FLORIDA SOCIETY OF PHYSICAL MEDICINE AND REHABILITATION
FSPMR
1962

PHYSIATRIST'S VOICE

NEWSLETTER SEPTEMBER 2018

Enhancing Health And Function Through Education And Research In The Field Of Physical Medicine And Rehabilitation

IN THIS ISSUE

PRESIDENT'S MESSAGE

Craig H. Lichtblau, M.D.

First, thank you for putting your trust in me and electing me President of the Florida Society of Physical Medicine and Rehabilitation (FSPMR), 2018 – 2020. I look forward to serving the Physical Medicine and Rehabilitation (PM&R) community and working with the new board members. You will find your new Board of Directors later in this issue.

Of current importance to our members and to all physiatrists in Florida, is an additional requirement for pain clinics to remain exempt from registration. Even though our specialty is one of four exempted by statute (FS 458.3265, 2012, exempting PM&R, anesthesiology, neurology, and rheumatology from registration) the Florida Department of Health and the Board of Medicine is developing a form which will now have to be completed in order to maintain exemption. This is due to 2018 FS 456.0301. More about this in a summary in this issue from our Vice President, Dr Mark Rubenstein.

One of the directions that I want to take as president is to create the Florida Physical Medicine and Rehabilitation Pioneers. The Florida PM&R Pioneers will consist of physicians who have been active members of the FSPMR and have been practicing 25 years or more. My intention is to have these physicians listed in the Florida PM&R Pioneers section of the newsletter to be recognized, identified, and made available to the new PM&R physicians starting to practice, as well as to any physiatrist needing guidance or help. The idea is to provide quick access to information to help with any potential problems, concerns, or issues as new doctors start their practices and continue through their practice experience. The PM&R Pioneers will have developed knowledge, training, and experience that can help guide and protect the new practitioners. I think mentorship is very important. The Florida PM&R Pioneers will be a vehicle to provide the necessary mentorship for all practicing PM&R physicians that are members of the Florida Society of Physical Medicine and Rehabilitation.

In July, FSPMR held its annual meeting at The Breakers, Palm Beach. We enjoyed a very good continuing medical education breakout that Saturday morning. I would like to thank the following for their presentations: Anthony Dorto MD: "Depositions, Trials, and Other Sworn Testimony: What the Expert Needs to Know"; Wilda Murphy MD: "In-Patient Rehabilitation Update"; Jesse Lipnick MD: "Cannabis and Autoimmune Disease"; Orlando Florete MD: "Pharmacology of Medical Cannabis; Christopher Alexander MD and Martin Weaver MD (UMiami

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PRESIDENT'S MESSAGE CONTINUED

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2018 Annual Meeting: Drs Matt Imfeld, Craig Lichtblau, Diana Hussain, Jesse Lipnick, Michael Creamer, Rob Kent.

PM&R Residents): "Ultrasound Guided Baclofen Pump Refills, A Novel Technique"; Marjorie Mamsaang DO (Larkin Community Hospital PM&R Resident): "Weakness and Paresthesia After Gastric Bypass Surgery; Morgan Pyne DO (USF PM&R Resident): "Ossteointegration with Targeted Muscle Reinnervation." Thank you also to Drs Matthew Imfeld and Michael Creamer who served with me as the Expert Panel for the Resident presentations.

Later that evening we held our Annual Business Meeting and Dinner. We had received 40 RSVPs and 54 people showed up….a good thing! We are very excited about and grateful for the Florida PM&R Residents' involvement…an impressive lot of up and coming physicians! They are the future of our specialty and the future of this organization.

Another important goal for my tenure as president, with your help and the board's help, is to significantly increase FSPMR's membership. It is my suggestion to the current members of the Florida Society of Physical Medicine and Rehabilitation that when you speak to other physiatrists, you encourage them to join the Florida Society of Physical Medicine and Rehabilitation because there is strength in numbers. Increasing the membership of FSPMR is of paramount importance because of so many negative forces influencing medicine today. As new problems arise, we will need a stronger and more powerful voice. The way to have an effective voice is with increased membership.

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SEPTEMBER 2018

Congratulations to the 2018 – 2020 FSPMR Board of Directors

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Vice President
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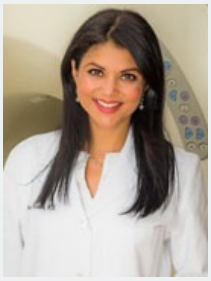

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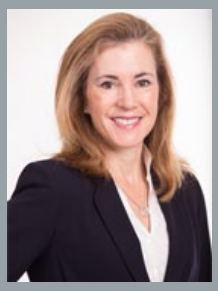

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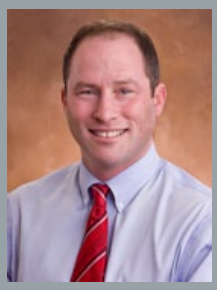

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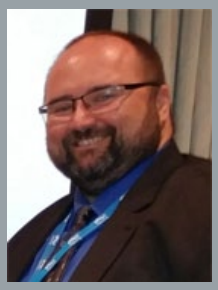

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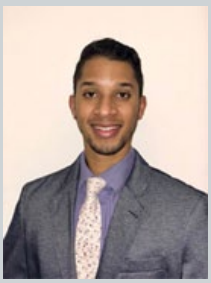

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SEPTEMBER 2018

Update on Controlled Substance Rules and Regulations

Mark Rubenstein, MD
Vice President, FSPMR
Chairman, Council for Ethics and Judicial Affairs, Florida Medical Association

The nationwide hysteria related to "the opioid crisis" has led to a myriad of new guidelines, rules, and regulations that we as physicians must be cognizant of. The federal government began its public assault on the opioid crisis with the published CDC Guidelines. These "guidelines" led to many changes in the way controlled substance prescriptions were being recognized and/or accepted. Many states then sought to tighten control of both prescribed and illicit substances through legislation. Florida has been no exception to that. The Florida Senate and the Florida House both moved proposals through Tallahassee and in March of 2018 Governor Rick Scott signed into law HB 21.

HB 21 has had both intended and unintended consequences. The bill itself is 205 pages in length. There are multiple requisites that physicians in the State of Florida which bear discussion in this update.

HB 21 is the State's attempt to regulate controlled substance prescribing via modification of Florida State Statutes. The Bill is titled "An Act relating to controlled substances" and begins as follows:
"An Act relating to controlled substances; creating s. 456.0301, F.S., requiring certain boards to require certain registered practitioners to complete a specified board-approved continuing education course to obtain authorization to prescribe controlled substances as part of biennial license renewal and before a specified date; providing course requirements; providing that the course may be offered in a distance learning format and requiring that it be included within required continuing education hours; prohibiting the Department of Health from renewing the license of a prescriber under specified circumstances; specifying a deadline for course completion; providing an exception from the course requirements for certain licensees; requiring such licensees to submit confirmation of course completion; authorizing certain boards to adopt rules; amending s. 456.072, F.S.; authorizing disciplinary action against practitioners for violating specified provisions relating to controlled substances; amending s. 456.44, F.S.; defining the term "acute pain"; requiring the applicable boards to adopt rules establishing certain guidelines for prescribing controlled substances for acute pain; providing that the failure of a prescriber to follow specified guidelines is grounds for disciplinary action; limiting opioid prescriptions for the treatment of acute pain to a specified period under certain circumstances; authorizing such prescriptions for an extended period if specified requirements are met; requiring a prescriber who prescribes an opioid drug for the treatment of pain other than acute pain to include a specific indication on the prescription; requiring a prescriber who prescribes an opioid drug for the treatment of pain related to a traumatic injury with a specified Injury Severity Score to concurrently prescribe an emergency opioid antagonist; amending ss. 458.3265 and 459.0137, F.S.; requiring pain management clinics to register with the department or hold a valid certificate of exemption; requiring certain clinics to apply to the department for a certificate of exemption; providing requirements for such certificates; requiring the department to adopt rules necessary to administer such exemptions; amending s. 456.0155, F.S.; providing requirements for pharmacists for the dispensing of controlled substances to persons not known to them; defining the term "proper identification"; amending s. 465.0276, F.S.; prohibiting the dispensing of certain controlled substances in an amount that exceeds a 3-day supply unless certain criteria are met."

The bill continues to address a myriad of other issues and makes many other specifications. It does allow an exception for physicians to prescribe medication assisted treatment of opiate addiction, and also defines what we as physicians must recognize in terms of appropriate identification of a patient not known to us. The bill allows electronic prescriptions if certain criteria are met. It revises requirements for the prescription drug monitoring program, and modifies the rules to insure that dispensers report prescriptions to the department. It requires certain reports to be produced to the Governor and the Legislature within time certain specifications.

The bill requires that physicians must consult the prescription drug monitoring database before issuing a prescription

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prescription for a controlled substances (except for Schedule V non-opioids). The bill represents the following: …"requiring specified persons to consult the system for certain purposes within a specified time." Failure to follow these requirements are also addressed in the bill, as it continues:
"requiring the department to issue citations to prescribers or dispenses who fail to meet specified requirements relating to consulting the system; providing a system for discipline of specified persons for failing to meet such requirements."

The bill itself created a new Florida Statute (s. 456.0301) that is important enough to list in its entirety in this update:
456.0301 (2018 F.S.) (1) (a) "The appropriate board shall require each person registered with the United States Drug Enforcement Administration and authorized to prescribe controlled substances offered by a statewide professional association of physicians in this state that is accredited to provide educational activities designated for the American Medical Association's Physician Recognition Award Category 1 credit or the American Osteopathic Category 1-A continuing medication education credit as part of biennial license renewal. The course must include information on the current standards for prescribing controlled substances, particularly opiates; alternatives to these standards; non-pharmacological therapies; prescribing emergency opioid antagonists; and the risks of opioid addiction following all stages of treatment in the management of acute pain. The course may be offered in a distance learning format and must be included within the number of continuing education hours required by law. The department may not renew the license of any prescriber registered with the United States Drug Enforcement Administration to prescribe controlled substances who has failed to complete the course. The course must be completed by January 31, 2019, and at each subsequent renewal. This paragraph does not apply to a licensee who is required by his or her applicable practice act to complete a minimum of 2 hours of continuing education on the safe and effective prescribing of controlled substances."

456.0301 continues as follows:
(b) Each practitioner required to complete the course required in paragraph (a) shall submit confirmation of having completed such course when applying for biennial license renewal.
(c) Each licensing board that requires a licensee to complete an educational course pursuant to this subsection must include the hours required for completion of the course in the total hours of continuing education required by law for such profession unless the continuing education requirements for such profession consist of fewer than 30 hours biennially.
(2) Each board may adopt rules to administer this section.

WHAT DOES THIS MEAN TO US AS PHYSIATRISTS?

First of all, the new rules and regulations pertain to all physicians in the State of Florida, not just physiatrists. While many of us sub-specialize in Pain Management, we all need to abide by the rules or face disciplinary action.
The most pertinent take-away points are the following:

1) We must all complete the 2 hour mandatory controlled substance course before 1/31/19, and the course must be administered by a body certified by your appropriate Board (i.e. Board of Medicine or Board of Osteopathy).
2) The course must be reported to the Board or other governing agency as required in the Statute. It is worth mentioning here that this should happen without additional action by most of us. CE Broker in Florida is a place to store your educational requirements and have them report to the licensing agency that you utilize. Assuming you use CE Broker this step should be inherent simply by the entity which administers the course reporting same to that organization.
3) The course is limited in terms of who can provide and administer, but both the FMA and FOMA have made it relatively easy and inexpensive, if not free, to attend and complete said course. Currently the FMA is offering an on-line course approved by the Board of Medicine and the Board of Osteopathic Medicine at a price of $25 for members, and $75 for non-members. FOMA has posted on its online CME catalog a course charging $75 for

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4) There are absolute limits on quantities of prescriptions of controlled substances, particularly "opiates". Acute pain is now defined by State Statute (not by our individual organizations), and pursuant to the bill signed by Governor Scott, limits a controlled substance script to 3 days. There is a 7 day exception which can be recorded on a prescription that would allow a pharmacist to fill said script. If you are treating chronic, non-malignant pain, and you deem a prescription medically necessary (assuming it meets the Federal regulations of being for a "legitimate medical purpose") then you can provide a longer script. This would require denoting on the prescription the basis of the exception (i.e. "non-acute pain").

5) I would urge all physiatrists to monitor the literature, review publications from the Department of Health and Board of Medicine/Board of Osteopathy, as well as the Drug Enforcement Agency. We should expect that there will continue to be both "guidelines" as well as "rules" which will affect the way we practice medicine. Currently there is a joint committee on controlled substances comprised of the Boards of Medicine, Osteopathic Medicine, Dentistry, Nursing, Optometry, Pharmacy and Podiatric Medicine that are drafting standard of care rules for treating acute pain. The joint committee has met once and will meet again on September 21st to approve the language. The public book, which includes the draft rule, can be found by accessing the DOH website.

6) Assessing the PDMP is now mandatory before providing a prescription for a controlled substance (except for Schedule V non-opioids). At the recent annual FMA meeting, several entities submitted resolutions to the FMA asking them to "seek legislation" to restrict mandatory PDMP assessment to opioids and not all scheduled drugs. It is unlikely that in the face of the current nationally noted "opioid crisis" that we will expect any change in this rule. Please note that the FMA and other entities were quite vocal during the legislative committee meetings providing testimony about what would be appropriate from a physician perspective. Our testimony may have been appreciated, but the government was determined to set strict regulations in an effort to reduce unnecessary opioid overdose deaths.

7) In 2011, the State formulated new rules and statutes which defined a "pain clinic" as any entity which prescribed or dispensed controlled substances to more than 50% of its patients. This rule was developed to help regulate and eliminate the "pill mills" which had become so prominent in Florida in 2010. The 2011 Statute (F.S. 458.3265) exempted 3 specialties from having to register as a pain clinic (Neurology, Anesthesia, and PM&R). In 2012, the statute was modified to add Rheumatology to the list of exempt specialties. However, the new 2018 Florida Statute modified s. 456.0301 to require exempt specialties to complete a form declaring said exemption. This is a NEW requirement, and any of us who would meet the criteria/definition of "pain clinic" must now register. This form must be completed by January 1, 2019. The form is not yet available, and a comment period is currently underway. While it appears onerous to us (why should an exempt specialty have to complete a form confirming exemption?), this is also not likely to change. Note that it is not just the exempt specialties who have to complete this form, but the requirement applies to any entity or clinic that qualifies for exemption.

8) HB 21 also grants the boards the authority to discipline physicians who have not met the requirements. It not only gives them the authority, but directs them to enforce same. Board penalties can range from letters of admonishment, requirement for additional CME, fines, license suspension or even license revocation. It became mandatory for us to check the PDMP before granting a controlled substance prescription as of 7/1/18. While the pharmacist may not be aware that you did or did not assess the PDMP, the software of our state-wide system clearly shows whether you viewed same. The enforcement agencies can clearly check. It appears that the current penalties include the following: a) First offense is a fine of $100. b) Second offense is a fine of $150. c) Third offense is a fine of $200. The subsequent three violations have more severe penalties. The next series of violations would be a) Anything from a letter of concern to a reprimand and an administrative fine of $1,000-$2,500; b) second in this next series could be a reprimand and an administrative fine of $2,500-$5,000, and c) third in the subsequent series of violations could include suspension to revocation of your license and an administrative fine of $5,000-$10,000.

9) The Department of Health will require the exemption form as of 1/1/19. There will not be a fee to complete said exemption form. There is not yet a published penalty for failing to submit said form, but it will likely fall under Rule 64B8-9.0132 which would range a sentence from probation of not less than one year with a fine of $5000-$10000 up to license revocation. The Board of Medicine legal team has been researching this and should be publishing their findings soon.

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Update on Controlled Substance Rules and Regulations

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10) Lastly, the Florida Department of Health is instructing all practitioners to log into their licensure accounts and indicate (declare) if they are registered with the U.S. Drug Enforcement Agency (DEA) to prescribe controlled substances for chronic non-malignant pain. While this seems intuitive to most of you, it may surprise you to see that you have not declared this on your license filed with the State. You may also find that you had done this previously but you are not registered as such. This is a simple step and you should take the following step to insure that you have such a declaration:
A) Log onto the state website at the following address: http://www.flhealthsource.gov/mqa-services
B) If you already have an account, then click "Yes" and log in using your MQA Online Services user ID and password. If you do not, then click "No" and follow the instructions provided to complete your one-time account registration.
C) Once logged in, go to the "Manage my license" section.
D) Select "Add/Change DEA Registration" in the dropdown list and follow the instructions to indicate if you hold a current registration with the U.S. Drug Enforcement Administration. If you are using the DEA registration of an institution or supervisor and do not have an individual DEA registration, then indicate that you are not registered with the DEA.
E) If you hold a current individual DEA Registration you MUST provide your DEA number.
F) If you do not have a current individual DEA registration, indicate that you are not registered with the DEA.

Rules will likely be modified by multiple different entities. As mentioned in this article, the various State Boards are planning to publish standard of care doctrines. We will do our best to keep you apprised of pertinent changes that affect the practice of PM&R in Florida. In the meantime, please continue to practice quality, ethical medicine as we have all been educated to do.

Dr Rubenstein is on the Board of Governors of the Florida Medical Association. He serves on the Executive Committee and the President's Advisory Council. He has been the Chair of CEJA (Ethics and Judicial Affairs) for a number of years, as well as on the Council of Legislation for many years. Dr Rubenstein says, "I am happy to represent the voice of PM&R at the FMA, but it would be great to bring along some of the younger physicians to get involved in leadership in the future."

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FMA
FLORIDA MEDICAL ASSOCIATION
1430 Piedmont Drive E., Tallahassee, FL 32308

September 10, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, D.C. 20201

Re: File Code CMS–1693–P; Medicare Program: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Dear Administrator Verma,

On behalf of the Florida Medical Association (FMA), I appreciate the opportunity to provide input on this proposal. As an organization representing more than 22,000 members in a state that is home to millions of Medicare beneficiaries, we are keenly aware of the impact that changes to the Medicare Physician Fee Schedule (PFS), the Quality Payment Program (QPP), and other aspects of Medicare payment policy can have on the practice of medicine and the lives of individual patients.

We also recognize the urgent need to reduce the excessive regulatory burdens impacting medical practices. We applaud CMS for adopting the Patients over Paperwork initiative, which has the potential to increase efficiencies across the health care system while improving the experience of Medicare beneficiaries. As researchers have found, it is not unusual for physicians to spend nearly two hours performing administrative work for every hour with patients[i]. The excessive regulatory burdens driving much of this administrative work have contributed to the epidemic of physician burnout and tragically require the most highly trained members of our health care system to perform unnecessary clerical functions at the expense of patient care.

As CMS is aware, the Medicare program is a crucial part of Florida's health care system. Florida has the second largest Medicare population in the country, with more than four million residents relying on Medicare for coverage[ii]. In addition, state forecasters project that close to 50 percent of Florida's population growth between 2010 and 2030 will be driven by seniors 65 and older[iii]. At the same time, Florida suffers from a physician shortage, with researchers estimating that the state will have a shortfall of 3,690 physicians by the year 2025[iv]. This substantial shortage is complicated by Florida's expansive geography, which includes numerous rural and underserved communities.

Read the Entire Edition.

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September 10, 2018

Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1693-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-1693-P Medicare Program; Revisions to the Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Dear Administrator Verma:

On behalf of the more than 9,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAPM&R), we appreciate the opportunity to submit comments to the Medicare Physician Fee Schedule and Quality Payment Program proposed rule. AAPM&R is the national medical specialty organization representing physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability, and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life. Several of the provisions in the proposed rule will impact physiatrists nationwide. We therefore appreciate your consideration of the following comments.

II. Provisions of the Proposed Rule for PFS

D. Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

3. Interprofessional Internet Consultation (CPT Codes 994X6, 994X0, 99446, 99447, 99448, and 99449)

AAPM&R supports coverage for the interprofessional internet consultation codes beginning in 2019. Physiatrists are regularly called upon by their peers to provide their insights in management of patients. As a smaller specialty,

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FMA House of Delegates meeting August 3-5, 2018, Orlando, Florida.

Author: Lindsay Shroyer, M.D.

The FMA House of Delegates met August 3-5, 2018. The meeting began with the installation of the142nd president of the FMA Corey L Howard, M.D. It is exciting news that Dr. Howard will also be running for Vice Speaker of the American Medical Association. He would make an excellent liaison for the FMA to the AMA. The message by Dr. Howard to the House of Delegates was clear: "We are stronger when we are united." We have to continuously learn "how to work out problems and how to come out as friends." It is the goal of the FMA to help physicians practice medicine.

Dr. Howard's presidential speech involved the alarming news of the increase in physician suicide rate and physician burnout. The physician suicide rate is up to almost 400 suicides per year. Depression is increasing for residents and students. The FMA is currently forming committees to study these alarming issues and provide resources for physicians. According to Medscape, "A systematic literature review of physician suicide shows that the suicide rate among physicians is 28 to 40 per 100,000, more than double that in the general population." https://www.medscape.com/viewarticle/896257

Topics covered in the Reference committees and the House of Delegates involved Scope of practice, HB21, public safety including gun violence and lead levels in public water. The House of Delegates debated the complexities of what issues the FMA should take to legislation.

As of July 1, 2018, ARNPs will now be called APRN (Advanced Practice Registered Nurses). In 2015 The National Council of the State Boards of Nursing (NCSBN) approved state model legislative language entitled the "Advanced Practice Registered Nurse (APRN) Multistate Compact (the "APRN Compact), which would create multistate licensure for APRNs. The APRN Compact eliminates the physician involvement requirements for APRNs practicing. The APRN Compact requires only ten states to enact the Compact into law before it goes into effect. Idaho and Wyoming assed the legislation into law in 2016 and North Dakota passed it into law in 2017. In 2018 the Florida Legislature passed legislation (H 1338) which changed the nomenclature from ARNPs to APRNs. The concern is that if the APRN Compact is passed, it would allow the APRN to become licensed in a different state which may not have the same requirements of Florida's medical boards. The APRN would not have to obtain a license from the state of Florida board of nursing, as they would have their license from the APRN Compact. This would allow APRNs to not be supervised by the board of Nursing by the state of Florida, and yet be able to practice in the state of Florida.

There was much discussion about public safety and how the FMA will become involved in societal issues such as gun violence and mass shootings, texting while driving, lead levels in public water and schools. There was much debate regarding these issues and how they affect our patients both now and in the future.

We heard several discussions on HB21. HB 21 in summary, states that Acute Pain is the normal, predicted, physiological, and time-limited response to an adverse chemical, thermal, or mechanical stimulus associated with surgery, trauma, or acute illness. Acute pain does not include pain related to (1) Cancer; (2) a Terminal Condition; (3) Palliative Care; or (4) a Traumatic Injury with an Injury Severity Score of 9 or greater.
HB21 prescribing limits state that UNLESS, in your professional judgment, a more than a 3-day supply is medically necessary to treat the patient's acute pain, AND you indicate "ACUTE PAIN EXCEPTION" on the prescription, AND you document in the patient's medical records the acute medical condition and lack of alternative treatment options that justify deviation from the 3-day supply. Then you can prescribe up to a 7-day supply. If you write a prescription for any Schedule II controlled substance (not just an opioid) for chronic pain, or for pain that is excluded from the definition of acute pain (see above), then you must indicate "NONACUTE PAIN" on the prescription.
Prior to prescribing or dispensing any controlled substance (except for a non-opioid Schedule V) to a patient 16 years of age or older, you must first review the patient's controlled substance dispensing history in the E-FORCSE database. If the database is nonoperational or cannot be accessed because of a temporary technological or electrical failure, you

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FMA House of Delegates meeting August 3-5, 2018, Orlando, Florida.

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Prior to prescribing or dispensing any controlled substance (except for a non-opioid Schedule V) to a patient 16 years of age or older, you must first review the patient's controlled substance dispensing history in the E-FORCSE database. If the database is nonoperational or cannot be accessed because of a temporary technological or electrical failure, you do not have to check the database but you must document the reason why and you cannot prescribe more than a 3-day supply of the controlled substance. This also includes the antiepileptic medications Phenobarbital, Parempanel and Clonazepam. The concern is that patients may go into withdraw from these medications if they are unable to obtain the mediations. Withdraw from antiepileptic medication such as Clonazepam can become dangerous and potentially lethal for patient's who are unable to obtain these medications. There were discussions of situations, which occurred during the 2017 hurricane evacuations. During the Hurricane Irma Evacuations and weeks after, some Wi-Fi was not accessible and prescribers were faced with situations of not being able to access the PDMP. Per HB21, they could only provide a 3 day supply of the controlled substance. This became problematic for individuals who evacuated due to the hurricane. These patients had difficulty obtaining their medications from prescribers in other states or areas where they evacuated. The FMA is working with legislation to improve HB21 especially for these types of situations.

Anyone interested in participating in the Karl M. Altenburger, M.D. Leadership Academy (KMA) and the FMA Online Leadership program to further your career, it is available through the FMA's website.
http://www.fma-leadership.org/about-2/

Thank you for allowing me to be your 2018 delegate to the Florida Medical Association.

Congratulations to
Jesse Lipnick MD
President
Florida Society of Interventional Pain Physicians
2018 – 2020

FSPMR Past Presidents and Founding Member: Rodolfo Eichberg MD, Mitchell Freed MD, Justine Vaughen MD (Founding Member), Anthony Dorto MD, Michael Creamer DO, Rigoberto Puente MD, Matthew Imfeld MD

LaMisa Rayside ACNP-BC, Dr Michael Creamer, and Dr Paulette Smart-Mackey.

FSPMR 2018 Annual Meeting: Mitch Freed MD, Jane Imfeld, Matt Imfeld MD, Yvette Eichberg, Rodolfo Eichberg MD, Morgan Pyne DO, Mike Creamer DO, Robin Creamer DO

RESIDENTS SECTION

Elizabeth Mortazavi DO

University of South Florida PM&R Residency Update

It's the beginning of another year and the USF PMR residency program is coming out quick! Already we have had two residents present at conferences with Dr. Morgan Pyne presenting on Osseointegration for FSPMR and Dr. Eric Catlin presenting his poster on a "Retained Curved Needle After Balloon Kyphoplasty: Complication with a Novel Device and its Management" at the Florida Society of Interventional Pain Physicians conference. They had a fabulous time!

And behind the scenes there is much research being done. Dr. Anabel Anon-Vila is currently working on two case reports, one involving the use of fluoxetine for cervical myelopathy and the other discussing a novel method of ganglion cyst treatment. Two of our new second year physicians, Dr's. Krystal Yankowski and Liz Mortazavi, are currently working on a prospective study looking at Botox for the treatment of hyperhidrosis in residual limbs. Senior Dr. Pyne has just submitted a paper titled, "Neurofibromatosis Type 2: A Review of Pain Management Options" to the Cancer Control Journal and is currently waiting on acceptance.

With all of that going on, our residents still find time to volunteer, with Dr. Brian Higdon and Dr. Pyne volunteering at the Veterans National Wheelchair Games being held in Orlando.

Other things happening in our program are the addition of a new rotation in Hospice and Palliative care at Moffit Cancer Center. USF is also working on building and moving the current medical school to a fabulous spot in down town Tampa!

Dr. Morgan Pyne volunteering at the National Veterans Wheelchair Games in Orlando, FL.

RESIDENTS SECTION

Shiel Jhaveri, DO PGY-4
Larkin Community Hospital
Department of PM&R
AOCPMR Resident Council
Social Media Chair

Larkin Community Hospital PM&R Residency Update

Larkin PM&R kicked off the new academic year with the annual PM&R BBQ. The new chief residents, Patricia Goodwin, DO, PGY-4 and Thiago Queiroz, DO, PGY-4 were officially congratulated on their new positions and the incoming PGY-2s were welcomed to the Larkin PM&R family. One of the many wonderful aspects of the Larkin PM&R residency program is our location, where residents can enjoy beautiful beaches and sunny weather year round.

The Larkin Graduate Medical Education and PM&R Department received ACGME pre-accreditation status during the last academic year. The transition process continues to remain in full swing in order to meet the July 2020 implementation date.

Congratulations to the residents who currently are holding leadership positions on the AOCPMR residency council this year Patricia Goodwin, DO, PGY-4 (Secretary/Treasurer), Alexander Morales, DO, PGY-4 (Website Chair), Shiel Jhaveri, DO, PGY-4 (Social Media Chair), and Marjorie Mamsaang, DO, PGY-4 (Membership Vice Chair). The AOCPMR residency council is just one way the Larkin PM&R residents are contributing to the field and making things happen on a nationwide level.

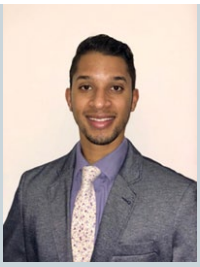
Also, congratulations to Larkin PM&R resident Prathusha Maduri, DO, PGY-2 on her recent case report publication in Neurocase, entitled "Illustrating where spatial perception versus memory-based representation: spatial neglect in a distinguished artist; a case report."

Additionally, Larkin PM&R residents attended the FSPMR Annual Meeting in on July 21, 2018 at The Breakers in beautiful Palm Beach. Marjorie Mamsaang, DO, PGY-4 presented an interactive case titled "Weakness & Paresthesia After Bariatric Surgery"

Presented by Dr. Marjorie Mamsaang, PGY-4 at the FSPMR Annual Assembly at The Breakers

NSU/Larkin PM&R is seeking Florida physiatrists interested in clinical and didactic exposure. If you would like to learn more about opportunities to become an Assistant Clinical Faculty, Associate Professor, or present a lecture in your field of expertise, please contact the PM&R Program Director, Jose Diaz, DO (josediaz@larkinhospital.com) and Maikel Gonzalez (mgonzalez@larkinhospital.com) the Graduate Medical Education Program Coordinator.

RESIDENTS SECTION



Martin Weaver, M.D.
PGY-2 Resident
FSPMR Liaison
Department of PM&R
University of Miami Miller School of Medicine

Andrew Sherman, MD, MS
Residency Program Director
FSPMR Treasurer
University of Miami Miller School of Medicine

University of Miami Miller School of Medicine/Jackson Memorial Hospital PM&R Residency Update

Greetings from the University of Miami Miller School of Medicine / Jackson Memorial Hospital PM&R Residency Program.

Residents, Christopher Alexander, MD PGY4 and Martin Weaver, MD PGY3 were honored to present on "Ultrasound Guided Baclofen Pump Refills" at this year's FSPMR annual meeting. It was a pleasure meeting and learning from many Physiatry residents and attendings throughout the state.

We would like to welcome our new residents and SCI fellow:
Michael Dove, MD – Internship: Mary Catholic Medical Center; Philadelphia, PA
Scott Klass, MD – Internship: Ochsner Clinic Foundation; New Orleans, LA
Brittany Mays, MD – Internship: Medical College of Wisconsin; Milwaukee, WI
Rosa Rodriguez, MD – Internship: St. Joseph Hospital; Denver, CO
David Valdes, MD – Internship: University of Texas HSC; San Antonio, TX
GianCarlo Perez-Albela, MD – Residency: NYMC Metropolitan Hospital; New York, NY

Furthermore, our program is pleased to announce that our program director, Andrew Sherman, MD has been elected Treasurer of the FSPMR at our recent annual assembly.

Martin Weaver, MD PGY3 has been appointed to the Editorial Board of the American Journal of Physical Medicine & Rehabilitation and will be contributing to the journal's new "Residents and Fellows Section".

Additionally, Marine Dididze, MD, PhD PGY3 received three Resident & Fellow Awards for her AANEM abstracts:
- M. Dididze, W. Ward, K. Ramos-Vargas. "Spinal Accessory and Suprascapular Nerve Injury following Human Bite: A Case Report"
- M. Dididze, S. Khurana. "Do Patients with Multiple Comorbidities Require Screening for Venous Thromboembolism on Admission to the Inpatient Rehabilitation Facility?"
- M. Dididze, K. Dalal. "Urinary Retention Following Quetiapine: A Case Report".

Finally, our resident of the quarter award was presented to Myriam Lacerte, MD PGY3

We are excited to catch up with our colleagues from various PM&R residency programs at the American Academy of Physical Medicine & Rehabilitation Annual Assembly in Orlando in October where we will be displaying a number of poster presentations.

ALLIED HEALTH UPDATE

LaMisa S. Rayside, MSN, ACNP-BC
Doctor of Nursing Practice (DNP) Student
University of Alabama at Birmingham (UAB)
Central Florida Pain Relief Centers
Orlando, Florida

I recently had the pleasure of attending the FSIPP/FSPMR annual conference held in West Palm Beach at The Breakers from July 19-22. Numerous topics were covered including the history of marijuana and its use for medicinal purposes and there was also a plethora of information regarding spinal cord stimulation treatment modalities. The platform allowed an opportunity for networking with PM&R physicians from across the state as well as fellow nurse practitioners and physician assistants who also specialize in chronic pain. In addition, I had the opportunity to display my Doctor of Nursing Practice (DNP) scholarly work entitled "Increasing Appointment Adherence in an Outpatient Pain Clinic with the Use of a Digital Appointment Reminder System." Past FSPMR president, Michael Creamer serves as my clinical mentor.

As many are aware, House Bill (HB) 21 went into effect on July 01. The law places a three-day limit on opioid prescription for acute pain. However, the practitioner may prescribe up to a 7-day if it is determined to be medically necessary. If a prescription is written for chronic pain, the prescription has to state "for non-acute pain" as the reason for extended therapy. Moreover, the law requires that a prescribing practitioner see a patient being treated with controlled substances for chronic nonmalignant pain at least once every three months. Use of Florida's Prescription Drug Monitoring Program, EFORCSE is mandatory. These restrictions do not apply to patients suffering pain from cancer, terminal illness, palliative care, or serious traumatic injuries. The American Academy of Physical Medicine and Rehabilitation (AAPMR) will be holding its annual general assembly from October 25-28 at the Orlando Convention Center. Visit http://www.fspmr.org/events.html for more information. For Advanced Practice Practitioners (ARNPs and PAs), Orlando 2018 Conference - Skin, Bones, Hearts & Private Parts will be held September 11-14 at Disney's Coronado Springs Resort. The topical outline will include dermatology, orthopedics, cardiology, women's health, emergency medicine, and more.

Please visit
https://www.enpnetwork.com/user/events/102831-orlando-2018-conference-skin-bones-hearts-private-parts#!info for further details.

Lastly, I would like to open an invitation for all ARNPs and PAs who specialize in PM&R to join the Florida Society of Physical Medicine and Rehabilitation. The opportunities to learn more about the specialty of physical medicine and rehabilitation and to disseminate research findings are endless. For more information on how to become a member and register for upcoming conferences, please visit www.fspmr.org.

PHYSIATRIST'S VOICE
NEWSLETTER
SEPTEMBER 2018

UPDATE ON OSSEOINTEGRATION

Craig Lichtblau MD
FSPMR President

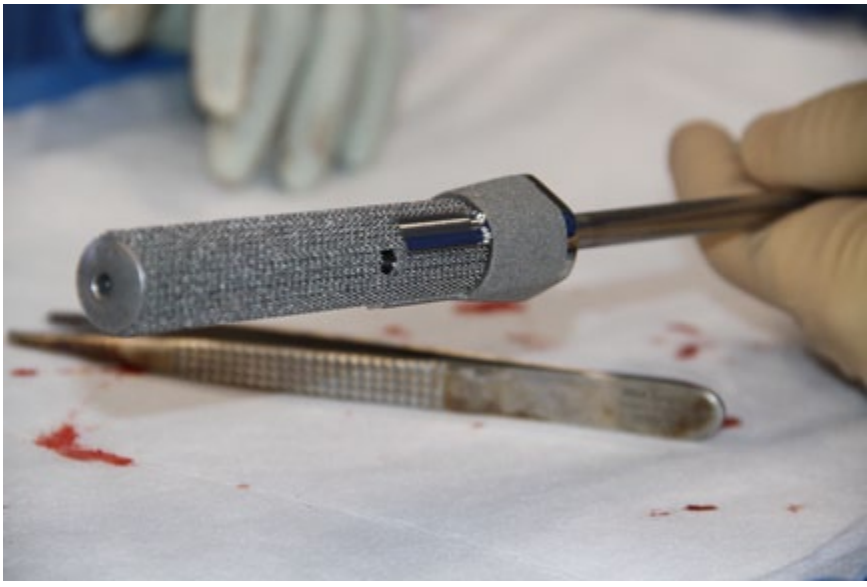
Osseointegration is derived from the Greek "osteon" meaning bone and the Latin "integrare" which means to make whole. The term is defined as a direct contact between living bone and the surface of the load-bearing titanium implant. Osseointegration has not only dramatically enhanced the science of bone and joint replacement surgery, but also has improved the quality of life for amputees.

When somebody undergoes an amputation today, the component parts (socket, knees, feet, hands) are much more sophisticated than they were years ago; however, the distal stump shrinks and expands, and the socket becomes too tight or becomes too loose and in many instances is the source and the cause for skin breakdown and infection. Prosthetic devices are heavy because the device requires a socket for attachment. Because the artificial limb is attached with a socket, proprioception for the extremity is completely lost.

Osseointegration improves the quality of life for all amputees. Osseointegration for amputees has been in clinical use since 1995 utilizing a skeletal integrated titanium implant which is connected through an opening in the stump to an external prosthetic limb. This allows direct contact to the ground, which provides greater stability, more control, and minimizes energy consumption.

A poorly fitting socket can increase an amputee's energy consumption by 100%. Even a well-fitting above knee socket is much less efficient than osseointegration. Osseointegration improves the direct load transfer between the muscles of the residual limb and the bone to the prosthesis. This improves both the efficiency and lever arm of load transfer.

Surgery is usually a single procedure followed by early mobilization a few days after the surgery, allowing rapid recovery and minimizing the time spent away from normal day to day activities. In some cases, a two-stage procedure is required with a short interval of six to eight weeks between the first and second stage surgeries followed by an early mobilization rehabilitation program. This type of implant for amputees makes a conventional socket in a prosthetic device unnecessary. This titanium implant is modeled on the anatomy of the human body and takes the load back directly to the bone, the joint above, and associated muscles. This titanium implant allows the prosthetic device to be taken on and off with a simple quick and safe connection between the stump and the lower prosthesis. No longer is the prosthetic device attached to you, but it becomes a part of you, resulting in much greater comfort and walking control as proprioception is gained in the extremity. Socket pressure issues are eliminated by eliminating the need for a socket.



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UPDATE ON OSSEOINTEGRATION

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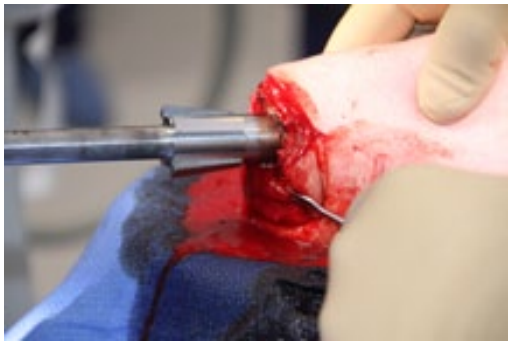
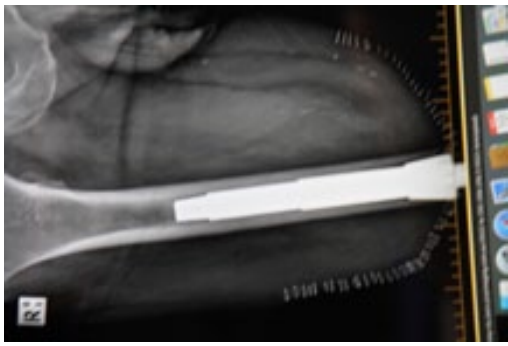
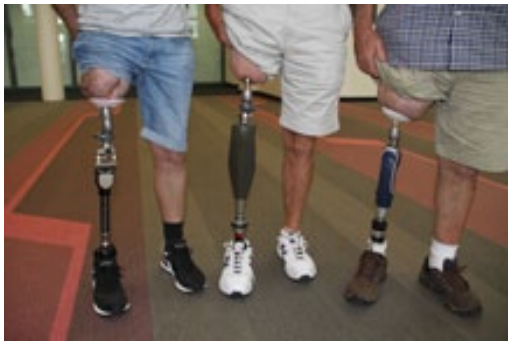
Taking on and off the prosthesis is very easy and takes less than ten seconds. Due to the solid fixture to the bone it accurately connects in the exact spot each and every time you attach the prosthesis. This device can be used with all types of prosthetic componentry. With this new technology the days of fiddling around with time consuming and cumbersome suction, socks and liners is over. Using this titanium bone implant allows for natural loading of the hip joint and the femur, which encourages bone growth and creates a more natural gait and requires less physical exertion. Any weight gain or fluid variations of the distal stump have no effect on the use of the prosthetic limb. It eliminates the bulky socket proving a much more natural streamlined look in clothes. This device allows for full freedom of movement from walking to cycling and recreational activities. Muscular strength is developed freely, which minimizes muscle wasting of the distal stump. Movement of the affected extremity is not restricted by the protruding edges of a socket, allowing for greater ease and comfort sitting, standing and walking. The direct connection between the femoral bone implant and knee enables free natural pivoting movements. The knee prosthesis can be easily attached and removed within just a few seconds. Because the titanium implant goes directly into the bone, the patient regains the ability to feel the ground and can differentiate between different surfaces such as carpet, grass, tile and uneven ground, which also allows for movement in unfamiliar areas in dim light.







It is my feeling that osseointegration is a new surgical and rehabilitation process physiatrists should be actively involved in. Currently, there are only three centers authorized to perform osseointegration in the United States. The University of California in San Francisco, Walter Reed Army Hospital, and the Paley Orthopedic & Spine Institute in West Palm Beach, Florida are authorized to perform osseointegration. The Paley Institute in West Palm Beach, Florida is the number one extremity reconstruction clinic in the world. This is headed by Dr. Dror Paley who reads, writes and lectures in six languages and continues to perform difficult surgical procedures on six continents.
The Paley Institute receives referrals from all 50 states and over 90 countries from around the world.

Anyone who has an above knee amputation and/or a transhumeral amputation, please let me know. At this time I am helping to develop postoperative protocols for osseointegration and once these protocols have been set, these protocols will be disseminated to other physiatrists who are interested. However, in time, as this procedure becomes more commonplace, other centers will be performing osseointegration and I believe physiatrists should take an active role in recommending osseointegration to appropriate patients and sending them to the appropriate centers/orthopedic surgeons for surgical management, and then being actively involved in the postoperative rehabilitation process.

PHYSIATRIST'S VOICE
NEWSLETTER
SEPTEMBER 2018

OPIOIDS, PAIN KILLERS AND OTHER SUBSTANCES

By Fiaz Jaleel MD, Personalized Medicine Consultants, Jacksonville

The use of opioids here in the United States has been met with a lot of controversy. In 2016, the U.S. Centers for Disease Control (CDC) stated there were 63,632 drug overdose deaths, of those, 42,249 involved the use of an opioid.

Non-steroidal anti-inflammatory drugs are also commonly used to treat both acute and chronic pain but they are also associated with significant adverse events. Common side effects include gastrointestinal problems such as stomach bleeding, and intestinal erosions, cardiovascular issues (strokes, heart attacks), and renal complications (kidney impairment/failure). On average, in the United States each year, approximately 100,000 people are hospitalized because of NSAID use and of these, there are 15,000 deaths reported.

Acetaminophen is a drug that is commonly used in the United States for aches, pain and fever. Although it can be easily obtained over the counter, acetaminophen-associated overdoses are responsible for approximately 50,000 emergency room visits and 25,000 hospitalizations each year. This drug is the leading cause of acute liver failure here in the U.S. and approximately 450 deaths occur each year with 100 of these being unintentional. Before 2011 the maximum daily dose of acetaminophen per Food and Drug Administration (FDA) guidelines was 4000 mg, it is now 3000 mg. The approximate lethal dose of acetaminophen is 10,000 mg per day. Thus, if one were to use more than 3 times the maximum daily dosage, this would result in a potential lethal dose.

The use of alcohol is very common in most parts of the world. In the United States, this socially acceptable substance has led to approximately 88,000 deaths and 2.5 million years of potential life lost per year from 2006 to 2010 as reported by the CDC. Excess alcohol use is associated with motor vehicle accidents, drowning, homicide, suicide, domestic violence, risky sexual behaviors, miscarriages and still births, heart disease, stroke and liver disease, cancer of the breast, mouth, throat, esophagus, colon and liver; mental health problems such as depression and anxiety, poor school and work performance.

Tobacco use, although common, also leads to significant disease and disability. More than 16 million Americans are living with a disease caused by the use of tobacco. There are 480,000 tobacco related deaths per year in the United States that includes 41,000 deaths resulting from second hand smoke exposure. In other words, approximately 1,300 people die each day due to tobacco. In 2016, 9.5 billion dollars was spent on advertising and promotion of tobacco products. This is associated with a total economic cost of more than 300 billion dollars per year.

The management of chronic pain is very complex. It depends not only upon the disease process or injury but also the underlying psychosocial and economic factors that prevail. Currently, opioids are often used for the management of chronic pain. For the most part, no other drug is as powerful as an opioid for the treatment of acute or chronic musculoskeletal pain. Although opioids are efficacious in managing different types of pain, they are not without significant side effects, including sedation, fatigue, itching, constipation; potential for abuse, respiratory depression and death.

The toxicity of opioids are governed not only by its dose or rate of dose escalation, but also by the concomitant use of alcohol, and sedative drugs, such as carisoprodol and benzodiazepines (diazepam and alprazolam, etc). Another consideration is a person's underlying pharmacogenetics, which dictates how quickly a drug is metabolized by the body.

Different sources quote different figures but generally speaking, abuse and addiction rates of opioid medication in a chronic pain population is approximately 20 to 25 percent, with many of these patients having a personal or family history of mental health disorders, sexual abuse, post traumatic stress disorder and alcohol and tobacco misuse.

Practically every drug or recreational substance can lead to significant morbidity and mortality if used in excess and not in accordance with a doctor's advice.

The responsibility of proper use of a drug, chemical or substance lies upon compliance and the sincerity and good intention of the user.

PHYSIATRIST'S VOICE
NEWSLETTER
SEPTEMBER 2018

Myositis Ossificans Causing Compression

Morgan Pyne, DO
Physical Medicine and Rehabilitation PGYIII
University of South Florida
Residency Program Liasion

Neuropathy of the Ulnar Nerve: A Case Report

Morgan L. Pyne, DO (University of South Florida)

Setting: Inpatient Rehabilitation Unit

Patient: A 35 year old male with compressive ulnar neuropathy.

Case Description: Patient suffered severe trauma from a car vs. motorcycle collision, resulting in an inferior left iliac bone fracture, left patella fracture, scapular body fracture, multiple displaced rib fractures, T8-T11 transverse process fracture, left brachial plexus injury, along with multiple other injuries. The patient presented to the rehab floor six days after the accident with two noticeable hematomas, one over the right brachialis and the other over the left quadriceps muscle. About a month later, the patient started to develop pain with a decrease in range of motion in his left hip. X-rays revealed extensive heterotopic ossification encapsulating the joint. Around this same time the patient started to develop a right ulnar neuropathy, resulting in "clawing" of his right hand and he began to notice the site of the initial hematoma over the right brachialis felt firm. XRAY's suggested and MRI confirmed myositis ossificans compressing the right ulnar nerve.

Assessment/Results: Three months after the initial injury, the surgery team was asked to evaluate the patient for possible removal of the myositis ossificans. Although typically surgery is withheld for twelve to eighteen months after heterotopic ossificans or myositis ossificans is discovered, this was a case that could easily lead to permanent nerve injury. The general surgery team ultimately decided that any surgery, even if just to relocate the ulnar nerve, would result in further trauma that could possibly trigger more heterotopic bone formation.

Discussion: This is the first reported case, to our knowledge of myositis ossificans causing compression neuropathy.

Conclusion: Even if heterotopic bone formation is causing potentially permanent complications, if not life threatening, surgery is often times withheld until the bone has matured, due to the risk of more trauma from the surgery resulting in further bone formation.

OPINION PIECE

by Rodolfo Eichberg MD,
a former FSPMR President

Quo Vadis Physiatrists?

The recent annual meeting of the Florida Society of Physical Medicine and Rehabilitation (FSPMR), with its large turnout of PM&R Residents, as well as the list of new physiatrists who passed their Boards and Sub-Specialty certification exams as reported by the American Academy of Physical Medicine and Rehabilitation (AAPMR), made me think about the future trends within our specialty. This is my very personal and probably biased opinion. The bias, if it exists, would be based only on background and preferences. I retired about four years ago and have no financial or other interests.

Our FSPMR meeting being held in conjunction with the Interventional Pain Society projected the image of a close affinity. According to the new list of AAPM&R Certified Physiatrists, the most numerous Sub Specialty at the national level is Pain, by far. This is a departure from the original intent and purpose of the PM&R specialty, which was the rehabilitation of the physically disabled.

My mentor, Dr Howard Rusk, who was still active when I trained, wrote a book about our target population called "A World to Care For." The Americans With Disabilities Act made the care of the disabled a Federal Law. Dr Rusk maintained that this legislation was not as generous or humanitarian as it seemed, and was an insurance for everybody since "We are ALL only temporarily able bodied " and are likely to become disabled at some point in our lives. Wars, civilian trauma, crime and similar lifestyle factors, in addition to the constant increase in life expectancy, make his dictum truer than ever.

Pain management is being practiced by Anesthesiologists, Physiatrist s, other specialists, and Primary Care Physicians. Stroke, Spinal Cord Injuries, and Trauma Rehabilitation is for the most part left to PMR. Changes in payment systems, monetary rewards and government regulations like the recent narcotics prescription laws, may well make pain management more or a lot less attractive. An increase in the evaluation and management fees may make Stroke Rehabilitation more glamorous.

One area that PMR has always neglected, for no reason that I can explain, is Disability Evaluation. It took four editions of the AMA Guides for a Physiatrist to be listed as an Editor. When I retired I was one of a handful of Florida Physiatrist s who made it a significant part of their practice. At one point it occupied one third of my time, but represented about two thirds of my income. Residency training on the subject was scant or nonexistent. I taught a short course for the Louisiana State Residency Program for several years, but this was not common at the time. Dr Oregon Hunter, a former FSPMR President, was very much involved with the Florida Workers Compensation Guide which is still being used today.

My suggestion to the Physiatrists who are in the early stages of their careers is: Think about all this history when you decide what you want to do for the next several decades. The Spanish philosopher George Santayana wrote that those who ignore history are condemned to repeat it.

JOB OPS/OTHER OPS

Job Ops are posted at no cost as a service to our members and others in the Florida physiatric community, and run for 6 months.

Practices for Sale, Office Space for Lease, Equipment for Sale, other appropriate medically-related items: these ads can be placed for a 3 month period for $150.00. Please go to http://www.fspmr.org/opportunities.html for details.