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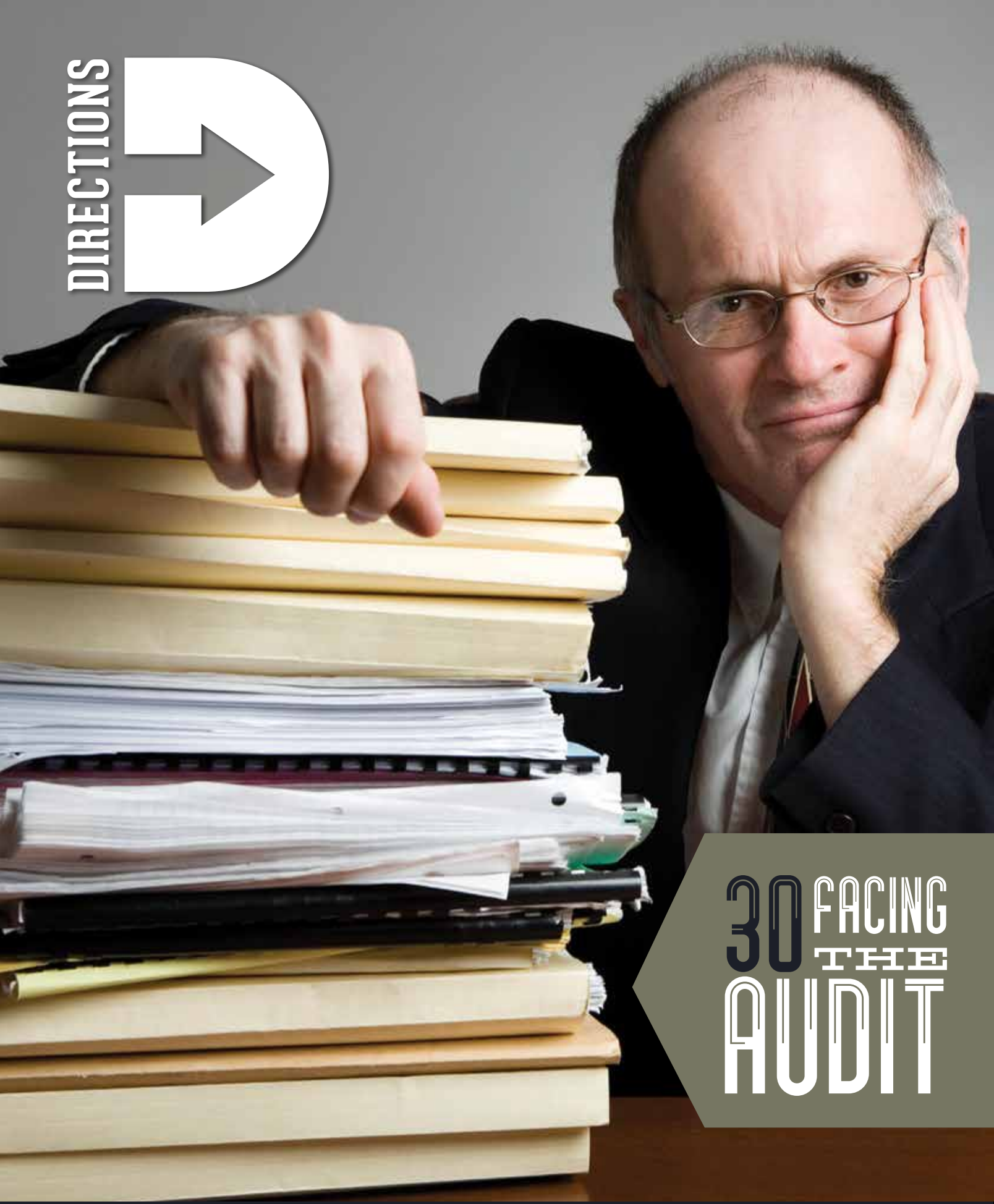

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- NCART Members - $225
- Other Attendees - $295

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CONFERENCE SCHEDULE

LEADERSHIP DAY

TUESDAY, APRIL 29, 2014

7:30am to 8:30am	Registration
8:30am to 5:00pm	General & Breakout Sessions
6:00pm to 8:00pm	"CRT United" Reception

CRT focused presentations for providers and manufacturers will include: healthcare reform trends; views from an industry CEO panel; financial management best practices; CRT related revenue opportunities; using technology and social media; handling hearings and audits; and more.

ADVOCACY DAY

(includes Medicaid Summit and CELA)

WEDNESDAY, APRIL 30, 2014

7:30am to 8:30am	Registration
8:30am to 5:00pm	General & Breakout Sessions
5:00pm to 6:00pm	Congressional Prep

Funding and advocacy sessions for CRT stakeholders will include: Medicare and Medicaid updates; federal and state CRT legislative activities; using state protection and advocacy resources; lesser known funding sources; prep for visits with Congress; and more.

CAPITOL HILL VISITS DAY

THURSDAY, MAY 1, 2014

9:00am to 5:00pm	Capitol Hill Visits
5:00pm to 7:00pm	Debriefing Reception

Our annual presence in Washington has been a key factor in the progress to date on our legislation to create a Separate Benefit Category for CRT. Consumers, clinicians, providers, and manufacturers will take the CRT message directly to Congress through in-person meetings on Capitol Hill.

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ALEXANDRA (ALEX) BENNEWITH

Bennewith is vice president of government relations for United Spinal Association. Bennewith advocates for legislation and regulations regarding disability and health policy at both the federal and state level. She works closely with a range of stakeholders in the durable medical equipment and supplies, prescription drug, public health and disability communities. She graduated from Brandeis University and received her Master of Public Administration from American University. SEE PAGE 50

DON CLAYBACK

Clayback is executive director of the National Coalition for Assistive and Rehab Technology (NCART). Clayback has more than 23 years of experience in the Complex Rehab Technology and Home Medical Equipment industry as a provider, consultant and advocate. He is actively involved in industry issues and a frequent speaker at state and national conferences. SEE PAGE 36

LAURA COHEN, PhD, PT, ATP

Cohen is the principal for Rehabilitation & Technology Consultants in Arlington, Va. She is the executive director of the Clinician Task Force (CTF), a national group of seating and mobility clinicians working to influence Medicare and Medicaid coding, coverage, and payment policies for complex rehab and assistive technology devices. The CTF provides clinically relevant information about seating and wheeled mobility device assessment and decision making to policy makers to ensure appropriate access for individuals with disabilities. SEE PAGE 52

JIM DOUGLAS, ATP, CRTS®

Douglas is a new at-large director for NRRTS who works for National Seating & Mobility in Atlanta, Ga. SEE PAGE 26

SUSAN HOUSTON

Houston is the branch operations supervisor for Hudson Seating & Mobility in Franklin, Mass. She is also a consumer advocate who attended the National CRT Conference in that role. SEE PAGE 16

JILL MONGER

Monger focuses on mobility solutions for people with severe disabilities of all ages. She received her bachelor's degree in physical therapy from East Carolina University in 1984 and her master's in health professions education from the Medical University of South Carolina in 1998. She was certified in assistive technology from the Rehabilitation Engineering Society of North America in 1994 and currently serves on the boards of several organizations related to advocacy and independent living for people with physical disabilities. Monger is on the steering committee of the Clinician Task Force (a coalition to modernize Medicare and Medicaid coverage of mobility products). Since 1996, Monger has been invited to give more than 100 presentations in the United States, Canada, Europe and the Caribbean. SEE PAGE 38

MIKE OSBORN, ATP, CRTS®

Osborn is president of NRRTS. Osborn has been a NRRTS Registrant since 2000 and is part owner of Alliance Rehab & Medical Equipment in Ozark, Mo. SEE PAGE 14

JULIE PIRIANO, PT, ATP/SMS

Piriano is director of rehab industry affairs at Pride Mobility Products Corp. SEE PAGE 22

ANGELA DILLBECK REGIER, OTD, OTR, ATP

Regier is an occupational therapist and assistive technology professional at Craig Hospital in Englewood, Colo. She works full time in the Wheelchair Seating and Mobility Clinic at Craig Hospital, evaluating the seating and mobility needs of individuals with traumatic brain and spinal cord injuries. SEE PAGE 42

JOSHUA I. SKORA ESQ.

Skora is an attorney in the health care group of Brown & Fortunato, P.C., a law firm based in Amarillo, Texas. Skora represents HME companies, pharmacies and other health care providers throughout the United States. He earned his Bachelor of Arts from Dartmouth College and his law degree from the University of Minnesota School of Law. Skora is licensed to practice law in Minnesota and is a member of the American Health Lawyers Association. SEE PAGE 34

ANDREA VAN HOOK

Van Hook is the communications and marketing manager at RESNA. She has more than 18 years experience working on successful, award-winning campaigns that promote equal access to health care, education and employment of diverse populations, including people with disabilities. SEE PAGE 56

PEGGY WALKER, RN

Walker is director of member education for U.S. Rehab/VGM. Walker's expertise is in billing and collections. Prior to joining U.S. Rehab, Walker worked at Region C DMERC in the post-pay medical review area. SEE PAGE 30

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If you're with a company that provides or manufactures Complex Rehab Technology (CRT) you know coverage and payment challenges continue to mount at the federal, state, and private payer levels. It's a real battle out there.

To protect the interests of your customers and your business, we invite you to invest in the future of CRT by joining the National Coalition for Assistive and Rehab Technology. NCART works with policy makers, legislators and others to establish and maintain appropriate coverage and funding in order to protect and improve access. But NCART needs additional companies to join the fight.

We're asking you to join other committed CRT providers and manufacturers in supporting efforts to protect access to CRT by becoming an NCART member. Companies can submit an online membership application by going to the NCART website at www.ncart.us and visiting the Membership area.

For questions or additional information contact Don Clayback, NCART Executive Director, at 716-839-9728 or dclayback@ncart.us. Thanks for your support!

www.ncart.us

JOIN TODAY!

NCART was established to provide the leading advocacy voice on CRT issues. Our mission is to ensure individuals with significant disabilities and chronic medical conditions have adequate access to needed CRT products and services.

The resources and activities of NCART are focused on three primary priorities:

-- Securing a Separate Benefit Category (H.R. 942 and S. 948) to provide formal recognition of the specialized nature of CRT and improve coverage policies and safeguards.

-- Addressing Medicaid CRT problems by providing strategic advice and advocacy on CRT coverage and funding issues.

-- Building relations with Consumer and Clinician organizations through joint advocacy among all CRT stakeholders.

NCART brings together dedicated CRT providers and manufacturers to make a positive difference. Join NCART today to fight for CRT so people in your community can access the specialized equipment and services they require and depend on.

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TUESDAY, APRIL 22, 2014
5:00PM TO 7:00PM PACIFIC

Ethics for All

SIMON MARGOLIS, CO, ATP/SMS

THURSDAY, APRIL 24, 2014
5:00PM TO 7:00PM EASTERN

Advanced Positioning

Pressure Issues and the Latest Research and How This Impacts Our Recommendations

SHARON SONENBLUM, PH.D. AND TERESA CONNER-KERR, PT, PH. D., CSW, CLT

TUESDAY, MAY 20, 2014
5:00PM TO 7:00PM PACIFIC

Clinically Speaking

A Practical Guide to Evaluation and Documentation for Mobility Assistive Equipment

JULIE PIRIANO, PT, ATP/SMS, MEMBER OF CTF

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WEDNESDAY, MAY 21, 2014
9:00AM TO 11:00AM CENTRAL

Seating Considerations for Clients with SCI

JILL MONGER, PT, MS, ATP, MEMBER OF CTF

THURSDAY, MAY 22, 2014
5:00PM TO 7:00PM EASTERN

Optimizing Manual Wheelchair Propulsion

in Pediatrics, Product and Configuration Clinical Indicators

LAUREN ROSEN, PT, MPT, MSMS, ATP/SMS, MEMBER OF CTF

TUESDAY, JUNE 17, 2014
5:00PM TO 7:00PM PACIFIC

Business Practices

Shaping the Future of CRT and the Professional RTS

WEESIE WALKER, ATP, SMS

TUESDAY, JUNE 17, 2014
5:00PM TO 7:00PM PACIFIC

Business Practices

Shaping the Future of CRT and the Professional RTS

WEESIE WALKER, ATP, SMS

THURSDAY, JUNE 19, 2014
5:00PM TO 7:00PM EASTERN

Restraints and Wheelchair Seating and Positioning

BARB CRANE, PH.D., PT, ATP/SMS, MEMBER OF CTF

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TUESDAY, JULY 15, 2014
5:00PM TO 7:00PM PACIFIC

Dealing with Difficult Clients and the Tools You Need to be Successful!

JILL SPARACIO, OTR/L, ATP/SMS, ABDA, MEMBER OF CTF

WEDNESDAY, JULY 16, 2014
9:00AM TO 11:00AM CENTRAL

Positioning out of the Box

Kinesio® Taping in Seating

KATHERINE L. CLARK, MOT, OTR/L, ERIN M. POPE, PT, MPT

THURSDAY, JULY 17, 2014
5:00PM TO 7:00PM EASTERN

Advanced Power Mobility

Emerging Technologies

LISA ROTELLI

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TUESDAY, AUGUST 19, 2014
5:00PM TO 7:00PM PACIFIC

Posture and How it Develops

Standing and Sitting Considerations for the Young Child

SHARON SUTHERLAND (PRATT), PT

THURSDAY, AUGUST 21, 2014
5:00PM TO 7:00PM EASTERN

Power Mobility Options

For Clients with Muscle Weakness

MICHELLE L. LANGE, OTR, ABDA, ATP/SMS

TUESDAY, SEPTEMBER 16, 2014
5:00PM TO 7:00PM PACIFIC

Self-Advocacy

Where to Start and, by the way, I Don't Have Time!

GERRY DICKERSON, ATP, CRTS®, MEMBER OF CTF

WEDNESDAY, SEPTEMBER 17, 2014
9:00AM TO 11:00AM CENTRAL

Dynamic Seating

MICHELLE L. LANGE, OTR, ABDA, ATP/SMS

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THURSDAY, SEPTEMBER 18, 2014
5:00PM TO 7:00PM EASTERN

"Traffic School"

Tips for Creating a Power Mobility Training Program

ANGIE KIGER, M.ED., CTRS, ATP/SMS

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TUESDAY, OCTOBER 7, 2014
5:00PM TO 7:00PM PACIFIC

Pediatric Power Mobility

Earlier Intervention

AMY MORGAN, PT, ATP

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THURSDAY, OCTOBER 9, 2014
5:00PM TO 7:00PM EASTERN

The Relationship of Vision, Posture and Mobility

Implications for seating and mobility for neurologically involved clients

TERESA PLUMMER, PHD, OTR, ATP, CEAS, CAPS

TUESDAY, NOVEMBER 11, 2014
5:00PM TO 7:00PM PACIFIC

Back it Up!

Basics of Back Supports

BRENLEE MOGUL-ROTMAN, OT REG.[ONT.], ATP/SMS

WEDNESDAY, NOVEMBER 12, 2014
9:00AM TO 11:00AM CENTRAL

Complex Rehab Mobility

Medicare Reimbursement Requirements and Documentation Strategies

ELIZABETH COLE, MSPT, ATP, MEMBER OF CTF

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THURSDAY, NOVEMBER 13, 2014
5:00PM TO 7:00PM EASTERN

Choosing the Best Therapeutic Support Surface

LINDA NORTON, OT REG.[ONT], MSCCH

TUESDAY, DECEMBER 16, 2014
5:00PM TO 7:00PM PACIFIC

WHO Training Materials

An Overview and Usage Suggestions

JAMIE NOON

THURSDAY, DECEMBER 18, 2014
5:00PM TO 7:00PM EASTERN

It's More Than Just Physical

Considering All the Needs of Complex Clients in Seating and Mobility

TAMARA KITTELSON-ALDRED, MS, OTR/L, ATP/SMS, MEMBER OF CTF

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CONTACT MAKES PERFECT

WRITTEN BY: MIKE OSBORN, ATP, CRTS®

The National CRT Leadership and Advocacy Conference is just around the corner. Many people have already made their room reservations and booked their airfare. We will be converging upon our nation's capital May 1, 2014, to support and promote legislation for the Separate Benefit Category. The trip is always exciting for me. The fact that I have the opportunity to attend the conference and address our legislators on behalf of my company means a lot. More importantly, seeing the number of individuals who give up their time away from family and their businesses to represent our industry and what it stands for excites me. Over the past several years, the Complex Rehab Industry has grown closer and has come together as one to support change – change for the end user, change for our industry and change so I can continue doing the job I love to do.

Unfortunately, it is a difficult time in our industry. The requirements have increased and the time it takes to do our jobs has increased as well. The reimbursement is down, but the needs continue to grow. Not everyone who wants to attend an event like the CRT Conference is able. Well, you can still make an impact. The trip to Capitol Hill is only one way to support change in our industry. The work required to develop true change takes place all year long and – believe it or not – it takes place locally.

> "...seeing the number of individuals who give up their time away from family and their businesses to represent our industry and what it stands for excites me."

Every member seen in Washington, D. C., has a home office. Actually, they have several offices. Building trust and earning a mutual respect for working with legislators begins in those local offices. I know our time is precious, and many times the day is gone before we can get to everything on our already long to-do list. However, it is our right to make a difference. It only takes a few minutes to make a phone call to a senator or representative. It takes even less to send an email. For those who really want to make a difference, scheduling a quick trip to see your congressman is not that difficult. Believe it or not they don't have much time to see us either. Short visits throughout the year work the best. It doesn't take long and soon you'll find they start to listen. Listening turns into understanding, and understanding Complex Rehab can lead to support. Support is what we need to create change. The information you need for these efforts can be found at www.nrrts.org or www.ncart.us.

Please take a moment over the next several weeks and reach out to your legislators. The impact of an in-person visit is positive, but the impact of an in-person visit that follows hundreds of phone calls or emails is great. It is easy to think someone else will do it, someone else will know what needs to be said better than you. Wrong! Only you can tell your story and your client's story. You can make a difference, a difference for our consumers, our jobs, our companies and our industry as a whole.

CONTACT THE AUTHOR

Mike may be reached at mosborn@alliancerehabmed.com.

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AN EVERYDAY KIND OF LIFE
lived in an EXTRAORDINARY kind of way

WRITTEN BY: DANETTE BAKER

Susan Houston describes her childhood as the proverbial experience filled with school, extracurricular activities, neighborhood friends and sibling antics. Ironic, Houston said, given the doctors told Tom and Mabel Flood their baby girl would "never walk, probably never sit up and would more than likely have intellectual disabilities."

Houston has childhood memories of her older siblings picking her up by leg braces and dangling her like a puppet, of having sleepovers with her girlfriends, going to high school dances and on dates, working summer jobs and playing wheelchair basketball.

Houston was born at Norwood Hospital in Norwood, Mass., and immediately transferred to nearby Boston Children's Hospital for emergency surgery. Her parents had her baptized at the hospital after being given the dismal prognosis for their fourth child, who was born with spina bifida. One of the most common types of birth defects, spina bifida can result in permanent disabilities depending on the disease type. Surgery done within hours of birth, and often continuing throughout childhood, can help prevent further nerve damage, but cannot reverse damage that has already occurred, according to the Spina Bifida Association.

HOUSTON, AGE 4, WITH HER SISTERS.

For Houston, life never seemed any different than that of the other Flood children – Patty, Lynn, Mary and Tom – or of her neighborhood friends, which included Claire Leonard. Houston said that credit belongs to her parents who refused the doctor's devastating diagnosis. Instead they adopted the optimistic outlook offered by one nurse who told them "take her home and treat her like the rest of your kids."

Houston's mother did just that. She spent time with her friends and encouraged Houston to have relationships with their children. In fact, Houston took her first steps at age 3, emulating one of her playmates. Her legs, affected by the nerve damage, weren't strong enough to support her, so Houston began wearing braces and using crutches to walk, yet it never slowed her down.

> "I roller-skated and did everything everyone else did, including fall down."

"I roller-skated and did everything everyone else did, including fall down," said Houston. When that happened, her mother would wait patiently for Houston to get up and insisted others do the same. "She taught me that sense of independence early on," Houston recalled.

Her mother also wanted Houston to have the same educational opportunities as her siblings, but balancing traditional public school with the numerous orthopedic surgeries she required was a challenge. A viable alternative was for Houston to attend the Massachusetts Hospital School in nearby Canton, Mass. According to the state-run school's website, it serves the educational, medical, rehabilitative and recreational needs of children and young adults with physical disabilities who require medical management.

Houston said the experience at Massachusetts Hospital School was such a positive one in establishing a well-rounded sense of self within her.

(CONTINUED ON PAGE 18)

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AN EVERYDAY KIND OF LIFE
(CONTINUED FROM PAGE 16)

"We weren't treated differently because of our disabilities, and we were able to do everything everyone else did – just in a different way," she noted.

That acceptance was echoed when Houston returned home on the weekends.

"Claire always made sure we hung out together, and she included me in whatever the neighborhood friends were doing," Houston said. "I count that as a real positive to have had a social life at home and at school."

At 15, Houston got her first job teaching arts and crafts in Norwood's summer recreation program, a job she returned to annually during her high school years. For a couple of those summers, she led a class specifically for children with disabilities. Houston had dreamed of a becoming a teacher for years, partially influenced by her love for children and by a favorite high school teacher, who also inspired Houston's passion for advocacy work.

Houston said the teacher also taught a course called HELP, Handling Everyday Living Problems, which preceded the concept of independent living centers. She got the high school students involved in governmental proceeding, taking them to Boston, Mass., for hearings on accessibility and rights for those with disabilities. Houston recalls one trip during which the students had to be carried up a flight of stairs at the courthouse to attend an accessibility hearing.

She said they also attended a protest in Boston for the Rehabilitation Act of 1972 vetoed by President Richard Nixon. "We went to downtown Boston and took an old wheelchair and a pair of crutches with us," Houston said. "Someone with a Nixon mask on took an ax to them, and we sang a song our teacher had written … I can only remember one line, 'Did he pass the bill?' Of course, the protestors around would shout 'No!'"

After high school graduation, Houston had the honor of attending the President's Committee on Employment of the Handicapped in Washington, D.C. She went on to study social services at Massasoit Community College. Today, Houston continues her advocacy efforts, professionally and personally.

For the past eight years, she has worked as branch operations supervisor for Hudson Seating and Mobility at the company's branch in Franklin, Mass. There she is responsible for daily operations and customer service. Being a wheelchair user, Houston said she understands the consumer and the supplier's frustrations when issues delay access to equipment and repairs.

"When I explain to them I (use a wheelchair and) truly do understand their frustration, that seems to be such a relief," said Houston, who began using a wheelchair as her primary source of mobility in her teens.

PICTURE 1

"And when things go right, and we get equipment to them, and they are thrilled with how it can help them with independence, I truly feel like I'm making a difference in people's lives."


PICTURE 2

Houston credits another best friend, Alois Wachoski, for introducing her to the industry in 1979. The two met while attending Massachusetts Hospital School and remained friends until Wachoski's untimely death a couple of years ago.

Wachoski, who had muscular dystrophy, told Houston about an opening at PDC Inc., Medi-Shack Watertown, Mass., where she had her wheelchair repaired.

"I came home from visiting Alois in Brookline, Mass., and announced to my parents I was moving," Houston said. "I thought my mom was going to freak, because I was moving to the city."

Today, Houston and her husband, Joe, live in Wrentham, Mass., a small New England town population of almost 11,000 located between Boston and Providence. She makes the daily 9-mile commute to Franklin after loading her lightweight foldable wheelchair into the back seat.

In Wrentham, she is active on several boards and commissions, including the Wrentham Commission on Disability, her first advocacy endeavor when they moved there more almost 20 years ago. Through the commission she and a group, albeit small in number, were able to get power doors put on the town hall facility, increasing accessibility for all.

Houston has also previously served several terms as a board member for HOMES (Home Medical Equipment & Services Association of New England), and she has made several trips to Washington, D.C., to attend CELA. She will be back again in April, but in the meantime she looks for opportunities to meet with her legislators to explain the importance of proposed legislation such as HR 492 and HR 1717. In fact, she recently took advantage of a meet-and-greet in Wrentham with Rep. Joe Kennedy, delivering a packet of information to him about the importance of a separate benefit category


PICTURE 3


PICTURE 4

PICTURE 1 - *WRENTHAM COMMISSION ON DISABILITY, 2012*
PICTURE 2 - *REP. MCGOVERN MEETING, CELA 2012*
PICTURE 3 - *REP. KENNEDY MEETING, NATIONAL CRT 2013*
PICTURE 4 - *MS. WHEELCHAIR MASS BOOTH AT ABILITIES EXPO, 2013*

(CONTINUED ON PAGE 20)

AN EVERYDAY KIND OF LIFE
(CONTINUED FROM PAGE 19)

for complex rehab technology and competitive bidding for durable medical equipment.

"We had a nice one-on-one talk, but I came away disappointed, because he didn't seem ready to take action. He still has not signed onto the bill, so I've got work to do."

In the meantime, Houston has a state contest to manage this spring. She is president of the Ms. Wheelchair Massachusetts Foundation. The organization serves as a forum for education of disabilities and to influence changes in public policy for individuals with disabilities. The foundation is near and dear to her not only for its advocacy role, but also because her friend Wachoski was Ms. Wheelchair Massachusetts in the 1970s. There had been an absence at the state level until 2006 when independent delegate Laurel Labdon brought the program back to Massachusetts.

"When I heard it was back in the state, I got actively involved because it is truly about empowering women to speak out," said Houston. "This gives them an opportunity to show there is more to them than their wheelchairs."

For Houston, having grown up with a very secure sense of self-worth has made it all the more important to pave the way for others living life on wheels.

"The greatest compliment for me would be that your first impression of me and of anyone who uses a wheelchair would be of me and not of me and my wheelchair."

CONTACT

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'GO AND MAKE A DIFFERENCE:'

Piriano passionate about providing life-empowering technology

INTERVIEW BY: JULIE BARNETT

Julie Piriano has served as director of Rehab Affairs at Pride Mobility Products Corporation based in Exeter, Penn., for the last six years. She spends most of her day educating decision makers about complex rehab technology and the importance of providing access to the products and services that are essential for patients' independence, safety and well-being.

DIRECTIONS recently had the opportunity to visit with Piriano about her current work on legislative and regulatory issues that impact the provision of complex rehab technology, as well as her extensive experience in the seating and wheeled mobility industry.

What is your current position, and what are your day-to-day activities and responsibilities?

As director of Rehab Affairs at Pride Mobility Products Corporation, I have been given the opportunity to work on legislative and regulatory issues that impact the complex rehab industry and beneficiaries we serve. This includes coding, coverage, payment, and – most importantly – access to seating and wheeled mobility products and services used by individuals with disabilities and complex medical needs. I spend most of my day educating decision makers as to what complex rehab technology is, what it does, who it is for, how it is different from standard items of durable medical equipment, and why it is imperative to have a team of professionals with advanced knowledge in the practice area of seating and mobility involved in a client-centered approach to the provision of this life-empowering technology.

What are the most significant milestones in your career?

At the time I did not know it, but in 1983 my first experience working in rehab as a physical therapy student from the University of Illinois Medical Center would set the stage for the direction my career has taken and what I do today. My patient, who had suffered a stroke, displayed significant flaccid hemiplegia, was non-ambulatory and spoke only Russian, was going to be discharged with his wife using a wheelchair. While I knew the hospital-issued "chromer" he was using as an inpatient did not fit or function for him, I learned very quickly that there were not many other options. I was going to have to teach him and his wife how to manage as best as they could with what was available. At my next affiliation, which was in pediatrics, I built on that experience, saw the importance of postural support components and began to make whatever I could out of materials that were available so my students could function against gravity and have the opportunity to learn. By the time I started my first job in 1984 at Marianjoy Rehabilitation Hospital in Wheaton, Ill., I knew there had to be a better way to provide individuals with disabilities safe, independent mobility and support their posture during the time I was not working with them one-on-one. I was on a mission to find it and did so for the next 10 years.

During this time there were not very many products available on the market to select from. As a result, this emerging industry presented numerous opportunities to get involved, and I took advantage of as many as I could. It afforded me the opportunity to meet and collaborate with so many people I am honored to call my friends, all of whom share the same passion I have for what we do and why we do it. I was also fortunate to work with some of the most dedicated and creative RTSs I have ever met. We listened to our clients

> I took it with the urging and support of my mentor to "go and make a difference," which I try to do each day.

and their caregiver(s), learned from one another and created individual solutions together as a team, often from scratch. Little did I know, others around the country were doing the same thing. When I attended my first RESNA conference I "found my people." From that point on, I never looked back.

When I attended my first RESNA conference I "found my people." From that point on, I never looked back.

I left Marianjoy and the applied rehab technology department I helped start, to pursue an opportunity to bring the pediatric positioning products I was making in my garage to market. Along the way, I learned the "business" side of product design, development, testing, marketing and sales while maintaining a therapist's "hands-on" approach to these concepts. I also learned it was a much better business decision to sell products to companies which had demonstrated a commitment to the provision of highly specialized, intimately fit products that would need to change with the changing needs of the individual using them than it was to open an account with every supplier that asked. In support of their mission, the company I represented became a charter corporate friend of NRRTS at the organization's first request.

I joined many of my previous colleagues at a large, national rehab company in 2003. This was not long before "everything changed" with Operation Wheeler Dealer and the subsequent implementation of the National Coverage Determination (NCD) for Mobility Assistive Equipment. I was put in charge of managing the Medicare orders for our division and became a quick study on the laws and regulations that impact the provision of durable medical equipment in the Medicare program. It became evident that the "rules of the road" meant for the majority of people who age into the benefit did not work well for individuals with disabilities covered under the same program and things had to change.

I became very actively involved with the industry on a much broader stage and when the opportunity arose to become the director of Rehab Industry Affairs at Pride in 2008, I took it with the urging and support of my mentor to "go and make a difference," which I try to do each day.

Who has been instrumental in your success?

When I approached my boss, the late Dagmar Simon, PT, MBA, about the possibility of starting a seating clinic at Marianjoy Rehabilitation Hospital shortly after I was hired in 1984, she said she did not know what it would require to undertake something like that, but if I would get the proposal together, she would get me a meeting with the hospital administration. Ginny Girten, PT, Joan Padgitt, PT, ATP, and I opened it on a part-time basis in 1986. The department quickly grew, as did my knowledge and understanding of all aspects of assistive technology under the guidance and direction of Carol Sargent, BSEE, OTR/L, ATP. She is also the individual who took me to my first RESNA conference and insisted I become a member and get involved.

During my tenure at Marianjoy, I had the opportunity to work directly with Simon Margolis, ATP/SMS, at a school for children with multiple needs as he was developing the Bi-Angular back and the Sub-ASIS bar. While I was fascinated with the products and how they worked, I was more interested in how he brought the biomechanics of the seated position to life and it has stuck with me to this day. I was so intrigued by this concept that I attended a course on "Positioning the Client with Central Nervous System Deficits," taught by Adrienne Falk Bergen, PT, which launched my own foray into creating unique seating and positioning systems for this same population.

While I was at Marianjoy I also had the pleasure of meeting and befriending Randy Brooks, who became my mentor, my boss and my inspiration. He taught me how to balance the needs of the business with the needs of the individuals who needed our services. He pushed me to get involved and challenged me to "make right the wrongs" that stand in the way of individuals with disabilities and complex medical needs when it comes to access to the products and services that are essential for their independence, safety and well-being. I hope I am doing just that today, under the guidance of Seth Johnson and in collaboration with all the people I am associated with in this industry.

What challenges do you currently face in the industry?

While CMS has adopted the RESNA Assistive Technology Professional certification as the requirement

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'GO AND MAKE A DIFFERENCE'...
(CONTINUED FROM PAGE 23)

for DME companies to provide complex rehab technology such as ultra-lightweight manual wheelchairs, tilt-in-space manual wheelchairs, certain power wheelchairs and their associated power seating functions, the knowledge and skills necessary to perform the technology assessment to match the identified needs of the individual with the appropriate seating and wheeled mobility solutions is more advanced than the general certification of an ATP. Even with this requirement in place for Medicare, many Medicaid programs and non-government payors do not require even this most basic level of certification for the companies that are assessing the needs of individuals with disabilities and then billing and collecting for a wide array of highly configurable products that must fit and function properly for the individual using it.

Medicare, many state Medicaid programs and non-government payers also mandate clinician involvement in the CRT process. Unfortunately, these same payers have little understanding of the highly specialized knowledge and skills these licensed physical and occupational therapists posses, or the time it takes to properly execute the numerous aspects of the complex rehab technology evaluation process.

What challenges do you see on the horizon?

I am, and have always been, an optimist so I firmly believe the "Ensuring Access to Quality Complex Rehabilitation Technology Act of 2013" will be passed into law in whole or in part in the future. Great care was taken in working with our champions as the legislative language was developed. However, the devil is always in the details. We will have a lot of work to do as the regulations that govern coding, coverage, payment and accreditation of complex rehab technology companies and the individuals who work for them are being developed.

What leadership positions, activism, board positions, etc. have you held?

I am a member of RESNA, the RESNA Professional Standards Board and the RESNA Wheeled Mobility and Seating SIG, a Friend of NRRTS and a member of the AAHomecare Complex Rehab and Mobility Council. I serve on the NCART Medicaid Committee, the User's First Alliance Advisory Board and the Editorial Board of ***Mobility Management.*** I am also on the board of directors for the Illinois Association for Medical Equipment Services (IAMES) and the Midwest Association for Medical Equipment Services (MAMES), and I am an active member of the four DME MAC Advisory Councils. I have held my ATP certification since 1997 and was part of the group that set the passing score for the SMS exam in 2010.

What are your interests and activities outside of your day-to-day work?

I am married with three grown children, three grandchildren and a dog. I love to boat, sail, ski, fish, garden and read. I also enjoy cooking with my family, but my grounding comes from my annual, weeklong mission trip with the teens at my church where we get the opportunity to serve others somewhere in the U.S. in a way that is often miraculous.

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GOING OLD SCHOOL

Taking a step back can move technology forward

WRITTEN BY: DANETTE BAKER

Jim Douglas, ATP, CRTS®, doesn't try to mask his emotions as he talks about the 9-month-old preemie he saw earlier in the day who just might get to experience life a little differently thanks to technology and a team of complex rehab technology experts.

To have had even a small part in that still tugs at the heart strings of this 40-year industry veteran. Douglas, ATP, CRTS®, for National Seating and Mobility, has logged years of service that have done nothing to pale his passion, especially when he talks about changes in the industry that have created roadblocks for consumers instead of opening doors.

"There are tremendous innovations on the market, things no one had ever dreamed of 10 years ago and there's more of that out there, but the layers of bureaucracy and red tape have gotten between the service provider and the consumer to the point where managed care is too often mismanaged care," Douglas said.

"It's time to return to a free market type industry where it comes down to a guy who needs a wheelchair and one who has one to sell," he said. "I would really love to see us take a great step backward to where manufacturers of complex rehab could spend their time and creative energy on new innovations and not be as concerned about how to make it cheaper so the government will pay for it."

"I'm proud of our industry for taking up this fight for our consumers."

Douglas referred to the telecommunications industry as example. Before government deregulations in the 1980s, there was essentially one type of home phone, which the phone company owned and you paid a monthly fee to lease it. Touchtone dialing was the biggest innovation. Deregulation made way for competition, the consumer had choices on which products and services and where he would spend his money. Deregulation gave the consumer control over the purse strings. With industry competition for those dollars, innovations in services and technology flourished, and those products and services became less expensive with each generation.

One doesn't have to look further than a comparison between the iPhone 5S and Motorola's first mobile device. "There is a significant lifestyle difference that comes about with technology," Douglas said. "We went from a Fred Flintstone phone to, in essence, a palm-size computer that has capabilities that far exceed the most advanced computers in existence at the time of deregulation."

That's why it is so important for organizations such as NRRTS to advocate for its professionals, an area Douglas believes NRRTS has succeeded in. This detail factored into his desire to join the board as director at-large. He is serving a two-year term, which began in 2013.

"I think NRRTS is invaluable not only to this profession, but to the medical and health care industry as whole," Douglas said. "What we need to make sure we don't do is become a closed shop that discourages people from getting into the profession. We do not want to make it so restrictive that the process discourages the young blood and the innovators we need in the industry to further its development.

"Until now, I really hadn't gotten involved in this aspect of industry, but instead had kind of minded my own business. I guess there was a twinge of

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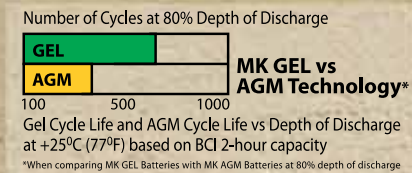

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GOING OLD SCHOOL
(CONTINUED FROM PAGE 26)

consciousness that hit me when I got that email saying the positions were open. I knew I had gotten a lot out of this industry, and I needed to give something back not just to my clients, but also to those with whom I stand shoulder to shoulder with every day."

Douglas' career has spanned four decades and numerous advancements in custom seating and mobility. But the advent of the industry certifications, he said, has done much to move the industry forward. Douglas was one of the first suppliers to become a NRRTS Registrant.

> "Our commitment to continuing education takes us leaps and bounds beyond in providing excellent service."

"This has become the hub for the complex rehab profession," he said. "As the industry developed, there were so many out there like me, individuals inventing in our own enclaves and not aware of others and what they were doing. NRRTS has served as a foundation for the coalition of these individuals into a professional community.

"These industry certifications provide a definition of who we are and what we do, but also provides basis and framework for transforming us from a disparate group of technicians or wheelchair guys and gals into professionals so consumers can be assured they are a certain level of knowledge, experience and ethics when we are on the scene."

And that's really what, Douglas said, this industry is about.

"This is not just about working with technology. We have a privilege to make an imprint on the lives of incredible people.

"As part of that, we have now been strapped with the responsibility of finding ways to pay for it. Unfortunately, this industry has become burdened with paperwork and red tape. And that's why I say I would like to see us go back to being market-driven with the consumer making decisions without a cadre of folks between them and the provider of their choice. The process should not to take the technology out of the reach of those who need it."

There is a 9-month-old baby who has a lifetime of issues ahead of him. Douglas finds it difficult to get him – or his mother – off his mind as he wraps up another work day, but he takes heart in knowing the equipment they fitted the little one with this morning will make a huge impact on his and his mother's lives.

It already has his.

"I never know when I work with a consumer if I'll ever see them again. I have some I have worked with almost my entire career. I do know that I've intersected this one life and hopefully given something useful to them. I know I walked away from that opportunity blessed to be able to do something in his life that has some meaning.

"That's why I have my soap box," Douglas said. "But I'm also ready to stand in the gap to move this ship forward."

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FACING THE AUDIT

WRITTEN BY: PEGGY WALKER, RN

Multiple audits in all jurisdictions throughout the industry are causing financial burdens, and individual suppliers are having great difficulty facing these audits. They can't maintain the work flow and care for their patients and continue to face the barrage of audit issues and the time it takes to get these overturned.

The supplier must focus on a piece of paper being exactly correct and not on what a patient truly needs. I see people struggling every day just to get oxygen paid for a patient who has been on oxygen for years. We must remember when we look at any patient we must focus on the ABC's of the Medicare world.

A. Audits are the No. 1 issue we face.

B. Businesses are losing the patient focus and now have to focus on the flow of paperwork.

C. Competitive bidding is going to be across the rural areas, as well as large metropolitan cities.

D. DOCUMENTATION, DOCUMENTATION, DOCUMENATION! IF IT IS NOT DOCUMENTED, IT IS NOT COVERED.

How can we survive this?

1. Education of your staff and referral sources is a must.
2. Know the policies.
3. Focus on your denials and work them in order received.
4. Use the DME MAC check-off sheets for individual denials.

(CONTINUE ON PAGE 32)

Staff Education: Meetings

How often do you have meetings with your staff? These should be weekly. The first topic of discussion should be last week's denials and how to correct them so they do not happen again.

Referral Sources: Use the policy and policy articles and point out exact issues you see being repeated.

Their resources can assist you and make sure you keep up with the current policies and changes. Use your NRRTS list serve to communicate issues you are seeing and let the members know there is a funnel for you to take questions to your DME MAC. I watch this list closely and when I see the comments with specific issues I will convey them to all of my members and to the DME DAC committees on which I preside. Jurisdictions B, C and D have a DMERC Advisory Committee you can contact for additional information as well. Jurisdiction A has a POE (provider outreach and education committee). These resources are available to all suppliers. Educational updates are put out daily from these resources.

VGM/US Rehab has great educational opportunities via webinars and attendance at state meetings, as well as one-on-one opportunities for members. Education is the key to change.

Documentation: Make sure you check the dates and signatures on every piece of paper you send. I see more denials related to dates than any other reason.

1. When you send in additional documentation, make sure you send in a cover sheet that tells exactly what is included.
2. Number all pages and put the patient's name on each page.
3. Keep you confirmation on your fax of number of pages sent.
4. Identify exactly what you are wanting. For example if you are seeking Redetermination, Reconsideration or ALJ use their forms.
5. ALJs are way behind. You can bundle groups of reviews. If you send in multiple claims in one package, make sure you identify a list of patients with appeal numbers and put them all in one packet. Use paper clips to keep each individual review separate.
6. You can ask for "on the record" and write a brief outline of the issue. Do not send the information you have already sent to the C2C reconsideration review. It is already sent to the ALJ by C2C. Be specific about the issue and why you feel it should have paid.

There have been some changes that will come into effect when the next contractor is selected (remember there will be only one RAC contractor for all of DME).

1. The new scope of work will instruct the RAC to respond to you within three days once they have received your request.
2. They will not send a letter to the DMEMAC until your open conversation with them has been completed and they determine a refund will be requested.

   (This will prevent a recoupment being sent before you finish your correspondence with the RAC)
3. The RACs will not receive their payment until the second level of review is completed in the future.

Complex Rehab providers need to be especially aware of the process of review for rehab bases and make sure they check every piece of documentation they have.

1. F2F means F2F date and not that the patient is in for follow-up of multiple medical problems
2. Subjective data is something the patient or family member tells the clinician about. For example, something the patient "feels" or "thinks." The patient "seems" extremely weak, "the patient has very weak upper extremities or the patient is severely SOB on exertion," are statements that would not be considered.

3. Objective data is something that can be measured. "Patient ambulated 10 feet and pain increased from a three to an eight on scale of one to 10." "Pulse oxygen was 90 and patient ambulated 10 feet and it dropped to 87 and took eight minutes to recover; respiration was 18/pulse 88 but after ambulating."

4. If patient is seen by the physician before therapist and does mmt and says, for example, it is 4/5 then the therapist does not see the patient until three months later and her/his mmt is 3/5. Was there a change in the condition? Remember these should be approximately the same or explanation is needed.

The cardio/pulmonary conditions should have a history of decreased respiratory function or something that shows change in condition. For existing patients who have been in chairs previously make sure the documentation is still there and don't assume you don't have to have certain items. Review it the same as if it is brand new.

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MEDICAL NECESSITY DOCUMENTATION WHEN BENEFICIARIES RELOCATE

WRITTEN BY: JOSHUA I. SKORA, ESQ.

Imagine the following situation: a new Medicare customer rolls through your front door with a high-end powered wheelchair and tells you she just moved to town from out of state. She explains she's been having difficulty with the motor not operating properly and wants you to fix the wheelchair. If the motor cannot be repaired, she wants a new wheelchair. To avoid the delay involved in obtaining new medical necessity documentation, you would like to use the documentation the previous provider completed. However, you might be hesitant because you are not sure how to get the original medical necessity documentation from the previous provider, and you are unsure what your responsibilities are if you get the documentation and you think (or know) the documentation has been embellished by the physical therapist or someone else involved in the documentation process. These are valid concerns that should be addressed to avoid problems in the event of a Medicare audit.

How to obtain medical necessity documentation from other providers.

The Health Insurance Portability and Accountability Act (HIPAA) regulates the use and disclosure of protected health information (PHI) created or received by "covered entities" and their business associates. Covered entities are health plans, health care clearinghouses and health care providers that transmit health information in electronic form in connection with covered transactions.[1] PHI is defined as any information that is created or received by a covered entity and that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual, if the information identifies the individual or could be used to identify the individual.[2] This definition is broadly interpreted to include any part of an individual's medical record or payment history. Therefore, medical necessity documentation kept by a provider is considered PHI, and covered entities are required to disclose any PHI they have to the individual within 30 days upon request.[3]

The original wheelchair provider might be hesitant to provide you with its medical necessity documentation. However, if the customer requests, in writing, the release of the medical necessity documentation, the provider is required to furnish a copy of the information within 30 days. It should be noted that this is the federal HIPAA rule. However, if a state law is stricter and requires a release of PHI in less than 30 days, the state law must be followed. The customer should contact his or her previous provider and request a copy of the file with all documentation included. The request can require the provider to send the records directly to you. If for some reason the provider refuses to comply, a gentle reminder of the obligations under the HIPAA privacy rule should suffice.

What should you do if you know, or have reason to believe, that the medical necessity documentation has been embellished?

Powered wheelchair providers are increasingly at risk of audit by CMS. The documentation requirements have become more and more arduous, and at times, it appears that perfectly documented claims are rejected and overpayments assessed for no clear reason. For example, it should be obvious that a patient with advanced multiple sclerosis who needs a new powered wheelchair after being in a chair for the last five years is incapable of using a walking cane, and that a walker will not sufficiently resolve the patient's functional mobility deficit. However, overpayments have been assessed solely because the medical necessity documentation did not state that a walker or cane would not suffice.

Providers who use medical necessity documentation from other providers are increasingly susceptible to audits. It is imperative that you review the documentation for accuracy. If you are going to supply the patient with a new powered wheelchair, you should consider asking the patient to get a new prescription and starting a new assessment. If you know or believe the original documentation is embellished, it is your obligation to either correct the embellishment or get new medical necessity documentation. In an audit, CMS will not care that you used another provider's documentation. The embellishment will be attributed to you and CMS could evidence the embellishment in audit results.

The current audit environment we find ourselves in has devastated many wheelchair suppliers. It is of the utmost importance that your documentation is accurate and all steps in the claims process are completed in the proper order. If there is an error, no matter how insignificant or small, CMS will find it during an audit. Unless you are certain the old medical necessity documentation is accurate, it is suggested you have customers get new physician orders and start the process over.

CONTACT THE AUTHOR

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References

1. *45 C.F.R. § 160.103.*
2. *Id.*
3. *45 C.F.R. § 164.524(b).*

A SPRINGTIME CRT REVIEW

Federal CRT Legislation: The MS Society Makes It A Priority

WRITTEN BY: DON CLAYBACK

While the National Multiple Sclerosis Society was one of the initial supporters of our federal CRT legislation, they have taken their support to a much higher level.

As part of their National Public Policy Conference held in Washington, D.C., the week of March 10, the MS Society adopted passage of the "Ensuring Access to Quality Complex Rehabilitation Technology Act" (S-948/HR-942) as one of their three federal legislative priorities for 2014. Thank you, MS Society!

As a result, their national conference included a 90-minute panel discussion covering what CRT is, the access issues being encountered, and the details of the CRT bill. The presentation was given to more than 300 MS activists from across the country. The CRT panel was moderated by Weyman Johnson, past National MS Society Board Chairman. I was included on the panel, representing our industry, as well as Alex Bennewith, vice president of United Spinal Association, Jennifer Digmann, an MS activist from Michigan who also uses a CRT power wheelchair, and Laura Weidner, director of Federal Government Relations for the National MS Society.

We are making plans for an even bigger 2014 National CRT Awareness Week.

Special thanks to Alex Bennewith for working with MS Society leadership last fall regarding making CRT and our legislation one of their priorities. They agreed to do that in recognition of the important role CRT plays in the lives of people with MS who require specialized mobility and seating, along with other types of assistive technology.

The CRT panel discussion went very well and generated many questions from the attendees. The even better news is that more than 300 MS activists took the CRT message to their congressional representatives on Capitol Hill the following day seeking support for S-948/HR-942. They will also be taking the CRT information back to their local and state MS Society chapter members as they return to their home towns.

As to our congressional scorecard, at the time of writing, we stand at 88 representatives signed on to HR-942 and eight senators signed on to S-948. You can visit www.access2crt.org and review the co-sponsor list (arranged by state) to see which members from your state have signed on. More importantly, you can see who has NOT signed on. They need to hear from you and others in your state!

The site has all the information you need to tell the CRT story and ask for support of our legislation. To help in your efforts, you can download and distribute the "CRT Legislation Information Pack," which contains the key details and documents relating to our bills. It's a great tool to get your members educated and signed on.

State CRT Legislation Moves Ahead

While we are making progress on the federal level, there is also legislative activity going on at the state level. As you may recall, in 2013 we were able to get the first state CRT bill passed into law. The Washington State Legislature passed HB-1445 to provide separate recognition of CRT within the state's Medicaid program. We are building on that and continuing to work on other states as we move into 2014.

In the past month, CRT legislation has been introduced in the states of Colorado (House Bill 14-1211) and Connecticut (Senate Bill 325). We also expect legislation to be introduced in the states of Pennsylvania and New York soon. These are ongoing initiatives to create increased recognition and awareness for CRT at the Medicaid level and set the stage to protect and improve CRT coverage and payment.

National CRT Conference

We are continuing to recruit attendees for the second annual National CRT Leadership and Advocacy Conference April 29 through May 1, 2014 at the Hyatt Regency Crystal City in Arlington, Va. The three-day program includes:

Leadership Day- CRT focused presentations for providers and manufacturers to include: health care reform trends; views from an industry CEO panel; financial management best practices; CRT related revenue opportunities; using technology and social media; handling hearings and audits; and more.

Advocacy Day- Funding and advocacy sessions for CRT stakeholders to include: Medicare and Medicaid updates; federal and state CRT legislative activities; using state protection and advocacy resources; lesser known funding sources; prep for visits with Congress; and more.

Capitol Hill Day (CELA)- Our annual presence in D.C. has been a key factor in the progress to date on our legislation to create a Separate Benefit Category for CRT. Consumers, clinicians, providers, and manufacturers will collectively take the CRT message directly to Congress through in-person meetings on Capitol Hill.

The goal is to bring CRT stakeholders together in one place for high value education, networking and advocacy. It allows providers, manufacturers, clinicians and consumers to collectively focus on important CRT issues and activities. This has never been more important than it is today, so visit the NCART or NRRTS website, get more details, and sign up!

CRT Awareness Week

Mark your calendars! As we all know, increasing CRT awareness with federal, state and private policy makers is an important objective in promoting and protecting access. With that in mind, we held our first National CRT Awareness Week last year. It proved to be a success as CRT stakeholders from across the country took the opportunity to connect with their members of Congress during their August recess. Providers, manufacturers, clinicians and consumer groups used a variety of venues to deliver the CRT message and ask for support of our legislation. Multiple on-site visits were held at provider or clinical facilities with members or their senior staff visiting to see firsthand what CRT is, who uses it, how it's provided, and the important role it plays in the lives of people with disabilities.

We are making plans for an even bigger 2014 National CRT Awareness Week. This year it will be held the week of August 18, and we will be providing CRT stakeholders suggestions and tools to spread the CRT message on both federal and state issues. Mark those dates on your calendar and stay tuned for more details.

Thanks to everyone for the continued efforts to protect and promote CRT access on the federal and state levels!

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SEATING CONSIDERATIONS FOR PEOPLE WITH SPINAL CORD INJURIES

WRITTEN BY: JILL MONGER, PT, MS, ATP

Spinal cord injury (SCI) and disease often result in devastating disabilities. However, people with SCI live life successfully and fully every day. For this to happen, clients with SCI who require a wheelchair and seating system need to be seen by a therapist and supplier who collaborate with the client toward common goals. Both the therapist and the supplier should be skilled, qualified professionals with specific training and experience in seating and mobility, and specifically in SCI, if possible. Once the therapist determines the motor level of function for the individual with SCI and educates the team as to potential functional outcomes, the patient and supplier can be more informed participants during the decision-making process. They will then be able to best determine the most effective products for clients to strive to meet their highest possible level of function.

The Anatomy and Function of the Spinal Cord

The actual spinal cord is about 18 inches in length and extends from the base of the brain (C1) to about the waist (T10/L1). The brain and spinal cord together make up the central nervous system (CNS). The nerves that are situated within the spinal cord are called upper motor neurons (UMNs), and their function is to carry the messages back and forth from the brain to the spinal nerves. The spinal nerves that branch out from the spinal cord to the other parts of the body are called lower motor neurons (LMNs). These spinal nerves exit and enter at each vertebral level and communicate with specific areas of the body. There are seven cervical vertebra, 12 thoracic vertebra (these have ribs attached) and five lumbar vertebra. The sacrum is fused, but also has LMN nerves exiting and entering between segments. Other important functions of the CNS include the sympathetic and parasympathetic nervous systems, which control involuntary functions such as blood pressure and temperature regulation.

It is important to perform a manual muscle test and general sensory review to determine the "functional" level of injury before determining functional outcome potentials.

Spinal Cord Injury Overview

A spinal cord injury (SCI) is damage or trauma to the spinal cord that results in a loss or impairment of function, causing reduced active movement and sensation, spasticity, neurogenic bowel and bladder and other complications. The most common causes of damage are trauma (car accident, gunshot, falls, sports injuries, etc.) or disease (transverse myelitis, polio, spina bifida, etc.).

Cervical SCIs usually cause loss of function in the arms and legs, resulting in quadriplegia. Injuries below the cervical spine usually cause paraplegia. The physical level of injury and the neurologic presentation can differ. After weeks or even years of healing, neurologic improvement can increase by a few levels.

It is important to perform a manual muscle test and general sensory review to determine the "functional" level of injury before determining functional outcome potentials. It is also important to know whether the injury is complete or incomplete and the level of ASIA (American Spinal Cord Injury Association) impairment scale. This information is critical to the Complex Rehab Technology (CRT) clinical specialty evaluation. Knowing the functional level of injury is very helpful in predicting what parts of the body might be affected by paralysis and, therefore, what functional outcome potentials can be expected. Remember that with incomplete injuries there will be some variation in these prognoses. This information is especially important when making recommendations for the newly injured individual.

Related Medical Complications and Considerations

There are many complications that can occur because of SCI, including amputations, orthopedic injuries, brain injury or interventions such as spinal fusions, removal of ischium or any part of the pelvis or femur, etc. Obviously other diagnoses can also complicate outcomes, such as diabetes and cardiac history. Funding, motivation and support system, as well as many other social factors can affect outcomes, also. When considering recommendations for CRT features and products, issues other than motor function and functional potential must be considered.

THESE CAN INCLUDE:

- Bladder management, including the need to extend at the trunk and hips to use a urinal or catheterize
- Transfer technique (if client uses a sling, it must be removed) and how the chair is utilized
- Physical pressure release technique and effectiveness
- Pressure sore/surgery history
- Any environments client plans to access
- Lifting: does the client need to physically lift a manual wheelchair?
- Transport: will the client drive from the chair? How will the chair be transported?
- Range of motion:
  - Cervical – can the client easily "look up" at someone who is standing?
  - Upper extremities – can the client push the wheels, access a joystick in standard position, and reach during daily functional activities?
  - Trunk – is the trunk flexible to a symmetrical position?
  - Hips, knees and ankles – what spasticity response occurs in sitting and during transitional movements and when rolling over uneven surfaces?
- Assistive Technology: other technology the client needs to access

Outcomes and Recommendations at Specific Levels of Injury

C-4 AND ABOVE

Cervical injuries usually result in quadriplegia. Complete injuries above the C-4 level can impact breathing, and the client may require a ventilator. These individuals will likely have no potential for active function beyond the use of their head and neck and shoulder shrugging. Power mobility will be required using alternative controls such as sip 'n puff, head array or chin joystick. Power seating is also required such as power tilt, recline and articulating elevating leg rests (AELR) for full pressure relief, bladder management in the chair, spasticity management, postural management, and prevention and management of LE dependent edema and circulatory issues. Memory seating (pre-programmed combinations of movement) is extremely helpful with this population, since they are using switches for access. Seating products must include excellent pressure relief for the coccyx, sacrum, trochanters and ischium as well as excellent distribution along the thigh to prevent peak pressures and resulting skin breakdown. Due to the spasticity response when transitioning between positions and when the chair is moving over any uneven surface, stability is also critical to prevent sheer and change of overall position. Since these individuals must use their head and neck to access driving, power seating, and other functions, the head and neck must remain in position at all times for access. If the pelvis, trunk and LEs are not stable, the head will move out of position. Depending on the spasticity response, snug-fitting lateral hip and thigh supports and/or medial knee supports are helpful. In most cases, lateral thoracic supports will also be necessary. Depending on the level of movement, varying levels of cervical and lateral head supports may be necessary. (See Picture 1)

C-5

At this level of function, injuries often result in preserved shoulder (deltoid) and elbow flexion (biceps) control, but no control of elbow extension (triceps) or of the wrist or hand. Some people may use a manual chair with push rim pegs or power assist for therapeutic purposes, but functionally, they will likely require power mobility. Most of these individuals will require the same power seating as a person with C2-4 level injuries. The client will usually need to access a mode change switch using their heads. Some individuals at this level may need to use head access for operation of the chair to reserve the strength and endurance available in their arms for other activities throughout the day. Depending on

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the stability of the cushion and the balance control of the client, lateral pelvic, thigh and trunk supports will also be necessary. (See Picture 2)

C-6

Injures resulting in the C6 level function generally preserve shoulder, bicep and wrist extension control, but not triceps, hand or finger function. This is a tricky level. Many people with C6 complete SCI are fully independent using a manual wheelchair. The client can learn to transfer, dress, bathe, drive and perform many other tasks independently. However, this level of function requires many months, even years, of intensive rehabilitation that many do not have the ability to complete. Newly injured people with C6 level function require a lot of education and peer counseling to determine their ultimate goals. One of the biggest challenges with seating in the manual wheelchair for these individuals is the active pressure relief. We can provide good pressure distribution with a cushion and back, but it takes months or even years for the person to be able to perform an effective physical pressure relief. So, manual mobility is a risky, albeit individual, choice.

The other difficult function to consider is transfers. Often, the set-up of the chair and seating necessary for stability for independent propulsion interferes with the ability to meet transfer goals, with or without a transfer board. Driving goals can also be problematic for people with C6 level injuries who choose manual mobility. Transferring to a six-way seat (common in many vehicles driver's seats) may not be possible, so they will need to drive from the chair (although not the safest form of driving). Lockdown systems tend to require a lower bar to mount the locking mechanism, and there are very few ultra-light configurable manual wheelchairs on the market today that have this lower bar feature. Of course, addition of this lockdown feature adds significant weight to the chair, further interfering with successful self-propulsion. If power is the client's choice for primary mobility, then at least power tilt should be used. Usually power tilt and recline with AELR provides better outcomes regarding bladder management, spasticity management, LE dependent edema prevention and management, access to complete pressure relief and positioning/repositioning tasks. The seating design should provide pressure relief, ability to transfer (in most cases) and stability. (See Picture 3)

C7, C8 AND T1

People with C7, C8 and T1 presentation will have tricep control, and those with only C8 and T1 nerve injury will demonstrate some hand function. These individuals now have a much better chance of using a manual wheelchair after a few months of rehabilitation. If they are able to learn to transfer independently, they can manage their bladders, spasticity and LE edema outside of the chair. These clients should be able to perform efficient, effective pressure relief. If they do not meet these goals, a power chair is required for mobility. Again, power tilt, recline and power legs may be necessary since the client cannot transfer easily throughout the day. High-level pressure relief cushions are still necessary and stability is critical at this level due to lack of trunk musculature control.

T2-T9

High level thoracic injuries (generally above T9) result in poor-to-no trunk control. In most cases, these individuals will use ultra-light, properly configured, manual chairs. Some will still need power assist or power wheelchairs, depending on their ultimate level of function. The seating in manual chairs must be very stable to prevent development of spinal deformities and collapsed spine. The cushion needs to provide a level and stable pelvis to prevent obliquity and severe posterior tilt, as well as provide pressure relief from bony prominences. The backrest needs to be low-to-mid-level height with excellent posterior pelvic support with allowance for thoracic extension and at least mild lateral contouring. In some cases, true lateral thoracic support through increased lateral back depth or actual LTS (lateral thoracic supports) will be necessary. (See Picture 4)

T10-12, LUMBAR AND SACRAL

Lower thoracic and lumbar/sacral injuries leave the client with good-to-excellent trunk control potential. Manual mobility is the choice for most of these individuals. They should be able to move away from and return to the back support without using their arms. If this is the case, these clients will not require as much back support, but will still require pressure relief and some stability from the seat.

Conclusion

When assisting an individual with a spinal cord injury in choosing a wheelchair, the focus must be on the

The client plays a vital role throughout the process and should be an active and involved member of the decision-making team...

individual client's goals, functional abilities and potential. For example, two people with the same injury may have very different body types and presentations, which must be considered when recommending equipment. In addition, an individual's motivation, access to rehabilitation, and support system will impact the decision-making process. It is critical that all tasks and environments in which activities will be performed be considered when recommending a device.

Finally, once the equipment arrives, a fitting and training session with the original team is important to assure goals are met and that team members learn from the process. Training in the use of power seating for full pressure relief is important and should include pressure mapping for biofeedback for the client if possible. When providing manual chairs, assurance of the most ergonomic set up for propulsion, as well as instruction in most effective propulsion method is critical to assist in prevention of UE injuries. For new users, instruction and practice of wheelchair skills and negotiation of the environment is also important.

The client plays a vital role throughout the process and should be an active and involved member of the decision-making team along with a knowledgeable clinician and supplier.

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References

Arledge, S., Armstrong, W., Babinec, M., Dicianno, B. E., Digiovine, C., Dyson-Hudson, T., ... & Stogner, J. (2011, January). RESNA Wheelchair Service Provision Guide. In RESNA. RESNA. 1700 North Moore Street Suite 1540, Arlington, VA 22209.

Dicianno, B. E., Arva, J., Lieberman, J. M., Schmeler, M. R., Souza, A., Phillips, K., ... & Betz, K. L. (2009). RESNA position on the application of tilt, recline, and elevating legrests for wheelchairs. Assistive Technology, 21(1), 13-22.

Outcomes following traumatic spinal cord injury: clinical practice guidelines for health-care professionals. J Spinal Cord Med. 2000 Winter; 23(4):289-316.

The Application of Ultralight Manual Wheelchairs Position Paper, resna.org, accessed 2/4/14.

PICTURE 1 – *C3 COMPLETE, REQUIRES HEAD STABILIZATION TO CONSISTENTLY ACCESS PNEUMATIC SWITCHES*

PICTURE 2 – *C5 COMPLETE, REQUIRES CONTOURED BACKREST, CHEST STRAP AND LATERAL THIGH SUPPORTS*

PICTURE 3 – *WEAK C6 COMPLETE, REQUIRES WRAP AROUND BACKREST AND ORTHOTIC CUSHION WITH AIR INSERT FOR ABILITY TO BE STABILE TO SELF-PROPEL YET PREVENT PRESSURE SORES*

PICTURE 4 – *T3 COMPLETE REQUIRES LATERAL PELVIC SUPPORT LEFT AND LATERAL THORACIC SUPPORT RIGHT TO CORRECT LEFT PELVIC OBLIQUITY AND RIGHT SPINAL CURVE TENDENCY*

BALANCING PRESSURE RELIEF AND POSTURAL SUPPORT

WRITTEN BY: ANGELA REGIER, OTD, OTR, ATP

For individuals with spinal cord injury, proper postural support is the foundation for participation in functional activity. Pressure relief and distribution is imperative as well, due to the limited mobility and sensation that often accompanies a spinal cord injury. With an annual pressure ulcer incidence of up to 30 percent[1] and up to 85 percent of individuals with SCI experiencing pressure ulcers at some point in their lives[2], the importance of adequate pressure relief is clear. There has been much research conducted on the use of powered seating functions for performing pressure relief when an individual is unable to do his or her own weight shifts. Use of a tilt and/or recline[3, 4, 5], as well as the frequency and duration of weight shifts[6] must be addressed. Despite knowing how weight shifts should be performed, research indicates individuals do not often complete weight shifts to the appropriate degree of tilt/recline nor at the appropriate frequency and duration[7]. This supports the need for, and importance of, comprehensive client education. The following case study highlights the balancing act of achieving postural alignment and pressure relief in an individual with tetraplegia.

Background

Ms. T. is a 60-year-old female who was referred to the Wheelchair Seating and Mobility Clinic by her primary in-patient occupational therapist. She had been injured approximately two months prior, resulting in motor complete, sensory incomplete C4 tetraplegia. She presented consistent with her level of injury with good head/neck control and shoulder shrug, but no other active movement. She did have some preserved sensation throughout her body. She was initially mobilized in a rear wheel drive power wheelchair with a sip and puff alternative drive control (utilizing hard and soft sips and puffs to control the power wheelchair and seating system), power tilt, and a seating system with necessary primary and secondary postural supports, including a combination gel/foam cushion.

Evaluation

At her initial evaluation, she was found to have a mild left pelvic obliquity with flexibility past midline; a tendency of a left thoracic convexity/right lateral trunk flexion, also with flexibility; and a tendency of posterior pelvic tilt. Her lower extremity range of motion was within functional limits for the seated position, although she was able to achieve only neutral dorsiflexion in her ankles. In evaluating the seating system in which she was initially mobilized, it was found that her cushion was too long, resulting in her calves hitting the front of the cushion and preventing achievement of a neutral pelvic tilt. In addition, an 18 inch wide seat was required due to her overall hip width, but she was much narrower in her trunk. The 18 inch wide back support that was utilized made it difficult to place the lateral trunk supports close enough to achieve correction of her right lateral trunk flexion. The wider back support also made it difficult to bring the arm supports in close enough for optimal upper extremity support and alignment.

In discussing her goals for mobility, she stated she would like a chair that maneuvers well indoors. While she enjoyed spending time outdoors, she felt it important that the base was intuitive to drive and would handle well in her living space. She reported she did not like the sip and puff drive system and inquired about other alternative drive control options. After being educated on power wheelchair base options (front-, rear- and mid-wheel drives), she requested to trial other rear

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> One of his parents' main concerns, however, was the position of his head. Brian kept his head forward most of the time and would actively pull forward when tilted.

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BALANCING PRESSURE RELIEF AND POSTURAL SUPPORT

(CONTINUED FROM PAGE 42)

wheel drive options as well as mid wheel drive options due to her indoor living space. Education was also completed on alternative drive options, and she requested a trial of a head array alternative drive control (tripad head support with embedded drive switches and a mode switch).

During the equipment evaluation, she trialed both a mid-wheel drive base and a rear-wheel drive base set-up with a head array drive control and a power tilt. Initially, it was difficult for her to activate a mode switch placed at her left cheek due to her tendency of right lateral trunk flexion, so a mode switch at her left shoulder was utilized.

While not ideal, as this increased activation of her already very active upper trapezius muscle, it was a temporary solution that improved her independence in accessing the drive features and power tilt. Several days later, more time was spent addressing her postural needs, and the following changes were made. Her back rest was switched to 16 inches wide with gel lateral trunk supports (to reduce pressure, particularly at her left apex and to improve comfort due to her intact sensation) set low on the left and high on the right. This allowed for better correction of her tendency of a left thoracic convexity. The back angle was adjusted to maximize balance and reduce tendency of her kyphotic/forward head posture. In addition to the narrower back support and laterals, a Y-style belt was installed for use over her left shoulder to further reduce her tendency of right lateral

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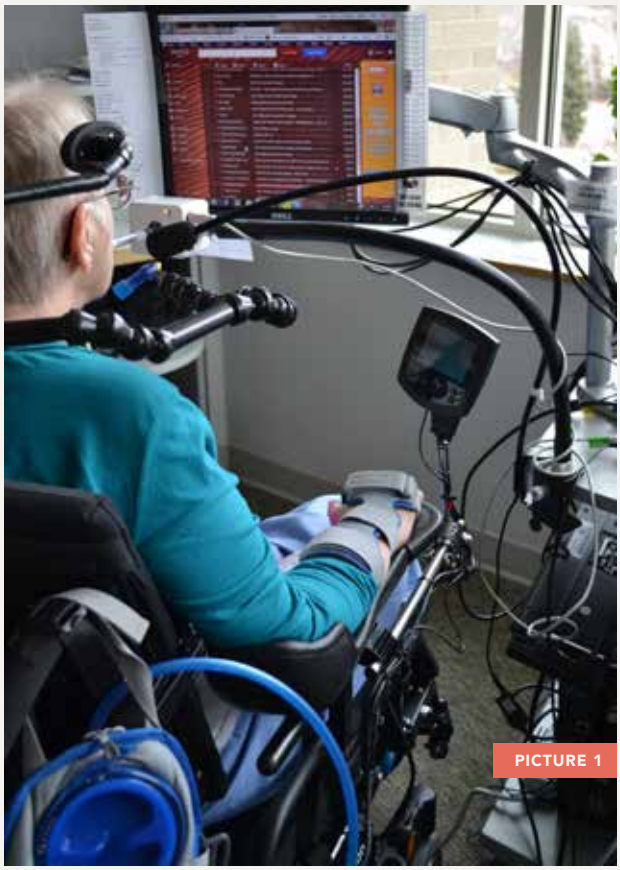
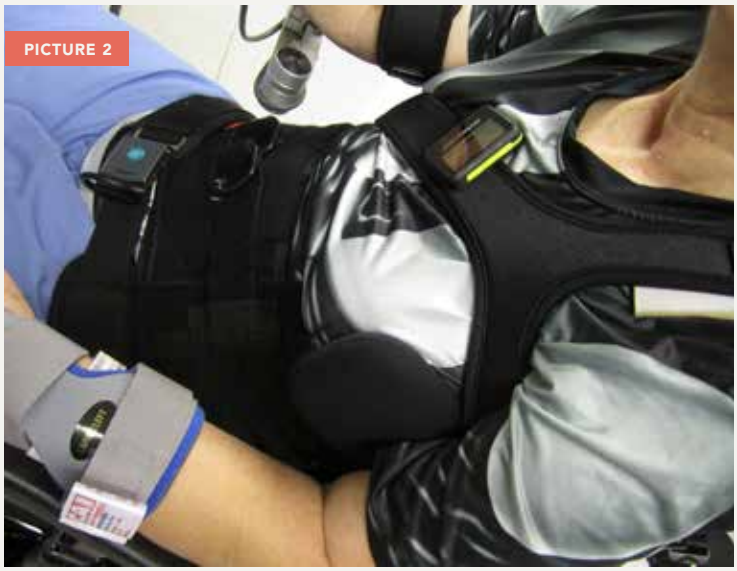


PICTURE 1

PICTURE 3



PICTURE 2

PICTURE 1: *USE OF HEAD ARRAY DRIVE SYSTEM VERSUS CHIN DRIVE OR SIP AND PUFF ALLOWED FOR INDEPENDENCE IN PULLING INTO COMPUTER STATION.*

PICTURE 2: THE Y-BELT AND LATERAL TRUNK SUPPORTS PROVIDE SUPPORT AND CORRECTION OF LEFT THORACIC CONVEXITY AND RIGHT LATERAL TRUNK FLEXION.

PICTURE 3: HEAD ARRAY DRIVE SYSTEM WITH TILT SEATING SYSTEM AND NECESSARY PRIMARY AND SECONDARY POSTURAL SUPPORTS FOR SYMMETRICAL SITTING POSTURE AND ADEQUATE SUPPORT. GOOSE NECK DRINKING SYSTEM MOUNTED TO CHAIR TO ALLOW FOR INDEPENDENT ACCESS TO WATER.

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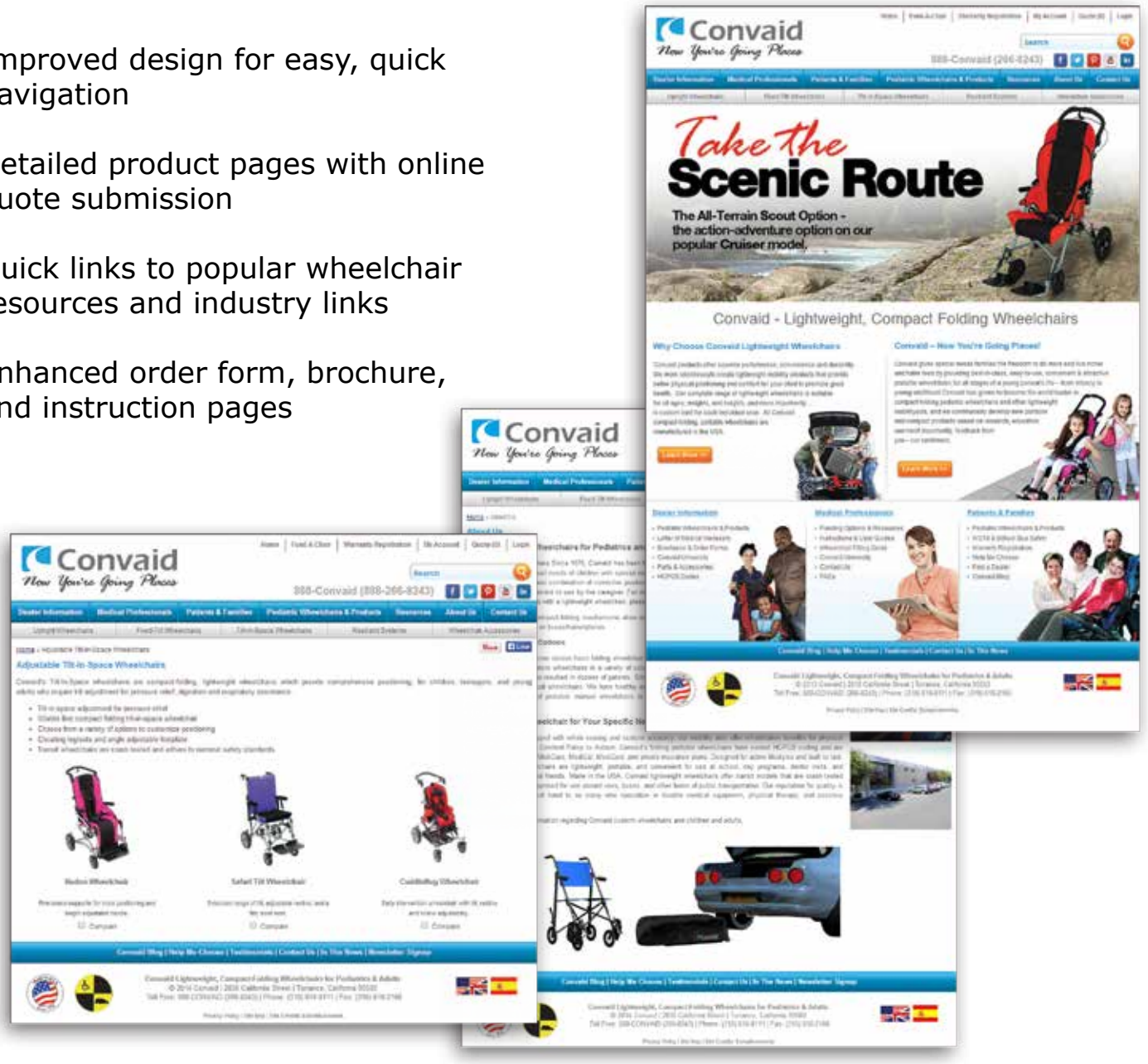

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BALANCING PRESSURE RELIEF AND...
(CONTINUED FROM PAGE 44)

trunk flexion. With these secondary postural supports in place, the use of a lateral pelvic support on the right as a third point of control and a shorter cushion, she was able to maintain a neutral pelvic and trunk alignment. Her improved posture resulted in an ability to more consistently and successfully utilize the head array, as well as use the mode switch by her left cheek. She had difficulty depressing an egg switch mounted at her left cheek, so a micro light switch was selected to ease her ability to consistently activate the mode switch.

With the use of appropriate depth, she was able to sit within the well of the cushion. The correct cushion size in conjunction with a right lateral pelvic support resulted in the ability to maintain a more neutral pelvic alignment with reduction of her pelvis going into a left obliquity (left side of pelvis sitting lower than right) and shifting right. A posterior base wedge was also utilized, and foot supports adjusted accordingly, in order to maintain a neutral pelvic tilt, improve thigh support/loading, and increase overall stability within the chair.

Recommendations

After the power wheelchair base and postural evaluation, a prescription was completed for a mid-wheel drive base with tracking technology (to maximize efficiency with the alternative drive use), a head array drive system with display and attendant drive control should a care giver need to operate the power wheelchair, and a power tilt. In addition, the necessary primary and secondary support surfaces were prescribed including: a back support mounted approximately six inches above the seat pan to allow space for soft tissue (posterior to pelvis) which contributed

to achievement of a more neutral pelvic alignment, lumbar support, adjustable lateral trunk supports with gel, Jay 2 Deep Contour cushion for pressure relief/postural correction, trough arm supports with built in elbow support for maintenance of glenohumeral alignment when in tilted position, individual foot supports with angle adjustable foot plates to address limited dorsiflexion, and positioning belts including the Y-style belt for use over left shoulder. To maximize independence, an electric leg bag drainer, which is controlled through the power wheelchair's output module, was also prescribed. This, along with independence in accessing her cell phone, door opening (both being addressed in conjunction with the occupational therapists who work in the technology lab), and having access to water, will allow her increased independence and the ability to be left at home alone for short periods of time.

In assessing the type of seating system that would be most appropriate, it was determined that a tilt system would allow for good pressure relief while assuring access to her drive control throughout her pressure relief. Because she selected a head array drive control, it was imperative that she was able to access the switches for operation of her power tilt throughout the weight shift cycle. The chair was ordered with a 50 degree tilt.

As mentioned previously, assuring consistent and full use of the powered seating function is imperative in preventing skin breakdown. Ms. T.'s education on the importance of utilizing the full 50 degrees for adequate pressure relief, as well as the proper frequency (initially every 15 minutes, building up to every 30 minutes) and duration (two to

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BALANCING PRESSURE RELIEF AND...
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three minutes) began from day one of her rehabilitation program[6]. At initial mobilization, she was issued a timer that automatically alarms to serve as a reminder for frequency of pressure relief, as well as to cue her when the target duration has been achieved (Gymboss Interval Timer). This was utilized throughout her in-patient rehabilitation program and use was encouraged after discharge from the hospital as well. She also participated in a patient education module with nursing staff regarding prevention of pressure ulcers.

Conclusion

Through configuring primary and secondary support surfaces to achieve ideal postural alignment, the footprint of Ms. T.'s body was optimized prevent peak pressures and reduce risk of skin breakdown. Education on the importance of pressure relief and training in effective use of the power tilt system will assure protection of her skin well into the future. In addition to achieving pressure distribution and relief, the configuration of the seating system optimized functional use of her head/neck for drive control and use of assistive technology for independence in environmental, computer and phone access.

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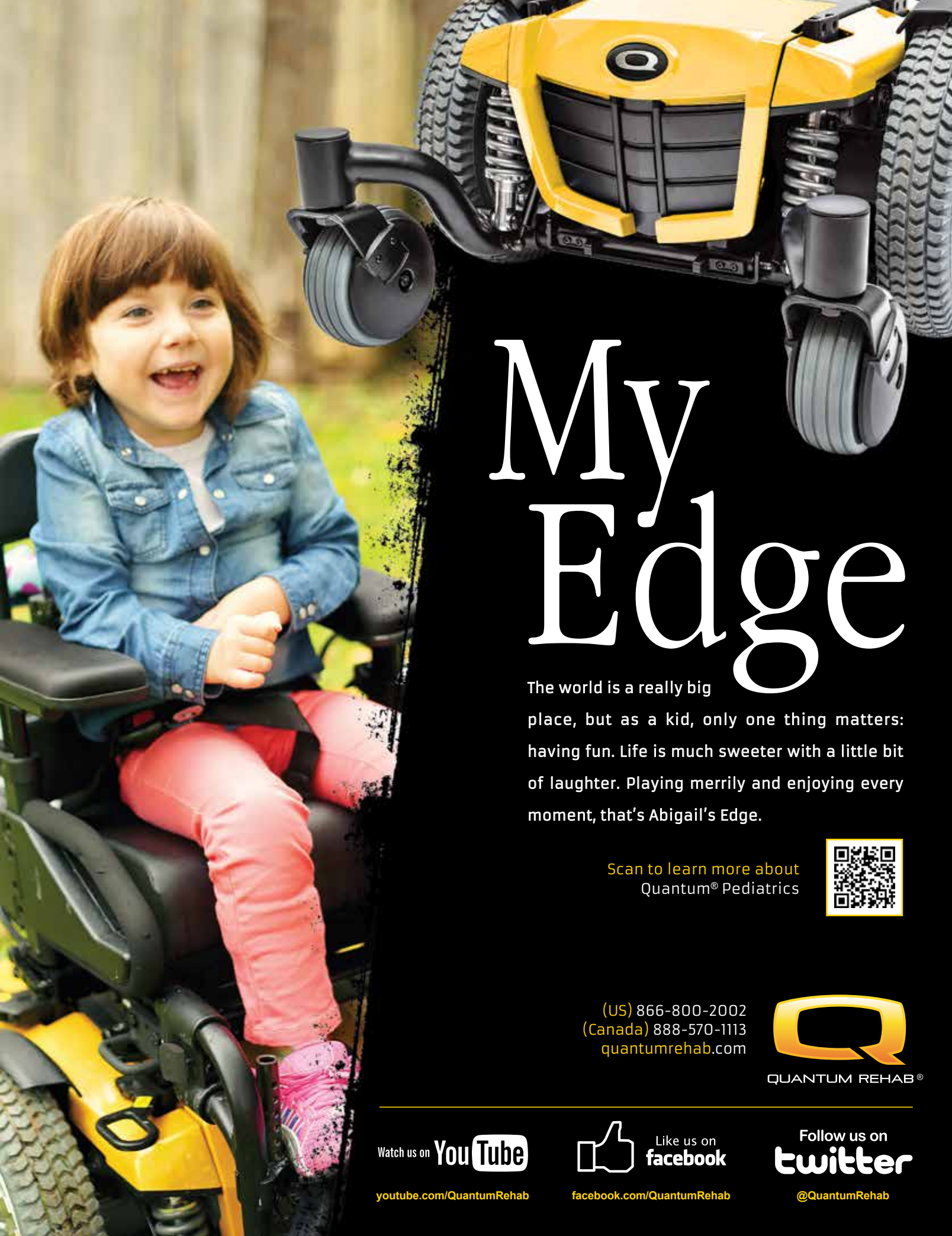
References

1. *Young JS, Burns PE. Pressure sores and the spinal cord injured: part II. Model Systems'. SCI Digest, 1981; 3: 11--26, 48.*
2. *Fuhrer MJ et al. Pressure ulcers in community-resident persons with spinal cord injury: prevalence and risk factors. Arch Phys Med Rehabil, 1993; 74: 1172 -1177.*
3. *Giesbrecht EM, Ethans KD, Staley, D. Measuring the effect of incremental angles of wheelchair tilt on interface pressure among individuals with spinal cord injury. Spinal Cord, 2011; 49(7): 827-31.*
4. *Sonenblum SE, Sprigle SH. The impact of tilting on blood flow and localized tissue loading. Journal of Tissue Viability, 2011; 20(1):3-13.*
5. *Jan YK, Jones MA, Rabadi MH, Foreman RD, Thiessen A. Effects of wheelchair tilt-in-space and recline angles on skin perfusion over the ischial tuberosity in people with spinal cord injury. Arch Phys Med Rehabil, 2010: 91(11): 1758-64.*
6. *Jan YK, Liao F, Jones MA, Rice LA, Tisdell T. Effect of durations of wheelchair tilt-in-space and recline on skin perfusion over the ischial tuberosity in people with spinal cord injury. Arch Phys Med Rehabil, 2013; 94(4): 667-72.*
7. *Sonenblum SE, Sprigle S. Distinctive tilting behaviors with power tilt-in-space systems. Disability and Rehabilitation: Assistive Technology, 2011; 6(6):526-35.*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ADVOCACY CAMPAIGN TO SAVE THE WHEELCHAIR CONTINUES

WRITTEN BY: ALEX BENNEWITH

Jenn Wolff, a disability advocate, lobbyist and Ms. Wheelchair Iowa 2011, has been selected as the manager of United Spinal Association's UsersFirst program and its mission to ensure greater access to appropriate wheelchairs, mobility scooters and seating systems for people with disabilities nationwide.

"As a new voice for UsersFirst, I hope to continue to educate, inform and help give a stronger voice to wheelchair users and the policies and issues that affect us," said Wolff.

Wolff is looking forward to continuing the progress made by Ann Eubank, LMSW, OTR/L, ATP. Eubank has departed as vice president, Community Initiatives and head of UsersFirst for a new opportunity as the executive director of the Center for Independent Living in Nashville, Tenn, her home state. United Spinal is grateful to Ann for the great work she did for grassroots advocates both within and outside United Spinal.

"As a new voice for UsersFirst, I hope to continue to educate, inform and help give a stronger voice to wheelchair users and the policies and issues that affect us."

"I want to thank everyone for supporting the work I've accomplished with UsersFirst. The program has successfully mobilized wheelchair users and advocates and will continue to do so. Now, a new chapter begins," said Eubank in a recent message to her supporters.

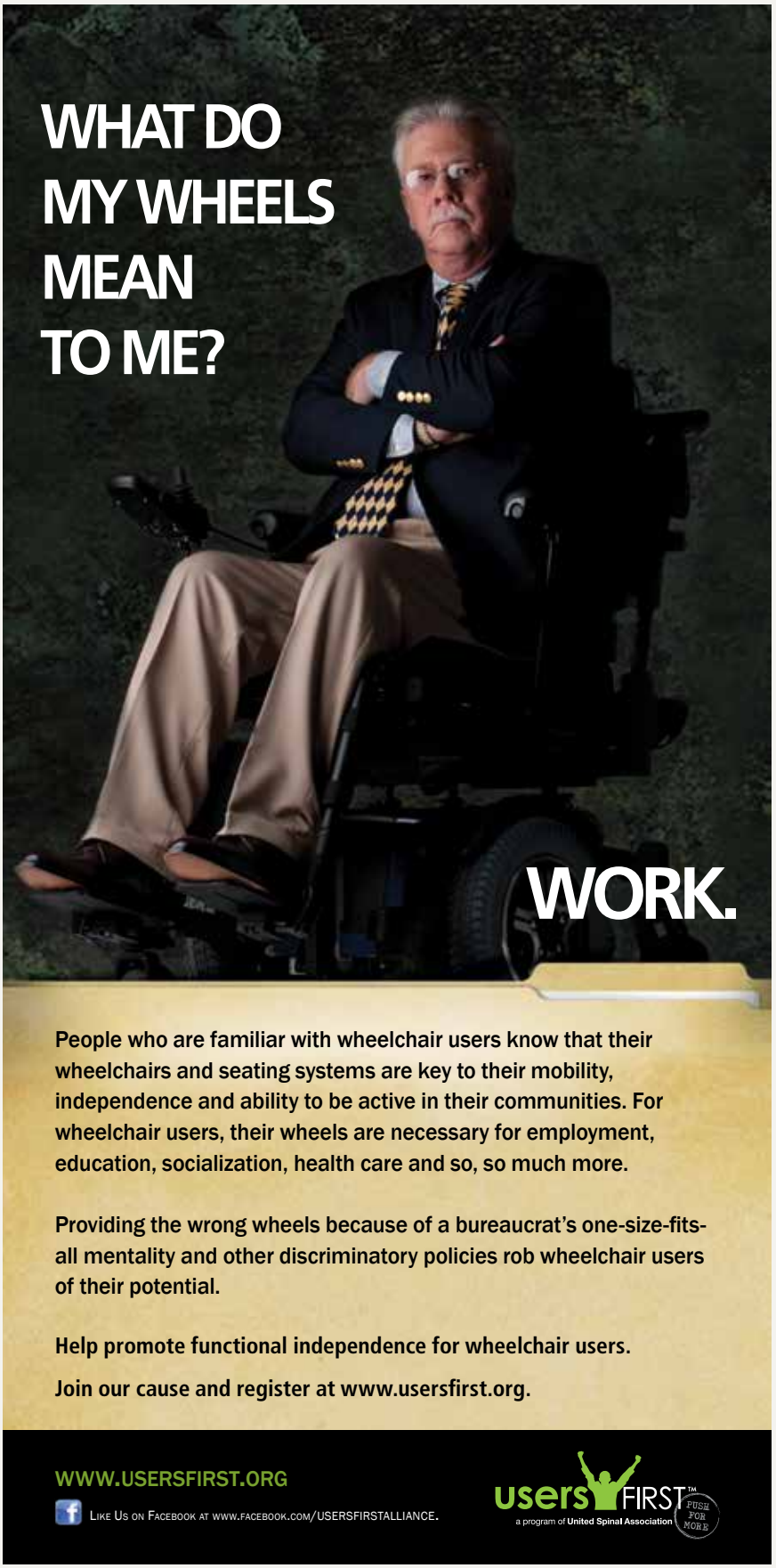
Wolff will work closely with United Spinal members and disability advocates, as well as wheelchair manufacturers and legislators to provide wheelchair users' access to mobility equipment that is right for them.

"Wolff has been a dedicated advocate to the disability community and a strong voice in United Spinal's efforts on the Hill. Her thorough understanding of wheelchair policy issues will be a great asset to UsersFirst," said James Weisman, SVP and general counsel of United Spinal.


JENN WOLFF

"We're lucky to have Wolff representing UsersFirst, and I look forward to working with her," added Alex Bennewith, vice president of Government Relations.

Wolff earned her master's degree in occupational therapy (OT) from the College of St. Catherine in St. Paul, Minn., and has used a wheelchair since 2003 after a tumor inside her spine was removed. She has lobbied for improved transportation and wheelchair issues on Capitol Hill, has been involved with several advocacy groups, including United Spinal, and is taking a lead policy role at the SCI Association of Iowa. As Ms. Wheelchair Iowa, Wolff advocated



for better insurance coverage for CRT. Wolff is also a member of the Olmstead Consumer Task Force which serves as a watchdog for all Iowa legislation that could affect people with disabilities.

UsersFirst believes the right wheelchairs, mobility scooters and seating systems are fundamental elements in maintaining the health, quality of life, and independence of people with disabilities.

UsersFirst accomplishes its mission by:

- Nurturing self-advocacy
- Improving access to funding for mobility equipment
- Advocating on Capitol Hill and at the state level to bring the mobility concerns of our community to the attention of federal and state legislators
- Improving access to proper wheelchair evaluations
- Holding equipment providers and manufacturers accountable in maintaining the highest standards in customer service and support

Like us on Facebook at Facebook.com/UsersFirstAlliance and register at www.usersfirst.org/forms/join.html to receive important policy updates.

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CLINICIAN TASK FORCE CELEBRATING 10 YEARS OF ACCOMPLISHMENTS

WRITTEN BY: LAURA COHEN PHD, PT, ATP/SMS

"Never doubt that a small group of thoughtful, committed, citizens can change the world. Indeed, it is the only thing that ever has."
-Margaret Mead

It is hard to believe the Clinician Task Force (CTF) was formed a decade ago by 45 volunteer members and two part-time co-coordinators. The majority of our members are practicing seating and mobility clinicians representing reputable regional medical centers and rehabilitation facilities. We are small, but mighty, allowing us to fill a unique and important position to represent the clinical voice for CRT issues.

This anniversary is an opportunity to look back and take stock of our accomplishments and progress. It is well recognized that the Complex Rehab Technology (CRT) industry has faced our fair share of challenges in the past ten years. We have had a busy agenda working to ensure individuals with mobility impairments have appropriate access to CRT products and services.

What we have learned: Persistence and partnership result in progress for those we serve!

A team effort and a consistent message from the CRT industry stakeholders has resulted in influencing significant change. Since 2004, the CTF has worked closely with consumers, suppliers, CRT companies and manufacturers to build credibility and rapport with policy makers and legislators. This approach is working!

(CONTINUED ON PAGE 54)

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CLINICAL TASK FORCE CELEBRATING...
(CONTINUED FROM PAGE 52)

Highlights of 2013 CTF Accomplishments:

Through ongoing and consistent communication, education, meetings and letters, our teamwork has had some success worth celebrating. Let's take a moment to acknowledge and recognize our successes.

CTF Top Achievements for CY2013: Efforts are Ongoing

• **INTRODUCTION OF CRT LEGISLATION-** CTF MEMBERS DIRECTLY PARTICIPATED IN ASSISTANCE TO SECURE SPONSORSHIP SUPPORT WITH CONGRESSMAN SENSENBRENNER AND CONGRESSMAN CROWLEY, AS WELL AS SENATORS SCHUMER AND COCHRAN. CTF MEMBERS HAVE SUCCESSFULLY INFLUENCED CO-SPONSORSHIP SUPPORT AND PARTICIPATED IN MEETINGS WITH TARGET REPRESENTATIVES.

• **K0009 RECLASSIFICATION PROJECT FOR CMS-** CMS REQUESTED THAT CTF ASSEMBLE AND SUBMIT ADDITIONAL INFORMATION RELATING TO K0009 PRODUCTS INCLUDING TECHNOLOGICAL DISTINCTIONS, UTILIZATION, COST, USER POPULATION, CLINICAL INDICATORS AND EVIDENCE TO SUPPORT A SUPERIOR CLINICAL OUTCOME. THE CTF PREPARED A 147 PAGE REPORT PRESENTED TO CMS ON JANUARY 28, 2013. THE FULL REPORT MAY BE DOWNLOADED HERE. COMMUNICATED AND MET WITH CMS OFFICIALS AND DMAC MEDICAL DIRECTORS- CONCERNING MWC LCD REVISIONS, FIRST MONTH PURCHASE OPTION PROPOSED FINAL RULE, PMD E CLINICAL TEMPLATE, AND THERAPY CAP IMPACT ON PROVISION OF CRT SPECIALTY EVALUATION.

• **PROVIDED CLINICAL SUPPORT TO STATE CRT LEGISLATIVE ACTIVITIES-** SUPPORTED EFFORTS IN WA, CA AND CO TO INTRODUCE LEGISLATION FOR CRT RECOGNITION AND PROVIDED INPUT TO LEGISLATIVE LANGUAGE.

• **PARTICIPATED AS COMMITTED MEMBER TO E CLINICAL TEMPLATE INITIATIVE WITH HHS AND CMS-** SERVED AS SUBJECT MATTER EXPERT AND PARTICIPANT PROVIDING INPUT AND COMMENT TO INITIATIVE TO DEVELOP, TEST AND IMPLEMENT ELECTRONIC HEALTH RECORD SOLUTIONS FOR PMD ELECTRONIC COLLECTION, TRANSMISSION AND REVIEW OF PMD CLAIMS.

• **FACILITATED APTA PARTICIPATION ON CRT ISSUES-** GAINED SUPPORT OF APTA ON CRT ISSUES INCLUDING CRT LEGISLATION, DRAFTED AT CONTENT FOR INCLUSION IN APTA GUIDE TO PT PRACTICE CURRENTLY UNDER REVISION, PASSED MOTION IN APTA HOUSE OF DELEGATES TO SUPPORT AND ADVOCATE FOR PATIENT/CLIENT ACCESS TO HIGH QUALITY DME AND SERVICES, GOT DME/CRT MOVED TO REGULATORY/ LEGISLATIVE PRIORITIES OF ASSOCIATION.

• **FACILITATED AOTA PARTICIPATION ON CRT ISSUES-** GAINED SUPPORT OF AOTA ON CRT ISSUES INCLUDING CRT LEGISLATION, COMMISSION ON PRACTICE WORKING TO FORMALLY DEFINE CRT PRACTICE FOR OT PROFESSIONALS.

CTF Top Strategic Priorities for CY2014:

1. Provide clinical support to garner legislative co-sponsorship for passage HR942 and S948 Communicate, meet and educate legislators about CRT issues by way of office visits, letters of support from large rehab centers, individual clinicians, clinical groups: APTA, AOTA, and physician groups: AAPMR, AAP, AACPDM, AASCI.

2. Provide clinical input to state Medicaid programs on issues surrounding consumer access to CRT products and services. Offer guidance, technical support and clinical involvement to influence state Medicaid issues. Assist in developing strategy, positions and testimony on issues such as matching laws to Medicaid policies to limit inappropriate adoption of Medicare policy, introduction of state legislation for separate CRT recognition, removing barriers to appropriate Medicaid coverage and payment for specialty evaluation services, elimination of the seven year rule for PWC replacement, revision of Medicaid payment policies that create barriers to consumer access, and communication with CMS Medicaid state program officials as needed to request clarifications and directives to states.

3. Develop clinical guidance materials and evidence for CMS and CMS contractors. Respond to formal requests for comments and provide clinical input to timely policy matters.

4. Electronic Medical Records Initiative Participate as subject matter expert(s) in Standards and Interoperability Framework workgroups for Office of the National Coordinator (ONC)

Health Information Technology (HIT) related to development of electronic medical records standards development, implementation and testing initiatives. This work will define the standards for electronic health records for the purpose of electronically processing PMD requests and ultimately will be the basis for design criteria for vendor specific proprietary software.

5. Advance the practice of CRT within the APTA and AOTA to ensure a qualified workforce to provide CRT clinical services Continue work with APTA and AOTA to increase the visibility and advance the practice of CRT. The Guide to PT Practice is under revision with extensive proposal and recommendations (submitted by CTF) related to CRT. AOTA is finalizing a Knowledge and Skills document for CRT (lead by CTF members). When these documents are ratified they will become organizational policies formally recognizing CRT and the clinician role for the first time. CTF is also working to develop educational tools to assist with preparing the workforce and students to meet the CRT needs of the public. A documentation guide is being developed to meet the PMD documentation requirements, advanced clinical practice programs, etc.

We believe the various initiatives we are focused on are critical to protecting and promoting access to CRT. The CTF continues to work on our defined priorities to ensure individuals with mobility impairments have appropriate access to seating, positioning and mobility products and services. The year 2014 promises to have no shortage of increasing CRT access issues on the federal and state level.

The financial support of our donors is critical to enable the CTF to continue its important work in support of activities aimed at protecting and improving access to CRT for people with disabilities. Thank you to the CTF donors who continue to support our work!

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IS IT A POSITIONING SUPPORT OR A RESTRAINT?

RESNA's new position paper considers the difference

WRITTEN BY: ANDREA VAN HOOK

RESNA's latest position paper, available for free on the website, addresses a potentially contentious topic that particularly affects practitioners working in settings where restraint policies are in effect. "The Application of Wheelchairs, Seating Systems, and Secondary Supports for Positioning vs. Restraint" is intended to give professionals information, guidance and recommendations so they can better assist their clients in these particular settings.

"There's misinformation in the community that you can't recommend certain things that are of benefit to your client, because it's considered a restraint," explained co-author Michelle Lange, OTR, ABDA, ATP/SMS, of Access Independence, Inc. "It's really important that practitioners understand the regulations, because usually it turns out you can recommend appropriate seating interventions, but you have to provide specific documentation."

"There's misinformation in the community that you can't recommend certain things that are of benefit to your client, because it's considered a restraint."

For example, some practitioners have found that tilt and recline technologies can be perceived as a restraint, because it makes it more difficult for a client to get out of a wheelchair if it is tilted rearward. However, the purpose of tilt and recline is actually not restraint. It is to re-orient or re-position the body for clinical reasons, such as pressure redistribution, postural control, pain and fatigue management, and feeding. When tilt and recline is used for any of these purposes, then the clinical benefits may still outweigh independent exit.

Another example is when a client is self-abusive, such as what happens due to conditions such as Lesch-Nyhan syndrome or Cornelia de Lange syndrome. In these extreme situations, it may be necessary to "restrain" the client in the wheelchair seating system to reduce the risk of serious self-injury. The documentation in these cases should note that the purpose of the restraint is not to control behavior, but to reduce risk of injury to self. Case studies drawn from real-world examples illustrate the principles and approach to managing self-injurious behavior, fall prevention, and managing agitation.

"This paper answers the question of how to explain that it's not a 'seatbelt,' it's a postural support," said Lange. "It's very important that professionals understand the actual regulations."

For example, the Food and Drug Administration (FDA) has defined the word "restraint" in their program regulations as a device that attaches directly to the person for the specific intent of controlling the movement of a person in the context of a medical treatment. However, the FDA does not define restraints as any other products or devices that may be adjacent to a person and also used to control movement of a person. That means when the intent is to provide postural support, stability, pressure distribution, and pressure relief, the FDA regulations do not apply to wheelchairs, seating systems and secondary supports. The paper cites similar examples from the Department of Health and Human Services (for hospitals and health facilities) and OBRA, the Omnibus Budget Reconciliation Act of 1987 (for facilities receiving federal funding). Other settings may adopt these regulations, interpret them, and add to them.

As regulations have evolved, there has been a shift, conceptually, from

discussion of a particular device to a discussion of the device's overall effect on the individual. When some agencies continue to use definitions that are not current, it can be challenging to meet the client's needs. On the other hand, if the professional has a thorough understanding of the regulations, he or she can not only successfully explain why a seating intervention is not a restraint, but can also work to assure the rights of the individual are being met. It's good to emphasize and encourage professional seating assessment since optimal seating may reduce the need for secondary supports which can be perceived as a restraint. The decision-making process should always include consideration of the least restrictive secondary support devices that still meet the client's needs.

RESNA regularly publishes position papers and guides on various assistive technologies, and has an established and rigorous developmental review process. This process includes open meetings, presentations of drafts at the annual conference, and solicitation of comments from the field. The authors of this paper are practicing clinicians from across the country, and include representatives from Invacare; U.S. Rehab; University of Hartford (CT); Rusk Institute of Rehab Medicine; Kaiser Permanente; Mobility in Focus, LLC.; Access to Independence, Inc.; Lakeview School (NJ); North Dakota Life Skills and Transition Center; Rehabilitation Institute of Chicago; Healthquest Community Services; Community Services Group; and Kessler Institute of Rehabilitation. RESNA thanks everyone for their dedication and tireless hours of service.

(CONTINUED ON PAGE 58)

IS IT A POSITIONING SUPPORT OR...
(CONTINUED FROM PAGE 57)

Other position papers now available on the RESNA website include:

- The Application of Wheelchair Standing Devices: 2013 Current State of the Literature
- The Application of Pediatric Power
- The Application of Seat Elevating Devices
- The Application of Tilt, Recline, and Elevating Legrests for Wheelchairs
- The Application of Ultralight Manual Wheelchairs
- Wheelchairs Used as Seats in Motor Vehicles
- Wheelchair Service Provision Guide

Visit www.resna.org/resources and click on "Position Papers and Guides" in the left-hand navigational menu.

CONTACT THE AUTHOR

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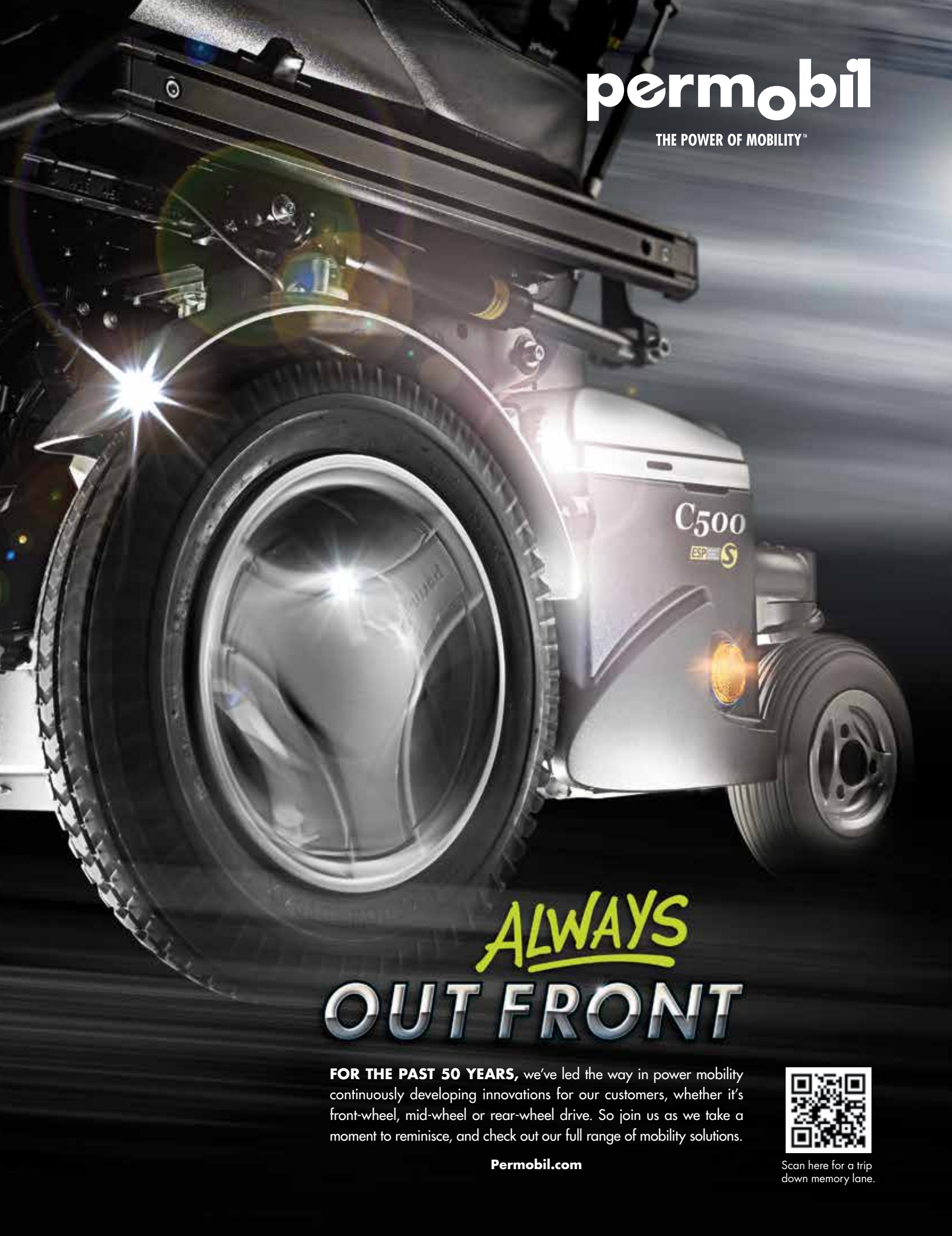
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