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18 cover story
Shear: Physics, Risks & Management
While advances in technology give clinicians and providers new ways to reduce risk, shear remains a daily challenge — even for active wheelchair users. Here's how to assess for shear and educate clients.

22 Early Intervention Update
There's more to early intervention than wheeled mobility! Experts discuss the many benefits of introducing alternate positioning to infants and toddlers. PLUS: A different take on seat-to-floor heights for your littlest clients.

6 Editor's Note:
8 MMBeat
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31 New Products
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34 CMS Update

What's New Online: TheMobilityProject.com
If you haven't checked out TheMobilityProject.com, by the publisher of Mobility Management, you and your clients don't know what you're missing! From clinical stories clearly expressed in everyday terminology, to consumer and caregiver news, to articles on how to live a more enabled life, this new Web site delivers information to support today's active, vocal, articulate and passionate seating & mobility clients and their families.

On the Cover
Why shear, an old foe, is still a positioning concern.
Cover by Dudley Wakamatsu
Freedom Designs introduces...

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editor’s note

Industry
Moonlighting

It's 7:30 p.m. here in Southern California, and because it's March as I'm writing this, there's still a hint of blue in the evening sky.

Of course, that's only true for the western-most parts of the U.S. The skies have been pitch black for the rest of the country for hours.

Mala Aaronson, OTR, ATP, CRTS, from National Seating & Mobility’s Natick, Mass., office, has just sent me some comments for this month’s story on early-intervention (see page 22). I first heard her comments about seat-to-floor heights for toddlers during a conversation with Colours Wheelchair’s Rick Hayden at this year’s International Seating Symposium (ISS) and knew they’d be a perfect fit for our story. As for my guilt over literally keeping her up at night, Mala laughed it off. Sleep, she said, "won’t be happening for hours" as she works to catch up from her business travels.

A little earlier in the evening, I’d had a very similar conversation with Jean Sayre, OTS, ATP, director of clinical education for The Comfort Company, and contributor to our clinical story on shear (page 18). Jeannie, another East Coast resident playing catch-up from ISS and other duties, was talking to me at about 9 p.m. her time.

Closer to home, Divya Kapadia, PT, ATP, CRTS, from American Medical & Equipment Supply in San Jose, Calif., took a few minutes this evening to continue a conversation we’d started at the Vancouver airport on the way home. Like all providers in this current economic reality, Divya and her colleagues are being squeezed from all sides: payors, consumers, referral sources, government regulations. But they are continuing to fight the good fight, which includes attending events such as ISS to further their clinical and product education. In fact, I’d met Divya at last year’s Abilities Expo in Northern California, where she and her colleague, Donald Jones, ATP, had taken time the week before Thanksgiving to give clinical and product education for The Comfort Company, and contributor to our clinical story on shear (page 18). Jeannie, another East Coast resident playing catch-up from ISS and other duties, was talking to me at about 9 p.m. her time.

Tonight’s late night chatter is the norm rather than the exception in this industry, which is full of people who put in 10 hours with clients, then do paperwork by moonlight. You know who you are.

That’s why it is at the very least ironic — and to me, very frustrating — that so many consumers remain at arm’s length when this industry needs them the most. This industry, after all, belongs ultimately to the people who use its products and services. No one stays in this industry for any length of time because it’s a sure way to get rich.

So why are we at such odds with the consumers you’re serving every weekday and twice on Sundays? And why do I keep receiving e-mails from consumers that say, “I need a power wheelchair, please tell me where to buy the cheapest one?”

Because they don’t know what you know. They don’t know what you know.

We have a wealth of intelligence, experience, talent, skill and empathy in this business. But if all those riches aren’t relayed to consumers, caregivers, policy makers, payor sources, referral sources and the mainstream public…then we remain on opposite sides.

Consumers don’t know what you know. It’s time to change that.

You may have heard we have a new consumer Web site — TheMobilityProject.com. We’ve been about as subtle as thunder about its birth. That’s because we believe it can be a great vehicle to relay the mainstream public…then we remain on opposite sides.

If so, please let me know. Let’s put our collective knowledge to good use. And let’s show consumers once and for all whose side we’re on.

Laurie Watanabe, Editor
twatanabe@1105media.com
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LAS VEGAS — What happens here stays here, according to the famous tourism slogan for this glittering desert town.

But United Seating & Mobility (USM) staffers who gathered for their organization’s 2012 sales & operations planning meeting had a farther-reaching goal. They joined forces at The Venetian Las Vegas to share best practices, to celebrate past achievements, to receive clinical and product education, and to network with colleagues who are geographically far flung, but who also truly understand the day-to-day challenges of ATPs and their managers.

All Together Now

The event kicked off on Thursday afternoon, Feb. 16, with a lunch that included all USM ATPs, operations managers and corporate staff and featured a company and industry update from USM President Bob Gouy (see sidebar).

Last year, logistics — caused in part by USM’s ongoing acquisitions of complex rehab provider business — made it necessary to hold ATP and operations meetings separately. But this year, as in years past, the meetings were held together.

“It’s about bringing both the operations and the sales teams together,” Gouy said. “It’s building on that team concept. We don’t just have a sales meeting, we have a sales and operations meeting. We see the managers as important as our ATPs. They’re all important as a team, so we think that their interaction and working together to solve problems creates even more value.”

Thursday afternoon was reserved for education, with ATPs attending CEU courses, and operations managers attending operational initiatives courses.

CEU course presenters on the first day of ATP education included Peter Wankelman from Altimate Medical (Standing Justified); Allen Siekman from Bodypoint (Controlling the Pelvis in Wheelchair Seating); Theresa Berner representing Frank Mobility Systems (Power Assist: Fundamentals, Evidence of Efficiency and Applications for Success); and Ron Boninger from Out-Front and Jim Black and Josh Anderson from TiLite (Putting the "Custom" Back into Manual Mobility).

Thursday evening was devoted to recognizing 2011’s successes, with awards being given out to ATPs, branch offices and managers during a reception that included exhibit hall participants. In addition to traditional sales awards, USM staffers were also lauded for volunteer work and community involvement.

Friday morning started with another round of classes from Brad Peterson, Motion Concepts (When Lymphedema Impedes Seating & Mobility); Gabriel Romero and Mark Scott, Stealth Products (Head, Neck & Shoulder Positioning); Andy Brown and Jonathan Biggers, The Comfort Company (Un-Complicating Custom Seating); and Dennis Sharpe, MK Battery (Battery Application for ATPs). Following a group lunch, ATPs and operations managers gathered in the expo hall, where nearly 50 manufacturers showed off their complex rehab technology products and DME.

The event concluded on Saturday, with the meeting’s platinum sponsors delivering four more CEU courses: Lois Brown, Invacare Corp. (It’s Not Just the Product That Counts, It’s What You Do with It!); Matt Weaver, Permobil (The Power of You: How to Be an Advocate in Today’s Service Delivery Process); Jay Brislin, Quantum Rehab (Innovations & Complex Mobility Solutions); and Claudia Amortegui and Tim Morrison, Sunrise Medical (Custom-Configured Seating: Product Selection, Order Process & Funding Challenges).

Staying True to the Consumer

In total about 250 ATPs, operations and corporate staff participated in the meeting. And while operations managers and ATPs attended separate classes, they also spent plenty of time together during meals and in the exhibit hall, where ATPs and operations managers checked out the new technology together.

Gouy said having everyone together again in a single meeting provided “a better atmosphere.”

As for what the meeting set out to accomplish, Gouy said, “Our primary goal is really to get everybody together and make sure we’re all on the same page with our company initiatives and we’re all being true to that mission of delivering value to our customers. We look for ways to share best practices across the company, both at the ATP level and the operations level, and I think we did that very successfully. Our ATPs basically gained their education and CEUs for the year, so we accomplished all that training, and shared ideas.”

“I think we did what we wanted to do.” — Laurie Watanabe •
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Gouy on Consolidation: “It’s Had a Very Positive Effect”

When United Seating & Mobility’s (USM) ATPs and operations managers get together these days, they need a very large space — evidenced by the size of the ballrooms and seminar rooms they recently occupied during their annual sales & operations planning meeting in Las Vegas.

USM has been acquiring complex rehab technology businesses at a brisk pace of late. The company added nine businesses to its fold last year, and USM President Bob Gouy says he expects to make a comparable number of acquisitions this year.

Acquisitions make for good headlines, but Gouy and his team are simultaneously tasked with maintaining cohesion and unity in the company as new employees arrive and existing employees adjust to having new colleagues.

Growing Through Acquisition

It’s easy to assume that providers are selling their businesses in response to the many funding and policy challenges facing them.

But Gouy thinks the situation is more nuanced than that.

“There’s a generation that has reached their late 50s, early 60s,” he says of providers. “We’re in a tough, stressful industry, so if they’ve been successful, they’ve said, ‘I think I’ve had enough.’ They’ve decided they don’t want to spend the energy they’ve been expending. So you’ve got a group of people that are looking for the opportunity to retire or semi-retire. Then you have a group of a little bit younger people that see the opportunity in a consolidating industry to belong to one of the companies that is consolidating and is bringing a lot of value to them and their employees in the long term.”

Gouy agreed that traditionally, many rehab businesses were created and run by ATPs who excelled at assessing client needs and building customized seating & mobility systems, but were less enthusiastic about the business end of things.

“They’re juggling those day-to-day customer services with running a business,” he points out, “and that can be very overwhelming in today’s world.”

Gouy adds that people who have stayed with USM after being acquired have become regional or territory managers, “whatever role is appropriate for them. Our acquisitions director came from an acquisition, so we’ve built a team of people from the organizations we’ve acquired that we’re very pleased with. We’d like the company to continue to grow, and we take a whole lot of stress away from those previous owners. They might enjoy growing their business and doing business, but sometimes they’re very pleased to let go of the accounts payable and the accounts receivable and not have to deal with those kinds of stresses.”

Fostering a Sense of Teamwork

At February’s sales & operations meeting, several of USM’s longer-term ATPs voiced surprise over how large a ballroom was needed to accommodate everyone at the awards reception. Given the influx of acquisitions with more expected, how does USM foster a spirit of teamwork among new and existing staff?

“We’re careful to try to acquire organizations that have the same culture that we have,” Gouy says. “We’ve been fortunate to attract what I think are some of the top ATPs in the country and a great group of managers with a tremendous amount of skill. So we’re pretty comfortable with our team, and they continue to perform every year.

“We believe we’ve hired carefully and built a very open attitude within the organization, and we’re very much about encouraging people to share their ideas and look for value wherever they can, to deliver a better value to our customer. That kind of customer focus creates a camaraderie that is important in our business. We’re trying to be excellent at what we do, and hiring those people that are passionate about what they’re doing and actually care about their customer. That’s what creates the team.”

Gouy also believes recent acquisitions have been good for the industry at large.

“I think it’s had a very positive effect on the industry,” he says, adding that manufacturers have been “very supportive of consolidation.”

He adds, “It gives us more focus and strength as a business and an industry that wasn’t there before. We all are very familiar with the funding challenges and getting the message to the right people. Creating understanding in the payor community and the Medicaid community and Medicare community requires resources and focus, and we’ve been a very fractured industry, with all kinds of different suppliers. Consolidation is creating the opportunity to bring a lot of educational focus and resources to bear so that the consumer continues to have access and opportunity that they may have lost otherwise. It seems to be the right time for that type of change.”

— L. Watanabe
mobilitymgmt.com
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mm beat

United Seating & Mobility 2012

USM President Bob Gouy (back row, far left) and USM VP of Sales Scott Lopez (back row, far right) with a few of many awards recipients.

T.D. Schenck, ATP, CRTS, accepted Bodypoint’s challenge involving sizing of positioning belts.

TiLite’s new pediatric chair, the Twist, is full of creative, kid-targeted details, such as this fun and friendly footplate. Hello, kitty!

Scott Brown (far left), the new business development manager for Stealth Products, met with United Seating & Mobility staffers in the expo hall to discuss the finer points of positioning.
Bodypoint’s Allen Siekman spoke on the importance of “Controlling the Pelvis in Wheelchair Seating.”

Motion Concepts’ Brad Peterson discussed the many challenges of creating customized seating & mobility systems for clients with lymphedema.

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Invacare Corp.’s Doug Harper Is New Group VP

Doug Harper has been named the new group VP of sales & market development, North America, for Invacare Corp. (invacare.com).

Harper most recently has been the general manager for Invacare Supply Group (ISG), a position he’s held since joining the manufacturer six years ago.

A news announcement about his promotion noted Harper “has been responsible for delivering lower-cost solutions in supplies to providers, resulting in strong growth for both the provider and ISG.”

In his new role, the company said, “He will now be applying these principles and his industry knowledge to the Invacare Homecare and Invacare Continuing Care markets.”

Carl Will, Invacare Corp.’s senior VP of global commercial operations, said, “Doug is a proven performer who has been a tremendous asset with his work at Invacare Supply Group. With national competitive bidding impacting all aspects of business, Doug’s ability to craft lower-cost solutions is a must for both Invacare and the providers we serve.”

Harper said, “I am excited to work with our proven leaders — Mark Kline of Invacare Continuing Care, Rob Boeye of Invacare Homecare, and Brad Peterson of Motion Concepts — to provide our valued customers with innovative products, services and solutions to grow their businesses and meet our customers’ needs at the highest level.”

Brown Named Stealth Products’ Business Development Manager

Industry veteran Scott Brown has a new gig: business development manager for Stealth Products (stealthproducts.com).

In a news announcement, Stealth Products’ director of sales & marketing, Gabriel Romero, said, “Scott will be working closely with Stealth management to provide supplier and clinician education, identify industry needs and expectations, identify new opportunities, as well as new product offerings to the seating & mobility industry.”

Brown has worked in the seating & mobility industry for 20 years, most recently as a seating specialist for Sunrise Medical.

Romero added, “Stealth Products is committed to providing innovative, high-quality products to the mobility industry. Part of this commitment is to place the right people in key positions. We believe that Scott is the perfect choice for this venture, and we welcome him to our family!”

Stealth Products, based in Burnet, Texas, specializes in positioning and seating components and hardware for an array of clients with complex postural and functional needs.

DME MACs Clarify Item 29 “Amount Paid” on Assigned Medicare Claims

The Medicare DME MACs have issued a clarification on the submission of the “amount paid” on assigned claims.

The clarification applies only to assigned claims, and specifically refers to Item 29 on the CMS-1500 claim form or its electronic equivalent, according to a March bulletin distributed by NHIC Corp., the Jurisdiction A DME MAC.

“Suppliers are reminded that Item 29 of the CMS-1500 Claim Form or the electronic equivalent is to be completed with the ‘total amount the patient paid on the covered services only,’” the bulletin said. “Any beneficiary payment amount collected for the specific covered items submitted on the claim (i.e., co-insurance and deductible) should be reflected with the claim submission.”

The bulletin added, “Suppliers should not report any money collected on noncovered items, upgraded items or items expected to be denied as not reasonable and necessary with an ABN (Advance Beneficiary Notice of Noncoverage) on file. In the event Medicare is the secondary payor, suppliers should not report any primary insurance payments in the ‘Amount Paid’ field.”

The bulletin also reminded suppliers that deductibles are applied “based on the first claim to complete processing and not necessarily the claim with the earliest date of service in the year. … Therefore, suppliers are strongly encouraged to wait and collect the deductible after a claim has been finalized and included on the remittance advice.”
briefly…

The **University of Pittsburgh** is accepting proposals for presentations to be given at the **29th International Seating Symposium (ISS)**, March 5-9, 2013, in Nashville, Tenn. Prospective presenters can submit proposals for one- or two-hour instructional courses; 15-minute paper sessions; and poster sessions. The deadline for submissions is May 30, 2012 — for more information, visit [iss.pitt.edu](http://iss.pitt.edu)… If you’ve attended ISS and wished for more exhibit hall time, good news: The exhibit hall will be open to ISS attendees and the public on Wednesday, March 6, the day before ISS officially opens. **Pre-symposium workshops** take place March 5-6, as well… **Bussani Mobility Team**, a mobility dealer providing adaptive automotive and home accessibility equipment to consumers in the New York metropolitan area, has launched a mobile app that helps customers with smartphones, iPods or iPads to quickly access a range of information. Consumers with the app can get immediate emergency roadside assistance 24 hours a day; can access maps; can schedule service appointments; or can download information about Bussani Mobility products. Consumers can obtain the free app by scanning the tag on Bussani ads or by searching app stores for Bussani Mobility ([bussani-mobility.com](http://bussani-mobility.com))… Are you — and your clients — getting enough **vitamin D**? According to new research presented at the 2012 Annual Meeting of the **American Academy of Orthopaedic Surgeons**, 77 percent of trauma patients had deficient or insufficient levels of the vitamin. That lack can cause muscle weakness, bone fractures and an inability of fractured bones to fully heal, the study said. Researchers studied medical records of 1,830 adults at a university level 1 trauma center from Jan. 1, 2009 to Sept. 30, 2010.●

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UroMed & Dorland Health Partners Publish Learning Series

Brislin Named New Quantum Rehab VP

Looking for your next great read? Check out dorlandhealth.com/uromed for a continuing series of articles about various aspects of urology health.

The articles are written by clinical experts representing prestigious healthcare organizations, including Children’s Hospital of Atlanta, Vanderbilt University, Cincinnati Children’s Hospital, Rainbow Babies Hospital and Brooks Rehabilitation Hospital.

While the articles focus on urology health, they approach the topic from a variety of angles. One article, for example, is titled After Spinal Cord Injury: Returning a Patient Back to School.

That article, by Nancy Lokey, RN, discusses the many challenges that teenage patients with spinal cord injuries face when returning to class. Is the campus accessible? Do students have a process in place to remind them to do weight shifts while in school? Can students perform intermittent catheterizations in school bathrooms, or is the nurse’s office a more convenient location?

The story even broaches the topic of bowel or bladder accidents and where students will turn for physical and emotional support should an accident happen at school.

The series — the result of a partnership between UroMed and Dorland Health, a healthcare publisher — also includes stories on spina bifida, multiple sclerosis and caregiver issues.

"UroMed strives to provide relevant educational resources to the medical community as part of our lifelong commitment to the patients that we serve together," said Craig Stevens, CEO/president of UroMed, in a news announcement. "We believe that by supporting educational programs that share ideas on emerging treatment and care options from thought leaders in the healthcare community, we will help advance the level of care and resources available to our customers across the country."

Certain healthcare professionals — including clinical nurses, nurse practitioners and case managers — can earn credits for reading the articles and taking exams afterward. The articles don’t qualify for CEU credit for ATPs, but they’re still a great source of background information for seating & mobility specialists who want to improve their urology health expertise.

Jay Brislin, MSPT, is the new VP of Quantum Rehab, the manufacturer has announced.

Brislin has been with Quantum Rehab, Pride Mobility Products’ complex rehab technology division, for 11 years. Prior to the promotion, Brislin served as director of Quantum products & clinical development.

An announcement from Pride Mobility said Brislin’s role “will be to continue strengthening Quantum Rehab’s sales relationships with providers and clinicians, implementing strong clinical development strategies, establishing collaborative product development partnerships with industry professionals, setting product development priorities for all Quantum brands, and continued quality and operational support.”

“Jay has a unique, collaborative, consumer-centric approach to Quantum Rehab,” said Pride CEO/Chairman Scott Meuser. “This allows him to give our research & development team strong direction regarding product advancement priorities. Jay’s strong relationships with providers and clinicians has allowed Quantum to build multiple options and accessories with consumers in mind.”

Brislin, a frequent educational presenter at industry conferences, said, “Providing products that make a difference in someone’s life is the most important outcome we strive for, and we must continue to create new and better ways to do that. We recognize the importance of creating an overall exceptional customer experience, and we are determined to work diligently to reach that level.”

Jay Brislin
Q’Straint & Sure-Lok Name New Canadian Sales Manager

Adaptive manufacturers Q’Straint and Sure-Lok have hired Paul Faucher as their new Canadian sales manager. Faucher has an extensive sales support and project leader experience in North America and overseas, the companies announced in a joint statement. He most recently served as a training coordinator with McDonald’s.

Faucher, who speaks English and French and resides in Quebec, has competed in short-track speed skating throughout North America, and has also coached the sport.

Ride Designs Announces Certification Course Dates

If you’re seeking to become a Ride Designs custom certified provider, you’ll want to jot down the dates of the cushion manufacturer’s 2012 certification courses in Denver.

Courses will be offered April 12-13; June 7-8; July 12-13; and Sept. 13-14.

For more information, call Ride Designs at (866) 781-1633, or visit ridedesigns.com.
Once upon a time, shear was one of the biggest positioning foes for seating providers and clinicians. But over time, conversations about shear have somewhat waned, largely because of improvements in tilt & recline systems.

Nevertheless, many clients remain at risk for shear — and may not even be aware of it. Knowing the risk factors and how to prevent or at least manage them can therefore make a significant difference in overall skin health, client activity and independence.

**The Physics of Shear**

Mosby’s Medical Dictionary (2009) defines shear as “an applied force or pressure exerted against the surface and layers of the skin as tissues slide in opposite but parallel planes.”

That force can damage blood vessels and prevent or reduce blood supply to underlying tissues, leading to tissue death.

For wheelchair users, that force can often occur as part of the repositioning process.

In her presentation “What We Forgot We Knew About Tilt & Recline,” Stephanie Tanguay, OTR, ATP, clinical education specialist at Motion Concepts, discusses the history of tilt and recline systems, including designs that made recline systems prone to shearing forces.

“Historically, pivot points used to be level with the seat rails,” Tanguay says. “The majority of manual recliners in the industry today are still built with the pivot point of the recliner at the level of the seat rail. You have to always think about the distance of the pivot point in proximity to the pivot point of the body. The pivot point of the equipment and the pivot point of the body are really what dictates a lot of this.”

In her presentation, Tanguay notes, “For decades, manual and power reclining chairs utilized a pivoting point from which the back canes moved to open (recline) and close (sit upright), which was level with the seat rail of the chair. The shearing effect of the back support moving against the seated person’s skin was related to this lower pivot point.”
difficult, but reclining in elevating legrests might really be difficult says. “If you have tight hamstrings, for example, reclining might be condition.

that also skew that.

“Everybody’s power recline system has a three-inch raised pivot point to it.”

“Manufacturers are building power recline with raised pivot points to address shear, but then people put on really thick backs that move (the client’s) pelvis. You can move somebody anterior, away from the pivot point of the recline system, and you can have a cushion that is very thick that raises them up and away from the pivot point as well. If my cushion is too thick, I’m high up above it; if my back is too thick, I’m farther forward from it. We can also see that happen with someone who has a lot of soft tissue on their body.”

Shear Risk During Transfers

Less active wheelchair users who don’t reposition themselves or perform weight shifts often enough are commonly thought to be at higher risk for developing pressure ulcers.

Shear injuries, however, can occur even with very active wheelchair users who regularly move among different seating surfaces.

In fact, making those transfers can present elevated risks.

“It’s going to depend on the quality of their transfers,” Tanguay says. Many of these transfers will be lateral, and ideally the client is able to entirely lift himself or herself up. “Or at least when I get to whatever surface I’m transferring onto, if I can do a little bit of a pushup and my tissue isn’t displaced, it would be better,” Tanguay adds. “The people who really struggle with this are people who drag themselves. If you use a sliding board, you’re displacing tissue on the sliding board. So people slide across it, or they use it like a bridge and do little hops across it. So people who displace tissue or don’t even use a sliding board, but just transfer from their bed to their chair, are dragging their tissue across the tire, and they drag across the seat surface. You’ve always got therapists looking for more slippery covers so people can slide easier, but anything that’s involving sliding, if you’re not clearing the contact of your weighted tissue, the chances are that you’re occluding some bloodflow because you’re displacing tissue.”

Adding to that, Tanguay says, is the fact that many clients can’t feel that they’ve displaced tissue because they’ve lost some or all sensation.

“They don’t even know when they’ve done this,” Tanguay says, “which can be very problematic for them.”

Jean Sayre, OTS, COTA/L, ATP, CEAC, is the director of clinical education for The Comfort Company. Because of the prevalence
Shear Management

In all reality, every one of us is affected by shear

— Jean Sayre

of shear, she says, she makes the assessment for it a part of all client evaluations.

“When I’m doing my evaluation, the first question I ask is what they do throughout the day, from the time they get up in the morning to the time they go to bed,” Sayre says. “I even ask them how they’re positioned in bed.”

Sayre’s frequent work in the home accessibility field has caused her to look for shear risk in a number of everyday locations and scenarios.

With transfer benches, for example, she says, “I see a lot of chafing, a lot of abrasions occurring from that shearing effect. A lot of clients I work with are also having neuropathy and are diabetic, so they have to be very careful with their skin integrity, which is already compromised.”

Though shear is perhaps most often talked about in conjunction with seating systems, Sayre makes sure to consider all other possibilities.

“I think about footrests,” she says. “I think about shearing of the feet — plantar shearing, which is breakdown on the bottoms of the feet. We’re so concerned, obviously, with seating & positioning that the feet are forgotten about a lot of times. That happens a lot with (clients with paraplegia) and younger, active patients: You have shearing that occurs in the feet, so you have to make sure you’re taking care of proper positioning of the lower extremities and the footrests.”

Looking at All the Possibilities

Figuring out what activities and environments are causing shear can be tricky, particularly among active clients.

As an example, Sayre cites a veteran she once worked with. “He purchased a Camaro and was so excited,” Sayre says. He also showed signs of injuries to his skin.

“I was very baffled, because we couldn’t figure out where the redness was coming from,” Sayre says. “I actually had to do a skin inspection to see where the redness was, and it looked like a little abrasion.”

Sayre asked him to bring his Camaro to the VA and then had him perform transfers in and out of his new car as she observed.

“That’s when I noticed he was dragging across his (car) seat, and also his seat had some piping and seams,” Sayre says. “That piping on the edge is what he was dragging across, so he was shearing across it.”

The solution: “We had to modify his seat with a low-profile air cushion to protect him from the seat as he was going across the surfaces.”

Sayre also noted he had some difficulties transferring his chair in and out of the car, and suspected he may have also experienced some shear while transferring on and off toilet seats.

“Even though they’re able to do their own pressure management,” she says of active clients, “they’re not being able to prevent that shear.”

Educating Consumers About the Risks

Ultimately, educating consumers about shear — what it is, its risk factors and how to reduce them — is critical. And seeing is believing.

Tanguay says she likes clinicians and providers to take lateral-view photos of clients when they’re sitting up and when they recline.

“You can really see where everything moved,” she explains. “Some people are so displaced even with one recline cycle that they have to be repositioned every time they recline and sit back up.”

Sayre says she promotes sliding transfer benches for many of her clients. “You get yourself onto the seat — swivel or non-swivel, depending on where the transfer is occurring — and then the gravity will take effect, so you pull yourself over, and it locks into place. You’re not sliding across, so you’re preventing that shearing, abrasion and friction.”

She’s also recommended gel covers for toilet seats, since gel’s viscosity (along with air-filled cushions) helps to prevent shearing. And for clients who are more static, she says, “That’s when you can use manual or power lifts instead of pulling them across the bed.” Sayre adds that transfer or repositioning bed sheets are also designed to reduce potentially dangerous friction.

But while providers, clinicians and caregivers may be naturally more inclined to worry about shear among sedentary clients, Sayre says active wheelchair users — with their multiple transfers every day in and out of cars, onto and off bathroom equipment, onto and off of different pieces of furniture, etc. — also need to know about shear.

“Just from my experience, I feel that they’re at higher risk for shearing than some of the static patients,” she notes.

Education for all wheelchair users, therefore, is important.

“I’ve worked with people who transfer into the chair, but can’t get all the way back,” Tanguay says. “They put themselves into tilt, and they tilt back to let gravity push them back into the chair.”

Consumers who don’t understand shear forces — but who are resourceful in other ways — may end up problem-solving themselves into dangerous situations.

Tanguay remembers a power chair user who would drive up to a wall, then put her feet against the wall. “Then she would drive closer to the wall to use the force of her feet on the wall to shove herself back into the chair,” she says.

All the more reason to learn as much as possible about a client’s everyday activities when evaluating for shear. Because as Sayre says, so many things “could possibly be a piece of the puzzle.”
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In complex rehab technology circles, discussion of early intervention for very young children often centers around independent mobility in the form of manual or power wheelchairs. Providing infants and toddlers with the means to explore their environments on their own terms, experts say, is crucial to their cognitive, social and emotional development.

But there’s more to early intervention than wheeled mobility. Young children can also benefit from early-intervention positioning and alternate positioning. And as with independent mobility, early-intervention alternate positioning can also result in a range of benefits, including clinical ones.

**The Role of Standing in Child Development**

Every child is different of course, but generally speaking, by around the 9-month mark babies begin pulling themselves into a standing position with the aid of a coffee table, sofa or other furniture. This is an exciting developmental milestone for babies, giving them literally a whole new view of their environments, and increased access to it, as well.

But Amy Morgan, PT, ATP, Permobil’s pediatric & standing specialist, points out that standing also has a range of physical benefits. “The biggest one that comes to mind is the development of the hip joints,” Morgan says. “When a baby is born, the acetabulum — it’s the socket of the hip, where the femur goes into the pelvis, and that makes the hip joint — is very flat. If you take an x-ray of a baby’s pelvis, you’ll see flat areas there.”

The acetabulum develops, Morgan says, through a range of mobility-related activities. “As a child goes through typical developmental sequences — including weight bearing on hands and knees in the quadruped position, and crawling, in combination with standing — all of those forces that act upon the pelvis as the baby is moving develop that acetabulum.”

Failure of the acetabulum to fully and properly develop can cause a variety of problems, Morgan adds. “The deeper the acetabulum, the more secure the hip joint is. So what you see is kids with cerebral palsy (CP), for example, having a very high incidence of hip dysplasia. Maybe their acetabula didn’t develop and go through those sequences as they should, so maybe they remain shallow. There’s some depth to them, but overall they remain pretty shallow, and so the femurs can easily be displaced out of those sockets. The other combination that adds into that is spasticity, so the spastic muscles are pulling the femurs out of the sockets.”

Andy Hicks, ATP, SMS, CAPS, Altimate Medical’s eastern regional manager, says standing can impact a range of pediatric skills and abilities. “When we developed our pediatric education program, we looked at how standing and position change can affect development, and were surprised at the strength of the studies indicating several developmental benefits,” Hicks says. “One of the primary benefits is how
standing can improve overall motor skills. “Children that are in a consistent standing program had better sitting skills, lying skills and upper-extremity coordination than children that did not stand. So they could sit on the commode with more independence or are more capable of moving in bed. Standing gave the children better proprioception, or a better understanding of their body in space and how to control it to their best ability. This gives them a significant improvement in bilateral upper-extremity activities, which translated to improved ADL skills.”

**Postural Benefits from Standing**

Morgan adds that standing also can lead to overall postural benefits. “Being in an upright position challenges postural muscles differently than being in a supine or even in a seated position,” she notes. “One can argue that in trunk stability and trunk postural control, (sitting and) standing have similar benefits. But there’s definitely a difference when you get up into a standing position as far as the ability to activate muscles that cross the hip joint. ‘They’re in a different position to allow them to be activated differently.

“Some of the major muscles that give us balance and allow us to balance are our gluteal muscles and our postural extensors. So when you’re standing, you’re able to activate those glutes and maybe assist with other stability and stabilization activities of the trunk.”

Those postural benefits extend to the upper body as well, Hicks says. “One of the first motor control challenges for babies,” he points out, “is to hold their heads up to look around. Children with CP continue to have challenges with coordination and strength to hold their head up, and many — up to 75 percent — have poor vision. Standing can help children develop stronger and more controlled head movement to help with their field of vision, as well as bring them up closer to people and objects, like a smart board.”

In addition to the physical benefits of standing, of course, there are many social and emotional benefits.

“Definitely supported by observations and experience,” Morgan says, “is that there’s increased arousability when a child is standing, that they’re more engaged, more awake and more likely to engage in activity. So that’s another benefit of getting upright, into that standing position.”

Hicks concurs: “Another simple benefit (is that) standing allows a child to see, interact and play more engagingly with their siblings/classmates than in a sitting position.”

**When Should a Standing Regimen Begin?**

Since children without disabilities start standing at a very young age, ideally, standing intervention should reflect that developmental timeline.

“Any child that is 1 year old and cannot stand because of a neurological impairment should be evaluated for a stander for physical and developmental reasons,” Hick says. “Caution should be given to children that are in poor general health. If there seems to be pain when standing or the child had recent surgeries, caution in positioning pads should be taken so pressure is not applied to the area of a G-tube or Baclofen pump.”

“I always like to bring it back to the typically developing infant and what they are doing,” Morgan says in regard to determining when children could be ready for standing intervention. She notes that typically developing infants are “rolling around. They may get up on their hands and knees and rock. They may pull to stand. But even before they’re pulling to stand on their own, they’re standing in ExerSaucers and different types of baby toy standing apparatuses. Therapists will argue — is that good for the hips? Is that bad for the hips because it puts hips into this kind of abducted, externally rotated position?”

Morgan says the “jury’s out” on whether such mainstream standing toys are beneficial, but adds, “the fact of the matter is they are upright in an extended position with their feet on the floor. Obviously, we’d like the alignment of the hips to be more neutral, but they’re still experiencing that activity, a standing position.”

She explains that learning to balance and control one’s body starts with extension. “Babies are experimenting with that balance of flexors and extensors, but what they know first is extension. Even with very young infants, that’s what they do because those extensors are the primitive muscles, and they’re activating and starting to learn how to control and use them.”

Children with neurological insults, she says, “may have trouble controlling those muscles. Typical babies learn to control them pretty quickly. They have the ability for their brain to get the correct signals to their muscles to learn to manage that. With children with CP or some other type of condition, that connection between the brain and the muscle — whether it’s at the brain level, at the spinal cord level or the muscle level — that connection is disrupted, so it’s more difficult But they still need to be in that position to try to make those signals connect appropriately.”

With infants, Morgan says, therapists might use other means and equipment to provide that sort of experience.

“When I was doing developmental therapy,” she says, “we’d use things like bolsters. We’d put the babies prone over the bolster, on their bellies, and kind of rock it back, supporting their trunks and heads and allowing their feet to be on the ground in the weight-bearing position.”

“Those are some of the interventions and home programs we would...
Pediatric Series

Early-Intervention Positioning

teach families to do, to get them to do this weight bearing. Weight bearing also has a spasticity management or tone management component because it’s putting proprioceptive input through the joints. When you do it with a bolster or even in a stander with a tray, you can get that weight bearing through the upper extremities as well as through the lower extremities.”

Making a Gradual Transition
While there are many benefits of standing, the rehab team does need to keep in mind that different children will respond differently to this new positioning.

“The reactions are varied,” Hicks says. “Some children enjoy standing to have a different perspective and experience: others have a harder time adapting to it. As with any child at a young age, they will likely need adult interaction and distraction to gain more time standing.”

Fortunately, Morgan says, standing even for shorter periods can result in significant benefits.

“From the research I’ve seen — not necessarily in early intervention, but just with standing — the better pattern is to stand more frequently for shorter durations during the day,” she says.

She again takes cues from the way typically developing infants and toddlers change positions all day long, from sitting to crawling to pulling to a stand, then going back to sitting.

“Think about kids getting in and out of different postures and positions,” she says. “That’s actually preferred. The problem is when you have a child who’s completely dependent — it’s not easy for a parent and a family to switch them back and forth all throughout the day. So they usually end up standing for a longer duration. But if they can’t tolerate that, it doesn’t mean they didn’t benefit from that activity.”

Hicks notes that research indicates that with standing, “more is better, and the rule of thumb is to try to have a consistent standing program that can grow into one hour per day. But much like exercise, the age, the strength and tolerance of the child have to be taken into consideration. Also, the child has to work up to (standing for longer periods) over time, because it can be taxing in the beginning. To gain strength and standing tolerance, children should be allowed therapeutic rest within the standing program. For example, if the child is having problems maintaining head control, then they should be allowed to rest by reclining back so their neck muscles can recover when the head is on the headrest. Sadly, some insurance and state funding agencies will only pay for an upright stander for young children, so...
they must get out of the stander to rest, which makes it harder for the caregiver and harder for the child to stand enough to gain endurance and obtain the full benefit from standing.

When introducing standing into a child’s regimen, Morgan also recommends making a gradual transition.

“With the younger child or the person that’s extremely dependent and difficult to transfer into a sit-to-stand stander, I like to do more of the supine positioning standers,” Morgan says. “That’s a position they’re used to being in. They’re used to lying down. They can lie down and get the straps on them and secure, and then you gradually elevate them. They have the same risk of blood pressure drop as an adult would, so you have to monitor them physiologically to make sure they’re tolerating that activity, and the way you do that is by very slowly progressing them and gradually bringing them up to a standing position.

“Some children with severe respiratory issues may desaturate when they’re in a standing position, so you have to watch their oxygen saturation, make sure that they’re doing OK from that perspective.”

Trying a tilt table first for someone using a supine standing model can be helpful, she added. The child, she explains, is probably thinking, “I’m used to the ceiling as my reference point, and now I can’t see it anymore.”

**The Joys of Standing**

A child who is able to stand gives his or her clinical team some new and potentially therapeutic opportunities.

“The last thing you want is for somebody to get a stander and stand all day,” Morgan says. “That’s like sitting all day. But a standing device would give another option for that baby instead of being in the swing all day or the adaptive chair or the wheelchair. It gives them another option for a different position to be in.

“The OT or the speech therapist might say, ‘Wow, she can manage her food or suck or swallow much better when she’s weight bearing on her feet. Instead of feeding her in her feeder chair, let’s try to do some feeding while she’s in her standing frame.’ It’s totally individual for the client.”

Toddlers seem to be constantly moving and changing positions. Morgan points out that they’re good role models.

“They’re transitioning in and out of positions all day long. The more we can mimic the activities of a typically developing child, the better it’s going to be.”

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Early-Intervention Positioning

Proper Positioning from the Start

Gabriel Romero is the director of sales & marketing for Stealth Products, manufacturer of specialty positioning components and hardware, including many products for pediatric seating & mobility. Here, in his own words, Romero describes the challenges — and rewards — of working with families of kids with special needs.

Families don’t always know what to look for, and we can’t put all the responsibility on therapists and ATPs. Everyone has to be proactive. I am a very strong believer in educating families, because the family is going to be with the child for the longest periods of time.

When I say “educating them,” I just mean knowing what things to look for — not to actually make changes. I’m not taking that power away from professionals who should really work on that.

I started talking to the dad. I asked how long she could be in her chair, and he told me, “Only two hours.” That wasn’t very functional, because she’s at school, which means they’re picking her up and putting her in a recliner, which doesn’t give her the proper positioning.

What was amazing to me is that this gentleman really relied on the product that was given to him to be the product that he needed.

I didn’t do a mat evaluation or anything, but I could see that her armrest was too low, so one arm was hanging off. And guess which arm it was: It was the arm where the scoliosis was leaning to. There was no support there.

So I asked him: Do you have a tray? He said yes, but she hardly ever used it. I told him we rely a lot on our arm supports as able-bodied people, because gravity pulls us. He said, “I didn’t even think about that.”

I said, “You see the laterals there? People think they will stop her...”

Seat-to-Floor Heights & Early Intervention

What’s the best wheelchair seat-to-floor height for very young children?

Mala Aaronson OTR, ATP, CRTS, National Seating & Mobility explains how she typically makes that decision. — Ed.

As appropriate, I begin mobility evaluations for children with fair to normal cognition at about 9-12 months of age. At this stage of development, able-bodied children are beginning to be able to explore their environment independently through crawling or walking. It is our responsibility as clinicians and mobility providers to enable physically disabled children to do the same.

I generally do 17” to 18”-plus seat-to-floor heights for children. Unless climbing into the chair is at the top of the priority list, I feel that a developing child’s independent mobility system needs to provide him or her with optimal performance and independence equal to his/her able-bodied peers to facilitate optimal cognitive and perceptual development. This means access to toys, desks, tables, bookshelves, sinks, etc., in a typical home and preschool environment, and to be as close to eye level as possible with his or her peers.

We know that many neurological functions such as depth perception and special relations do not develop without independent means of traveling and negotiating distances.

Some of the early wheelchairs targeted for this population were very heavy, designed with front-wheel-drive configurations to accommodate the short arm length of very small children. Also, the extremely low seat heights did accommodate some independent transfers.

But once those children are seated in the chairs, they are prisoners of this low height, resulting in an environment that continues to be somewhat inaccessible to them. Fortunately, the manufacturers of ultralight wheelchairs have developed some great little chairs over the recent few years that are configured with these small children’s needs in mind and weigh in at almost half of those earlier models.

Clinicians and parents have come to understand the non-necessity and detriment of a crossbrace folding-frame style, which has driven manufacturers to mobility devices that are far lighter, perform better, and facilitate greater independence and cognitive development than ever before.
from going to that side, but there are no hip guides to stop the hip from sliding the other way,” which was causing the scoliosis and a lot of the other things that were happening. So I think it’s really important to look at that positioning with children.

The girl, now 13, has used a wheelchair for years.
(Her father) started thinking about it and said, “A lot of these things probably could have been prevented” with early-intervention positioning. So when you look at this realm we’re in — and there are a lot of good people that are in it who are doing this — the importance of educating dealers is without a doubt the most important thing.

As companies we need to be very transparent in the media of what we do and in explaining it to families. (Our company) plans on talking to families, having videos of us talking to moms about simple things, like making sure the hip guides stay in the position they need to and understanding that.

With this father, I gave him an example. I put my arms in the middle of my lap with no arm support. I said, “What you’re going to find out is my arms will pull my body down because they’re weight that’s not supported.”

I told him that trays could be viewed in a lot of different ways — they could be padded and be made really nice for her. And they don’t have to be so big — they can be cut in half and just used for supporting her hands.

She has tilt, too. I asked if she used it, and he said yes, but only when she’s going to sleep. So I talked to him about looking at and understanding her body and what it’s going through. She’s not dynamic; the laterals are keeping her in a neutral position. If we stayed in a neutral position being able bodied, we’d be sweating, we’d be fatiguing, we’d be showing tone. We’d be so frustrated that our bodies would react. Our muscles would react. We have to do proper gravity shifting, but families don’t understand that.

So now we have children whose heads are touching their shoulders because they’re so fatigued. They’ve never had an opportunity to tilt back to relax for a little bit.

Maybe it’s never been thought of — understanding how to manage the child’s positioning every hour so the child re-energizes, so the child can relax and now the body naturally comes into a non-fatigued position.

Things like that are really important to address and important for the industry to put focus into.

It’s great when we come from a show and say, “Did you see that tilt study from the U.K.??” But when that doesn’t get out to families, I end up talking here with a father who doesn’t understand the true benefits.

Understanding of the importance of positioning. Romero says, will benefit both the child and the family — and he gives an example.

Information needs to be explained to families so they can understand how important eye contact is and what it promotes — that it promotes good communication for their child, so their child’s going to be able to understand and interpret body language and facial expressions when they see them. I have a 5-year-old, and I learned to come down to his level, to look at him so he didn’t feel intimidated and he could understand me.

A lot of children in chairs can’t hold their heads up. They have a hard time understanding what you’re saying because one of their ears is covered up by their shoulder because their head’s leaning that way. Or a hard time being able to see correctly what you’re trying to show them.

When we’re doing inservices and seeing families and working with ATPs, the first thing I look for is Where is this family? How educated are they on their child’s diagnosis? If they’re not as educated and they’re more interested in a product’s aesthetics, I’ve got to find a way to leave them with the thought Maybe we should be more educated.

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EquaGel
Available in most standard, non-bariatric sizes, EquaGel cushions are coded E2601, E2603 and E2622. The EquaGel Adjustable Protector is designed to be a low-cost adjustable cushion that doesn’t require additional servicing to maintain adjustment beyond the first visit. Toss-It disposable cushion protectors are available for cushions used by multiple clients, such as in long-term-care facilities.

EquaPressure
(801) 756-2600
equipressure.com

Matrix Flovair
This hybrid cushion captures the stability of foam, the pressure redistribution of air, and the shear management of fluid. The cushion works in tandem with the ThinAir bladder to maximize surface area for optimal pressure redistribution. It’s designed to provide pelvic stability, leg positioning and pressure management for users with postural asymmetries and skin-integrity concerns. Available in gentle and max contours.

Invacare Corp.
(800) 333-6900
invacare.com

Aquos
The new Aquos combines the benefits of liquid and foam. Ottobock’s rest suspension foam is designed to produce a stable, lightweight cushion that doesn’t bottom out, and the ultra-thin Liquicell inserts (in the water-resistant Dartex cushion cover) help reduce shear forces and maintain skin integrity without compromising stability.

Ottobock
(800) 328-4058
ottobockus.com

Synergy Spectrum Air
With a 4" multi-cell air insert and Sil-Air silicone foam base, the Synergy Spectrum is designed to provide stability and positioning while allowing for maximum airflow and moisture protection. Precision air volume adjustment prevents bottoming out or high pressure from overinflation. The Sil-Air base features an antibacterial agent that greatly reduces odor and is fully waterproof.

Quantum Rehab
(866) 800-2002
quantumrehab.com

Embrace
The Embrace includes aggressive leg adductors in conjunction with medial thigh separator and deep leg troughs to promote proper leg alignment. Tapered leg adductors increase in width near the back of the cushion to give support to the greater trochanter shelves. A contoured, molded base foam is topped by a layer of memory foam for skin protection and comfort. The moldable aluminum base allows for on-site customization.

The Comfort Company
(800) 564-9248
comfortcompany.com

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Ottobock
(800) 328-4058
ottobockus.com

Synergy Spectrum Air
With a 4" multi-cell air insert and Sil-Air silicone foam base, the Synergy Spectrum is designed to provide stability and positioning while allowing for maximum airflow and moisture protection. Precision air volume adjustment prevents bottoming out or high pressure from overinflation. The Sil-Air base features an antibacterial agent that greatly reduces odor and is fully waterproof.

Quantum Rehab
(866) 800-2002
quantumrehab.com
Hybrid Elite
Designed for a user who wants the stability of a foam base with ROHO’s shape-fitting technology, the Hybrid Elite is made to provide skin protection and comfort. It’s available in widths from 14” to 24”, in depths from 14” to 20”, and features a ROHO cushion insert made of flame-resistant neoprene with a customized JAY contoured foam base. Maximum user weight is 500 lbs.
The ROHO Group
(800) 851-3449
therohogroup.com

JAY Union
This new cushion combines multi-layered soft memory foam, a JAY Flow fluid pad and innovative cover technologies to provide contoured comfort, skin protection and positioning. Its cover system features a stretchable inner cover with anti-wicking seam thread and Aqua-guard zipper, and a washable outer cover with X-static silver-impregnated, antimicrobial material. In widths and depths from 14” to 24”.
Sunrise Medical
(800) 333-4000
sunrisemedical.com

Custom Seating
Customized options and modifications for seats include additional poly foam in .5”, 1”, 1.5” and 2”, additional SunMate foam; additional Pudgee foam; gel overlays; mushroom foam; and SunMate foam-in-place kits. Extended foam or shortened base modifications are also available for hamstring relief.
Therafin Corp.
(800) 843-7234
therafin.com

cushion marketplace
Audit remain a challenging part of the landscape for today’s complex rehab and DME providers. Invacare Corp.’s Jim Stephenson works daily with providers on a number of funding issues, including strategies for responding to audits effectively. Information for this column comes from Stephenson’s February 2012 Mobility Management Webinar.

When it comes to its many types of audits — prepayment, postpayment, RAC (over- and underpayments), CERT (accuracy of payments), ZPIC (program integrity) — what is Medicare “looking for”?

In a nutshell, for the various types of audits, Medicare is looking for the following things:

• Correct code/modifier usage.
• Are coverage and billing criteria met?
• Are medical necessity requirements met?
• Was the payment correct?
• Are there signs of fraudulent activity?

Group 2 standard power chairs — HCPCS code K0823 — are currently subject to prepayment reviews in all four DME MAC jurisdictions. What can we learn from the ongoing results of these prepayment reviews?

We know that the denial rates are currently high, ranging from 55 percent in Jurisdiction A, to 88 percent in Jurisdiction D. Jurisdiction B’s denial rate is 74 percent, and Jurisdiction C’s denial rate is 69 percent.

We also know the reasons for these denials are very similar across all Jurisdictions. The most common reasons these claims are being denied, according to the DME MACS:

• The face-to-face evaluation did not provide a measurable assessment of upper-extremity strength and function.
• The face-to-face evaluation provided vague, subjective statements concerning the beneficiary’s functional abilities.
• The seven-element written order was combined with the detailed product description.
• The seven-element order and face-to-face evaluation were missing a date stamp showing when the supplier received the form from the physician.
• The physician’s progress notes failed to address the beneficiary’s mobility needs and did not support statements made in a standard “mobility assessment” form, attestation letter, etc.

Do you see other recurring patterns in claims that are being denied?

Yes. When claims are denied as not medically necessary or non-covered, for instance, we see recurring problems with the physician orders. The date of the face-to-face evaluation was not documented; the order was signed prior to the completion of the face-to-face evaluation; there was no date stamp or the equivalent to verify supplier receipt within 45 days; the length of need wasn’t documented; or no order was submitted.

Regarding medical records/information, we commonly hear that there was no documentation indicating that a mobility examination was the primary reason for the visit; functional limitations were not addressed in the face-to-face evaluation; letters of attestation or supplier-generated forms were submitted without supporting information from the medical record; or physician documentation contradicts the need for a power mobility device, for example.

When the problem is the detailed product description, it could be that it was signed or received after the date of service; that the amounts on the delivery slip are not the same as the amounts on the detailed product description; or that no detailed product description was submitted.

Other common miscellaneous reasons for denial include lack of a home assessment, or issues with proof of delivery, such as with dates, signatures or different equipment.

Since we know some of the common mistakes that are resulting in claims denials, what should we be doing up front, at the start of the process, to improve our chances of success?

Have a screening process in place on the front end, prior to submitting a claim.

Create a checklist to ensure you have all the required documents on file.

Make sure your documentation includes all the key elements — and don’t file the claim until it does. You don’t want to have to collect that documentation as you’re being audited and are under the gun, and you don’t want to give the auditor an easy reason to deny your claim. Get the documentation up front.

Be careful about your sequences of events: Make sure you’re following the process and steps in the correct order.

And first and foremost: When you get an additional documentation request, respond to it. Up to a third of all denials happen because the supplier doesn’t respond. Provide all of the documentation that’s requested in the letter, and be prompt. Missing the deadline can itself result in a denial.

Jim Stephenson, CMC, is the rehab reimbursement & coding manager for Invacare Corp.
new products

Honda Odyssey with Northstar Conversion

It’s Vantage Mobility’s silver anniversary, but adaptive automotive consumers get the big gift: A limited-edition anniversary model loaded with upgrades including a custom grille with chrome trim, lightweight chrome wheels, two-tone (dove/truffle gray) leather interior, 25th anniversary badging, and an upgraded body kit. Only 25 of these particular models will be made available (with the first one given away as part of the first-ever National Mobility Month in May), but VMI also offers the popular Honda Odyssey with in-floor and folding ramps.

Vantage Mobility International
(800) 348-VANS
vantagemobility.com

LiteRider PTC

Golden Technologies’ new personal transport chair is designed to be easily portable while also offering popular consumer features, such as underseat storage, an 18x16” stadium seat, width- and angle-adjustable armrests, and an 18AH battery pack for longer operating range. The LiteRider PTC has a top speed of 3.5 mph, a 26” turning radius and a brilliant red shroud.

Golden Technologies
(800) 624-6374
goldentech.com

Top End Reveal

The newest addition to the Top End family is this ultralightweight rigid chair designed to provide both the benefits of modern design and adjustability, in a package that pays special attention to overall value. The Reveal uses 7000 series aluminum to provide a smooth and energy-efficient ride and features adjustable center of gravity, rear seat height, caster angle and back angle.

Invacare Corp.
(800) 333-6900
invacare.com

Elan Stairlift

This straight-rail stairlift conforms to international requirements and features an attractive rail that hides all mechanical components, and a rack-and-pinion drive designed to provide a smooth, quiet ride. The straight rail can be installed within 5” of the wall, and with armrests, seat and footrest all folded, the Elan carriage takes up just 12” — providing plenty of usable staircase space.

Bruno Independent Living Aids
(262) 567-4990
bruno.com
mobilitymgmt.com

Frontier V6 Compact 73

This power chair, designed to be comfortable indoors and outdoors, is smaller in length and width than its all-terrain big brother and is ideal for consumers who want to cover longer distances thanks to its 73AH batteries. The Frontier V6 Compact 73 features a weight capacity of up to 400 lbs., or 342 lbs. with seat elevator or tilt.

Innovation In Motion
(800) 327-0681
mobility-usa.com
new products

JAY SureFit Custom Seating System

Custom seating challenges just got easier: The JAY SureFit custom seating solution is designed to offer a simple, smart option mix to meet a wide range of client requirements and provider reimbursement scenarios. An online configurator makes ordering more convenient. Cover material choices include vinyl/Naugahyde, Rubatex and Dartex, and high-resilience foam, SunMate foam or Pudgee foam is available.

Sunrise Medical
(800) 333-4000
sunrisemedical.com

Evoflex Padded Hip Belt

Imagine a hip belt that stays exactly where it can be easily found again. A patent-pending design enables the Evoflex Hip Belt to remain in place, regardless of how active the user is. It can be installed on most styles of wheelchairs thanks to a variety of mounting options and low-profile fasteners that can fit into even the tightest spots. The stiffened end straps hold their position without twisting or falling into the wheels, and the belt straps can also pivot forward and backward to facilitate transfers.

Bodypoint Inc.
(800) 547-5716
bodypoint.com

Terra

A super lightweight rest suspension foam developed by Ottobock is at the core of this new cushion. Weighing less than 2 lbs., the Terra is designed to absorb shocks while preventing bottoming out and quickly returning to its original resting position to maximize user comfort. The Dartex cover is water resistant and built for durability.

Ottobock
(800) 328-4058
ottobockus.com

Optima TSS

Described as a multi-use system for complex positioning needs, the Optima TSS excels at versatility and adjustability. Back height and angle, seat depth, frame height and armrest width are all adjustable, and consumers can choose from a high or low back. The soft, padded cushion is available in three sizes. Options include footrests, armrests, rear anti-tippers, commode pail, anterior support tray and pelvic positioning belt.

Columbia Medical
(800) 454-6612
columbiamedical.com

Standing Justified Seminars

Altimate Medical’s new CEU seminar covers a range of topics centered around standing and weight bearing. Presented by Andy Hicks, ATP, SMS, or Peter Wankelman, ATP, the seminar discusses evaluating clients for standing readiness, determining the best device configuration, writing successful letters of medical necessity and responding to claims denials. Visit the Altimate Medical site for specific dates and locations.

Altimate Medical
(800) 342-8968
easystand.com
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NGS Announces Q4 Power Chair Prepayment Review Results

National Government Services (NGS), the Jurisdiction B DME MAC, has released the results of its 2011 fourth-quarter widespread prepayment medical review for Group 2 power wheelchairs.

From Oct. 1 to Dec. 31, 2011, NGS’s medical review department examined 615 claims for which it had requested additional documentation, according to a news release distributed in March. NGS says 496 claims were completely denied, resulting in an error rate of 81 percent. The remaining 119 claims were paid in part or in full.

The prepayment review applies to HCPCS code K0823: Group 2 standard power chairs with captain’s seats and weight capacities up to and including 300 lbs. Related accessories for K0823 power bases are also included in the review.

The most common reasons for power chair base denials in quarter four of last year, NGS said, were the following:

• No valid medical records were found in the supplier’s documentation, or the medical records received as additional documentation did not establish medical necessity (found in 55 percent of denials).
• There was insufficient evidence that a physician face-to-face mobility examination occurred.
• The required seven-element order or detailed product description was invalid or incomplete.
• There was no response to the request for additional documentation.

Medicare Unveils Redesigned Claims & Benefits Statement

Medicare’s claims & benefits statement has been given a facelift to make it easier to understand for beneficiaries and their caregivers. Acting Centers for Medicare & Medicaid Services (CMS) Administrator Marilyn Tavenner showed off the redesigned statement in March. Starting in 2013, the statements, also known as Medicare Summary Notices, will be mailed to beneficiaries every quarter. The notices are also available online.

In announcing the redesign, CMS added that it will be making additional changes this year “to make information about benefits, providers and claims more accessible and easier to understand for seniors and people with disabilities who have Medicare.” CMS spent 18 months studying research and beneficiary feedback to create the form, which CMS displayed alongside the existing form.

briefly…

The Remittance Advice Remark Code (RARC) N 103 has been changed by the Centers for Medicare & Medicaid Services (CMS). Starting in July, the updated version will be used when denying Medicare claims for federally incarcerated beneficiaries. In part, the revision reads, “Social Security records indicate that this patient was a prisoner when the service was rendered. This payor does not cover items and services furnished to an individual while he or she is in a federal facility, or while he or she is in state or local custody under a penal authority, unless under state or local law, the individual is personally liable for the cost of his or her healthcare while incarcerated.”

If you’re headed to Medtrade Spring, you can chat with staffers from the four DME MACs, the National Supplier Clearinghouse, the Common Electronic Data Interchange contractor, and the competitive bidding implementation contractor. They’ll be in Booth 957.

The contractors will also be presenting on funding topics ranging from “Safeguarding Your Billing Privileges” to “Medicare Updates” during the conference (medtradespring.com). The show takes place at the Sands Expo in Las Vegas, April 10-12.

CMS has released a new MLN Matters edition entitled “The Role of the Zone Program Integrity Contractors (ZPICs), Formerly the Program Safeguard Contractors (PSCs).” The document discusses the function of the ZPICs. PDFs are available for download on the DME MAC Web sites.
A new consumer Web site for wheelchair users, assistive technology users and other people with mobility-related disabilities and their families.

A comprehensive resource with practical, in-depth information on accessibility, assistive technology, clinical conditions, advocacy, community and culture, new technology and funding that serves people of all age groups and levels of ability.

A forum where consumers can learn from clinicians, technology manufacturers, government policy experts and each other.
THE NEW M400
Introducing the new high-speed M400 by Permobil, engineered to get up to 7.5 MPH. Features the ground-breaking, patent-pending Climbing and Traction Link system with unmatched climbing capabilities—3” forward and 2” reverse. Provides tight 20” turning radius and PG 120 amp R-Net electronics. Boasts the revolutionary Corpus® 3G seating system with 50° tilt and recline up to 175°.

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