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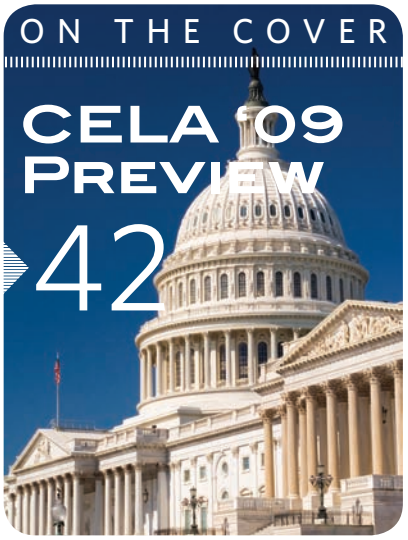

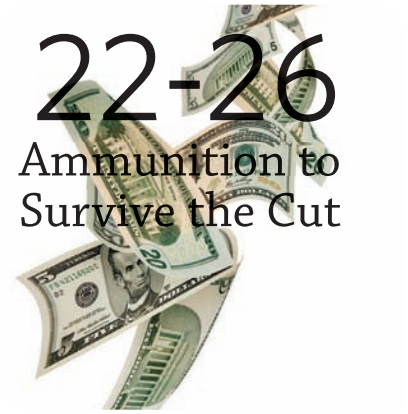

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NRRTS TELESEMINARS 2009
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[MORE INFO ON PAGE 52 & 53]

The First Georgia Rehab Technology Council

WEESIE WALKER, ATS, CRTS®
NRRTS President
BRANCH MANAGER, NATIONAL SEATING & MOBILITY

THE FIRST GEORGIA REHAB Technology Council was held in Atlanta on January 20, 2009. Chip Fiske, ATP, CRTS®, chairman of the GRTC planned the meeting in August. GAMES (Georgia Association of Medical Equipment Suppliers) created the council to give the complex rehab providers a voice. And, it came none too soon.

On January 2, 2009, Georgia Medicaid posted a new policy manual on its website. Most suppliers were blind sided by the sweeping changes put forth - and, the changes were effective January 1. The most notable change was the department's decision to eliminate the K0108 miscellaneous code. Other codes that were previously submitted by report were now assigned allowables that were under cost in many instances.

Suppliers were left with many questions and no answers. In the past, communication was open to the program specialist. Since Pat Ross' departure, no one was quite sure who to call. The GRTC formed a small committee and immediately set out to outline the issues and then present them to the Medicaid Policy Manager. After some exchange of information regarding the use of the K0108 code, DCH gave us verbal assurance they would suspend all changes in policy indefinitely, pending further investigation. They also agreed to give suppliers a 30-day notice of the changes.

This issue is far from being resolved. There are many levels of concerns for rehab providers all over the state. The agenda for the first GRTC Council meeting was "How to Survive" the funding cuts. But, more importantly, all the suppliers learned by having a unified voice would always get faster results. Each supplier was charged with getting the information needed to educate the new personnel at Medicaid on what Complex Rehab is and what services it requires. With help from NCART, Rita Hostak, Cara Bachenheimer and Simon Margolis to name a few, the Council can effectively mount a campaign to bring the necessary codes and allowables.

If anyone ever doubted the benefit of being part of a professional group, there is certainly no argument now. Georgia Medicaid cannot/will not deal with 30 different rehab providers making 30 different calls, sending 30 different emails and asking 30 different questions. By developing lists of issues, GRTC has gotten the attention of the policy makers. They know we want to be part of the solution.

This is same principal with NRRTS. The professional RTS only has NRRTS to represent us in the wild world of funding. No single RTS or company can put forth the time and effort to educate legislatures on the issues we are facing. NRRTS is doing on a national level what GRTC will do for Georgia suppliers.

Have you ever played a game called "Limbo?" The object of the game is to go under a bar while contorting your body in a backward bend. If you make through, guess what?

The bar goes lower and lower until you fall on your rear end.

Doesn't this sound familiar? No more Limbo for me!

I mentioned earlier Pat Ross is no longer with Georgia Medicaid. We will surely miss her. I think it is important to recognize she was the first program director to recognize NRRTS as a quality standard for rehab suppliers. She was our advocate. D

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HIPAA and E-mail: An RTS's Perspective

JIM NOLAND ATP, CRTS®
NRRTS Treasurer
PRESQUE ISLE REHABILITATION TECHNOLOGIES L.L.C.

THESE DAYS, SENDING E-MAIL is much like sending a postcard; anyone who comes into contact with it can see its contents. Unlike a postcard, however, when you send e-mail, you can accidentally hit a wrong button and send it to the wrong person—or to everyone!

HIPAA compliance used to mean making sure you didn't share a patient's name in the wrong place or that you sent a fax to the correct machine. Now the professional RTS practice accesses a great deal of electronic protected health information (EPHI) every day through various sources: desktop computers, laptops, PDAs, servers and data backup solutions—all present a risk for leaking EPHI.

These days, sending email is much like sending a postcard; anyone who comes into contact with it can see its contents.

The Department of Health and Humans Services requires that covered entities (that's us) be extremely cautious about controlling access to EPHI, which is at risk generally in three areas: access, storage and transmission. "Access" includes passwords, permissions and the live control of data, while "storage" covers the backup of data and its physical security. These two areas are best managed by starting with a proper assessment of your company's specific level of risk. Then, you can apply policies and strategies that mitigate those risks. I strongly encourage you to seek out sources to help you assess your risk in these areas.

Now onto "transmission." As an owner of a small RTS practice, what I needed was clarification on what could and couldn't be transmitted via e-mail. How did I need to protect my clients' EPHI? What information could I include when I sent e-mail specification sheets or client information to clinicians? Was encryption necessary, and if so, how should I communicate with my therapists and clients who were not on the same system?

I had some referral sources that allowed only initials when using e-mail for transmitting EPHI. Those same referral sources allowed the transmission of uncensored patient photos as long as there was no name attached to them. Other referral sources had no HIPAA compliance policies for e-mail. So, I was left to decide for myself what I could and couldn't send via e-mail. All of this did nothing to help me determine what was appropriate for my business.

In assessing my practice's risks, we determined we use e-mail for scheduling, client follow-up, status reports, equipment-trial updates, etc. We also use two web-based tools: one for client management (www.lmnbuilder.com) and the other for billing (www.brightree.com). These two tools are password protected via secure websites, so there was little concern there. E-mail transmission was the primary area where we were exposed, and we determined the use of our remote-access laptops and PDAs was a transmission risk area as well, even though they were password protected.

What follows is some of what we found helpful in addressing our risks. Every company is different and each must make its own assessment and plan. I'm sharing some of what we learned to give you a perspective on the basics of what can be accomplished.

Our e-mail security needed to be addressed in three general areas: internal e-mail messages (RTS to RTS support personnel), RTS-to-clinician e-mail messages and RTS-to-client e-mail messages. Each of the three posed a distinct risk and required us to implement some basic rules to reduce those risks.

When sending e-mail that concerns a client we type "EPHI" in the subject line, and we always use a disclaimer at the end of each message with the signature function in our e-mail program. We attempt to scrub all patient-identifying

...continued on page 8

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CONTINUED FROM PAGE 6

HIPPA and Email: an RTS's Perspective

information from the message, choosing to use initials only. The "initials only" policy increases our confidence that we will consistently meet the rigorous HIPAA standards even with the use of e-mail–capable PDAs and remote-access laptops. Additionally, we use the blind carbon copy (BCC) address line when sending messages to multiple recipients, and we double-check all addresses before hitting the send button.

For our practice, sending photos in a separate e-mail message is an acceptable solution to mitigate risk of the inappropriate sharing of sensitive client data. Photos have the client's face covered or omitted when it's possible to convey the clinical importance of the picture without it. For us, there is no perfect way to completely eliminate exposure from photos.

E-mail doesn't replace our patient notes, so if client details are discussed in an e-mail, our staff is required to copy/paste the information into Brightree's section for patient notes. At the very least, e-mail containing direct client communication or specific activity relevant to client care or outcomes are put into the client file. You may choose, like we do, to move e-mail with this type of information into the regular document stream to ensure that appropriate records are retained. Otherwise, these e-mails may have to be retained for the same period as all other hard-copy records. That is one hassle we chose to avoid.

E-mail sent internally is part of our practice's efficiency and success. Reducing the risk during these transmissions is essential to successfully protecting our clients' EPHI. We chose a balanced approach to minimize patient-identifiable data in e-mails. These messages reflect what is already in the patient notes and often refer the recipient to notes contained in client files (ours are electronic) for greater detail rather than repeating that information in the message.

We use our own e-mail client on a secure server. We don't allow staff to use web-based e-mail applications like Yahoo!, Hotmail or Gmail for communicating EPHI because there is no way for us to apply what we feel is an effective security layer to their use.

The next area we addressed was e-mail messages sent to clinicians. The bulk of these messages are related to specification sheets and LMN follow-ups. This is now done via a secure web tool, www.lmnbuilder.com. We even chose the "no last name" option so no EPHI is ever transmitted with our specification sheets. (You can tell an application is secure because it will have the letters "https" at the beginning of the Web address and a lock symbol at the end of the address bar in your Internet application.)

The other types of messages were still an issue. E-mail encryption works well for some situations, but it didn't work for us. We send e-mail to so many different types of accounts and users that no one encryption policy would work. So we decided the strategy of scrubbing the messages for EPHI and using initials only was sufficient to achieve our goal. If there is a questionable situation, the RTS support staff is to pick up the phone and document the call in the client record.

We determined we correspond via e-mail with less than 1 percent of our client base. We don't want RTS-to-client e-mail to replace direct contact with our clients; we want it to augment or facilitate client communications. Even with this small amount of client-to-RTS e-mail, we developed a strategy.

E-mail works well for some clients when arranging appointments and following up. If any clinical issues arise via e-mail (i.e., reddening areas of the skin, or fit and function problems), a phone call is initiated by the RTS support staff upon receiving the e-mail. Most e-mail generates a phone call and an e-mail reply. A phone call addresses the client's issue usually just as quickly as e-mail, and the extra effort we put out for our clients increases the likelihood of their return business and word-of-mouth business growth.

There are some general guidelines we have found helpful when using client-to-RTS e-mail. E-mail sent to a client's work address may give the employer the right to review the content of those messages, so we request clients provide us with personal e-mail addresses. And, client e-mail addresses are never to be used for marketing purposes.

If an e-mail we're writing gets lengthy or prolonged, making a phone call is usually a better option for us. If there's an e-mail complaint or a contentious issue reported via e-mail, a phone call is made or a RTS visit is scheduled so our response is conveyed appropriately. Returning a heated e-mail is easily misinterpreted. My former boss, Sandy Campos at Sunrise Medical, taught me a long time ago that a call or visit to an angry customer is usually is the quickest path to resolution.

If client e-mail is a regular part of your practice, then it is strongly recommended you have an e-mail communications agreement with your clients. The agreement should outline the limitations and scope of your e-mail practices. This document should be collected during the client intake or at initiation of services.

HIPAA standards require us to implement and mandate strong strategies for protecting EPHI. Everyone has to look at their business practices, assess their risks and formulate their own strategies and policies to manage their EPHI. *My situation is unique and should not be used as a model for what you should or shouldn't do for your own practice.* Use our experience to gain some perspective on the basics of what can be accomplished. Seek professional help if you are unsure of where to start.

For our business, the simplest and most affordable way to manage client EPHI is to minimize its use. Consider scrubbing all EPHI out of your transmitted messages and make it easier for you to comply from the start. Using a secure Web-based tool to send specification sheets and collect LMNs will reduce your risk as well.

Congress makes the rules and leaves it to us to interpret how to comply. We can always choose the most cost efficient and effective way to address those demands. Our industry has a great capacity to adapt and overcome. Remember, keep it simple and keep the faith! D

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Innovate or Perish

MARK SULLIVAN
Vice President, Rehab Category
INVACARE

THE REHAB WORLD LIKES to view itself as unique and believes if only others knew what we actually did and how great we are, our lives would be better and we would be paid what we deserve. In reality every industry has its unique characteristics, and ultimately, someone outside of the industry's participants sets the value for its products and services. This is what consumers and payers do in every industry regardless if it's medical, consumer goods, hot dogs or services. Consumers determine the worth.

Consumers determine the worth.

Most of us were taught the concept of the bell curve, where at the beginning of the curve the industry is immature, the volumes are low, the prices are high and services are plentiful and free. I believe our industry is now near or at the top of the bell curve, and the industry is maturing as exhibited by accreditation, CRTS® and ATP designations, consumer and payer awareness, and larger companies entering the field.

The larger volumes and costs have caught the attention of people who pay the bills, and now we start down the other side of the curve with higher volumes, lower prices, more informed consumers, reduced services and only the strong surviving.

So what does this have to do with innovation? Our industry cannot cost-reduce its way to profitability, and despite our protestations, the payers continue to cut. It will require innovation in product, innovation in training and education, innovation in services and innovation in billing to survive.

Those who have invested in improved systems like document imaging are already well ahead, but ultimately even more will be required. The scary part of this is innovation often comes from outside of a particular industry, and those within the industries who resist change or spend time complaining and not acting, will perish. (Remember Computerland? Remember having to go to Blockbuster to rent videos?)

Look at the services we offer as an industry: making home visits, providing loaners and free accessories to those who can't afford them, taking a $50 trip to fix flat tires—and the list goes on. Have your clients try getting their physicians to come out for home visits, try having them skip out on their hospital co-pays or have them ask their therapists to give them two hours of free therapy .

Why do we do it (besides the fact we are really nice people)? Because we were at the start of the bell curve where reimbursement was lucrative enough to absorb the services and "freebies," and because there were so many providers it became a marketing advantage to offer more home delivery and other service perks.

Most manufacturers have already had to reinvent themselves. They've been forced to lay off good employees as manufacturing is outsourced overseas, sales forces have been reduced and non-profitable businesses or products have been sold off or discontinued.

In manufacturing we measure productivity on a monthly basis by equivalent units, sales per employee and purchased product variances (PPV). We scrub every nook and cranny of the company to look for savings. Are you doing the same?

So what do we do? I suggest you adopt your own "10 steps to recovery and innovation," just as any addicted group of people would do. Following are some suggestions.

Step 1: Admit we have a problem and that some of the problem is of our own making.

Step 2: Do not blame others. Do you belong to one or more of the following: NRRTS, NCART or State Association? Do you participate?

Step 3: Make a commitment to fight. Talk to your referral sources; talk to your state Medicaid office; talk to your consumers. Educate them on the challenges and enlist

...continued on page 12

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CONTINUED FROM PAGE 10

their help. Be an advocate for your profession and insist your payers become educated about what you have to offer.

Step 4: Make a commitment to change. Change your process. Ask yourself: "Can I develop a more efficient schedule? Can I be more organized? What would I do if I were new to this industry?"

Step 5: Benchmark by studying successful companies. What do other companies inside and outside the industry do differently? Don't let your ego get in the way.

Step 6: Retool yourself. Consider questions like, "Am I complacent? Do I need to become a better marketer or sales person, or be better at anatomy? Do I understand the coding as well as I should? Am I in the top 20 percent of my profession or the bottom 20 percent?"

Step 7: Demand payment for the services you offer. Rehab has a mission to provide mobility for people with disabilities. Without money to fuel the industry, there is no mission to uphold.

Step 8: Differentiate yourself. Don't buy into the philosophy of "I have to provide a cheaper product or cut services." If you do, you'll become a "me too" company.

Step 9: Face the facts. Not all companies are going to survive, so ask yourself, "Am I going to make things happen or watch things happen and be one of those who perishes?"

Step 10: Innovate. Spend time mapping out your processes through every step of the way. Set a goal of 20 percent improvement in everything you do. Create a team between your company, your referral source, your payer and your manufacturer, and look at the entire supply chain from need to delivery.

We all hope we're successful in our efforts to get back the 9.5 percent cut that threatens our industry, but don't wait to retool yourself. Adopt the philosophy of continuous improvement now. D

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A Paralympian's Story

MATT UPDIKE

I WAS JUST YOUR average all-American boy from a small town outside Syracuse, N.Y. I'd moved out west to play in the mountains before getting serious about life. Everything abruptly changed in September of 1997, when a car accident left me paralyzed. While obviously very tragic, the accident also led to some amazing experiences that I'd never take back.

Many of these experiences can be credited to my accomplishments in handcycling, the sport I started competing in just a few years after the accident. I made the U.S. Paralympic Cycling Team, which has taken me all over the world, most recently to the 2008 Beijing Paralympic Games.

While obviously very tragic, the accident also led to some amazing experiences I'd never take back.

I was an avid skier and cyclist before the accident and have been able to remain so. Initially, I was clueless about the sports and recreational opportunities that were open to wheelchair users. A fantastic recreational therapy department at Craig Hospital in Denver, Colo., opened my eyes to all the possibilities. It was shortly after leaving Craig that I got my first handcycle, completed the grueling Ride the Rockies bike tour and realized I'd found my sport.

I began racing handcycles in 2000, moving from the back of the pack to a national title in 2002. The accomplishment landed me a spot on the U.S. Paralympic Cycling Team and Team Invacare, home to some of the best wheelchair athletes in the world. With Invacare, I've taken part in the evolution of handcycle design and innovation, something I thoroughly enjoy.

I've also worked with Aspen Seating/Ride Designs in Denver, designing and building custom seating systems for handcycles. The seating principles, designs and materials used by Aspen Seating/Ride Designs not only work well in my wheelchair, but are instrumental in helping me maintain my competitive edge via sports equipment, such as my monoski and handcycle.

Being on Team Invacare and the U.S. Paralympic Cycling Team, I've raced all over the world. The team has taken me from Australia to Alaska, from Cuba to Beijing and from London—at an event combined with the Tour de France—to the Netherlands and a successful attempt to achieve a world record for riding the longest distance ever in 24 hours. So not only has racing a handcycle been something I've excelled at, but it has been my ticket to see the globe, meet great people and make some good friends.

One opportunity that had eluded me until this year was the Paralympic Games. Having just missed making the U.S. team for the 2004 Games in Athens, I was determined to make it to Beijing. I knew it wasn't going to be easy. Relatively poor performances by the U.S. Paralympic Cycling Team from International Paralympic Committee (IPC)-sanctioned events in Athens (and through more recent opportunities) left us with few points, and thus, few spots for the men's team for China. We ended up with six spots, and I secured one of them. I'd made it and was on my way to Beijing!

I'd been to a couple of world championships since 2002 with the U.S. Paralympics Cycling Team, but it was nothing compared to the Paralympics in China, a country determined to shock the world with the most spectacular games ever held. While I'm sure they didn't spend close to the reported $400 million on the Paralympic Opening Ceremonies like they did on the Olympic ones, they definitely were out to impress. We marched into the Birds Nest Stadium on Sept. 6 to a sold-out crowd of more than 90,000 Chinese and foreign spectators. It was one of the most surreal experiences of my life, and one I'll never forget.

I was very impressed with the accommodations and the Paralympic

Village. The enormous new condo complex built to house all the athletes was much nicer than I expected, as were all the amenities. It really was a little village supplied with everything one would need to live. The dining hall was massive and contained just about any type of food you would want, even a McDonalds where, I'll admit, I caved and downed a Big Mac.

The race venue for the Paralympic road cycling events was several miles outside Beijing at the Ming Tomb Reservoir, near the mountains and sections of The Great Wall. I was to compete in two events. First, the time trial: a short 12 km., one-loop race against the clock—a brutal all-out effort for the entire distance. Then I had the road race, a much longer 4-lap mass-start race. My focus was on the time trial, as it had always been my stronger of the two events.

After several days of living in the village, taking trips out to the course for training and getting lots of rest to adjust to the time change and jet lag, we finally got to our first race, the time trial. It had been almost twelve days since we'd arrived in Beijing, and while other athletes/sports were in the full swing of competition, this was our first event. I was eager to get going. It was a great day, and I was feeling good. I felt I had a decent chance for a top-five finish, maybe even a medal. As it turned out, I never got the chance to find out.

Unbeknownst to me, when fitting my bike onto a stationary trainer for a warm-up, my quick release had been reversed, causing the lever to block my derailleur from shifting through all the gears. I didn't notice anything was wrong during my warm-up, as I was only using a few of the easier gears, so I started the race without correcting the problem.

I realized something was up soon into the race. After leaving the start ramp, I quickly picked up speed so I was shifting into harder and harder gears when, on my third shift, nothing happened. I tried again, and nothing. I yanked on the shift cable thinking it was stuck, but again, nothing.

Every crushing emotion hit me: anger, sadness, embarrassment .... I wanted to stop, but didn't. I knew, with limited gears, there was no way I had any shot of getting that medal, let alone a top-five finish, but I carried on. I finished the race. It wasn't until after the race—which I had just done in three gears—that I got back to our team tent, explained the problem and noticed what was wrong.

It's a difficult thing to get over—training for four years for one day, and having it blow up in my face, but nothing could be done to reverse the misfortune. All I could do was focus on the road race. Even though it wasn't my strongest event, I would give it my best shot.

Two days later I was out there! I hung in with the lead group for the first two laps of a four-lap, 36-mile race, but on the third time up one brutal hill, I dropped off the lead group just enough to lose them. It was an honest race, no excuses, and I ended up 10th.

Honestly, I love biking, but it was time to relax, have fun, do some sightseeing and attend some of the other events to cheer on my fellow U.S. team members. An obvious stop was The Great Wall and it truly was great. The Chinese had actually taken a section of the wall and made it reasonably accessible by adding ramps and an elevator so someone in a chair could actually get up on the wall!

The Chinese people were amazing fans. Whenever we were out of the village, whether sightseeing at the wall or just touring around Beijing, the Chinese were genuinely excited to see us, get autographs and take pictures with anyone who looked like they might be a Paralympian. I guess I can honestly say, as can all the other athletes that competed in Beijing, I am big in China. D

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THE PAST TWO YEARS have certainly provided no lack of ups and downs, challenges or changes for our industry. After the first NCART fly-in I thought that, despite our unified effort and sincere attempt to educate legislators, they really didn't understand what we do day in and day out. It felt like we were never going to get Capitol Hill to see the difference our industry makes in the daily lives of the people we serve, or the harm that misguided legislation could cause.

Then, little by little, we became more united and our voices got louder and stronger. As I left CELA 2008, I thought we just might have made a huge difference. More importantly, I think we all felt a tremendous sense of hope within the community. We had persevered. We had listened, learned and gained the valuable experience we needed to be stronger and better at overcoming the challenge at hand.

We all have a clear obligation to reassess the situation, plan our strategy and prepare to continue advancing our industry.

Now, as the new reimbursement environment provides a new challenge, we all have a clear obligation to reassess the situation, plan our strategy and prepare to continue advancing our industry. Providers must operate with a new level of efficiency while delivering a higher level of patient care. Clinicians need to make informed decisions about the quality, functionality and economic viability of products they select to best serve the patient.

Manufacturers need to raise their bar, too. The 9.5 percent reimbursement reduction makes it essential that manufacturers continue to produce the highest-quality solutions while finding any possible cost reduction. In addition, there are some important value-added services providers must demand from manufacturers:

Product and Accessory Innovation

Delivering high-quality solutions in an economically efficient manner should be a cornerstone in every manufacturer's operation. As reimbursement is reduced, delivering exceptional products that make sense economically becomes even more important. Products should be designed and built with providers and their clients' maximum satisfaction in mind.

Repeated service calls to repair lower-quality products under warranty can quickly escalate providers' back-end costs, damage consumer confidence and eliminate any savings from the initial purchase. Now more than ever, long-term cost reduction is essential. Lesser quality products may offer up-front savings, but products that deliver quality and reliability from the very beginning provide value throughout the life of the product.

With allowable reimbursements down in Group 3 Single & Multiple Power, there just isn't room to supply products that aren't both economically sound and right for the patient.

Strong and Focused Dedication to Government Affairs

Together we must continue to deliver the unified message of NCART and all complex-rehab stakeholders. Lawmakers must be shown the intensive patient-centric service that makes complex rehab exempt from competitive bidding should also make it exempt from the 9.5 percent reimbursement reduction.

Manufacturers should be entrenched in support of this necessary reform that is strongly supported by consumer groups. In addition, manufacturers, providers and other stakeholders should utilize our relationships to influence other organizations to further strengthen the voice of the complex-rehab industry.

Commitment to Education

Manufacturers should be fully committed to giving providers and rehab professionals multiple avenues for keeping them updated on the latest reimbursement information, product innovations and the state of affairs in Washington. This will help everyone involved ensure that patients' needs are best being met.

With everyone's budgets tighter than ever, manufacturers should be delivering a variety of educational outlets for reimbursement, technical

...continued on page 18

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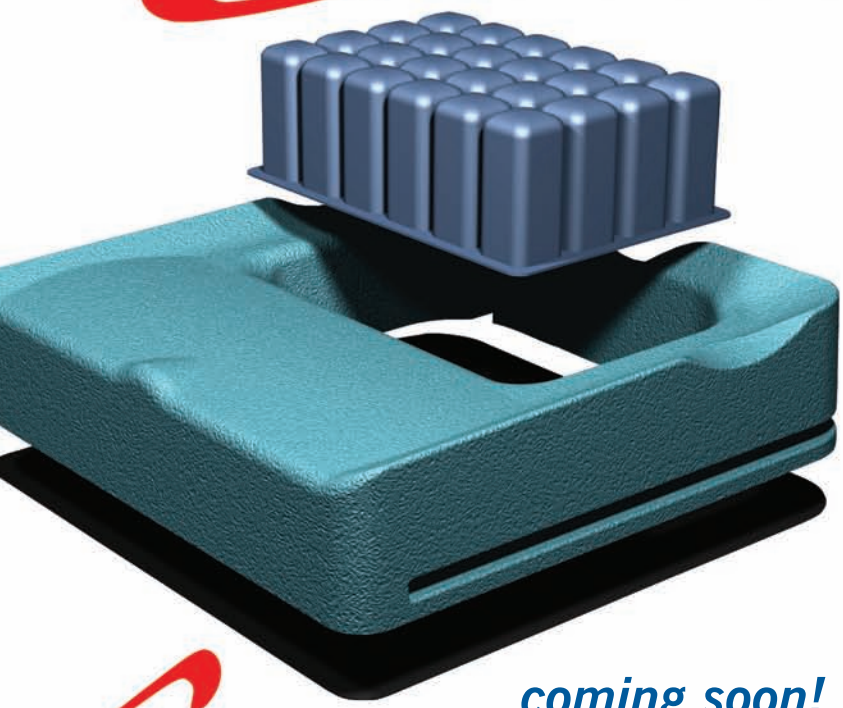

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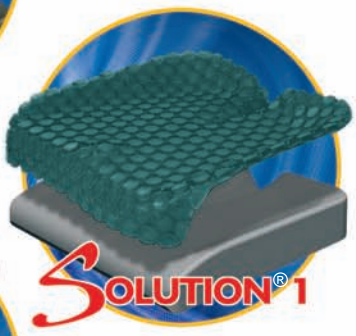

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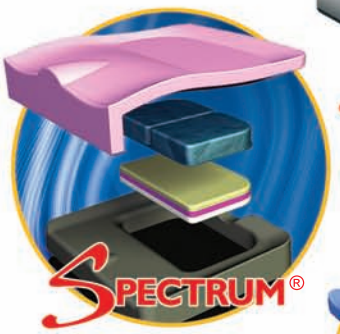

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CONTINUED FROM PAGE 16

and CEU curriculum. Educational forums should be held regionally to minimize travel expenses to the attendees, and they should not be limited to invite-only events. Online resources should be used to maximize information exchange. Attendance at major industry trade shows and displaying the latest product offerings in booths are also essential.

Defined and Enforced Provider Standards

Credentialing, which was recognized by CMS in medical policy, was the first national funding source reform of its kind and created the foundation for true advancement of the profession. There's been much banter about the ATS/ATP credential awarded by RESNA, but it's clearly a step in the right direction. The consolidation of ATP by RESNA again set the stage for advancement and further refinement for the profession of seating and wheeled mobility. The manufacturers you support should have written standards that align with this positive change in our industry.

Improved Representation

For some manufacturers, representation and on-site support is a lost art. Either through too much product diversity or too much regional coverage, it seems for many there's a deficiency in this area. For manufacturers of complex-rehab equipment, there should be quality local support in place. While it's one of the more difficult things to do, it's essential to have experts in the field to support your complex-rehab equipment requirements.

Willingness to Put Patients First

Most importantly, we must remember the reason we're in this industry. Despite the challenges we all face, manufacturers must always put the needs of the patient first and foremost, and we all must be sure that every one of our actions is guided by doing right by the people who are counting on us.

The business of complex rehab is a partnership in which providers should expect more from their manufacturers. Strength and trust that's built on a mutually beneficial business relationship, in which both parties not only listen to, but also hear one another, is vital.

I encourage each of you to remain positive and not subscribe to the doom and gloom; Instead improvise, adapt and overcome. No matter what your roles in this industry, each of us has an obligation to make intelligent decisions, meet our challenges and continue to strive for excellence. D

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About Me

MICHELLE JACKSON-MCMAHAN, ATP, CRTS®
NRRTS Review Chair for Region C
FOUNDER OF FRONTIER ACCESS AND MOBILITY SYSTEMS

ABOUT TWELVE YEARS AGO, when I was running a small orthotics and prosthetics shop in Cheyenne, Wyo., I was approached about expanding my business to include lift installations for local patients of the U.S. Department of Veterans Affairs, as well as capabilities to sell and service scooters.

I have a voice through NRRTS, and I've found that strength is definitely gained in numbers.

I was the community's only HME provider at the time, so local physicians were contacting me on behalf of their patients as well. Though I shared office space with four orthopedic physicians and was unsure of how I'd house an expanding product inventory, I wanted to help service the members of my community and also take the opportunity to grow my business.

It wasn't long before my new inventory started taking over the entire office space, so in March 2006, I went out on my own and founded Frontier Access and Mobility Systems.

Because I was already helping patients with orthotics and prosthetics—which included providing some chairs, walkers and canes—adding more inventory and expanding my services was a natural step. I decided I wanted to become a one-stop shop in the industry.

I'd always told myself if I started a business, I would carry what my customers wanted. I didn't ever want to hear them say they were going to go see what was available in Ft. Collins (a larger nearby city); I wanted my business to be the one and only resource for them and take care of their every need.

With this attitude, my business grew quickly within its first year, and it was once again time to move into a larger space to accommodate my customers and the products they needed. Now, people from Ft. Collins come to my store.

My whole staff cares about what we're doing for the community, and we make it a priority to show our customers the benefits and features of several items before they make their decisions. After all, these are their decisions, and we want them to be happy with the final outcomes.

Whether it's helping a customer find the correct bus route to our store, getting a product to a homebound individual for an in-home evaluation or just being a caring listener, we excel at going the extra mile, which as built us a reputation that's served Frontier well.

Being a part of NRRTS has also helped my business. As a board member, I'm the first to know about issues in the industry and what steps are being taken to overcome our continuous barrage of challenges. I have a voice through NRRTS, and I've found that strength is definitely gained in numbers.

Running Frontier while also serving on the NRRTS board means a lot of hard work and many long hours, but I consider it a gift to be able to help people with serious life challenges and changes. Being able to work in this industry is the best thing that's ever happened to me. D

ABOUT THE AUTHOR
Michelle may be reached at 307.637.7663 x.304 or michelle@frontieraccess.com.

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Ammunition to Survive the 9.5% cut

Executive Summary of *Rehab Provider Survey*

In July, 2008 Congress passed the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). One of the provisions of this legislation reduces the fee schedule for complex rehab products by 9.5 percent effective January 1, 2009.

To assess the impact of this reduction on the companies that provide complex rehab products, a national survey was conducted in September, 2008. The survey consisted of 15 questions and was completed on-line. Responses were received from 184 companies with over 550 locations across the United States.

The survey results indicate that the consequences of this reduction are far-reaching. 77 percent of the companies reported the cut will impact 20 percent or more of their revenue. 51 percent reported that the cut will impact 40 percent or more of their revenue.

The following summarizes rehab provider responses regarding changes they will be making relating to the products and services they provide:

Medicare 9.5 Percent Reduction Causes Significant Changes

	Reduce	Eliminate	Combine
1 Ability to do off-site assessments and evaluations	77%	10%	87%
2 Ability to provide demonstration and trial equipment	74%	14%	88%
3 Ability to work with clinicians and participate in clinic based assessments	54%	7%	61%
4 Ability to offer a variety of product choices	78%	17%	95%
5 Amount of time spent training and educating customers	60%	3%	63%
6 Timeliness and frequency of deliveries	76%	2%	78%
7 Range of products you currently repair and service	81%	85%	86%
8 Ability to do repairs and service at the customer's home	57%	345	915
9 Provision of loaner equipment at the time of repair	49%	36%	85%
10 Provision of clinician educational programs	47%	21%	68%

Copies of the study and the executive summary are available by contacting Sharon Hildebrandt, Executive Director, National Coalition for Assistive and Rehab Technology, at 202.776.0652 or sharonh@ncart.us.

Complex Rehab services and product choice threatened by 9.5% cut

Reprint of a September 29, 2008 NCART Press Release

Washington, DC - Providers of complex rehab technology may be forced to reduce services and limit product choice in response to a reduction in reimbursement, according to a survey spearheaded by the National Coalition for Assistive and Rehab Technology (NCART). The reimbursement reduction, totaling 9.5 percent for complex power wheelchairs and related accessories, was enacted as part of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). The survey, to which 184 complex rehab companies responded with locations in nearly every state, was conducted in September 2008.

In the comment section of the survey, many respondents expressed concern that product quality could be compromised by the reimbursement cut. Compromised product quality would result in greater need for service and repair, at a time in which the companies would be reducing their service/repair services or requiring that servicing be performed only on-site. Some respondents pointed out that many of the services they provide, such as demonstration equipment, are not reimbursed by third-party payers, so those services would be eliminated first, making it more difficult to fit the product to the individual. And some

Compromised product quality would result in *greater need for service and repair,* at a time in which the companies would be reducing their service/repair services or requiring that servicing be performed only on-site.

The survey results indicate that the consequences of this reduction are far-reaching. 77 percent of the companies reported that the reimbursement cut will impact 20 percent or more of their revenue, while 51 percent reported that the cut will impact 40 percent or more of their revenue. Profitability will also be impacted with 66 percent indicating their profitability will be decreased by up to 20 percent.

The impact on revenue and profitability will be reflected in both the services provided by complex rehab companies and product choice available to people with disabilities. 87 percent of the respondents indicated the reduction would affect their ability to do off-site assessments and evaluations, either reducing this service or eliminating it altogether. Providing demonstration and trial equipment would be reduced or eliminated by 88 percent. The ability to offer a variety of product choices, necessary to address the unique needs of individuals with disabilities, would be reduced or eliminated by 95 percent of the respondents. Service and repair would also be affected, with 91 percent indicating their ability to perform repairs and servicing at the customer's home would be impacted.

will reduce staff and close offices, which would especially impact small towns and rural areas. "These reported implications of the 9.5 percent reduction are not surprising" said Gary Gilberti, president of NCART and CEO of Chesapeake Rehab Equipment in Baltimore, MD, "although the impact is more pronounced than I had anticipated. Unless Congress is able to rescind the 9.5 percent cut to complex rehab products, providers will unfortunately have to make these changes to stay in business and continue serving their customers as best they can."

"It's unfortunate that these cuts will impact people with the most severe disabilities. However, these results are an important step in educating policymakers about the impact of reimbursement change enacted in the MIPPA," said Sharon Hildebrandt, executive director of NCART. "We plan on monitoring complex rehab services and product choices when the cut begins in January so that we can reliably report on the implications of the 9.5 percent reduction and seek necessary changes." D

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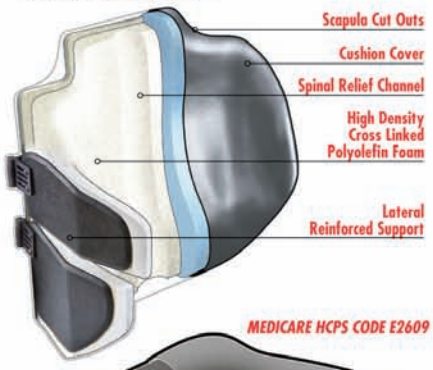

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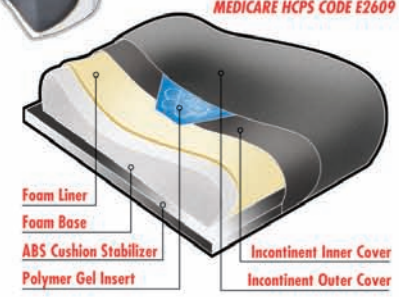

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Simon Business School Study says

The Simon Business School, University of Rochester was commissioned by NCART to analyze the business & operating performance of the industry comprising of complex rehab equipment suppliers (referred to as the "complex rehab industry"). The analysis was based on the quantitative analysis of the financial information which was shared by these suppliers in response to an email survey questionnaire. The survey was made available to the industry in the month of May 2008; and responses were obtained throughout the months of May & June in the same year. The response rate for the survey was 20%; which is considered fairly high taking into account the settings of the survey. The survey responses were clearly indicative of the highly diverse nature of the complex rehab industry. The companies that participated in the survey were from all across the United States; representing the states of New York, New Jersey, Wyoming, Ohio, North Carolina, Connecticut, Virginia, Idaho, California, Minnesota, Michigan, Florida & Texas to name a few.

The participants were companies with annual revenue varying from a compact $250,000 to an expanding $21,000,000. To enable the understanding of the business of the complex rehab industry in a more concrete, analytical & justifiable manner; the companies belonging to the industry have been divided into three (3) major groups:

Small Companies: Annual revenue - less than $5 Million (representing 53% of the industry)

Medium Companies: Annual revenue - $5 Million to $10 Million (representing 42% of the industry)

Large Companies: Annual revenue - more than $10 Million (representing 5% of the industry)

Valuable Observations

The above analysis clearly shows the high amount of expenses & costs associated with the complex rehab industry. Observing the common size income statement values derived from the average of the financials for 2007 for the various companies; we can clearly see that cost of sales & operating expenses are a significantly high percentage of the total revenue for each sector.

It is clearly observed that all the sectors have almost their entire "annual revenue" being consumed in paying for the "cost of sales" & "operating expenses." This leaves an almost "negligibly small revenue" left as the "net income" for a company once the income taxes, interest expenses & other expenses are taken into account. Hence, the reason for the low profitability of the complex rehab industry is clearly explained here.

This expense/revenue model is synonymous to the "airline industry" where the profitability is kept extremely low on account of the high costs & expenses involved in operating an airline company (fleets, pilots, stewards, staff, logistics & fuel).

However, there is no such erratic expense (like fuel) involved in operating a typical complex rehab company. There is a clear need for measures to help balance the expense/revenue equation in case of the complex rehab industry to improve the profitability of the companies belonging to the industry. Under such a low profitability it is extremely hard to forecast the future financial performance of the industry; because the threat of more & more firms exiting the industry becomes stronger as profitability goes lower.

Complex rehab industry: next to negligible pretax profits - what is driving it then?

Observing the pretax profits expressed as a percentage of revenue (common size profits) for all the three sectors:

No surprise here

"Complex Rehab is a High Expense Industry"

"Small" – 3.44%
"Medium" – 6.87%
"Large" – 4.83%

We can clearly observe that all the sectors in the complex rehab industry are experiencing extremely low pretax profits. The net profit (net income) can be considered next to negligible once the effects of income taxes & other tax/interest related expenses are taken into consideration in computing them from the pretax figures shown in our analysis/survey. These results are shocking since it is hard to imagine what drives these companies under such low levels of profitability?

Further, even from a macroeconomic standpoint – this is not a healthy environment since most of the small to large companies in this industry are sources of employment, services & revenue to the nation. Also, this is a cause driven industry which serves the needs of thousands of disabled people in the need of rehabilitation. An industry like this being struck by a financial crisis could further have detrimental microeconomic & macroeconomic effects as a whole. D

The entire Simon Business School study is available at www.nrrts.org under the Current Issues tab.

Should a Supplier Hire an Employee or an Independent Contractor?

DENISE M. FLETCHER
Attorney
BROWN & FORTUNATO, PC

SHOULD YOU HIRE AN employee or an independent contractor? This isn't always an easy decision, because there are advantages and disadvantages to both arrangements. An employer usually must withhold federal income taxes, withhold and pay social security and Medicare taxes, and pay unemployment tax on wages paid to an employee. On the other side, an employer generally doesn't have to withhold or pay taxes on payments to independent contractors.

Hiring an independent contractor generally isn't advisable.

In the home medical equipment (HME) industry, the government has some unique rules that a company must consider before making the decision to hire an independent contractor rather than an employee. The most common positions companies prefer independent contractor for are sales related. Marketing representatives in other industries are often independent contractors paid a commission based on their sales. Paying these individuals on a commission usually works to keep them motivated.

However, hiring an independent contractor generally isn't advisable for an HME supplier, and doing so may be viewed as a violation of the federal anti-kickback statute. The federal anti-kickback statute prevents a person or entity from paying any remuneration for arranging the referral of patients to a health-care provider for services covered by a federally funded program. The job of a marketing representative is to do exactly that.

Therefore, in order to avoid a potential violation of the anti-kickback statute, marketing representatives should be paid in a manner that allows their relationships safe harbor to the anti-kickback statute. Two safe harbors immediately come to mind.

The first safe harbor requires that any compensation from an arrangement be set in advance for a year and that it not take into account the volume or value of any referrals generated by the marketing representative. Because marketing representatives are accustomed to being paid on a commission basis, use of this safe harbor is limited in the HME industry.

The other safe harbor that comes to mind is the employee/employer safe harbor. Under this safe harbor, a company can pay a bona fide employee for marketing activities even if this payment includes bonus and commission payments. This is due to the nature of the relationship and the fact that an employer is responsible for the activities of its employees. If the employee is doing something illegal, the employer will be responsible and could be liable to the government for any wrongdoing. A company can pay an employee a straight commission if it would like; however, it's recommended that the employee be given a set salary with bonuses based on a number of factors other than volume of referrals generated.

In addition to marketing representatives, HME companies often want to hire clinical individuals on an independent contractor basis. This can be particularly important when the supplier doesn't have enough patients to warrant the full-time employment of a clinician. However, the Centers for Medicare and Medicaid Services (CMS) interprets 1834 (j) (1) of the Social Security Act to mean the supplier receiving payment from Medicare must be the entity furnishing and billing for the items or services. Specifically, a supplier may not contract with other entities to provide essential services.

Therefore, suppliers must have individuals on staff (W-2 employees) to support the specialties, products and services provided. For example, a supplier billing for custom-fabricated orthotics and prosthetics must have a qualified individual to do so on staff. The supplier may not

...continued from page 30

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CONTINUED FROM PAGE 28

Should A Supplier Hire an Employee or an Independent Contractor?

contract for these services. The NSC has become stricter on this issue in the past several years and has required proof that essential services are provided by W-2 employees.

In addition, Medicare's Supplier Standard Number One states a supplier must operate its business and furnish Medicare-covered items in compliance with all applicable federal and state licensure and regulatory requirements.

The purpose of this standard is to ensure that suppliers obtain and maintain the necessary state licenses required to furnish the services provided to Medicare beneficiaries. If a state requires a specific license to furnish certain services, it's the NSC's opinion that a supplier cannot contract with an individual or other entity to provide these licensed services; the supplier must hire a W-2 employee to provide such services.

CMS has proposed revising Supplier Standard Number One by adding language to clarify that a DMEPOS supplier must be licensed to provide licensed service(s) and cannot contract with an individual or entity to provide the licensed service(s). It is CMS' opinion that it's enrolling DMEPOS suppliers, not the third-party agents that subcontract with suppliers, because they aren't enrolled or cannot enroll in the Medicare program.

Because the HME industry is highly regulated, suppliers must carefully consider whether to hire an employee or an independent contractor. While the business considerations are important, the regulatory rules control and must be followed. D

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Innovate Today for Success Tomorrow

JOHN ALLMAN
Director of Business Solutions
THE MED GROUP

OVER THE PAST SEVERAL years, the number of respected industry leaders issuing calls for providers to become more innovative has steadily increased. Unfortunately so have the number and types of challenges the industry and its providers face. It's now apparent that innovation, creative change and implementing new operational methodologies are no longer options; they are a requirement for survival.

Measurement alone will never solve any problems.

In the past three months, we've witnessed a building wave of issues coming toward us. We're now looking forward to a new year in which we'll face a 9.5 percent cut in Medicare rates, another round of competitive bidding and a deepening recession. The recession continues to add new threats, as jobs are lost and private insurance coverage is diminished. All of this paints a bleak, but not hopeless, picture for our industry.

It's not hopeless because there're several things providers can do, and do now, to improve their efficiency and redesign their business operations. Among them are the following steps:

Measure what you do. The first step in maximizing control of your operation is to know what you do, when you do it, why you do and, perhaps most importantly, how well you do it. But measurement alone will never solve any problems. You must not only continually measure, but you must address any problems that you discover. While "benchmarks" are popular these days, and may have some utility, it's what your operation is doing and how acceptable your performance is that's most important—not what other companies may or may not be doing or how you compare to them.

Control your processes. Once you have a handle on what you're doing and how well you're doing it, you can begin taking action by controlling your everyday processes. You need to look for ways to remove steps that get between you and you customer and between you and your money. You must always ask yourself: "Is this step necessary? Are we doing it right the first time? How can we eliminate costly mistakes and repeated efforts?"

Automate and standardize. Whenever and wherever possible, automate processes. Look for ways to standardize what you do. The more variations you have in any process, intake, evaluation, reimbursement or delivery, the more opportunity you create for mistakes. The primary goal is to achieve first-time quality. Of course, to know you have achieved this, or at least that you're moving in the right direction, you must measure what you do.

Embrace technology. You must embrace technology at every opportunity. Look for areas where perhaps you've resisted in the past to streamline and improve your operation through available, and in many cases, low-cost technology. Go paperless, for example. Scanning patient records and using available systems for human resource management are examples of where you can embrace technology.

Go lean, not mean. Learn "lean flow management" and its concepts, and then implement what you learn. You'll find that by working with your existing staff to help them do what they do better, more efficiently and with an eye for first-time quality, you'll not find it as necessary to resort to a reduction in force. Many companies see reducing staff and asking remaining staff to pick up the slack as the way to meet financial challenges. It may, in fact have the very opposite effect if no attention is paid to what the work is and how it's done.

Get paid for everything you provide. This is not to say that you must become a heartless mercenary, but you do need to be aware of what products and services you may be providing without charge. Automation, metrics and process control—none of these will be of any benefit if you're not being reimbursed appropriately.

Diversify. It's time to look around and to identify new areas in which you can use your skills and expertise to take advantage of new opportunities in your marketplace. As industry expert Miriam Lieber (of Lieber Consulting in Sherman Oaks, Calif.) stated in a recent issue of HomeCare Monday:

...continued on page 34

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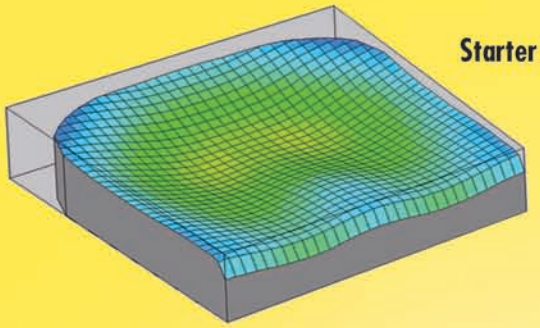

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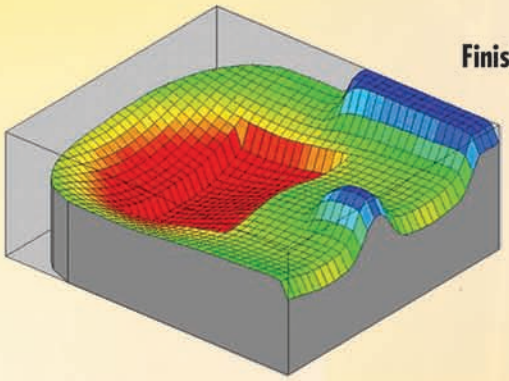

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CONTINUED FROM PAGE 32

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"We need to look ... to change in a much more creative and innovative fashion. We are really talking about potentially changing the entire scope of what we do to make it completely diversified so we won't keep getting stabbed by these endless cuts."

While these are difficult and challenging times, we can and will emerge from them. We've seen difficult times before, and in all cases, those who are resilient, those who adapt and those who look for and implement innovative ways to redesign their business are those who succeed. Only by implementing new ways of operating our businesses will we be able to weather these turbulent times. D

ABOUT THE AUTHOR
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Wheelchair Cushions: Design vs. Materials

THOMAS R. HETZEL, PT, ATP
RIDE DESIGNS/ASPEN SEATING

INTRODUCTION

At the most basic level, a wheelchair cushion needs to address comfort, skin care and postural control. It must be durable and provide consistent performance over time and in varying climates, environments and temperatures. If a cushion is provided that accomplishes reasonable comfort and postural control, but inadequate protection against sitting-induced pressure ulcers, then the cushion isn't an appropriate choice. If the use of a wheelchair cushion results in skin breakdown, regardless of the benefits relative to other outcomes, it cannot be used.

At the most basic level, a wheelchair cushion needs to address comfort, skin care and postural control.

Each wheelchair user presents a unique skin-risk profile. The National Pressure Ulcer Advisory Panel (NPUAP)1 recognizes several key risk factors for pressure-ulcer development. Decreased mental status, exposure to moisture, incontinence, device-related pressure, friction, shear, immobility, inactivity and nutritional deficits are outlined in their educational materials. Additional variables that are independently associated with pressure ulcers have also been identified.

Salzberg, et al,2 identified seven independent factors out of a list of 15 from a previously published scale. These independent factors were established for risks related to paralysis: level of activity, level of mobility, complete spinal cord injury, urine incontinence or moisture, autonomic dysreflexia, pulmonary disease and renal disease. Notice that pressure is not identified as an independent risk factor, therefore it must be coupled with other factors to create risk for pressure-ulcer development (e.g., pressure and time, or pressure and moisture with shear).

Wheelchair cushion design should directly address the extrinsic risk factors cited above (heat and moisture, pressure, friction and shear) and, through effective design, influence the intrinsic issues, especially those related to activity and mobility. Therefore, wheelchair cushions should be selected relative to their ability to protect skin and maximize mobility and activity. As basic and intuitive as this may sound, it isn't so simple in practice.

Understanding the Extrinsic Risk Factors

Pressure—This is the normal force experienced perpendicular to the cushion surface. Traditional wheelchair cushions for at-risk sitters have focused on the principle of pressure distribution, i.e., the ability of the cushion material to conform to bony prominences, decrease peak pressures and uniformly distribute pressure over the sitter-cushion interface. A multitude of materials have been incorporated into cushion design to accomplish this goal with varying degrees of success. Pressure mapping has evolved as a useful, though limited, tool to measure interface pressures and help predict a cushion's viability as a pressure management tool.

Shear—The force experienced parallel to the support surface is called shear. A high shear interface can result in friction between the sitter's skin and the cushion when the sitter actively moves across the cushion surface. Additionally, a high shear interface can "lock down" clothing and skin to the cushion surface, resulting in tension and potential tissue trauma and capillary tears/trauma as bony prominences move against underlying soft tissue and vascular structures.

Pressure and Shear—The management of pressure influences shear; shear doesn't occur in the absence of pressure. Rub your hands together and, as you do, slowly increase the pressure. What happens? Do you feel increased heat as you increase pressure? Now keep your hands moving laterally but

...continued on page 38

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Recline

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CONTINUED FROM PAGE 36

separate your hands to eliminate pressure. What happens? There is no more shear as pressure is eliminated. Measurement of shear is still very much in its infancy, and its prognostic value has yet to be clearly defined.

Heat, Moisture and Shear—Recent studies, as cited by Berlowitz and Brienza,3 have demonstrated that superficial dermal injuries without deep underlying tissue damage results from moisture and shear. Also noted is the impact of elevated temperature in exacerbation of ischemia related to pressure-ulcer development.

Managing the Extrinsic Risk Factors

Pressure—Increasing performance in pressure distribution typically compromises cushion performance relative to stability and postural control. If the materials selected for skin protection are temperature sensitive, then performance characteristics of the cushion will be influenced by temperature. Air pressure is affected by altitude and influences performance of cushions that utilize contained air. If a cushion support is inherently unstable, then optimizing activity and mobility is a challenge at best.

Seating design at its best works to control extrinsic risk factors.

The alternative to pressure distribution is incorporation of prosthetic and orthotic sciences where firm, accurately contoured and stable materials are selected to intentionally support select areas of the body that may be tolerant of pressure, reducing or eliminating pressure from at-risk areas. This approach tends to provide greater stability without compromising skin protection. Improved stability and postural control are the key ingredients to the promotion of activity and mobility.

Shear—Once again, materials such as fluids and air, which are most capable of transferring the effects of interface shear into the cushion, tend to be relatively less stable than non-flowing static materials. Less stable means less mobile. For decades, prosthetists have been reducing or eliminating pressure at distal ends of residual extremities and, by doing so, eliminating shear as well. Again, these principles, when used in cushion design, can increase shear where possible and eliminate it elsewhere.

Pressure and Shear—Pressure and shear are essential for postural control and stability in cushion design. Safe application of these forces is very much dependent on the user's presentation. Successful use of prosthetic and orthotic principles in seating is dependent on the amount of weight-bearing soft tissue that can be safely loaded. The proximal thighs and posterior-lateral buttocks tend to be tolerant of the supportive forces of pressure and shear, while bony prominences are not.

Heat, Moisture and Shear—Maintenance of dry air space at the sitter-support surface interface is essential for regulation of body temperature, both locally and systemically. Accurate design and material selection is necessary to create dry air space around risk areas, and should be coupled with cover materials that wick moisture from the sitter into the air space for evaporation. Additionally, protecting the cushion materials from saturation by urinary and/or fecal incontinence, sweat and other substances is imperative for cushion durability and maintenance of a sanitary microenvironment.

CONCLUSION

Seating design at its best works to control extrinsic risk factors, thereby influencing intrinsic factors toward improved health, activity and mobility. Traditional mechanisms of pressure and shear management have shortcomings relative to the degree of stability and control they provide. Appropriate application of prosthetic and orthotic principles provides an alternative to the traditional use of the pressure distribution model, and may promote greater activity and mobility while also promoting skin health. Design and material development that can maintain dry air space at the sitter-support surface interface may reduce superficial skin trauma related to heat, moisture and shear. D

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2. Salzberg CA; Byrne DW; Cayten CG; Kabir R; van Niewerburgh P; Viehbeck M; Long H; Jones EC. Predicting and preventing pressure ulcers in adults with paralysis. Advances in Wound Care. 11(5): 237–46, 1998 Sept.

3. Dan R. Berlowitz, MD, MPH; and David M. Brienza, PhD. Are All Pressure Ulcers the Result of Deep Tissue Injury? A Review of the Literature. Ostomy Wound Management. ISSN: 0889-5899, Vol. 53, Issue 10, Pgs 34–38, October 2007.

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Ti
LITE

2008 NCART Accomplishments

SHARON HILDEBRANDT, BS, MHA, JD
Executive Director
NCART

NCART was successful in obtaining an exemption for complex power wheelchairs (Group 3 and higher) from the national competitive bidding program. To achieve this goal, NCART drafted legislative language that was introduced in the House of Representatives (HR 2231) on May 9, 2007 by Rep. Tomas Allen (D-ME). By the time the legislation passed in July 2008 of part of the Medicare Improvements for Patients and Providers Act of 2008, it had garnered 58 cosponsors. Companion legislation was introduced in the Senate on April 29, 2008 by Sen. Olympia Snowe (R-ME) as S. 2931 which obtained 10 cosponsors. NCART cosponsored with NRRTS CELA in April, which resulted in over 200 visits to members of congress. NCART also sponsored a Rehab Exemption Call-in Day which generated over 4,500 telephone calls to members of congress to lobby for exempting complex rehab from the national competitive bidding program. NCART worked with disability groups, specifically the ALS Association and the Muscular Dystrophy Association on joint visits with members of congress and their staff and they conducted their own outreach with congressional representatives against including complex rehab technology in competitive bidding. NCART worked with an outside lobbyist, Quinn Gillespie, to garner leadership support for both the House and Senate bills and for its inclusion in the legislation that delayed competitive bidding, the MIPPA of 2008.

NCART cosponsored with NRRTS CELA in April 2008 which resulted in over 200 visits to members of congress.

To pay for the delay in competitive bidding, the Congress included a 9.5 percent reduction in reimbursement for the category of products included by CMS in the first round of competitive bidding. Although complex power wheelchairs were ultimately excluded from round one of competitive bidding, Congress applied the 9.5 percent reduction to complex power wheelchairs. NCART worked to obtain a parallel exemption but was unable to find a champion in either the Senate or the House to strike the complex power wheelchair reduction. NCART continued to monitor the possibility of including a parallel exemption in other legislation for the remainder of the 2008 legislative year.

NCART testified on the impact of rising gas prices on small business before the House Small Business Committee and submitted testimony to the House Ways and Means Health Subcommittee on competitive bidding.

In September, NCART spearheaded a survey on the effect of the 9.5 percent reduction which forecasted that services would be reduced and product choice would be limited when the reduction becomes effective on January 1. This information was shared with congressional staff and certain disability groups to educate them about the ultimate effects.

To respond to reports from the HHS' Office of Inspector General on the costs associated with providing power wheelchairs and other DME, NCART and other industry and consumer representatives met with the OIG on their report on internet pricing of power wheelchairs in an effort to educate them about the services necessary in providing complex power wheelchairs that are not reflected in internet pricing nor in the Medicare fee schedule.

Also in response to the OIG report on internet pricing of PWCs, NCART partnered with the Simon School of business at the University of Rochester (NY) to survey complex rehab companies to determine their expenses in providing complex rehab technology. This report demonstrated that the costs of goods and operating expenses left an average pre-tax profit as a percentage of revenue for the small, medium

and large categories of business of 3.4%, 6.0%, and 4.8% respectively. This information was communicated to Congress, other policy makers and disability groups to show the precarious nature of many complex rehab providers servicing their clients, and that continued cuts to reimbursement would have disastrous implications.

NCART sponsored a conference call on March for NCART members to discuss a survey sent to complex rehab suppliers by the HHS Office of General Council. The survey requested information on product and non-product costs. The call was led by Rita Hostak and Don Clayback.

NCART conducted a fundraising effort to pay for a major project being undertaken by the Sam Schmidt Paralysis Foundation. This project is a multi-phase, multi-year study that NCART is funding with additional financial assistance from NCART members and others. This study will identify and document the activities surrounding the provision of complex rehab, attach costs to these activities, and assess outcomes from the services provided. The independent research team performing this study is from the Georgia Institute of Technology and the University of Buffalo.

NCART continued to monitor the CMS coding initiatives, especially CMS plans on manual wheelchair coding. NCART put together a coding workgroup on head supports and will submit code requests to CMS the first week in January.

NCART monitored legislative initiatives to protect the first month purchase option for power wheelchairs.

NCART revamped part of its website to include a special Medicaid section that lists fee schedules, coverage policies and court cases by state. The Medicaid section of the website links directly to state documents, ensuring information will remain up to date.

Prior to the delay of competitive bidding. NCART worked with CMS to allow payment for certain complex power wheelchairs by noncontract providers after the July 1 competitive bidding implementation date for those providers that may have ordered equipment prior to July 1 but could not deliver until after July 1.

NCART began working on the issue of battery pricing and the low fee schedule given the increased cost of the raw materials for batteries. D

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Consumer Involvement in CELA '09

I have some thoughts I'd like to share. In past years on all occasions, when I have had to the opportunity to visit my representatives on the "Hill," one thing keeps coming up. In most cases, we meet with the various healthcare aides, seldom the reps themselves, and talk logically about the industry and all the good we do for our clients, the special knowledge we must have to do that job, the credentials we have earned to help individuals become more functional in their environments by providing special equipment and advice, and sometimes tell the success stories we all have had.

There have been a few instances where users have come with us, some even sponsored by the diverse group of companies we all represent. How much ground have we gained? My thought is to ask all who will make the visit to the "Hill" to sponsor someone, even one person --- one successful outcome because of being provided the proper equipment --- one person who leads a more normal life because of US.

The media should be alerted of these disabled people turned able. I think the evidence seen in the results would be something the media would cover, with a good showing, and thereby attract more of the politicians who always like to be in front of the media. The trick is to get sponsorship of very qualified people. People who are articulate and can make a passionate plea for better support for equipment necessary to live a productive life.

Employed disabled people are a rare commodity these days, but with a small investment in equipment can become tax payers rather than accepting government disability checks. We need to see there is an understanding of "investment" rather than "cost" in the human potential of our consumer base.

As long as we all speak from the perspective of our profit making companies that produce the equipment, we will not get enough attention to our successes. We need to show the successes in person, in the offices of the representatives.

If the media responds with photographs and interviews our clients, it would seem the congressional reps would too. At least in my mind they would. Just a few thoughts I wanted to share. I have had such success in another career, that of sports years ago. By showcasing ability rather than disability in athletics we made tremendous gains in the recognition of the abilities of many disabled people who, with proper equipment, could excel far beyond anyone's expectations. It is far more important to showcase those abilities in everyday life than it is in athletics.

And done the right way, we instill the pride and confidence in those we have helped through the addition of proper medical equipment, to become tax payers. That is how we must be seen by our representatives in Washington D.C.

Thanks for listening,
Marty Ball
TiLite, Vice President of Sales

NRRTS Announces Consumer Scholarships with Matching Funds Available for CELA '09

TRINIDAD, C0 – NRRTS announced it will provide matching funding to bring consumers who use Complex Rehab seating and wheeled mobility products to Capitol Hill during CELA '09.

"NRRTS is anxious to supply matching funding to Complex Rehab companies who bring their consumer clients to Baltimore and CELA '09," said Simon Margolis, executive director of NRRTS, "As well as contributing up to $500 for each consumer attendee's travel and lodging expenses, NRRTS and the HME Expo, will provide complimentary CELA '09 registration to both the consumer attendee and a representative of the sponsoring Complex Rehab company."

"NRRTS is looking for consumers in all age groups and diagnoses." said Weesie Walker, NRRTS President, "The legislators and their staff needs to understand the impact of their policies on all people with significant mobility and postural impairments. Scholarship applications are now being accepted. Suppliers and other interested individuals or organization can click here to access the online application."

REGISTER

CELA Makes a Difference!

Last year, I was encouraged by Judy Dexter to consider attending the CELA conference in Washington D.C. (I had included her in my "policy-driven e-mail rants" since before she was employed by NRRTS.) Her encouragement landed me in my boss's office, asking to be sent to D.C. to advocate on our company's behalf and on behalf of the citizens that we serve. He hesitated, but agreed.

Because of a delayed flight, I showed up late to the most advanced continuing education seminar I had ever attended and was amongst some of the industry's most experienced advocates and clinicians. That evening, the goals and game plan for a full day of legislative advocacy on Capitol Hill were laid out.

The next morning, I put on a suit that I hadn't pulled off the hanger in more than a year. I boarded a bus with a group of individuals with whom I wished I could spend more time to learn from their experience and knowledge. When I stepped off the bus in front of the Capitol, I felt overwhelmed. I had goose bumps as I looked at the enormous building—an icon for something far greater than me, and built there for a purpose that was as noble as anything I could imagine.

As I walked closer to the building, I imagined my softhearted father, fighting a war so that this building could continue to serve its purpose. I know he never imagined that his son would be there one day to try and make a difference.

I proceeded to meet the legislative advisors for each of my congressmen. I went through the bullet points that were given to us the previous evening and added cases from my personal experience, explaining how competitive bidding, in effect, would yield different outcomes. The response was exciting. These legislative advisors were affected that day, but more importantly, they were informed.

On the bus ride home that evening, the group of individuals, who I now saw as teammates, had varying reports. It was then that I decided it didn't matter if my congressmen led the fight, because our strength would come in numbers. As long as one congressman walked away affected enough to lead the fight, then the team's goal was achieved. Every meeting that seemingly yielded no results was the foundation to the few meetings that did yield positive outcomes.

We all know how the fight ended. Competitive bidding was delayed and complex rehab was permanently removed from competitive bidding's future. But it came at a cost: beginning Jan. 1, complex rehab will suffer a 9.5 percent cut. It looks like our legislators need another visit.

If you've ever felt unsure that you could make a difference, you're wrong. Coming to CELA, you may still feel small in the big legislative arena, but you'll understand that you're part of a bigger team that's advocating for a great cause.

Sign up; make a difference. CELA 2008 changed how I look at my government. It changed how I look at my industry. It changed how I look at myself.

Your teammate in "The Good Fight,"
Durwood Tenny, OTR/L, ATP, RRTS®

TODAY FOR CELA 2009!

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An Experience I'll Never Forget – CELA 2008

The first day of the conference was a day full of great speakers and educational material. After dinner, the last hour and a half consisted of debriefing us on what we needed to achieve on our visits to Capitol Hill. At 9:00 p.m., the debriefing ended and we were to pair up with other folks from our state to talk about who was going to say what in our scheduled meetings. Since I had no other representatives, I packed up my stuff and went to my room to read over the materials several times and map out my course for the scheduled appointments the next day. The next day came early at 6:30 a.m.; I had just enough time to grab a quick bite at the continental breakfast and get loaded on the bus. The bus trip was fairly long due to traffic, but it offered a great opportunity to take in the sites.

Upon arriving at the Capitol, I looked over the office building layouts to get my bearings straight and headed to my first appointment. After a fair amount of walking, I arrived at the first office building where I was to meet with Representative Dave Camp. After going through nearly a full-body cavity search, I was allowed to enter the building.

Considering I had never done this before, I was nervous and was hoping I could keep it together and get my point across. When met with Dave Camps liason, I discussed what exempting complex rehab for competitive bidding would mean to the beneficiaries we served. The liaison was very supportive and said he would talk to my representative and would make some calls.

I was confident. I finished the meeting and proceeded to take the long walk to my next one. For the rest of the day I went from meeting to meeting, all of which were back to back a few buildings apart from each other, leaving just enough time to make it to my last one. I had great success and felt I made an impact on everyone with whom I met.

Simon had one request: to bring another person with us to CELA 2009. So come on all you Michiganders, let's band together and stop waiting for the other guy to do it.

Randy Malcolm, RRTS™
Saginaw Medical Service

You can do it!!!!

CELA 2008 was quite an experience for me. I have planned and attended many conferences in my career; however, I had never before had the opportunity to meet with members of Congress. Frankly, it scared me to death. The congressional meeting with Senator John Cornyn's office went extremely well, and it was not a difficult task. Members of Congress serve because of us, and they are supposed to work for their constituents.

I highly encourage you to register for CELA 2009 today. You can sign up at www.hmeexpo.com! It is well worth the time, effort and money spent. If I can visit with a member of Congress, so can you!

Amy Odom, BS
NRRTS Marketing Coordinator

CELA'09

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April 20-23, 2009

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Presented By: [NRRTS]

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- Capitol Hill & Orientation
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- Capitol Hill Debriefing & Breakfast
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$175 for NRRTS Registrants (*enter Priority Code: HME007)*
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CELA 2009 Program

Monday, April 20, 2009

7:00pm

Welcome Reception & NRRTS Open Meeting

Tuesday, April 21, 2009

7:00am

Breakfast and Orientation to Capitol Hill visits

8:00am

Buses depart for Capitol Hill

5:00pm

Buses depart Capitol Hill

6:00pm to 7:00pm

Decompression Wine & Cheese Reception

Wednesday, April 22, 2009

7:00am to 8:30am

Breakfast and Capitol Hill Visit Debriefing

8:45am to 9:30am

Saying No - a survival skill for Complex Rehab Providers and Therapists

Surviving and continuing to provide quality seating and wheeled mobility services in the face of continuing regulation and funding cuts often seems like an impossible task. The key for both suppliers and therapists is learning how and when to say "no."

Presenter: *Gerry Dickerson, CRTS®, Director of Rehab Technology, Medstar, Inc.*

9:30am to 11:00 am

Doing More With Less -Making Appropriate Seating and Wheeled Mobility Clinical Decisions in the Face of Funding Cuts - Part 1 - Manual Wheelchairs and Seating

The reality of our industry and profession is that there will be less reimbursement for what we provide but the clients' needs will remain the same. What strategies can we use to meet these needs? How will manufacturers provide alternatives that work within the emerging funding structure? How can we manage the expectations of the client and those of the referral source?

Moderator: *Joni McGhee, OTR, Clinical Coordinator, TIRR/Memorial Hermann*

Presenters: *Foster Davis, Freedom Designs; Tom Whelan, Global Vice-president, Seating, Sunrise Medical; Tina Roesler, MSPT, ABDA, Director of Sales & Education, TiLite*

11:00am to 12:30pm

Doing More With Less -Making Appropriate Seating and Wheeled Mobility Clinical Decisions in the Face of Funding Cuts - Part 2 - Power Wheelchairs and Seating

The reality of our industry and profession is that there will be less reimbursement for what we provide but the clients' needs will remain the same. What strategies can we use to meet these needs? How will manufacturers provide alternatives that work within the emerging funding structure? How can we manage the expectations of the client and those of the referral source?

Moderator: *Joni McGhee, OTR, Clinical Coordinator, TIRR/ Memorial Hermann*

Presenters: *Mike Babinec, OTR/L, ABDA, Product Manager: Power Wheelchair Electronics, Invacare Corporation; Julie Piriano, PT, ATP, Director, Rehab Industry Affairs, Quantum Rehab; Ann Eubank, OTR/L, Director of Education, Permobil*

Thursday, April 23, 2009

8:00am to 9:00am

Looking Back - Lessons for the Future

The presentation will ask and answer questions like "What, if anything, did we as a Complex Rehab industry and profession do wrong to get us where we are today?" "What do we have to do individually and as an industry to get back on course?"

Presenter: *Hymie Pogir, Vice President of Product Planning, National Seating and Mobility*

9:15am to 10:45am

Powered Mobility Training for Children with Complex Needs

Powered mobility training for individuals who have never experienced independent mobility cannot continue to utilize strategies used in the past. How chairs are configured, the electronics programmed, the seating developed and the environment planned are all critical to successful use. These strategies will be shared with real case studies.

Presenter: *Karen Kangas, OTR/L, Seating and Positioning Specialist in private practice in Shamokin, PA*

OR

Fixed Postures? Flexible Opinions

Many postures described as "fixed" are actually very flexible. Unfortunately they are flexible in the direction of further deterioration, not towards improvement. This presentation will challenge participants to improve their evaluation and documentation skills to more accurately describe what has traditionally been labeled as fixed postures. Strategies to optimize flexible components of posture through seating and alternative positioning devices will be presented.

Presenter: *Tom Hetzel, PT, ATP, CEO, Ride Designs/Aspen Seating*

11:00am to 12:30pm

Bariatric Seating - Challenges, Techniques and Technology

Participants in this session will be able to identify the scope and problems associated with obesity and bariatrics, identify the causes and dynamics of bariatric clients medical management, demonstrate various safety issues associated with the bariatric client, describe the solutions for choosing appropriate equipment and caring for the bariatric client's skin, understand the challenges faced in seating and wheeled mobility and will discuss the multidisciplinary team efforts to plan the bariatric client's care.

Presenter: *Pat Meeker, MS, PT, CWS, The ROHO Group*

OR

Stable, Not Static - Dynamic Seating to Improve Movement and Function

To some, dynamic seating is the design and fabrication of equipment that will withstand the strong movement patterns of many wheelchair users. To others, the provision of dynamic seating is focused on seating that allows or restores natural postural movement while maintaining comfort and stability. This presentation will focus on seating that allows or restores natural postural movement.

Presenter: *Allen Seikman, Siekman Consulting*

NEW REGISTRANTS

Congratulations to the newest NRRTS Registrants!

(October 17, 2008 through January 23, 2009)

Alan Barker, RRTS®
Rocky Mountain Medical Equipment
3535 S Platte River Dr
Unite H
Sheridan, CO 80110
Telephone: 303-806-8001 x.108
Fax: 303-806-8030
Registration Date: 11/25/2008

James L. Ingraham, ATP, RRTS®
Interior Medical Supply
915 30th Ave
Suite 106
Fairbanks, AK 99701
Telephone: 907-457-8486
Toll Free: 877-457-8486
Fax: 907-457-8488
Registration Date: 10/27/2008

David A. McNair, RRTS®
EB & J Medical, Inc.
5 Hospital Park
Moultrie, GA 31768
Telephone: 229-891-2723
Fax: 229-891-2793
Registration Date: 10/20/2008

Gregory Allan Moorhouse, ATP, RRTS®
Active Home Medical
655A McCormick Drive
Lapeer, MI 48446
Telephone: 810-667-6962
Toll Free: 888-667-6962
Fax: 810-667-9204
Registration Date: 1/22/2009

Angela Smith, RRTS®
Gateway Medical Equipment
302 Shelley
Suite 8
Springfield, OR 97477
Telephone: 541-747-5430
Fax: 541-744-7122
Registration Date: 11/25/2008

Durwood Tenny, OTR/L, RRTS®
LTC Providers, Inc.
115 Progress Circle
Sullivan, MO 63080
Telephone: 573-860-6800
Toll Free: 800-860-6836
Fax: 573-860-6801
Registration Date: 11/4/2008

Jim Thompson, RRTS®
A & A Home Health Equipment, Inc.
1403 S. Green St.
Tupelo, MS 38804
Telephone: 662-844-8545
Fax: 662-844-7421
Registration Date: 12/29/2008

Gary T. Varner, Sr., RRTS®
Wolf Medical
100 Arnold Mill Way
Suite B
Woodstock, GA 30188
Telephone: 770-924-1277
Toll Free: 866-924-9653
Fax: 770-924-6698
Registration Date: 11/24/2008

James E. Waldrop, Jr., RRTS®
West Home Health Care, Inc.
2277 Dabney Rd
Richmond, VA 23230
Telephone: 804-353-7703
Toll Free: 800-494-9378
Fax: 804-353-4371
Registration Date: 11/11/2008

Mary Hitt Young, RRTS®
Wheelchairs Plus, Inc
5150-6 Timuquana Rd
Jacksonville, FL 32210
Telephone: 904-779-5603 x.3023
Toll Free: 877-442-0963
Fax: 904-779-6452
Registration Date: 1/16/2009

FORMER NRRTS REGISTRANTS

The NRRTS Board determined RRTSTM and CRTS® should know who has maintained his/her registration in NRRTS, and who has not. Names included are from October 17, 2008 through January 23, 2009. For an up-to-date verification on Registrants, visit www.NRRTS.org, updated daily.

Toby Bergantino, ATP	Newington, CT
Travis James Czerny	ATP, Bemidji, MN
Bradley S. Hannan, ATP	Minneapolis, MN
Michael Harris, ATP	Kenner, LA
Nicholas Philip Helfrich, ATP	Bristol, PA
Jeff A. Herbig	Indianapolis, IN
Julie Iverson	Lakewood, CO
William R. Jenkins	Lakeland, FL
John Komuda, ATP	Syracuse, NY
Gerald D. Kurtz, Jr., ATP	Kenner, LA
Clark W. Landis, ATP	Seattle, WA
Jason Lang, ATP,	Gulfport, MS
Mary Jo Lindstrom, ATP	Duluth, MN
Danny Lumpkin, BS, ATP	Cleburne, TX
Glenn Manning, Jr.	Deland, FL
Mike Mansfield	Mountain View, CA
Louis A. Mattesen, Jr., ATP	Newington, CT
Michael J. McCarthy, ATP	Huntingdon Valley, PA
Siobhan Murphy	Grand Prairie, TX
Paul S. Protzman, ATP	Chula Vista, CA
Jessica L. Roberts	Eugene, OR
Russell M. Schellong	Kelso, WA
Ernie Sibrian, ATP	Cerritos, CA
Larry Slawson	Tillamook, OR
Miguel Torres	Azle, TX
Daniel R. Trapp	St. Louis, MO
William Lance Wheaton, ATP	Murfreesboro, TN
Jeremy Woodson, ATP	Antioch, TN
Ken L. Woodson, ATP	Antioch, TN

ATP CREDENTIALS

Congratulations to NRRTS Registrants who earned the ATP credential. Depending upon their registration date, they will be awarded CRTS® upon completion and approval of the renewal following fulfillment of required registration. Names included are from October 17, 2008 through January 23, 2009.

Ilan Michael Breiner, ATP, RRTS®
Health Aid of Ohio, Inc.
Cleveland, OH

Robert S. Green, ATP, CRTS®
Boas Surgical
Allentown, PA

Dewey L. Seagraves, ATP, CRTS®
Care Medical
Athens, GA

Wayne C. Smith, ATP, CRTS®
Douglas Medical Equipment Supply
Roseburg, OR

Jason P. Steiner, ATP, CRTS®
MeritCare Health Care Accessories
Fargo, ND

09-4000
Arm Support Trough

EE9H
Foot & Ankle Stabilizer

MOD-1UU
Cut, Carve, Contour
Modular Seat Modification

MOD-2UU
Easy
Conforming
Back
Adjustable Single
Wing Modification

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Features include:

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for more information

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Phone: 800-331-8551 • Fax: 888-582-1509

CRTS® CREDENTIALS

Congratulations to NRRTS Registrants recently awarded the CRTS® credential. A CRTS® receives a lapel pin signifying CRTS® or Certified Rehabilitation Technology Supplier® status and guidelines about the correct use of the credential. Names listed are from October 17, 2008 through January 23, 2009.

Paul Arnold, ATP, CRTS®
Marra's Homecare Equipment & Supply
Plattsburg, NY

David Bachelder, ATP, CRTS®
Life Care Solutions
Tucson, AZ

Robert Brown, ATP, CRTS®
Avera HME
Sioux Falls, SD

Mike L. Daniels, ATP, CRTS®
Acute Rehab Equipment, Inc.
Valdosta, GA

Alan Derr, ATP, CRTS®
Derr Medical Equipment, Inc.
Manheim, PA

Bill Dickerson, ATP, CRTS®
Care Medical Power Mobility
Athens, GA

Brian Gough, ATP, CRTS®
Hometown Medical
Vicksburg, MS

Robert S. Green, ATP, CRTS®
Boas Surgical
Allentown, PA

James L. Keating, ATP, CRTS®
Accucare, Inc.
Dunwoody, GA

Deborah J. Lazure, ATP, CRTS®
The Medical Store, Ltd.
South Burlington, VT

Scott S. McCallum, ATP, CRTS®
Juro's Home Medical-Pharmacy
Billings, MT

Lester Miller, ATP, CRTS®
National Seating & Mobility, Inc.
Memphis, TN

Michael A. Morelli, ATP, CRTS®
St. Marys Pharmacy, Inc.
St. Marys, PA

Derek Register, ATP, CRTS®
Custom Healthcare, Inc.
Atlanta, GA

CRTS® CREDENTIALS

Dewey L. Seagraves, ATP, CRTS®
Care Medical
Athens, GA

David J. Simpson, ATP, CRTS®
The Medical Store, Ltd.
South Burlington, VT

Wayne C. Smith, ATP, CRTS®
Douglas Medical Equipment Supply
Roseburg, OR

Eric Sorvillo, ATP, CRTS®
Boardman Medical Supply
Girard, OH

Pam Yates, ATP, CRTS®
Petersen Drug
Chadron, NE

Important Information

NRRTS is now offering teleseminars on West Coast hours. This makes it easier for people all over the country to access this high quality education. Visit the www.nrrts.org website for more information.

NRRTS is a sponsor of the 2009 International Seating Symposium in Orlando. Come by the booth to talk to Simon and Judy.

CELA '09 promises to be a bigger and better educational experience. This year, in addition to an outstanding educational program, there will be the HME Expo. Once again, we will be going to scheduled meetings on Capitol Hill. We need consumers to make the Hill Visits with us. NRRTS has a scholarship program to help suppliers bring individuals that have the most to lose with funding cuts. Applications are available on www.nrrts.org.

THANK YOU!

National Seating & Mobility deserves recognition for its long-term support of NRRTS. As a charter corporate sponsor, NSM has supported NRRTS programs in many ways. NSM not only require employee RTSs to be registered in NRRTS, it pays for each registration. *NRRTS DIRECTIONS* will be highlighting other Rehab Companies that provide this benefit to their RTSs.

National Seating & Mobility

The New EasyStand® Bantam™

The new EasyStand Bantam is right on target! Not only can it be a sit-to stand stander and a supine stander, it also has a Shadow Tray that follows the child from sitting to standing.

The Bantam helps ease the transition from supine standing to sit-to-stand, preparing them for a lifetime of standing compliance.

Plus, the Bantam basic unit is **priced to fit within most funding guidelines.**

Find out more about the EasyStand Bantam, the new pediatric stander that *"hits the bulls eye"*.

Work Smarter, Not Harder. Add the EasyStand Bantam to Your Product Line-up!

EasyStand

www.easystand.com
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NRRTS TELESEMINARS 2009

.2 CEUs FOR EACH TELESEMINAR HAVE BEEN APPLIED FOR

TeleSeminar Series Registration Fees

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

Individual TeleSeminar Registration Fees

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

Register on-line at www.nrrts.org or by phone at 800.976.7787.
Long distance charges may apply and .2 CEUs have been applied for.
Cancellation Policy: No refunds will be provided.

EASTERN TIME ZONE

Thursday, March 19, 2009 • 5:00pm to 7:00pm Eastern

WASHINGTON UPDATE

Gary Gilberti

This presentation will review what has happened in the last 12-18 months and the opportunities available in the next 12 months. Questions that will be answered include. What strategies can be employed in DC for the benefit of complex rehab? And what can NRRTS, NCART, etc. do? Gary is president of NCART and president of Chesapeake Rehab Equipment in Baltimore, MD.

Tuesday, April 14, 2009 • 5:00pm to 7:00pm Eastern

POWER W/C ELECTRONICS: NON-EXPANDABLE THROUGH EXPANDABLE WITH ALTERNATIVE CONTROLS

Mike Babinec, OTR/L, ABDA, ATP

The focus of this seminar will be on application, selection and programming suggestions. Michael Babinec, OTR/L, ABDA, ATP, is a licensed Occupational Therapist with 30 years experience in Rehabilitation, Seating and Mobility. Mike is the product manager for Power Wheelchair Electronics and Seating and positioning products for the Invacare Corporation.

Thursday, May 21, 2009 • 5:00pm to 7:00pm Eastern

SETTING UP AN OPTIMALLY CONFIGURED MANUAL WHEELCHAIR

Dr. Mark Schmeler, OTR/L, ATP & Kendra Betz, MSPT, ATP

Advancements in manual wheelchair technology provide people with disabilities the opportunity for improved function while minimizing known risks of upper limb pain and injury. However, with a wide range of wheelchair technologies available, practitioners and suppliers are often challenged in recommending optimal equipment for their clients and carry the burden of justifying lightweight custom manual wheelchairs to funding sources. Mark is an Instructor and Director of the Continuing Education Program in the Department of Rehabilitation Science & Technology at the University of Pittsburgh. Kendra is a Physical Therapist and RESNA certified Assistive Technology Practitioner (ATP) who has worked for the Veterans Health Administration (VA) since 1993 specializing in Spinal Cord Injury, wheelchairs and seating, and adaptive sports.

Thursday, June 16, 2009 • 5:00pm to 7:00pm Eastern

EARLY INTERVENTION

Delia "Dee Dee" Freney, OTR/L, ATP

This presentation will take a clinical look at seating and mobility for the birth to 3 year old population. Many babies and young children have been identified with neurological and orthopedic diagnoses that have seating challenges. Supported positioning is important for weight bearing as well as sitting for fine motor, feeding, respiration as well as a factor in sensory experiences and exploration. Present size and future growth for seating and mobility pediatric equipment for this population has been a challenge for both the clinician and the rehab manufacturer. The focus of this presentation will be the application of positioning devices with clinical case studies to discuss the problems this young population faces. Dee Dee has been an Occupational Therapist in practice since 1978.

July 2009 TBD

NRRTS TELESEMINARS 2009

.2 CEUs FOR EACH TELESEMINAR HAVE BEEN APPLIED FOR

The University of Pittsburgh is certifying the educational contact hours of this program and by doing so is in no way endorsing any specific content, company or product. The information presented in this program may represent only a sample of appropriate interventions. Each person should claim only those hours of credit that he or she actually spent in the educational activity.

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

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

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

PACIFIC TIME ZONE

Thursday, March 26, 2009 • 5:00pm to 7:00pm Pacific

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

Stephanie Tanguay, OTR, ATP, Motion Concepts

The ability to design a mobility device for maximizing function is the art that seems to be forgotten in the shadows of codes and margins. This session will utilize studies to illustrate what our industry has to offer power Mobility user. Stephanie Tanguay's career has focused on seating and mobility for more than nineteen years. She worked as an Occupational Therapist for thirteen years and as a Rehab Technology Supplier for almost seven. She has both ATP & ATS Certifications. Stephanie is currently the Clinical Education Specialist for Motion Concepts.

Thursday, April 30, 2009 • 5:00pm to 7:00pm Pacific

KEEPING UP: AN OVERVIEW AND COMPARISON OF NEW POWER WHEELCHAIR ELECTRONICS

Michelle Lange, OTR, ABDA, ATP

Participants will have the opportunity to increase their knowledge about power mobility and develop a better understanding about what to provide their client population. Specific issues to be discussed include the comparison and contrast of the four new power wheelchair electronics packages. Michelle evaluates children and adults in the areas of positioning, mobility, access to communication devices and computers, and electronic aids to daily living. She is a frequent author and speaker.

Tuesday, May 26, 2009 • 5:00pm to 7:00pm Pacific

PROVIDING PELVIC CONTROL

Allen Siekman, Siekman

Consulting Control of the pelvis in seating is complicated by the desire to provide a stable base of support and postural stability. This presentation will explore methods and devices helping to control pelvis and trunk location and allow functional controlled movement. Allen Siekman has 30 years clinical experience as a seating specialist, designer and educator, specializing in the design and provision of seating equipment for children and adults with moderate to severe physical challenges. He has been a popular instructor at the annual RESNA National Conference the International Seating Symposium, and presents workshops and seminars on Wheelchair Seating to varied audiences worldwide. He works on several ISO standards groups serving as Chair of the RESNA/ISO Wheelchair Seating Standards Working Group, and is an active participant in the research and development of standards for support surfaces.

Thursday, June 18, 2009 • 5:00pm to 7:00pm Pacific

WASHINGTON UPDATE

Gary Gilberti

This presentation will review what has happened in the last 12-18 months and the opportunities available in the next 12 months. Questions that will be answered include. What strategies can be employed in DC for the benefit of complex rehab? And what can NRRTS, NCART, etc. do? Gary is president of NCART and president of Chesapeake Rehab Equipment in Baltimore, MD.

July 2009 TBD • 5:00pm to 7:00pm Pacific

STANDING: ADVANCED PRINCIPLES, PRACTICES AND CLINICAL APPLICATIONS

Ginny Paleg, PT

This exciting course moves expert rehab providers to the next level. Bone density, bowel, bladder, spasticity and range of motion benefits of passive and dynamic standing (including vibration) programs will be highlighted. This session will conclude with a rousing session on funding that will leave you shouting "show me the money." Ginny Paleg is a pediatric PT from Silver Spring, MD. She works in a 0-3 (Early Intervention) program for Montgomery County Public Schools. She serves children in their homes and daycare centers. She is the Reimbursement Chair and listserve monitor for the pediatric section of the APTA. She is on the editorial board of Rehab Management and PT Products Magazines, and is on the consumer advisory board of VTech toys.

CORPORATE FRIENDS [CFONS] OF NRRTS

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

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The MED GROUP — Connecting Partners, Delivering Results™
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National Seating & Mobility
permobil
SUNRISE MEDICAL — www.sunrisemedical.com
the ROHO group — shape fitting technology™
SNUG SEAT — nothing compares to a smile!
TherAdapt
U.S. REHAB®

CFONS

AEL Adaptive Engineering Lab
AltimateMedical — Standing People, Changing Lives
ATG rehab
Bodypoint®
Convaid — ADVANCED SEATING & MOBILITY
FMS Frank Mobility Systems, Inc.
METALCRAFT
Motion Concepts
Otto Bock HEALTH CARE
Prairie Seating Corporation — Custom Contoured Cushions
PRIME ENGINEERING
PRM — THE POWER OF PRECISION
QUANTUM REHAB — INNOVATIVE REHAB SOLUTIONS — A Division of Pride Mobility Products Corp
Aspen Seating™
RIDE
rifton
Stealth Products
Ti LITE
United Seating & Mobility
VARILITE

AFONS

Big Sky AMES — Association for Medical Equipment Services
GAMES — Georgia Association of Medical Equipment Services
Midwest Association for Medical Equipment Services
NCART — National Coalition for Assistive and Rehab Technology
NEMED — NEW ENGLAND MEDICAL EQUIPMENT DEALERS ASSOCIATION
TXRPC

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I KNOW WHEELCHAIRS. I have worked in the industry for 35 years and have been a wheelchair user for 49 years.

The first time I saw a Permobil, I remember thinking it was *built to last* with a strong frame and big batteries, and I wanted to work for a company who produced a quality chair like that.

Once at Permobil, I was impressed with the *attention to detail* and caring attitude. We always look for ways to *improve service*, whether it is preparing written instructions to assist a caller or personally helping find a solution. Recently, a client's chair was damaged by the airlines. After just a few minutes on the phone together, we were able to get the chair running, allowing that person to enjoy a nice vacation in sunny Mexico.

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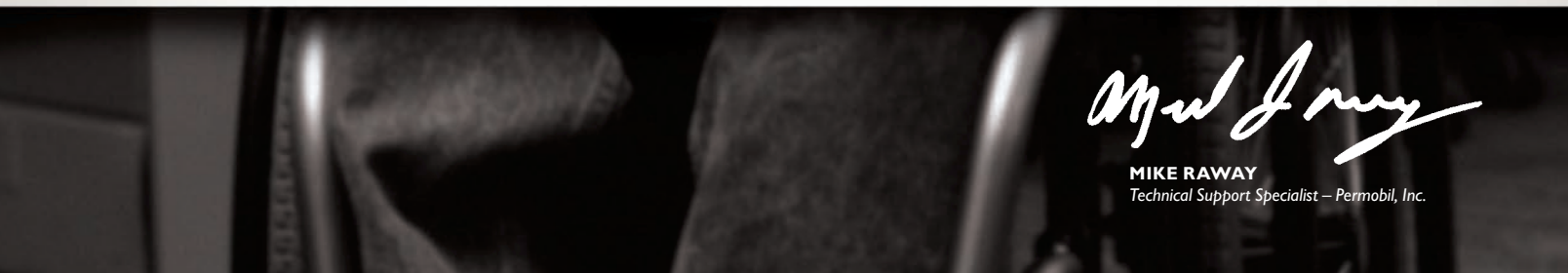

MIKE RAWAY
Technical Support Specialist – Permobil, Inc.

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TECHNOLOGY SUPPLIERS

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