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PHYSIATRIST'S VOICE

NEWSLETTER

MARCH 2013

IN THESE TURBULENT WATERS... WHO IS WATCHING OUT FOR YOU?



Rigoberto Puente-Guzman, MD

This coming year will be taxing for Florida physiatrists, as well as other specialty physicians, as they will be facing many practice changing challenges. These include but are not limited to the effects of the implementation of Obama Care (Affordable Care Act) where many provisions will take effect in both the in-patient and out-patient arena; the endless saga with scope of practice of allied health care providers (CRNA's, ARNP's, Doctors in PT, and others); legislation that threatens

physician dispensing in their offices which would decrease access to care and patient compliance for injured workers; physician fee schedule peril; and ICD-10 conversion just to name a few.

To further complicate matters, Florida has the challenge of maintaining a sustainable physician work force. Our current governor is aware that to tackle this issue he must address physician reimbursement issues; convert residency positions to medical student positions ratio from negative to positive value; make the medical practice environment more attractive in Florida in order to keep graduating physicians; and address tort reform. We will be there to offer our opinion and support for what we consider the best options for Florida physiatrists.

FSPMR believes that the best approach to patient care is accomplished by a multidisciplinary approach with transparency and full disclosure to our patients of their treating team. In our current evolving healthcare system the lines of expertise, specializations and terminologies, used to define one's training, have become more confusing to our patients. One can encounter patients who erroneously think that their current provider is a physician when they have been seen by a non-physician allied health care provider. When one presents themselves as a "Doctor" in a clinical setting, for most patients, it is equivalent to a DO or MD physician. We applaud ARNP, PT and other health care providers who further their knowledge and reach a "Doctorate" degree, but we

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PHYSIATRIST'S VOICE

NEWSLETTER

MARCH 2013

TURBULENT WATERS

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oppose the potential misrepresentation to patients. We support the idea that all clinicians, including but not limited to MD/DO, ARNP, PA, PT, Psychologist and others to clearly identify themselves to their patients, either as a physician, Nurse Practitioner or Doctor in Nursing, Physical Therapist or Doctor in Physical therapy, etc. For that reason we support FMA's push to make mandatory the proper identification of all providers, providing truth in advertising. Furthermore, specialty societies, like ours, should engage in public education programs distinguishing themselves by education, competence and other factors from non-physician groups.



FSPMR representatives are involved both in state and national levels informing and educating policymakers in order to keep in mind our specialty and the patients we care for at the forefront. A good example of how FSPMR works for you was the inclusion of physiatrist in pain laws passed in the last couple years. If not involved, our specialty would have not been included as one of the specialties exempt from the pain clinic definition. FSPMR relentlessly is working on your behalf with recent joint position statements with other societies like FSIPP, FAPM, FSA, FMA regarding the practice of interventional pain medicine by non-physician certified registered nurse anesthetists (CRNAs). We are also involved in ultrasound coverage in pain and musculoskeletal medicine and have an active delegate representation in CAC, FMA and AAPMR societies, just to name a few. As a result of our last assembly with the Council of State PM&R Society Presidents in Atlanta, we are currently working closely with the AAPM&R to establish a network of links between all state PM&R society websites in order to provide support and improve communication. This will give us the ability to learn from other state societies what potential challenges we may encounter and how to approach them in an efficient and productive manner. In this issue we also included our first two patient education handouts that members will be able to download and print for their patients. We plan to gradually expand our library of patient education as part of our commitment to promoting our specialty.

Physiatrists work in a multitude of settings including private practice, as hospital employees, university appointed staff, as consultants, as medicolegal experts, for insurance carriers as peer reviewers, and others. Irrespective of our current employment situation we need to realize that those employers and entities are not incentivized to watch out for our best interest. It is imperative that we keep united in our efforts and support our society by joining its membership. Please take a moment right now, if you have not renewed your membership or are not a current member and join at <http://www.fspmr.org/join-renew-payment.html>.

With best regards,
Rigoberto Puente-Guzman, MD
FSPM&R President



TAMPA BAY TO HOST 33RD NATIONAL VETERANS WHEELCHAIR GAMES July 13-18, 2013

The largest annual wheelchair sporting event in the world requires a tremendous amount of time—about two years' worth—so Tampa Bay get ready; the city has been chosen to host the 33rd National Veterans Wheelchair Games July 13-18, 2013.



NOTES OF INTEREST

2013 Crucial year for physicians to avoid possible pay reductions under physician quality reporting and health information technology programs: Physicians not reporting Medicare quality measures or participating in electronic prescribing and electronic health record (EHR) programs in 2013 will suffer financial loss in the long run. Medicare eligible professionals who do not meet the requirements for meaningful use by 2015 and in each subsequent year are subject to payment adjustments to their Medicare reimbursements that start at 1% per year, up to a maximum 5% annual adjustment. The programs have been voluntary for the past several years. However, federal laws require Medicare rates eventually to be reduced for physicians who do not participate in the physician quality reporting system as well as the electronic health records and e-prescribing incentive programs.

Participants can benefit from current incentive payments through 2016. The amount of your incentive payment depends on when you begin participating in the program. Each physician can potentially earn up to \$44,000 from Medicare or \$63,750 from Medicaid if they started the program in 2011, but those who choose to not participate will be penalized with their Medicare pay reduced over the years, but Medicaid rates would not be decreased.

In order for eligible physicians and other health professionals to stop a 2015 Medicare EHR noncompliance penalty of 1% in 2015 they must adopt and demonstrate meaningful use of an EHR system by Oct. 1, 2014. The penalty is set to grow to 3% by 2017 for physicians who continue not to participate. Eligible professionals who do not successfully participate in the physician quality reporting system in 2013 will see their Medicare pay reduced by 1.5% in 2015. Failure to report PQRS measures successfully in 2013 will lead to a Medicare penalty of 1.5% on 2015 rates. The reduction will be 2% in 2016 and each subsequent year.

For more information in this matter you may link to: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/beginners_guide.pdf

Spinal Meningitis 2013: On the aftermath of the multistate fungal meningitis outbreak, the Florida Department of Health and Dr. John Armstrong, Surgeon General, with input from diverse sources including, but not limited to the Council on Healthy Floridians from the FMA, is working on the development of best practices for epidural steroid injections. Once this is finalized we will bring forward their final recommendations to our members on our website.

2013 Sports Medicine Subspecialty Certification: The last year ABPMR diplomates may apply for the Sports Medicine Examination using the temporary criteria is 2013. After the 2013 examination, candidates applying for the Sports Medicine Examination must complete 12 months of training in an ACGME-accredited sports medicine program affiliated with an ACGME-accredited residency program in family medicine, emergency medicine, internal medicine, pediatrics, or physical medicine and rehabilitation. Full application criteria for all subspecialty examinations are available at www.abpmr.org.

2014 ICD-10 Implementation: Unless there is a further push back on the start date, on October 1, 2014, the US Department of Health and Human Services (HHS) has mandated the replacement of the ICD-9 code sets used to report medical diagnoses and inpatient procedures to be replaced by ICD-10 code sets. Now is the time to begin the organization and careful planning for a successful transition. This will require a significant effort and cost to implement. You will need to consider how it will affect your budget, information technology (IT), software, and staff. The transition to ICD-10 is required for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA). The change to ICD-10 does not affect CPT coding for outpatient procedures and physician services. For more information visit:

<http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/ICD10/>

2014 New ABPMR Subspecialty Certification in Brain Injury Medicine (BIM): Just when you thought you took all available subspecialty examinations, ABPMR and the American Board of Psychiatry and Neurology (ABPN) are collaborating to offer subspecialty certification in brain injury medicine (BIM). The first BIM Examination is tentatively scheduled for the fall of 2014.

2015 Change in ABPMR, subspecialty requirements: Currently, as per ABPMR any subspecialty certificate holder, diplomates, must maintain their primary certification in order to maintain their subspecialty certification, which requires completion of parts I, II, and IV of the Maintenance Certification (MOC) Program along with successfully completing the primary MOC Examination. As of 2015, the ABPMR will no longer require subspecialty certificate holders to maintain primary certification. The subspecialty certificate holders may choose to continue to maintain all certificates (primary and subspecialty) or may maintain only the subspecialty sub-certification(s). They will still have to participate in parts I, II, and IV of the primary MOC program along with successful completion of the subspecialty MOC Examination(s).

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NOTES OF INTEREST

Medical License News:

Florida link of licensure to recertification: The Department of Health was mandated by statute to have quality assurance measures in respect to medical licensure. This has led to a change of re-licensure from just a pay system with attestation of CME to a CME registration recertification process, with more stringent accountability. Currently there are no new bills in house and senate that change requirements for licensure. Currently the next renewal will be optional to register one CME log. The DOH can do sporadic audits, but on the following renewal period it will be mandatory to register and meet the CME requirements which will be 100% audited.

There was a push for **national licensure** by telemedicine association lobbying groups in order to practice over state lines that died last year. Currently most states allow some type of controlled telemedicine but the physicians involved have to be licensed in the state they cover and have hospital privileges. The fear and risk of a national licensure is that this could lead to Federal government mandates requiring physicians to see Medicaid in order to receive their license to practice. We support that licensure be state-by-state controlled, and the standardization of a single uniform physician credentialing form to be used by all managed care companies and hospitals in the state of Florida.

This Month:

National Nutrition Month – Sponsored by the Academy of Nutrition And Dietetics with focus on the importance of making informed food choices and developing sound eating and physical activity habits.

<http://www.eatright.org/nnm/>

March 17 - St Patricks Day: Saint Patrick's Day is in honor of the Patron Saint of Ireland, who brought Christianity to the Emerald Isles, as Ireland is known. It is truly a day of celebrating Irish history, ancestry, traditions and customs.

March 30 - National Doctors Day: First started back on March 30, 1933. It was started by Eudora Brown Almond of Winder, GA. The day marks the anniversary of the first use of general anesthesia in surgery. When you are sick, after your parents and God, who do you think of? Your doctor. We appreciate all that doctors do to keep us healthy and care for our ailments.



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THE NEW REALITY



Oscar B. DePaz, MD,
Chairman of the Board – SIMED
Connie Pegram, ACO Director

As we progress through the new reality of Health Care, The Affordable Care Act, we must understand that changes are unavoidable in medicine. The bottom line is that Obama Care is here to stay and we have a choice as clinicians to evolve and participate or to hold to our old ways and risk becoming extinct as practitioners.

At Southeastern Integrated Medical (SIMED), we have been closely following these changes and believe that an Accountable Care Organization (ACO) structure is eminent and we have invested the time and resources to understand and engage in developing an ACO over the last two years. As of April 2012, SIMED's ACO the Integrated Care Alliance was accepted as one of the few initial ACOs in Florida. We believe that the implementation of this program will be both challenging and rewarding.

I would like to share with you the ACO structure and its ultimate goals.

Medicare Shared Savings Program ACOs

The Affordable Care Act (ACA) enacted on March 23, 2010, includes a number of provisions designed to improve the quality of Medicare services, support innovation and establishment of new value-based payment models and put Medicare on a firmer financial footing. Section 3022 of the ACA established the Medicare Shared Savings Program (MSSP), intended to encourage the development of Accountable Care Organizations (ACOs) in Medicare. The MSSP is a key component of the ACA aimed at better care for individuals, better health for populations, and lower growth in Medicare Parts A and B expenditures (the Triple Aim). The Centers for Medicare and Medicaid (CMS) views value-based purchasing as an important step in revamping how care and services are paid for, moving increasingly toward rewarding better value, outcomes, and innovation, instead of merely increased volume.

An ACO is defined in Section 3022 as "groups of providers of services meeting criteria specified by the Secretary (of Health and Human Services) may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an ACO".

The ACA also provided that ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for "shared saving."

CMS ACO Vision

- An ACO promotes seamless coordinated care
- Puts the beneficiary and family at the center
- Attends carefully to care transitions
- Manages resources carefully and respectfully
- Proactively manages the beneficiary's care
- Evaluates data to improve care and patient outcomes
- Innovates around better health, better care and lower growth in costs through improvement
- Invests in team-based care and workforce

Financial

- CMS will use three years of prior claims to establish a per capita benchmark for the ACO's.
- There is a minimum expenditure savings rate determined by a sliding scale based on the number of Medicare beneficiaries attributed to the ACO.
- If the minimum savings rate is achieved, savings are shared from first dollar saved, based on the quality performance of the ACO.

Quality

- There are 33 quality measures in 4 separate domains:
 - Patient and care giver experience of care
 - Care coordination and patient safety
 - Preventive care
 - At risk beneficiaries based on specific conditions and evidence-based medicine

Medicare Beneficiary Attribution

- Primary Care Physicians (PCPs) are defined as Family Practice, Internal Medicine, General Practice and Geriatrics.
- Medicare Beneficiaries will be assigned first to ACO participating PCPs prospectively according to where they received the plurality of their primary care services within the past year.
- Specialists can be attributed beneficiaries if they provided the plurality of primary care services and the patient has not seen a PCP during the past year.
- Includes all Medicare Beneficiaries eligible for Medicare due to:
 - Age
 - Disability
 - Dually eligible for Medicare and Medicaid
 - End Stage Renal Disease
- Attribution of beneficiaries is for determination of Shared Savings only. The beneficiary can choose to use non-ACO providers at any time.

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THE NEW REALITY

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Claims Data and Medicare Beneficiary Information

- Lists of attributed beneficiaries and all their Medicare claims data will be provided to the ACO.
- Beneficiaries must be given a data-sharing opt-out form during an office visit where primary care services are provided explaining that:
 - Their physician is participating in a Shared Savings Program with CMS
 - Their personal health information will be used to coordinate their care and improve overall health care for Medicare beneficiaries
 - The program is to help reduce costs to CMS through more efficient use of health care resources.
- The beneficiaries must be given a meaningful opportunity to opt-out of CMS sharing their personal health information with the ACO. If they opt-out, their information will not be identified individually, but will be included in the aggregate claims data provided to the ACO.

Health Information Technology

- Meaningful Use of an EHR is included as a quality measure that carries twice the weight of any other measure.
- Must enable the ACO to collect and evaluate data and provide feedback to ACO participants, providers/suppliers across the entire ACO, including providing information to influence care at the point of care.

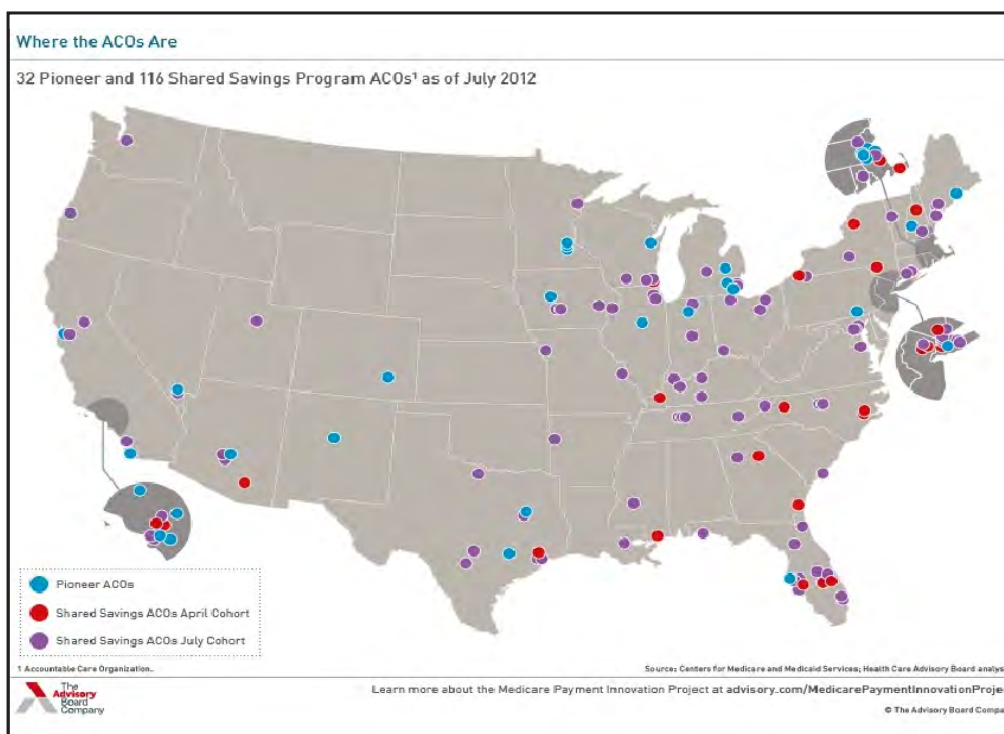
Network Participation

- Participating providers must supply materials to beneficiaries to notify them that they (the provider – not the patient) are participating in an ACO.
- Primary Care Physicians are exclusive to one ACO.
- Specialists are not required to be exclusive to one ACO (unless they are attributed beneficiaries).
- Notice of provider changes must be provided to CMS and could affect beneficiary attribution and the savings benchmark.

Public Reporting and Transparency

- Name, location, organizational information, participating providers, joint venture partners, representatives on governing bodies, committees and committee leadership
- Quality performance scores, amount of shared savings or losses
- Total proportion of shared savings distributed among participants
- Total proportion of shared savings used to support quality improvement; better care for individuals, better health for populations, and lower growth in expenditures

It is important to know that ACOs are not exclusive to Medicare. Health plans are working with providers in ACO-like arrangements. Several States are also working with ACOs for their Medicaid programs.



This map illustrates the Medicare Shared Savings Programs and Pioneer ACOs that were announced in 2012. In January 2013 CMS announced an additional 106 Medicare Shared Savings ACOs bringing the total participating to over 250.



FSPMR ALERTS



Jeffrey Zipper, MD
FSPMR CAC Representative

Dear Colleagues,
In an effort to keep you apprised of Legislation and policies that may impact your practice this year, please review my legislative update. I have highlighted within the articles, (in light blue) my opinions only!

You may click on the links below for full details located in our ALERT section at <http://www.fspmr.org/alerts.html>.

- ▶ 1) [Analysis of Congressman Fasano's new bill HB 831, pain bill revisions.](#)
- ▶ 2) [Work Comp Repackaging Bill Raises its Ugly Head again this Legislative Session.](#)
- ▶ 3) [Analysis of Senator Galvano's "Doctor of Nursing" bill SB 612 \(Galvano\).](#)
- ▶ 4) [Aetna nerve conduction study policy](#)
- ▶ 5) [Aetna injection policy for back pain](#)

Regards,
Jeffrey A. Zipper, M.D.

GET INVOLVED JOIN A COMMITTEE OR VOLUNTEER SOME TIME!

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MAINTENANCE OF CERTIFICATION – MOC



Jesse Lipnick, MD

OK everyone. Here it is – a quick and useful summary of the MOC program. MOC was developed by the American Board of Medical Specialties to ensure that you, the willing physician, maintain effective professional learning throughout your career. The American Board of Physical Medicine and Rehabilitation sets the requirements for board certified physiatrists and tracks your MOC progress. All diplomates certified in 1993 and beyond must complete requirements in 4 categories within

a 10-year cycle to maintain AAPM&R certification. They call it “Lifelong Learning”. If you go to the AAPM&R website and write “MOC” in the search box, the site will take you a page that creates for you a Personal MOC Plan, based upon the year you received your board certification and the work you have already put into the process.

Category 1 requires you to maintain a current, valid and unrestricted license to practice medicine. So be sure to pay your yearly licensure fees to the state, get all of the required CMEs (Medical Errors, Domestic Violence, Bioterrorism, etc.) and stay out of jail to meet all the requirements of the Florida Board of Medicine.

Category 2 requires you to obtain 300 Category 1 CME credits within the 10 year MOC cycle. The ABPMR recommends that you complete 30 CMEs per year. If you received your certificate in 2012 or later, they actually state that you are to receive 150 credits in the first 5 years and 150 credits in the second 5 years, and of these 150 credits, 40 CMEs must come from ABPMR Self Assessment activities, which are available on the website. The ABPMR recommends that you complete 8 credits per year of Self Assessment. These credits do count toward the recommended 30 total credits per year that you need for each 5-year cycle. Also, the Academy requires that you complete at least one Safety Self Assessment per 10 year MOC cycle and like the others, this is available on the website.

As far as the Self Assessment activities go, there are a number of interesting topics that you can purchase for the low, low price of \$99. We are still in Category 2 here and believe me, these activities would be a bargain at double the price. Choose from: Stroke Rehabilitation, Pain Management, Osteoarthritis,

Concussion and Mild TBI: Current and Future Concepts, Sports Medicine, Diagnostic and Interventional Musculoskeletal Ultrasound of the Lower Extremity, A Framework for Rehabilitation Focused Biologics, Principles of Manual Medicine, Diagnostic Ultrasound – Use and Techniques, Neural Plasticity, Fatigue – A New Frontier, Ultrasound of the Upper Extremity, Pediatric Rehabilitation, Assess and Manage Spasticity, Dystonia, and Related Motor Disorders.

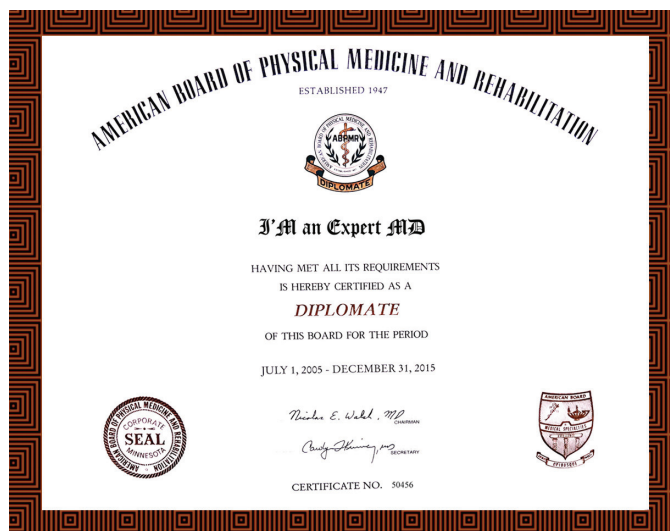
Category 3 consists of a computer-based, written exam, 160 questions, including material from all of the subspecialty areas of PM&R practice. We are eligible to take the exam in years 7 through 10 of the MOC cycle. I took the exam a few years ago and it was not too bad. While it was comprehensive, I would say that most of the material was taken from traditional PM&R education and not necessarily reflective of new research. Still, the best way to perform on this exam is to know your basics and to keep up with current literature. With this in mind, I recommend reading one of our journals regularly, both to review the foundations of our education and to keep up with new developments in PM&R. Also, the SAE requirements of Category 2 should prepare you for the exam.

Finally, Category 4, called “Practice Performance”, contains various activities designed to address quality improvement in your medical practice. Diplomates with time limited certificates issued before 2012 must complete a minimum of one Practice Performance project during the 10-year MOC cycle. Diplomates

with time limited certificates issued in 2012 and beyond must complete two ABPMR-approved Practice Performance projects (one in years 1 – 5 and one in years 6 – 10) of the 10-year MOC cycle. There are 3 separate potential projects listed on the AAPM&R website, and completing any one of them will fulfill this requirement. I will include a brief summary below of each option, and you should consult the website for a detailed description.

The first Practice Performance option is entitled “Clinical Care Practice Improvement Project”. The ABPMR has developed a self-guided Continuous Quality Improvement (CQI) process. The idea here is that you pick some

aspect of your clinical practice that you would like to improve. You measure this aspect in some way and then you propose an intervention to improve this aspect of the care you provide. You apply the intervention and then try to measure the impact on the care you provide. You can develop your own CQI project or you can participate in an established one through your practice or your hospital. I like this option because it gives you the freedom to address any aspect of clinical care that you believe needs attention.



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Maintenance of Certification – MOC

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The second option for completing Category 4 is entitled "AAPM&R Practice Improvement Project (PIP)". In this option, the AAPM&R allows you to select from a predetermined set of clinical areas, and asks you to create a CQI process to improve care specifically in that area. This option seems much more structured than the first in that your progression through the project is based on a set of steps available on the website. This option seems much more like plug and chug in that the steps are already written out for you. Clinical project areas include: Low Back Pain, Stroke Rehabilitation, Deep Vein Thrombosis, Osteoporosis, and soon, Prosthetics, Orthotics and Assistive Devices. The Academy recommends setting aside at least 5 weeks to complete this requirement.

The third and final option for completing Category 4 is entitled "AANEM Performance in Practice: Electrodiagnostic Report Writing." In this option, the AANEM addresses the six clinical areas of Electrodiagnosis and asks you to propose an improvement. You measure an aspect of care before and after your intervention to determine the effect of your intervention. This option involves chart review and also provides up to 20 category 1 CME credits.

Well everyone, there you have it – the 4 areas of MOC with some details about completing them. There is a lot to do to maintain your certification, so don't waste too much time in getting started. I will end by saying that the website of the AAPM&R has excellent resources and if you get confused the staff at the AAPM&R is very helpful.

Cheers.
Jesse Lipnick, MD

Dr. Craig Lichtblau, South Florida Native, Awarded for Outstanding Service in Pediatric Rehabilitation

North Palm Beach, Florida January 14, 2013



Dr. Craig Lichtblau has been recognized by The Florida Society of Physical Medicine and Rehabilitation (FSPMR) for his outstanding service in Pediatric Rehabilitation. He has been a consultant to Children's Medical Services for the past 23 years and has had a positive impact on many children within the CMS program (State Medicaid). Dr. Lichtblau practices

inpatient rehabilitation, transitional living rehabilitation, and outpatient rehabilitation. His staff privileges at 5 hospitals has been current for the past 23 years. Since 2007, Dr. Lichtblau has served as Clinical Assistant Professor at Nova Southeastern Medical School. He served as the Treasurer of the FSPMR in 1995, and has served in multiple board positions including President of the Southern Society of PM&R in 2006. Dr. Lichtblau is originally from South Florida and his practice is located in North Palm Beach. In 2011, Dr. Lichtblau was recognized with a Lifetime Achievement Award for the many years of extraordinary service and dedication to the specialty of Physical Medicine and Rehabilitation. The award was presented by both the Florida and Southern Societies of PM&R.

SAVE THE DATE
2013 ANNUAL MEETING
JUNE 28-30, 2013

IN CONJUNCTION WITH THE
FLORIDA ACADEMY OF PAIN MEDICINE





CMS RECOVERY AUDIT PROGRAM FOR INPATIENT REHABILITATION FACILITIES (IRF)



Wilda Murphy, MD

Physiatrists involved in the care of patients at Inpatient Rehabilitation Facilities (IRFs) face many documentation challenges imposed by Medicare. Whether or not the regulatory paperwork contributes to patient outcomes or level of care is debatable. The alternative of claims denial is not. We must document pre-admission assessments, post-admission assessments, Initial Plans of Care in addition to our well established Team Conference Notes. All of these documents do have a timeframe for

completion, or the whole hospital claim could be at risk.

Recovery Audit Contractors (RACs) is a Medicare auditing program that utilizes private firms to review physician, hospital, hospice, nursing homes and other claims to find instances in which the government has overpaid providers. At IRFs, claims may be denied if the RAC determines there was lack of medical necessity for admission and/or if regulatory documents are lacking within the established criteria. Once a RAC determines there has been overpayment, the physician or hospital is required to reimburse Medicare, even if they plan to appeal the decision. Sometimes this can be large amounts of money.

Medicare Modernization Act, Section 306 required the RAC demonstration. Tax Relief and Healthcare Act of 2006, Section 302 required a permanent and nationwide RAC Program by no later than 2010. Both Statutes gave CMS the authority to pay the RACs on a contingency fee basis. The RACs are paid by Medicare based on the amount of money they recover from physicians or hospitals. If a RAC loses at any level of appeal, the RAC must return its contingency fee.

Complex reviews occur when RACs have identified a likely improper payment and are requesting that the provider furnish the medical records attached to the claim to conduct a more in-depth review. In most cases, overpayments are made to inpatient hospital providers (85%), inpatient rehabilitation facilities (6%) and outpatient hospital providers (4%).

If you bill fee-for-service programs your claims will be subjected to review by the RACs. <http://www.cms.hhs.gov/rac>

Connolly is the exclusive RAC for region C the largest region, covering 35% of all claim volume from 17 states (including Florida) and territories in the southern portion of the US. RACs are required to employ a staff consisting of nurses, therapists, certified coders and a physician. To date, the program has resulted in the correction of more than \$3 billion in erroneous payments.

If your institution is notified of an improper payment, the providers' options are to pay by check if you agree with RACs

determinations, allow recoupment from future payments, request or apply for extended payment or Appeal. If you choose to appeal, you must send a discussion letter requesting a redetermination of the claim. The Appeal must be filed before the 120th day after the Demand Letter. If the claim denial is overturned, the carrier must include the appropriate payment with the letter. If the claim denial is upheld, the carrier will provide an explanation. If you're dissatisfied with the outcome of the redetermination process a request for reconsideration may be filed within 180 days (Second Level Appeal). Ultimately, cases can be successfully overturned at the Administrative Law Judge level.

AAPMR suggestions to prepare for a RACs audit include:

- Create a RAC audit team that includes a primary point of contact.
- Consider creating an electronic copy of the medical records for ease of handling.
- Track all correspondence with the RAC and manage all deadlines.

Florida physicians should also be aware that the Centers for Medicare and Medicaid Services (CMS) have authorized Medicare Region C recovery audit contractor (RAC) to initiate audits as of October 2012 on evaluation and management (E&M) codes. The code specifically being looked at is CPT® code 99215. A complex review of this code is under way, and findings are being allowed to be extrapolated based on a statistical sample of such claims.



The first line of defense in a Medicare overpayment, whether initiated by the RAC or the Medicare Part B carrier, is having adequate documentation to establish the medical necessity of the service.

Wilda Murphy, MD
Medical Director Shands Rehabilitation Hospital,
Gainesville FL

Region C:
Connolly Consulting Associates Inc.
1.866.360.2507
RACinfo@connollyhealthcare.com
States: Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia



SAVE THE DATE

SATURDAY MAY 18, 2013

TIME 7:30-12:00PM

**The Department Of
Rehabilitation Medicine At
The University Of Miami
Miller School Of Medicine
Will Be Presenting Its**

7TH ANNUAL RESEARCH DAY.

We will be celebrating the 10th year of the department's existence as a stand alone department in the medical school! The department would like to invite all PM&R physicians in the state of Florida, particular members of the FSPMR, and other interested guests to attend. Come down and learn about some of the research projects being completed by your PM&R colleagues and our resident trainees! We are excited to also announce that the Keynote address will be given by Walter R. Frontera, MD, PhD, Professor and Chair, Department of PM&R at Vanderbilt University School of Medicine, former Dean of San Juan Medical School and past Chair of Harvard University Department of PM&R at 9AM. What is new for this year is that the Research Day will take place on a Saturday to allow our community based PM&R colleagues to attend and that 3.0 CME will be offered to any physicians that attend at no cost to you as part of the Department of Rehabilitation Medicine's Yearly Grand Rounds series.

LOCATION:

**The Clinical Research Building (CRB),
1120 NW 14th Street, Miami FL.**

Further information regarding the event will be sent via email to FSPMR members when the event details are finalized. RSVP is not necessary but if you would like to alert the meeting organizers that you will be attending, you can send an email to Andrew Sherman, MD at asherman@med.miami.edu.



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In Memory of Richard M. Fry, MD



Dr Richard M Fry passed away peacefully at his home in Gainesville, Florida, on January 23, 2013. He was not a physiatrist, he was an orthopaedic surgeon; however, he was married to a physiatrist - Justine Vaughen MD, one of FSPMR's founders and presidents. Through the years, Dr Fry was a regular at our meetings and very supportive of his wife and our specialty. One of the first times I met him was at an FSPMR meeting in Orlando, and it was the same time I had first gotten CMEs for one of our events. Dr Fry brought his brother, Louis, to film the event.

Born in New York City, Dr Fry later attended Mount Herman School in Massachusetts. He served as a medical corpsman in the US Navy (Pacific) from 1944 - 46, and then graduated from Temple University School of Medicine in Philadelphia. He completed his Orthopaedic Residency with an interest in hand surgery from the University of Michigan, Ann Arbor. His Fellowship in Hand Surgery followed at The Derbyshire Royal Infirmary, Derby, England. Dr Fry moved to Gainesville first as a professor at the University of Florida School of Medicine, then to a private practice with surgical privileges at Alachua General Hospital, North Florida Regional Hospital, and also at the Veterans Administration Hospital.

Dr Fry (Dick) met the love of his life, Justine, in medical school and they married in 1955. They had a successful medical practice together. He

served as the President of the Florida Orthopaedic Society 1988-89. Since retirement, Dick was quite involved in the Gainesville community including but not limited to orthopaedic care of the Dance Alive National Ballet troupe, Girl Scouts and Boy Scouts, Florida Free Speech Forum, and the Gainesville Photography Group. He served as a volunteer tutor at Buchholz High School, and Altrusa House, an adult day health care facility that provides for the socialization and safety of frail, elderly and disabled adults, age 18 and over. Altrusa House of Gainesville became a reality after many years of advocacy by Justine.

Dick and Justine had two daughters, Martha Morrow (John) and Amanda Tung (Doug), and 5 grandchildren.

He loved a good book, a great variety of music, young people, and always said, "A man can never have too many screwdrivers and flashlights."

Dick had an outgoing personality and loved to tell jokes. One time, a number of years ago, he bought Justine a gondola for her birthday! Fortunately, they lived on a lake. The last time I heard a joke from Dick was last summer, 2012, when he accompanied Justine to the FSPMR annual meeting. We will miss him in the Florida PM&R community.

In honor and memory of Dr Fry, FSPMR has contributed \$500.00 to Altrusa House of Gainesville.

Lorry S. Davis, MEd
FSPMR Executive Director

Thank You from Altrusa House of Gainesville Board of Trustees

"On behalf of the Altrusa House Board of Trustees, we wish to thank you for your memorial donation of \$500.00 to Altrusa House in memory of Dr Richard Fry. A letter will be sent to the Fry family advising them of your donation.

Without support Altrusa House would not exist to fill the needs of families that need day care for a spouse, parent or family member who needs a secure and safe place each day for their loved one. Your donation will go into the Altrusa House endowment account so we can continue the sustainability of Altrusa House.

For all of us that worked so hard for so many years at garage sales, and other events to raise the funds to build Altrusa House, we know we are filling a real need in our community. We are extremely proud of the facility that we built and we invite you to visit Altrusa House if you are in the area.

Thank you for your support so we can provide the best care possible each and every day."





RESIDENTS SECTION



Bella Chokshi, D.O.
Co-Chief Resident
Physical Medicine & Rehabilitation, PGY-4
University of South Florida Program



As a graduating senior here are some important pearls of wisdom that I have gathered throughout my final year that may be of help to you on your journey into becoming an Attending. From the beginning recognize what you do not know and try to stay one step ahead.

Senior Graduation Checklist Pearls

1. Board Preparation

2. Licensure

3. Job Search

1. Board Preparation

- Review residency didactic lectures as these cover all relevant PM&R topics important to your training.
- Consider a national board review course to help solidify the information (Kessler, Baylor, Wash U).
- Review PM&R board review books as they contain high yield material (Cucurullo, Pocketpedia, PM&R Secrets).
- Review old SAE questions as most resident programs have a question bank.
- Consider investing in Maintenance of Certification SAE-P questions on AAPM&R. Cost for each test is approximately \$99 per section for AAPMR members.
- Read, read, and read! As clinical rotations are no substitute for reading.

2. Licensure

- Process your license early in the event you may need to make an appearance in front of the Medical Board.
- Apply for a state license through one of the following boards: Florida Board of Medicine (M.D.) or Florida Board of Osteopathic Medicine (D.O.) Visit http://www.fsbm.org/fcvs_state_specific_req.html for more information and an application.
- Send all documents via certified mail with return receipt as obtaining a state license is very important to your future in practicing clinical medicine.
- If practicing outside of a government setting you will require a DEA license to prescribe controlled substances. Federal employees can apply for a fee exempt personal DEA number to write for prescriptions at a non-VA pharmacy. Visit <http://www.deadiversion.usdoj.gov/drugreg/index.html> for more information and an application.

3. Job Search

- Keep your curriculum vitae (CV) up to date as this should be an accurate and descriptive reflection of yourself and the only resource employers initially have in getting to know you. Consider online websites on how to write a stellar CV.
- Prioritize what is important to you when looking for a future job: Location vs. Hours vs. Income Potential.
- Consider which arena you would prefer to practice in: Private setting vs. Academic setting vs. Government setting.
- Visit U.S. Small Business Administration at <http://www.sba.gov> for some great resources if your interested in starting your own practice. Private settings include solo vs. group, single specialty vs. multi-specialty to name a few.
- Consider Traditional vs. Non-traditional routes (hospital administration, consulting in medical-legal vs. pharmaceuticals, or independent medical examinations). Visit <http://www.seak.com/> for more information on non-traditional career options.
- Consider Locum Tenens for Temporary, Permanent, and Temporary to Permanent positions.
- Consider additional help through recruiters and head hunters. Most of them are compensated via future employers.
- Speak with previous or current employees if given the contact information.



PATIENT EDUCATION

Low Back Pain

By Rigoberto Puente-Guzman, MD

Low back pain describes pain localized anywhere from below the ribs to above the legs. It presents at any age and its causes are very diverse. It can be acute (less than 3 month duration) or chronic (over three month duration). Over 80 to 90 % of low back pain presentations is of short-term and will resolve in 3-6 weeks with no particular treatment. Risk factors that predispose you to back injuries include older age, family history of back pain, prior back surgery, prior back injuries, and pregnancy. Risk factors that increase your risk for back pain but you can change include: lack of regular exercise, obesity, smoking, poor posture and certain repetitive activities in and out of work environment. Some medical conditions and medications, like chronic use of corticosteroids and cholesterol lowering medications, can cause low back pain and may be remedied if addressed with your physician.

Symptoms of Low Back Pain:

Symptoms can be very mild to severe in nature. For the most part, pain may be described as either dull, achy, sharp, throbbing, burning or pressure like or a combination of these. Depending on the cause they may be localized or cover a broad area. They may start suddenly or gradually over days and months or be acute or progress to chronic of several months to years in duration. Pain can present intermittently or continuously. It may refer up or down the spine and even down into the legs (Referred pain down the back of the leg to the lower leg and foot is known as Sciatica). It may or may not be associated with muscle spasms, tingling, numbness, weakness, bowel, bladder and sexual problems. Patient may also suffer from depression.

Causes of low Back pain:

Determining the exact source of the low back pain may not be clearly identified at times. One must consider anatomical origin, activities, injuries, and medical conditions to reach a diagnosis. It can originate from bone and joints in the back (known as lumbar facet joints), muscles, soft tissue, nerves, disks, or even referred from distant structures like hip and sacral joints, visceral organs like the kidneys, liver, intestines, ovaries, uterus and other structures.

The most common cause is a strain or over use of the back muscles, ligaments or joints. Other medical conditions that commonly present with low back pain include but are not limited to herniated discs, osteoarthritis or also known as degenerative joint disease, spondylolisthesis, spinal stenosis, fractures, acquired or congenital spinal deformities like scoliosis or kyphosis, infections, post procedure or surgical interventions and tumors. Depending on the patient's age and history and physical exam a physician can narrow the most common causes for that group.

Red Flags in Low Back Pain:

If the patient presents as an older individual with gradual onset pain, worse at night, not associated to any activity and/or has associated bowel and bladder problems (known as cauda equine syndrome) and progressive extremity weakness, then they should seek immediate medical attention.

Other situations that require immediate medical services if symptoms resulted from severe damage to the spine from an accident such as a fall, motor vehicle accident or blow to the spine resulting in severe pain, weakness with inability to stand or walk and loss of bowel and bladder function. If pain does not improve after 1 to 2 days or progressively gets worse you should call or visit a doctor irrespective of any history of recent injuries.



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PATIENT EDUCATION

Low Back Pain

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Diagnosing Low Back Pain:

Your physician will perform a history and physical exam to narrow the potential diagnosis. In most instances, if no serious or alarming findings, your doctor will be able to recommend a treatment plan. Diagnostic studies like X-rays, CT scans, or MRIs are usually not needed on the initial encounter. But if you have back pain that has lasted more than 4 weeks and not improved with conservative care, or your doctor thinks this may be related to something more serious than a case of muscle pain, he or she may order the above test and others.

Treatments of Low Back Pain:

If your new onset of low back pain does not improve after 1-2 days with home remedies like ice, over the counter NSAID's (non-steroidal anti-inflammatory drugs) and activity modification, your doctor may recommend conservative modalities (ice, heat, ultrasound, TENS), medications (opiate and non-opiate painkillers, muscle relaxers and others), physical therapy, chiropractic care, massage, acupuncture, injections (Epidural steroid injections, facet blocks, nerve blocks, rhizotomies, trigger point injections), surgery, cognitive-behavioral therapy, biofeedback and relaxation techniques, yoga and others.

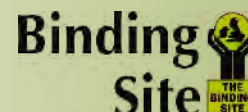
Always ask questions and get as much information as possible of your current diagnosis and treatment options. Ask about each treatment's possible complications versus benefits and duration. If surgical intervention is contemplated consider getting a second opinion. You must realize back surgery is not always successful and can potentially aggravate the pain and condition.

How to Prevent Low Back Pain and avoid further pain:

The best option for most conditions is to live a healthy life style. Do not smoke, since it has been shown that smokers are associated with higher incidence of low back pain conditions and have decreased recovery from injuries when compared to non-smokers. Do regular exercise and strive to maintain an ideal body weight. Obesity places extra stress in your back and is associated with a higher incidence of low back pain. A healthy balanced diet with regular, low-impact exercise helps maintain a healthy spine. Perform regular stretches and use proper ergonomics when working or doing any daily activity. Practice good posture when you lift, sit or stand. When doing sedentary activities, like sitting, for a prolonged period of time, take regular breaks to change posture and do other tasks that allow you to walk around. Use chairs with good back support and arm support with ergonomic adjustment to your body type and shape. If your activities require frequent bending, lifting or reaching, use proper techniques for lifting and avoid lifting anything that you consider too heavy for you.

To find a physician (PHYSIATRIST) to evaluate your back condition:
Go to <http://www.fspmr.org/search.html>.

*Disclaimer: The information and recommendations appearing on this article are appropriate in most instances, but are not substitutes for medical diagnosis. For specific information concerning your personal medical condition you can find a physiatrist at <http://www.fspmr.org/search.html>.



Did You Know?

March is Myeloma Awareness Month: Help Spread the Word!

- Get your free Myeloma Awareness Ribbon by clicking the button below
- Share this with your friends, family, and/or coworkers
- Display your magnetic Myeloma Awareness ribbon all throughout the month of March

Thanks for your help in the joint effort to spread myeloma awareness.

Sincerely,
Binding Site Inc.

Get Your Free Ribbon

Make it Official

Ask your town to declare March "Myeloma Awareness Month."

Thirty cities across the US have done so, through the efforts of wonderful myeloma advocates. [The International Myeloma Foundation \(IMF\)](http://www.imf-foundation.org) has assembled a TOOLKIT to make the process simple. Email Aimee Martin, amartin@myeloma.org, of the (IMF) for more info.



PATIENT EDUCATION

Runner's Knee

By Quang Nguyen, MD

Iliotibial Band Syndrome abbreviated as IT Band syndrome is commonly called "Runner's Knee" because of how prevalent it is among those participating in running sports; however it can be seen in any sport or activity that requires repetitive bending of the knees. It is said by some that "one is not a runner until one develops runner's knee."

The iliotibial band is the tendon attachment of hip muscles into the bone on the upper part of the lower leg (tibia) just below the knee to the outer side of the front of the leg. Where the tendon passes the knee (lateral femoral condyle), there is a bursa sac between the bone and the tendon. This tendon moves over a bony bump at the outer knee as it passes in front and behind it. The bursa functions like a water balloon to reduce friction and wear of the tendon against the bony bump. In this condition overuse causes excessive friction at this bump, resulting in inflammation and pain of the bursa (bursitis), tendon (tendinitis), or both.

Common Signs and Symptoms:

- Pain, tenderness, swelling, warmth, or redness over the iliotibial band at the outer knee above the joint, pain may travel up or down the leg
- Initially pain at the beginning of exercise that lessens once the muscle is warmed up; as the condition goes untreated pain may occur throughout the activity. This may cause the athlete to stop the athletic activity
- Pain may be worse as the runner runs downhill
- Pain that is felt when the runner's foot first strikes the ground
- In some instances there may be a crackling sound when the tendon or bursa is touched or moved

Causes of IT Band Syndrome:

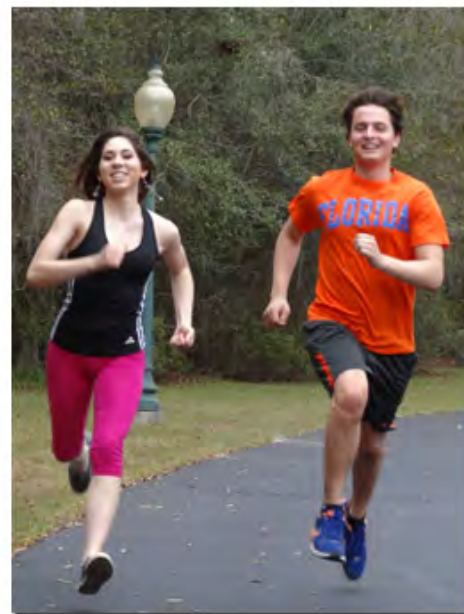
Iliotibial band syndrome occurs as a result of excessive friction of the IT band and the underlying bursa as a result of repetitive knee-bending activities. The syndrome is mostly seen as a problem with overuse; however, direct trauma to the outer knee may also cause the bursa to become inflamed though this is less commonly seen. Often times this condition is seen with outdoor trail runners who run in hilly areas which require frequent deceleration as they are running down the hills.

Factors That Increase Risk:

- Participation in sports that require repetitive knee bending such as with cycling and running
- Poor training techniques including sudden changes in the amount, frequency, or intensity of training along with inadequate rest between training sessions
- Poor lower extremity strength and or flexibility. Having a tight iliotibial band is a risk factor.
- Inadequate warm-up before practice or competition
- Having Bow Legs
- Osteoarthritis of the knees

How to Prevent Iliotibial Band Syndrome:

- Always remember to adequately warm up and stretch before doing the activity
- Remember to allow for adequate rest and recovery between practices and most importantly competition as during competition the intensity of the activity is much higher than in daily practice sessions.
- Maintain knee and thigh flexibility.
- Maintain overall muscle strength and endurance of the lower extremity muscles
- Often poor running mechanics is the root cause of IT Band syndrome. For example a runner who has an excessive long stride often times plants the foot far beyond his or her center of mass. This will result in poor control of the forces that act upon the knee joint which can result in excessive strain and friction at the insertion of the iliotibial band. Focusing on shortening one's running stride could help.
- Runners with this condition should consider reducing the mileage run and reduce the amount of time spent running up and down hills or banked surfaces.
- Consider wearing arch supports if you have high arches and note that your foot collapses inwards while running.



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PATIENT EDUCATION

Runner's Knee

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Expected Outcome:

Iliotibial band syndrome is usually curable within 6-8 weeks if treated appropriately with conservative treatment and resting of the affected area.

Possible Complications:

- Prolonged healing time if not treated or if return to play happens too quickly
- If the tendon and bursa become chronically inflamed this could result in constant pain that occurs not just with sports activities but could occur with regular walking.
- Inability to complete training or competition

General Treatment Considerations:

First line treatment consists of medications such as a non steroidal anti-inflammatory and ice. Stretching of the iliotibial band with exercises that aim to strengthen the muscles of the gluteal region, thigh, and legs should also be initiated. Most importantly modification of the activity that initially caused the problem should be explored. Referral oftentimes to a physical therapist for guided treatment can be very helpful. A trained physical therapist or medical doctor that is familiar with running mechanics can also analyze your gait to see if modifications can be made to optimize control of your knee while running. The therapist or medical doctor can also evaluate whether or not an orthotic device such as an arch support could improve your running gait.

With regards to training technique modification: lessening the amount of time per training session or decreasing the total mileage per training session, avoidance of hills, avoidance of running on stairs and banked tracks are all factors that can help.

If the condition was brought on by one sporting activity such as running then, consider adding a cross training day to your weekly training regimen where you focus on cycling or swimming. This could allow your knee to heal while still maintaining your cardiovascular fitness.



**Remember...
Stay Active!**

For cyclists a very common cause of iliotibial band syndrome is having a seat height that is too high resulting in excessive stretching of the iliotibial band causing an excessive pulling force at the iliotibial band's insertion at the outside knee. Lowering your seat height can potentially relieve the pain at the knee. A trained certified bicycle fitter found at your local bike shop can assist in proper bicycle fitting. In general, if you are riding more than 20 miles per week then being fitted properly on your bike is highly recommend for injury prevention and optimization of performance. To treat the pain and inflammation a corticosteroid injection may need to be performed into the bursa. In very rare occasions when conservative measures have failed surgical removal of the bursa can be performed for the following reasons:

- If symptoms get worse or do not improve in 2 to 4 weeks despite treatment,
- If new or unexplained symptoms develop such as low back pain with radiation of the pain down the affected leg, pain that awakens you from sleep, sudden unexplained weight lost, fever/chills.

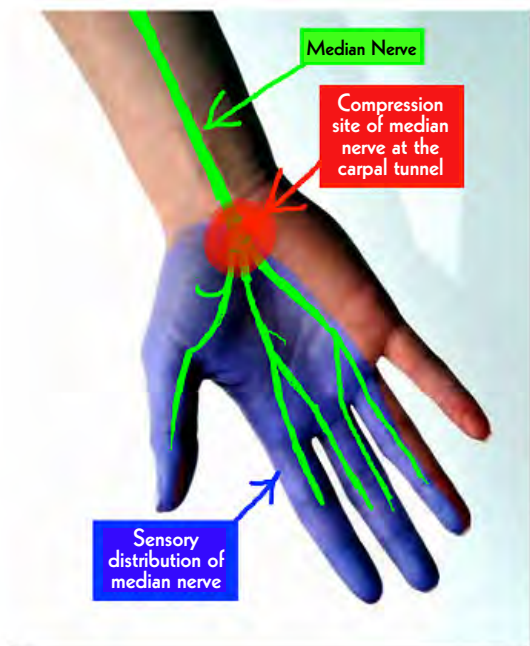
*Disclaimer: The information and recommendations appearing on this article are appropriate in most instances, but are not substitutes for medical diagnosis. For specific information concerning your personal medical condition you can find a physiatrist at <http://www.fspmr.org/search.html>.

PATIENT EDUCATION

Carpal Tunnel Syndrome

By Rigoberto Puente-Guzman, MD

Carpal tunnel syndrome (CTS) is considered one of the most common diagnoses in patients that present with hand pain and numbness. Simply stated, it is a condition where one of the main nerves of the hand, the median nerve, is compressed at the carpal tunnel causing symptoms typically seen in carpal tunnel syndrome. Multiple tendons that originate from the forearm that help bend your fingers and wrist and the median nerve pass through the carpal tunnel. The tunnel is composed of the carpal bones (bones of the wrist) and the transverse carpal ligament that forms a band across the base of the palm and wrist. Any condition that results in compression of the median nerve, at this location is classified as Carpal Tunnel Syndrome.



Symptoms Suggesting Carpal Tunnel Syndrome:

The median nerve provides feeling and movement to the "thumb side" of the hand (the palm, thumb, index finger, middle finger, and thumb side of the ring finger). Symptoms usually start gradually. The main presentation in CTS includes: pain, tingling, burning and/or numbness in the hand and fingers. The numbness and tingling is usually first noted in the thumb, index and middle finger. It tends to spare the 5th digit (little finger). You may encounter cramping of the hand and fingers. Patients often complain of awakening at night with the hand asleep or hand falling asleep when driving or doing a prolonged activity. Patients can present with complaints of clumsiness of the hand, and dropping things easily. These symptoms may also refer up the forearm and, if severe enough, to the shoulder area. If left untreated, in advanced or chronic cases, it may progress to develop weakness of the hand grip with muscle wasting (loss) under the thumb in the area known as the thenar eminence.

Cause of Carpal Tunnel Syndrome:

Any condition that results in narrowing of the space inside the carpal tunnel compressing or irritating the median nerve can cause CTS. Most common causes of compression of the median nerve include swelling of the tendons, known as tenosynovitis, that may occur from repetitive activity or trauma; repeated pressure at the wrist like resting the wrist on edge of a keyboard when using it; rheumatoid arthritis causing swelling of local tissue and joints; swelling during pregnancy, usually during

second and third trimester; infections; amyloidosis and other space occupying lesions like a ganglion cyst.

Risk Factors Associated With Carpal Tunnel Syndrome:

Sometimes there is no identifiable cause. Women are at higher risk than men to develop CTS. There are many known risk factors that can predispose the development of CTS. Although not scientifically proven, it is thought that symptoms are most often brought on by overuse of the hand like prolonged typing, working in manufacturing line, using power tools that vibrate and injuries to the wrist and hand area.

Other Conditions that Mimic Carpal Tunnel Syndrome:

Medical conditions that can predispose the patient to develop or masquerade as CTS must be sought out. Other neurologic diagnoses like central nervous system sensory or motor illness; cervical radiculopathy of C6, 7 and 8 roots; brachial plexus lesion; more proximal median nerve lesions; and generalized polyneuropathies like that found in diabetes. Musculoskeletal conditions like deQuervain's tenosynovitis, osteoarthritis of the wrist or base of the thumb, digital neuritis, vascular conditions like Raynaud's phenomenon, and radial artery thrombosis need to be considered.

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PATIENT EDUCATION

Carpal Tunnel Syndrome

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Testing for Carpal Tunnel Syndrome:

The first step in properly diagnosing this condition is a taking a thorough history by your physician followed by a physical exam looking at the different possible conditions that could cause your symptoms. This is then followed by an electrodiagnostic study, also known as Nerve Conduction Study and Electromyography (NCS/EMG).

"Buyer beware" – Inform yourself of who is performing your electrodiagnostic study. Electrodiagnostic studies should be conducted by physicians specialized in physiatry or neurology. If the NCS tests component is performed by a qualified technician, this should be performed in direct supervision of a trained physician in the field of electrodiagnostic medicine, and the EMG should only be performed by the trained physician. Unfortunately, unqualified physicians and non-physicians perform these tests and this may result in erroneous diagnosis which may result in unnecessary discomfort and improper treatment. The Florida Society of Physical Medicine & Rehabilitation (FSPMR) and Florida Society of Neurology (FSN) agree with the American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM) and other medical societies in that "The proper conduct and interpretation of neuromuscular electrodiagnostic studies need an in-depth knowledge of peripheral anatomy, physiology, pathophysiology and signs and symptoms of nerve and muscle disorders. EMG is not a 'test' in the ordinary sense; it is not a study which can be completed by a technician and interpreted at a distance or at a different time. It requires ongoing real time commitment from an expert to be done well. In that sense, it is more akin to an angiogram than to an EKG or an MRI."



Radiographs are also used to look for possible fractures and arthritis. Magnetic resonance imaging (MRI) can be ordered in cases where a space-occupying lesion is suspected. Blood work sometimes is obtained as part of the investigation of possible contributing medical conditions.

Treatment for Carpal Tunnel Syndrome:

Usually begins with the avoidance of the activity causing the problem, such as stopping repetitive motion, and using proper ergonomics in the work station. The use of a wrist splint at night and anti-inflammatory drugs are commonly prescribed in order to relieve pain and swelling. Your physician may order Occupational Therapy (OT). More aggressive intervention would consist of corticosteroid injection in the wrist. If symptoms do not resolve with conservative intervention then your physician may recommend carpal tunnel release surgery.

Because of the many conditions that can mimic CTS, surgery should not be performed unless the diagnosis is verified with an electrodiagnostic study. The surgery is commonly performed in an out-patient surgical center with regional anesthesia by an orthopedic surgeon or neurosurgeon. Note that the surgery is performed in order to release the pressure on the median nerve. The surgeon may decide to do an open surgery, making a larger incision in the palm for direct visualization of surgical field, or an endoscopic surgery, using a small endoscope through a small incision in your wrist or hand. Although carpal tunnel release surgery, in patients with mild to moderate conditions, tend to have a good outcome, it may take several months for the strength and numbness to resolve. In some cases where the condition is severe or not properly diagnosed the condition may not resolve.

Complications:

If CTS is ignored or not properly treated, it may result in permanent pain, numbness, weakness and impairment. Surgical risks include but are not limited to: no improvement, increase pain due to injury of nerve or vascular structure, bleeding, infection, and scar sensitivity.

*Disclaimer: The information and recommendations appearing on this article are appropriate in most instances, but are not substitutes for proper medical evaluation and diagnosis. For specific information concerning your personal medical condition you can find a physiatrist at <http://www.fspmr.org/search.html>



Volunteers Still Needed for Legislature's Doctor of The Day Program

The Florida Legislature's Doctor of the Day program provides lawmakers with medical care during the legislative session while serving to strengthen physician-legislator relations. During each of the 60 days of session, two physicians — one for the House of Representatives and one for the Senate — provide any necessary care to legislators, their staff members and others at the Capitol. The 2013 session begins on Tuesday, March 5, and is scheduled to end on Friday, May 3. The legislative clinic still needs volunteers, so if you are able to participate, please call Mavis Knight with the Florida Office of Legislative Services at (850) 717-0301 or email her at knight.mavis@leg.state.fl.us. The FMA thanks Council on Legislation Chair Neal Dunn, M.D., for volunteering to be a Doctor of the Day on the first day of session!

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Thanks everyone,
Michelle Jacquis
Director of Legislative Advocacy



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