FLORIDA SOCIETY OF PHYSICAL MEDICINE AND REHABILITATION
FSPMR
1962

PHYSIATRIST'S VOICE

NEWSLETTER DECEMBER 2013

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

IN THIS ISSUE

MC CAC SUMMARY

Jeffrey Zipper, MD
President FAPM
FSPMR CAC Representative

Since FSPM&R's last newsletter I have attended both the June 2013 and October 2013 FSCO CAC meetings in Orlando representing the interests of our society.

1) In May of 2013 FSCO submitted a letter of guidance concerning US code 76942 stating:

"It is the expectation that physicians utilizing ultrasound guidance for standard office based needle procedures either not code separately or bill the unlisted code (76999- unlisted ultrasound procedure (eg, diagnostic, interventional) with an appropriate fee."

In response CAC representatives from FSPM&R, FSN, FSIPP, FSR and FSA submitted a joint letter to the CAC Medical Director requesting reconsideration of this determination based upon sound medical literature. I am pleased to report that in August of 2013 FSCO rescinded their previous letter of guidance concerning this code.

In addition, I have been working closely with the AAPM&R as a member of their US Task force. Development of our Academy's official position statement concerning the use of US services for both diagnostic and needle placement services is nearly complete and I will share the position statement with you when it is finally published.

The AMA RUC committee has re-priced code 76942 for FY 2014 and reimbursement for this code will be in the range of $72 to $75 based upon MC locality. In 2015, reimbursement for US services when performing intra-articular injections will be bundled into three new codes for small, medium and large joint injections!! Will keep you posted!

2) In June of 2013 I requested the following changes be made to Draft LCD L-33688 Psychological and Neuropsychological Tests.

Examples of problems that might require psychological testing include: Keep numbers 1, 2 & 3 as is, add 4. Assessment of mental function in a patient recommend for an implantable pain control device. And 5. Assessment of mental function in a chronic pain patient with suspected somatization disorder.

Page 3: The paragraph beginning with "Neuropsychological testing is a sub classification of" can we add the Wisconsin Card Sorting Test or "WCST" to list of tests given as examples? This test is actually listed within the CPT descriptor.

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MC CAC Summary

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Page 4: Under limitations the 5th bullet point down should read "Repeated when not required for medical decision-making. Examples of medical decision making include: whether to start or continue a particular rehabilitative program or pharmacologic therapy."

Page 4: In the paragraph starting with the word "Evaluations" the beginning of the first sentence should read "Evaluations of the mental status that can be performed within the psychiatric clinical interview"…. The end of the last sentence should read "since they are typically part of a psychiatric clinical exam or interview"

Page 4: The first sentence of the last paragraph should read as follows: "The psychological/neuropsychological testing codes should not be reported by the treating physician for only reading the testing report or explaining the results to the patient or family unless the treating physician administered the testing."

All suggested changes were accepted and included in the final LCD!

3) In June of 2013 I requested the following changes be made to Draft LCD L-33703 Molecular Pathology Procedures.

Page 3: 2nd paragraph 2nd sentence should read: "The following examples off applications; may or may not be relevant to a Medicare beneficiary or, may or may not meet a Medicare benefit category and/or reasonable and necessary threshold for coverage."

Page 4: bullet point #1 under Indications should read: "Alternative laboratory or clinical tests to definitively diagnose a genetic disorder or identify a genetic allele variant (mutation, deletion, duplication) are unavailable or results are clearly equivocal; and". Bullet point 5 should read: "For testing panels, including but not limited to, multiple genes or multiple conditions, and in cases where a tiered approach/method is clinically available, testing would be covered ONLY for the number of genes or tests that are reasonable and necessary to establish a diagnosis or to identify allele variants that may effectively guide or alter medical and/or pharmacologic treatment regimens. AND".

Suggestions were not included in the final LCD!

4) In October of 2013 I suggested the following changes for Draft LCD's DL-29258 and DL-31461 concerning Peripheral Nerve Blocks and Autonomic Function Tests. These suggestions are still under consideration!

Peripheral Nerve Blocks

Under "Indication"

4. When a occipital nerve block is used to confirm the clinical impression of the presence of occipital neuralgia. Chronic headache (Chronic Migraine)/occipital neuralgia can result from chronic spasm of the neck muscles as the result of either myofascial syndrome or underlying cervical spinal disease. It may be unilateral or bilateral, constant or intermittent. Nerve injury secondary to a blow to the back of the head or trauma to the nerve from a scalp laceration can also cause this condition. Most commonly, it is caused by an entrapment of the occipital nerve in its course from its origin from the C2 nerve root to its entrance into the scalp through the mid portion of the superior nuchal line. Blockage of the occipital nerve can confirm the clinical impression of occipital neuralgia, particularly if the clinical picture is not entirely typical. If only temporary relief of symptoms are obtained, neurostimulation or neurolysis of the greater occipital nerve may be considered medically reasonable and necessary. Neurolysis via multiple techniques are permissible, including pulsed radiofrequency neurolysis, cryoneurolysis and chemoneurolysis. In addition, the lesser and third occipital nerves can be involved in the pathology of headaches, and can be treated in a similar manner.

8. In addition to the use of anatomical landmarks for needle localization, Nerve blocks may require further localization by use of stimulating needle electrode or ultrasound guidance.

Under "Limitations"

The signs and symptoms that justify peripheral nerve blocks should be resolved after one to three injections at a specific site. More than three injections per anatomic site in a six month period will be denied expect when neuronal blockade is used to facilitate participation in a rehabilitation program in patient suffering with spasticity, CRPS or adhesive capsulitis of a joint.

More than three anatomic sites injected at any one session will be denied. If the patient does not achieve progressively sustained relief after receiving two to three repeat peripheral nerve block injections on the same anatomical site, then alternative therapeutic options should be explored.

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MC CAC Summary

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Autonomic Function Tests:

Under "Indications and Limitations of Coverage and/or Medical Necessity" page 2 add below as 4th bullet point

- Cardiovagal functions test (CPT code 95943) – is a test that provides spectral frequency signal analysis of both heart rate variability and respiratory activity at rest, during paced breathing, with valsalva maneuvers and head-up postural changes. This testing allows for simultaneous but independent measures of both parasympathetic and sympathetic activity.

Under "Limitations" page 4 add the following bullet points in reference specifically to CPT code 95943

Limitations for coverage when using code 95943 should include:

- In patients with suspected cardiogenic syncope
- In patients with movement disorders, such as, Parkinson's disease, Tourettes syndrome, tremors etc.
- In patients with who have continuously paced cardiac pacemakers.
- In patients with acute pain.

{ANSAR (ANX 3.0) test (CPT code 95943) and related technologies are not medically reasonable and necessary since it is not proven that these tests are at least as beneficial as existing and available medically appropriate testing alternatives.} While there is some controversy concerning the ANSAR testing equipment at this point in time, it was brought to the attention of the CAC medical director that the term "and related technologies" be removed. Obviously other technologies exist and should not be held accountable if another company has an issue with the FDA!

Recommend language:
{ANSAR (ANX 3.0) testing equipment which utilizes CPT code 95943 is not considered medically reasonable and necessary at this time until the FDA has cleared the company's manufacturing process and use of the technology for its intended purpose.}

Will keep you posted when final versions of LCD's are released!

Regards,
Jeffrey A. Zipper, M.D.

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RESIDENTS SECTION

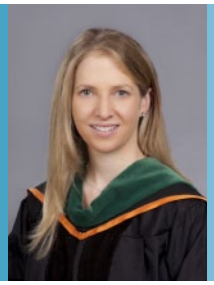
Jessica Gomes, D.O.
Physical Medicine & Rehabilitation, PGY-2
USF Program

Residents are half-way through another academic year and in PM&R, we are gearing up for the SAE-R (Self-Assessment Examination for Residents) next month. Annually this exam in administered to over 90 PM&R residency programs in the US, Canada and the Philippines. The SAE is a good assessment for areas of growth throughout residency and identifying areas needing improvement in preparation for the computer based portion of Board Certification. Although this is typically more important for senior Residents or Fellows who are preparing to take their Boards in August, it is something Residents typically prepare for throughout training.

At the University of South Florida, PM&R residents are preparing for the SAEs with formal didactic sessions reviewing previous SAE exam questions and thoroughly discussing answers. We also have an informal weekly session where residents may meet to review additional exam questions after work hours. In addition, EMG-related questions are commonly challenging, especially to PGY-2 Residents who have had limited exposure to EMGs thus far in their clinical training. Thus, in order to improve our understanding of board-relevant topics in EMG, we have remodeled our formal lectures this year to include training DVDs and discussion of relevance to clinical cases.

In preparation for the oral exam portion of Board certification, USF PM&R has started bi-annual OSCEs (Objective Structured Clinical Examinations). During the first OSCE, held this past September, all Residents were required to actively participate except PGY-2s, who were required to monitor the process. The PGY-2s will participate and be evaluated in the Spring OSCEs in 2014. Attending physicians prepared a series of five clinical cases involving a medical student simulating the patient or an actual, consented patient (in our case, a T10 SCI patient). The other scenarios were low back pain, stroke, lower extremity pain and upper extremity pain. For some cases, Residents were asked to perform a history and physical. For others, a physical exam, differential and plan were required. For example, in the SCI case we had to complete an ASIA exam and state a plan for short term and long term rehabilitation goals based on the findings. Residents had 15 minutes per case and Attendings had 5 minutes to provide immediate feedback. Residents rotated through each of the five cases. At the end of the exams, the resounding response from Residents was positive and the OSCEs is helpful tool to prepare for oral Boards.

Lifelong learning and SAEs have become increasingly important in PM&R physician licensure and Board Certification. We plan to meet these demands and excel beyond expectations during our training so we will have well prepared Physiatrists in practice.



Lauren Lerner, MD
PGY-2 UM PM&R

This has been an exciting year so far for the JMH/ Department of Physical Medicine and Rehabilitation at the Leonard M. Miller School of Medicine, University of Miami PM&R residency program. Our graduating class of six residents all successfully passed their written board exams and enthusiastically begin their jobs and competitive fellowships. Our program was again honored to be involved with the Dolphins Cycling Challenge, which is a two-day tri-county charity cycling event to increase cancer awareness, encourage healthy hobbies, and raise funds for the University of Miami Sylvester Comprehensive Cancer Center. Here at this event the JMH/UM PM&R residents provided medical attention for injured riders among the more than 2000 riders along a 170 mile course along 12 stations. Next, our residency will be the medical team staffing the ISAF Sailing World Cup Miami. This event draws elite sailors, including Olympic and Paralympics past medalists and future hopefuls from around the world. We expect up to 900 athletes to compete. By land or sea, our residents continue to participate in sports medical coverage!

As our residents continue to excel in the musculoskeletal ultrasound, we were proud to see our attending Ricardo Vasquez, MD be a co-instructor faculty for an in-depth ultrasound workshop at the AAPMR 2013 annual assembly. Many residents participated in the educational workshops and presented academic posters. Our future looks brighter than ever with the approval of an $830 million bond for our main training hospital, Jackson Memorial Hospital. With this passage there is a plan to build a $70 million new state-of-the-art Rehabilitation building. Finally, in the "Save the Date" category, the newly renamed Department of Physical Medicine and Rehabilitation is proud to announce that the annual "Research Day" will take place on Saturday June 8 from 12:30-4:30pm. Keynote speaker this year is Randall Braddom, MD so we hope that physiatrists from all over South Florida will attend to hear Dr. Braddom speak.

National Rehabilitation Awareness Celebration

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

The power and possibilities of rehabilitation are endless for the nearly 50 million Americans living with disabilities.

The National Rehabilitation Awareness Foundation designates a week in the month of September to promote its mission to educate people about the benefits and impact of rehabilitation, increase their opportunities and help those who are disabled to live up to their fullest potential through rehabilitation.

Physiatrists are the group of physicians concerned with the care of patients with long-term impairments. They render personal restorative care to their patients with the goal of minimizing disability in the community; enhance patient capabilities in their activities of daily living and quality of life. For those of us in the rehabilitation field, we now it takes "a village" to advance rehab efforts as we partner with the disabled patient and their families. Rehabilitation professionals must work efficiently to meet the challenges of providing the proper services for the disabled to maximize outcomes with the increasing amount of restrictions imposed on the number of services.

Rehabilitation programs have a favorable impact to society. US population projections for 2030 will include 72 million persons over age 65, or twice as many as there were in the year 2000. Early identification of problems and proper treatment may defer the economic and social cost of long-term institutionalized care.

Rehab services are provided to patients of all ages, from young children to the elderly. Older adults in particular have an increased demand due to growth in their numbers and because they have a higher incidence of disabling conditions such as stroke, cancer, arthritis, hip fractures and amputation.

Post-acute medical rehabilitation provides care to people with a disability after a recent hospitalization due to trauma or illness and has the goal of functional improvement to help the patient prepare to live as independently as possible. There are a wide range of services offered in different settings. The intensity and nature of the rehabilitation provided varies by the level of care. The amount of therapy is determined by the needs of the patient, statutory requirements and payment policies.

There are different levels of rehabilitation programs available:

- **Long-term acute care hospitals (LTACH) :** generally treat catastrophic medical conditions and incorporates therapy services as able.
- **Inpatient Rehabilitation Facilities (IRF) :** patients are medically complex and receive a minimum of 15hr of therapy per week from a multidisciplinary team of allied health professionals with the goal of discharge to the community.
- **Skilled Nursing Facilities (SNF), also known as Nursing Homes :** patients need less intense care and medical management and receive multidisciplinary rehabilitation as well as a residential option.
- **Assisted Living Facilities (ALF) :** are an alternative to independent living. They provide supervision or assistance with activities of daily living. There is no need for 24-hour medical care.
- **Outpatient Therapy provided by Home Health agencies if the patient is home-bound or free standing outpatient facilities :** provide therapy 2 or 3 times per week as needed.
- **Day Healthcare Programs :** are systems of care in which a patient receives rehabilitation during the day and returns home in the afternoon. There's no need for nursing or medical care.

All of these levels of care have the common goal of restoration of physical, psychological and social functions to the most optimal level possible.

Health reform is upon us and as the Accountable Care Act takes place and implementation of bundling payments and other penalties are instituted on acute care for 30 days readmissions, transition of care options will become more relevant. IRF readmission rates are substantially lower than those of SNF (9.5% vs. 22%) and discharge to community rates are also favorable for IRF (81.1% for IRF and 45.5% for SNF). (www.aha.org Fact Sheet: AHA Briefing on Deficit Reduction Strategy for Inpatient Rehab . American Hospital Association . October 18, 2011)
On the other hand SNF are an invaluable option for residential care for patients with physical or mental disabilities.

Day-in and day-out patients and rehabilitation teams including physical, occupational and recreational therapists, speech language pathologist, nurses, psychologists, dieticians, respiratory therapist and case managers/social workers engage in the empowering process of rehabilitation and the outcomes are fulfilling and humbling. Thru rehab there is hope, achievement and success. ***To all GO TEAM!***

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Questions Frequently Asked of Compounding Pharmacists

Anthony Menezes, PharmD.

Health professionals are trusted by patients to prescribe medications which will help with the patients' presenting conditions. This is most often done by writing prescriptions for commercially available medications. However, many patients have needs which are beyond the scope of the medications which are readily available. To help solve these patients' problems, prescribers work with compounding pharmacists to "think outside the box" in order to find solutions. The following are questions frequently asked of compounding pharmacists by prescribers as well as their patients:

What is a compounded medication?

A compounded medication is a preparation which is made specifically for a patient, by order of a prescription, when a commercially available medication cannot be used. An example of a compounded preparation would be a liquid made from tablets for a young child unable to swallow large pills. Some of these pills are dosed for an adult and the child may need a smaller dose. Also, patients may need a prescription compounded when they must avoid certain dyes or inactive ingredients which a commercial product may contain.

I was using a commercial drug and it is now discontinued. Can it be compounded?

In many cases a discontinued/back-ordered medication can be compounded as long as it is not currently commercially available and the active and inactive ingredients are still available.

I was using commercial tablets which had an expiration date of 3 years. Why is the expiration of the compounded version of the drug only 6 months?

There are certain compounding standards which compounding pharmacies must follow when compounding a preparation. USP 795 states that in the absence of stability testing, a solid oral dosage form, such as a tablet or capsule, which would not contain water, can have a beyond use date of up to 180 days. There are additional standards which guide compounding pharmacists on beyond use dates depending on what the dosage form is and if it is intended to be sterile.

How large of an area can a compounded analgesic cream be applied to?

Since most of the creams contain Lidocaine, which is also an anti-arrhythmic medication, the patient must be cognizant of the surface area which the cream is applied to. A good "rule of thumb" is for the total surface area to be less than the surface area of 2 palms of the hand.

Will a patient get systemic absorption of the medications in the cream?

It is assumed that there will be some systemic absorption. The rate and extent of the absorption depends on a variety of factors. Therefore, it would be difficult to predict how much would be absorbed. Care should be taken to make sure that the patient is not using too much of the cream.

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Questions Frequently Asked of Compounding Pharmacists
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Are there side effects associated with the creams?

Since there may be some systemic absorption, it is possible that a patient may experience the same side effects as the oral and parenteral versions. It is assumed by many doctors and pharmacists that since the medication is delivered to the site of action, there may be fewer side effects. For example, an NSAID applied to the skin may not have GI upset such as in an oral version.

Will a patient's insurance cover the compounded cream?

Some prescription insurances will cover compounded creams. However, some do not cover them. Medicaid and Medicare insurances do not cover any compounds made from bulk powders. It is against Medicare Part D law for a pharmacy to bill Medicare for any compounds which come from bulk ingredients. Most of the analgesic creams are made from bulk ingredients and therefore cannot be billed.

How much do the creams cost?

The prices vary depending on how much cream is dispensed as well as the number of active ingredients and the concentrations of each. In addition, if the cream is recognized and reimbursed by a patient's insurance, the co-payment will vary depending on the plan. Co-payments may vary due to the tier in which the insurance company places a particular drug. This is done by the insurance company evaluating certain criteria including benefit, efficacy, and cost.

Call For Patient Education Articles

If you have any pertinent patient education articles and would like to share with our community, please contact Lorry Davis, Executive Director at 352-226-8641, or email at: Lorry4@earthlink.net

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Protect Your Identity

Rigoberto Puente-Guzman, MD
President FSPMR

With technological advances come new and convenient ways to purchase goods, exchange information, run businesses, manage personal finances and much more. How did we manage our lives 20 to 40 years ago? However, even with our new conveniences there is an increased risk for anonymous scams and theft of your hard earned money, assets and good name. According to the US Department of Justice there are about 11,571,900 people who have suffered from identity fraud victims annually. Financial loss increased from 13.2 billion in 2010 to 21 billion in 2013. Florida is ranked third as the state with highest identity theft complaints with Arizona #1 and California #2. Unfortunately most victims of ID theft find out after significant damage has occurred to their personal and business financial world. Physicians and medical practices are a common target. If you become a victim of identity theft you will have to work hard to clean up the financial devastation and chaos that it will bring to your life.

Since we are fully immersed in our yearly holiday consumption mode I will cover personal identity protection in this article and cover business protection in future articles and what to do in the case your identity is stolen. We are accustomed to giving information to perfect strangers in doctor's offices, retail stores, over the phone, gas stations and so on. STOP and think before you do so. The best protection is to safeguard your personal data and keep vigilant for any signs of abnormal financial transactions in your personal accounts.

There are a few things you can do to help:

- Store all your important papers and credit card receipts in a safe place.
- Keep all credit card receipts and cross-check them with your credit card bill statement on a monthly basis before you discard them in the proper manner.
- Any mail or papers with personal information, financial statements, account numbers, credit card receipts, pre-approved credit card mail, utility bills, old bank statements, and so on that an identity thief could use should be shredded or burned before placing in the trash. Make a small investment in a good shredder that shreds the paper into confetti instead of just strips of paper. If you're throwing away any papers and not sure if you should shred, use the simple rule "When in doubt just shred".
- Monitor your credit accounts, bank statements, and unused credit cards on a monthly basis. If you have several credit cards that you don't use, consider closing them out. Just shredding the credit card will not be enough to do the job.
- Clean out your wallet at least once a quarter. Try to limit the number of credit cards you carry; only carry the minimal information you need. You should not carry your Social Security (SS) card in your wallet. When was the last time you had to show your SS card to someone? And if you did why did you? Keep the card in a safe location at home.
- By all means protect your and your child's Social Security number and only give it when absolutely necessary. If a business asks for it see if you can give an alternative number, or say you don't have it with you at that time and see if they will accept another option, or just take your business elsewhere. Never write you SS number in statements or checks. Remember, in certain circumstances it is normal for a financial business to ask for your SS number to check your credit when you apply for a loan, get medical services in hospital or doctors office, rent a apartment, or sign up for utility service.
- Make sure you copy your Medicare card and black out all but the last four digits on the copy, and carry the copy with you. If you are going to use your card at the doctor's office then carry it for that visit.
- Destroy labels in prescription bottles before discarding and don't share health plan information with anyone who offers free services or products. Do not leave your prescription bottles in the bathroom medicine cabinet that is used by guests. Keep medicine bottles in your personal bathroom or secured area.

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PROTECT YOUR IDENTITY

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- If possible, drop your paid bills and outgoing mail at the post office not your street mail box. Some criminals go fishing for information, checks, and packages, especially during the holidays. Remove any arriving mail from your mailbox every day. If you are going out of town, request a vacation hold or arrange for family or a trusting friend to pick your mail.
- Never give personal information to any one that initiates contact with you through the phone, e-mail, or even mail. If a company sends you an e-mail asking to verify your personal information (ALERT, ALERT, ALERT!!) don't click on the links in the e-mail. Instead, type in the company name in the web browser to go to their official site and then contact them through their customer service. Ask if they sent you a request for your information. Reputable companies usually will not solicit this information. If you initiated the call to contact the company then they may require such information to verify your identity.
- Get a credit report once a year (for free) or bi-annually (with charge) and correct any errors you find from the three credit report agencies (Equifax at www.equifax.com , Experian at www.experian.com , Transunion at www.transunion.com).
- You can, for a minimal fee, place a credit freeze to the credit reporting agencies (above three agencies) adding a layer of protection by making it more difficult to get unauthorized loans, credit cards, etc.
- Consider opting out of prescreened offers of credit and insurance by mail. To opt out for 5 years or permanently, call 1-888-567-8688 (1-888-5OPT-OUT) or go to optoutprescreen.com. These service are managed by Experian, Transunion, Equifax and Innovis Consumer Assistance reporting agencies.

If dealing with paper trace is not enough, now we also must worry about what information we enter into the internet and electronic world. Any information that is posted on the internet is permanent, regardless of whether your posts are manually deleted later. You have to take even more precautions. Remember the identity thief will research your life to get information. They will search Facebook, Twitter, LinkedIn and other social media sources for birth dates, what city you were born in, family members names, addresses, pet names, hobbies, what school you graduated from, when you are at home or traveling, etc. If any of these rings a bell you know what I'm talking about. Yes, when you set security questions for credit cards, accounts, e-mail accounts, store accounts, i-Tunes accounts, X-box accounts and others. These are the typical questions that most companies have for security questions for when you forget your password. Imagine if an ID thief has your name, birth day, e-mail address and above personal information they can get to your account and mine for more information given the keys to your financial vault, credit and good name.

Although you are not able to completely eliminate the risks there are a few steps that you can follow:

- Maintain updated anti-spyware, anti-virus software and firewall in your computer and other electronic devices. Set preference to update files for security patches for your operating system and other software programs.
- Public access Wi-Fi is becoming more readily accessible. However, most signals are unsecured sites and if you use your laptop or smartphone on a public wireless network like in airports, hotels, or coffee shop see if your information will be protected.
- Use strong passwords for laptop, banks and other accounts. Do not use sequential numbers, letters, last name. If you do not want to be an easy pick don't use common passwords like: "Password", "1234567", "abc123", "letmein", "iloveyou", "jesus" and "welcome". Recommend to change your password quarterly. Do not use the same password across all accounts. Don't use pet names, or information that could easily be associated to you when looking at your Facebook or any social media sites. Make a phrase like "I want to see patients strive for better health" and use the first letter of each word with a letter or number. For the above phrase you can have "1W2cps4bh" as your password.
- Don't use automatic log on features that save user name and password, and always log off when finished.
- Avoid opening files or links or programs sent by strangers.

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PROTECT YOUR IDENTITY

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- Avoid posting too much information about yourself in social sites, since an identity thief will use that information to answer security questions on your accounts. Limit access to who can join your network page. Never post your full name, SS number, address, phone number or any personal information. Remember that your friends have access to this social groups have access to that information and if they don't take security seriously your information will be open to the rest of the worlds through them. As a great rule to live by "Never post or type anything in the internet that you don't want everyone to see."
- If you dispose of an old computer or smart device make sure you wipe out all the personal information it stores. Deleting the files will not remove them until they get overwritten so you must get a wipe utility program to overwrite the entire hard drive. Another way to remove your data is to physically destroy your hard drive.
- If getting rid of old phones, remove the SIM card, remove your phone book, as well as your list of calls made and received, voicemails, messages, file folders, web search history, photos and any other data or go to the fool proof system and destroy the phone.
- Only shop in reputable web sites that offer a privacy policy and explains how they use your personal information.
- Read and save warranties and privacy policies and other important information.
- Look for the Trust-e symbol or a Better Business Bureau online seal.
- Any credit card charges should be done through a secure site and encrypted mode. You can look and see if web site starts with https instead of the usual http, indicating it is a secure site. Note even in secured web sites there may be scams to get your information, so be weary of whom you give your info to.
- You may use identity theft protection services like LifeLock and Identity Guard that provide monitoring and alert features and financial guarantees among other features.
- Equifax 1800-525-6285, Experian 1888-397-3742, Transunion 1800-680-7289

So remember, "you are not paranoid, someone is out to get your information". Statistics show that about every three seconds someone loses their identity. So it is important to teach our children, especially the high school and college bound to be savvy since they are the most likely to leave the information at the mercy of unscrupulous peering eyes. Take time to teach your family this important lesson.

IMPORTANT REMINDERS

Maintaining FL license: Practitioners will have to use CE Broker to register their CME history, registering is free, but physicians may want to pay for subscription services with the CE Broker for added benefits and services. Visit https://www.cebroker.com to learn more. To learn more about requirements by the Florida Board of Medicine for medical doctors – unrestricted license- visit:
http://www.flboardofmedicine.gov/renewals/medical-doctor-unrestricted

Updating your Practitioner Profile can easily be done using the Florida Board of Medicine's web page: http://www.FLBoardofMedicine.gov.

ICD-10 Implementation: Time is running out, the Centers for Medicare & Medicaid Services has indicated further delays will not occur, and the October 1, 2014 implementation date will be enforced. So get ready you only have 10 months left.

Dates To Save

- **FSPMR Annual Meeting in conjunction with FAPM**
  Hyatt Regency Grand Cypress Hotel, Lake Buena Vista
  Orlando FL
  June 20-22, 2014

- **AAPMR Annual Assemble**
  San Diego California
  November 13-16, 2014

- **2014 AANEM 61st Annual Meeting**
  Savannah, GA
  October 29 - November 1, 2014

- **ACRM (American Congress of Rehabilitation Medicine)**
  91st Annual Conference
  Toronto, Canada
  October 7-11, 2014

- **AOCPMR (American Osteopathic College of PM&R) Mid Year Meeting and Scientific Seminar**
  Atlantic City, NJ
  April 3-6, 2014.

- **For those interested in interventional pain medicine:**
  FSIPP 2014 Annual Meeiting
  Hilton Orlando Bonnet Creek
  May 15-17, 2014

Notice To All PM&R Physicians In Florida:

NeuroRehabana 2014

There will be a wonderful PM&R conference in Cuba and all of you are invited to participate. The conference is called Neurorehabana. It will take place in Havana March 10 - 14, 2014. The theme of the conference is The Art of Loving Life. I went to the last Neurorehabana conference in 2011 and it was a blast. The exposure to Cuba, the people of Cuba and the connection with PM&R physicians from all over the world were wonderful. I have fantastic memories of the last conference and I am sure that the next one will be exhilarating. You simply need to write a short presentation about any aspect of rehabilitation medicine that you wish to present and submit the main idea to me, Jesse Lipnick email: docrehab@aol.com. If you are interested, please contact me and I will respond with information about the meeting, it's location, travel visas, and any other information you need. I am including links below to the conference. Don't worry. English links are coming soon.

Jesse Lipnick, MD
docrehab@aol.com

http://neurorehabana2014.sld.cu
http://www.neurorehabana.com

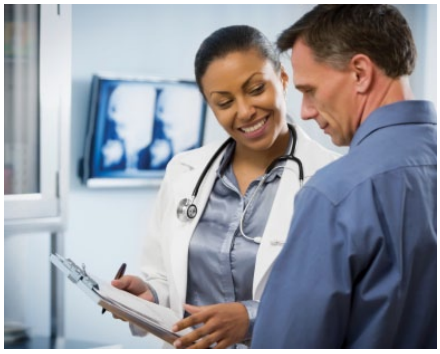
Speak Up and Be Heard

Daniel Kantor, MD
Medical Director
Neurologique
President-Elect
Duval County Medical Society
Immediate Past President
Florida Society of Neurology

Physiatrists are speaking up and being heard. Long past are the days when we could all afford to not be involved in what is going on around us, long past are the days when we could simply practice Medicine without constant interference., long past are the days when we could practice in silos and not interact with each other. The Florida Society of Physical Medicine & Rehabilitation (FSPMR) in partnership with the Florida Society of Neurology (FSN) set up an EMG/NCS taskforce in 2012 in response to the widespread misuse and abuse of EMG/NCS performed by non-specialists and non-MDs/DOs. We have been working with insurers to try to ensure that only well qualified MDs and DOs perform EMG/NCS. Diagnoses are missed when patients undergo EMG/NCS performed by people with sub-standard training, and our job in Medicine is to primum non nocere.

The only way for us to have a voice together, is for us to speak up together. This is why it is so important for physiatrists to join the rest of the House of Medicine in advocacy, and be actively involved in strategic partnerships, like the FSPMR-FSN EMG/NCS taskforce. Let your FSPMR know if you are interested in being more involved in the future of EMG/NCS n the State of Florida.

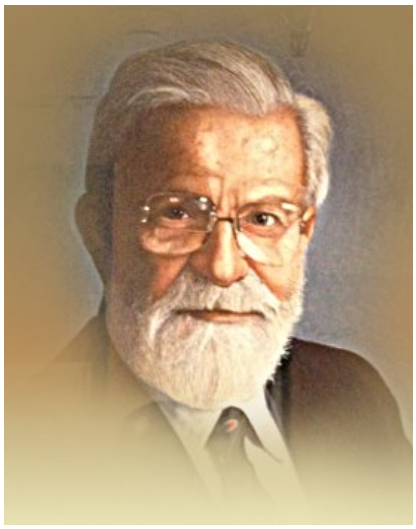
On January 1, 2014, many patients will wake up to find that their current physicians are no longer covered under their health insurance plan. Large insurance companies, like UnitedHeathcare in their Medicare Advantage plan (endorsed by AARP), are finding ways to drop expensive patients … by dropping their physicians. Since a heath insurance company cannot legally drop patients that require more treatments, diagnostic testing or expensive medications, these insurance companies have figured out a way of getting around that problem … they remove the patient's access to their physicians. This means that prior to the December 7th, 2013 Medicare Enrollment period, many patients were leaving UnitedHealthcare's Medicare Advantage plan and moving to other Medicare Advantage plans (or back to Traditional Medicare with our without a Medigap supplement). Patients who did not know that their physicians were being dropped (some are only being dropped February 1, 2014 and not January 1, 2014) may take advantage of the Medicare Advantage Disenrollment period that extends from January 1, 2014 – February 1, 2014. This is only one example of what is happening, and it is why we need to speak up and be heard. We, as physicians, are the front-line of medical care, and the public needs to know what is going on.



Aside from your patients taking personal action to ensure their continuity of care, your patients and you can get vocal and speak up and be heard. The Florida Medical Association (FMA) is seeking your stories and I welcome your feedback at Neurologique@gmail.com If you use social media, please use the twitter hashtag #KeepYourDoctor and spread the word about how the government needs to keep its promise, and patients need to be able to keep their doctors.

Daniel Kantor, MD is the Immediate Past President of the Florida Society of Neurology and President-Elect of the Duval County Medical Society. He serves on the Florida Medical Association Council on Legislation and is a ember of the FMA PAC (political action committee). He is the past chair of the FL Agency for Health Care Administration (Medicaid) Pharmacy & Therapeutics Committee and is the representative from Neurology to First Coast Service Options Medicare Contractor Advisory Committee. He is board certified in both Neurology and Headache Medicine and he is the Chair of the Subcommittee on Concussion for the Sports Medicine Advisory Committee of Florida High School Athletics Association (FHSAA). He practices neurology in Ponte Vedra, FL as medical director of Neurologique and sub-specializes in MS (multiple sclerosis), Headache and Concussion.

In Memoriam - Dr. Arthur J. Pasach



From Yvette Eichberg, MD:

If I had to summarise Dr. Arthur J. Pasach's medical carreer I would state that he was a true Pioneer. He completed his Residency in Physical Medicine and Rehabilitation at Georgia Warm Springs under Dr. Bennett and moved to Tampa in the late 50's, primarily to treat Polio. In reality Polio was one of many conditions that he treated, from Cerebral Palsy to Stroke, Head Injury, Spinal Cord Iinjury, and General PM&R. There were no Rheumatologists in town, so he filled the void until the mid 70's. He was the first Physiatrist on the West Coast of Florida. He ran a clinic in Sarasota once a week, in the days when the Sunshine Skyway did not exist and US41 was slow and heavy traffic. He made time to volunteer for Easter Seal clinics. He taught Medical Aspects of Rehabilitation in the Vocational Rehabilitation program at the U. of South Florida but was not very interested in an Academic career. The only time he threatened to publish a paper he jokingly stated that the title would be; Three Consecutive Motorcycle Accident Victims with Good Insurance. In the late 70's he campaigned for a Rehabilitation Center to replace the 16 beds we had on the Orthopaedic floor at Tampa General. By the mid 80's it was a reality and A.J. Pasach became its first Medical Director. He was a Founding member of the Florida Society of PM&R and eventually served as its President. Dr.Pasach was the recipient of Lifetime Achievement Awards from the Florida and Southern Societies of PM&R. He never really retired. Until a month before his death he would come to the office once a week to do Social Security disability evaluations. His keen intelligence was with him until the end. Three weeks before his passing four of his partners had lunch with him. When we said good-bye he answered *"I guess I will not be around much longer"*, a typical expression of his ever present pragmatism.

Merry Christmas
Happy Hanukkah
And
Best Wishes for the New Year

A Reminder To Renew Your Membership...

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