



"Where Customer Service Comes First"

July 22, 2010

Positional Therapy Pillows L.L.C.
Mr. Horacio C. Rubio
3691 Inca Street
Robstown, Texas 78380

Dear Mr. Rubio,

Thank you for allowing North Central Medical Supply, Inc. to coordinate a trial of your positioning pillow the *Comfybed Support Positioning System*. Enclosed, please examine a copy of the letter that describes the impact of your product.

We deleted or covered any private patient information with respect to HIPAA regulations. The information from the letter shows a favorable impact on the patient.

We sent the physician's order, therapist's letter, along with the required letter of medical necessity to Medical Assistance requesting coverage for the patient. We were able to get this covered for this client through M.A. funding. This child and the mom are thrilled with the product, and send their thanks for allowing them to use the product for the required trial. They were able to find a frame for the pillow, from the styles you recommended, in a local store. Both the mom and the child's therapist gave permission for you to share this letter with others, as was discussed when you agreed to give us the pillow for trial purposes.

Thank you for your assistance with this patient/customer.

Sincerely,

A handwritten signature in black ink that reads "Dianne Roth, OTR/L, ATP". The signature is written in a cursive style with a large, sweeping initial "D".

Dianne Roth, OTR/L, ATP
North Central Medical Supply, Inc.
(o) (888)-577-7331
(f) (218)-825-7293
Droth@northcentralmedicals supply.com
www.northcentralmedicals supply.com

Enclosures

DR/kr

**Certificate Of Medical Necessity
Durable Medical Equipment**

Patient's Name: _____
Residence: At home with parents
Address: _____

MA ID#: _____
D.O.B.: 6/12/2008

Phone: _____

Height: 100 cm

Weight: 33 pounds

Complete Diagnosis (Including functional deficit requiring equip.): presents with Oral
Aversion, Developmental Delay, GER, Gtube dependency, history of failure to thrive.

Prognosis: Excellent - Demonstrated improvement with 8 week in home trial

Length of need: Indefinitely

<u>Equipment</u>	<u>Special Features</u>	<u>Reason Needed</u>
all items must be listed		all must be justified

Comfybed Support Positioning System: This positioning system keeps the child elevated in the bed at 30 degrees, although the angle can be adjusted up if needed. The side supports keep the child from rolling out of the elevation position which is the problem with other reflux systems.

is a 3Y-year-old female with history of significant difficulties with night time reflux and frequent upper respiratory illness. has failed repeated attempts at reflux positioning with elevation of head of bed, pillows, propping child, would roll off the props, turn in the bed, and / or lie sideways on the bed. has a night time drip feeding via gtube by pump which is required for weight gain and growth.

ould frequently throw up if off pillow elevation and she would also have increased emesis with mucus production with colds/ congestion. was averaging emesis every other night before the implementation of the Comfybed Support Positioning System. If threw up during the night, she would loose all of the feeding completed at that point, and would not be able to tolerate resuming or replacing the feedings. has now had a 8 week trial with the Comfybed Support Positioning System, with no night time emesis since trial start. We have medically documented weight gain as well since bed usage.

Thank you for your consideration of this equipment for _____. If you should have any additional questions or concerns, please do not hesitate to call me at _____

I, undersigned, certify that the above-prescribed durable medical equipment is medically necessary for this patient's well being. In my opinion, the equipment prescribed is reasonable and necessary with reference to accepted standards of medical practice and treatment of this patient's condition, and has not been prescribed as "convenience" equipment.

See RX

4-26-10	_____	4-26-10
Date Prescribed	Prescribing Physician's Signature	Date Signed

Address:

City:

State:

Zip:

Signature of Physical and/or Occupational Therapist

ORDER FOR OUT PATIENT REHABILITATION SERVICES AND/OR
DURABLE MEDICAL EQUIPMENT

Name of Patient: _____ Parent(s) Name: _____

DOB: 6/12/06 MR#: _____ Phone (H): _____

Address: _____

Diagnosis: Oral Aversion Developmental Delay

Orders: Gastroesophageal Reflux & Tube Dependency
Hx of Failure to Thrive

Configured Support Positioning System

Therapist: _____

Ordering Physician: _____

Physician's Signature: _____ Date: 4-26-10