRTS Review Chair for DMERC A

Judy Vance has been a model of professionalism for us all. Her level of customer service is top notch and always with a smile and a tone of happiness in her voice. Her administrative capabilities still have me wondering how she could do so much by herself and still not complain. If every business had an individual such as Judy Vance on staff, there would never be a reason for creating a "complaint department!"

Jerry Keiderling
President, U.S. Rehab

Judy thanks for everything! I will miss you more than you'll ever know. Love you lots!

Amy Odom
NRRTS Marketing Coordinator

Judy is a very special person. I can't imagine how she gets everything done with such grace. I am sure NRRTS will survive without her, but her reign will be an era to remember! I am so happy to see her retire. She deserves to rest, relax and enjoy her family.

Leslie Rigg, MS, CRTS®
Vice President of NRRTS

Judy Vance has been the glue holding NRRTS together for many years. We all owe her big debt of gratitude for the service she has provided the organization. I will miss her dearly.

Rich Salm, ATS, CRTS®
NRRTS At-Large Board Member

As our profession remains under siege, Judy has always been a beacon of light—kind of like a calm voice. I was privileged to have served on the NRRTS Board of Directors and work with her closely. While she often left the really dicey stuff alone, she was always ready to offer a fresh, untainted opinion. And frequently, it was just that kind of opinion that we so desperately needed. Our profession is better having had the long relationship with Judy and will ache, for some time, without her. Way to go Judy!!

Jerry Stevens, ATS, CRTS®

There are no words to express the magnitude of dedication Judy has contributed to giving NRRTS a voice in our industry. Thank you for all of your guidance over the years. You will be missed, and all the best wishes in the years to come.

Elaine M. Stewart, ATS, CRTS®
NRRTS Review Chair for DMERC D

I have known Judy since she worked for The MED Group back in the day. She has helped so many of us grow professionally and has been a great leader for many years in and for our industry.

John Zona, ATS, CRTS®
NRRTS At-Large Board Member

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2007 NRRTS' BEST REHAB TRACK

TIME	PRESENTATION	PRESENTER(S)	COMPANY	DESCRIPTION	AUDIENCE	SPONSOR
Tuesday, October 2, 2007 8:30am - 10:45am	NCART Manual Wheelchair Coding Update	• Doran Edwards, MD, Medical Director, SADMERC • Rita Hostak, Vice-President for Government Affairs, Sunrise Medical"		The SADMERC has turned its attention to developing a new HCPCS code set for manual wheelchairs. The complicated process and outcomes to date will be explained by the individuals integrally involved in this complex undertaking	RTS, OT, PT, payers (all audiences)	NCART
Tuesday, October 2, 2007 11:00am - Noon	NCART Complex Rehab and Assistive Technology Competitive Bidding Update	Cara Bachenheimer, Esq.	Invacare	Competitive Bidding is a fact of life. This presentation will focus on how this process will affect the way Rehab Technology Companies deliver Complex Rehab and Assistive Technology products and services.	RTS, OT, PT (all audiences)	NCART
Tuesday, October 2, 2007 8:30am - 9:30am	Pressure Mapping When, Who and How to Get Paid For It	Sharon Pratt, PT	Sunrise Medical	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.	PT, OT, RTS (intermediate to advanced)	Sunrise Medical
Tuesday, October 2, 2007 9:45am - 10:45am	Providing Pelvic Control Using Static and Dynamic Seating Components	Allen Seikman	Allen Siekman Consulting	Control of the pelvis in seating is complicated by the desire to provide a stable base of support and postural stability. This presentation will explore methods and devices helping to control pelvis and trunk location and allow functional controlled movement.	PT, OT, RTS (intermediate to advanced)	Allen Seikman, Consulting
Tuesday, October 2, 2007 11:00am - Noon	Standing Wheelchairs, Mobile Standers, and Sit to Stand Devices	Ginny Paleg, MS, PT	Private Practice	This presentation will review the proposed RESNA Position Paper on Standing. Pediatric and adult research studies will be reviewed. Products from over 15 different manufacturers will be reviewed and compared using case study format.	PT, OT, RTS (intermediate to advanced)	Altimate Medical
Wednesday, October 3, 2007 8:30am - 9:30am	Coding & Billing for PMDs	Peggy Walker	US Rehab	The outline will contain the correct way to get coding the product and how to properly bill for what you provide. How to know the difference between coverage from a Group 1 through Group 5. Which chairs are covered and which will deny.	RTS, billing personnel (all audiences)	US Rehab
Wednesday, October 3, 2007 9:45am - 10:45am	Evidence Based Pediatric Seating- With What Evidence?	Lauren Rosen, PT, ATP	St. Joseph's Children's Hospital	This session will focus on the evidence available for the provision of pediatric manual wheelchairs. The course will discuss previous and current research in pediatrics and adult wheelchair research relating to pediatrics.	RTS, OT, PT, payers (intermediate to advanced))	NRRTS
Wednesday, October 3, 2007 11:00am - Noon	Minimizing the Risk - Legal Issues in Seating and Wheeled Mobility Practice	• Jeffrey Baird, Esq. • Denise Fletcher, Esq.	Brown and Fortunato, P.C.	There are legal risks in any form of healthcare related service delivery. This presentation will explore the specific risks associated with the provision of DME equipment in general and laser in on Complex Rehab and Assistive Technology in general.	RTS, management (all audiences)	NRRTS

TIME	PRESENTATION	PRESENTER(S)	COMPANY	DESCRIPTION	AUDIENCE	SPONSOR
Wednesday, October 3, 2007 8:30am - 9:30am	Seating and Mobility Medical Terminology From the RTS Perspective	Simon Margolis, ATS, ATP	NRRTS	This presentation, developed by RTS for RTS will focus on the anatomic and functional terminology needed by RTS to perform as a professional member of the clinical team	RTS (entry level to intermediate)	NRRTS
Wednesday, October 3, 2007 9:45am - Noon	Seating and Wheeled Mobility Evaluation and Measurement From the RTS Perspective	Mike Seidel, CRTS®	National Seating and Mobility	This presentation, developed by a RTS for a RTS will focus on the skills, knowledge base and techniques needed to translate physiologic and functional finding of clinicians into final equipment specifications.	RTS (entry level to intermediate)	NRRTS
Thursday, October 4, 2007 8:30am - 9:30am	Hosting a Site Visit with your Member of Congress	Simon Margolis, ATS, ATP Moderator	NRRTS	An important part of the industry's legislative strategy is to enlist help of suppliers and clinicians. This panel presentation will focus on the logistics of setting up and successfully conducting a site visit with members of Congress.	RTS, OT, PT (all audiences)	NCART/ NRRTS
Thursday, October 4, 2007 9:45am - 10:45am	Equipment Recycling: Good, Bad, Voluntary or Mandatory?	Rita Hostak, Moderator	Sunrise Medical	This panel will focus on recycling of used assistive technology equipment including manual and power wheelchairs. The panelists represent the industry, equipment recyclers and the Department of Education.	RTS, OT, PT, manufacturers, payers (all audiences)	NCART
Thursday, October 4, 2007 11:00am - Noon	Seating and Wheeled Mobility Case Studies	Gerry Dickerson, CRTS®, Moderator	MedStar, Inc.	This panel presentation will feature three case studies, presented by a RTS, of complex clinical scenarios and how the client's needs were addressed	RTS, OT, PT (intermediate to advanced))	NRRTS
Thursday, October 4, 2007 8:30am - 9:30am	The Medical Benefits of Tilt	Jane Fontein, OT	PDG	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.	RTS, OT, PT (intermediate)	PDG
Thursday, October 4, 2007 9:45am - 10:45am	There's More To Power Seating Than Tilt or Recline	Stephanie Tanguay, OTR, ATP	Motion Concepts	The ability to design a mobility device for maximizing function is the art that seems to be forgotten in the shadows of codes and margins. This session will utilize studies to illustrate what our industry has to offer power mobility users.	RTS, OT, PT (intermediate to advanced))	Motion Concepts
Thursday, October 4, 2007 11:00am - Noon	Technological Advances and Programming to Improve Successful Children's Powered Mobility	Jacqueline Macauley, PT and Sharon Pratt, PT	Sunrise Medical	Facilitated mobility is critical to the development of motoric, cognitive and social skills in the pediatric client. This course will discuss developing technologies and programming strategies to increase successful outcomes.	RTS, OT, PT (entry level to intermediate)	Sunrise Medical

new registrants

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Registration Date: 5/24/2007

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Fax: 940-484-0766
Email: dweatherman@tx.rr.com
Registration Date: 7/1/2007

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Family Home Medical
Carlisle, PA

Robert Garwood, CRTS®
Boardman Medical Supply Company
Boardman, OH

Divya H. Kapadia, ATS, CRTS®
American Medical & Equipment Supply, Inc.
San Jose, CA

Jeffrey A. Leverenz, ATS, CRTS®
Meriter Home Health
Milton, WI

Brad Looper, ATS, CRTS®
Resource Medical Group, LLC
Duncan, SC

James A. Noland, ATS, CRTS®
Presque Isle Rehabilitation Technology
Erie, PA

Robert J. Williams, ATS, CRTS®
Ed Medical, Inc.
Portland, TN

R. Cary Yarbrough, CRTS®
Arkansas Home Medical
Little Rock, AR

former 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 5/2/2007 through 7/1/2007. For an up-to-date verification on Registrants, visit www.NRRTS.org, updated daily.

John W. Burke	Ownings Mills, MD
Rene J. Chiasson	Baton Rouge, LA
Paul Even	Billings, MT
Rene Garcia	San Juan, TX
Richard D. Glynn	Lilburn, GA
Kelly Lyerla	Belleville, IL
Patrick R. Mazey	Orange Park, FL
John Michael Morris	Champaign, IL
Michael Scott Parker	Largo, FL
Darren Scheidt	Anaheim, CA
Jackie B. Simmons	Charleston, WV
Donald K. Slater	Seaside, OR
Joe Thieme	Raleigh, NC
J. Hugh Willis	Asheville, NC
Jack Wolfenbarger	Woodstock, GA

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