You’re the first to know about the latest research trends and advancements at the Academy’s Annual Assembly. Join us in National Harbor, MD, for the 2013 Annual Assembly, and get a head start on your next year of practice management with the help of these Assembly updates.

Stay Updated on Assembly News With Email and Twitter

If you’ve attended an AAPM&R Annual Assembly, you know the days are packed with education, networking, and other events. To help you prepare before you arrive for this year’s meeting, and to guide you through the meeting while you’re onsite in National Harbor, MD, your Academy will be providing frequent electronic updates until the end of the meeting.

Registrant News Delivered to Your Email

All Assembly registrants will receive enewsletters 6 weeks out, 1 month out, and 1 week out from the October 3 start of the meeting. During the meeting, registrants will receive enewsletters on Wednesday, Thursday, and Friday nights, providing a quick list of the next day’s activities and quick links to the course handouts, itinerary builder, and hotel maps.

Are You Managing Your Practice or Is It Managing You?

As you learned about in the last issue, this year, your Academy will host a Practice Management Theater in the Exhibit Hall during the 2013 Assembly. Each 20-minute session will put you in-the-know about managing your practice. Learn about practice-critical topics and walk away with how-to handouts.

Utilizing Modern Payment Technology

Faculty: Karen Zupko, Karen Zupko & Associates, Inc.

Preparing for ICD-10

Faculty: Frank Lagattuta, MD; Karen Zupko, Karen Zupko & Associates, Inc.

Compliance Made Easy and How to Minimize Coding Risks

Faculty: Gregory M. Warsowicz, MD, MBA; Karen Zupko, Karen Zupko & Associates, Inc.


Faculty: Christina Hilsberg and Beth Sartore, AAPM&R staff

Get Paid to Get Technical; Meaningful Use of Electronic Health Records

Faculty: Mark Huang, MD; Christina Kwasnica, MD

Dueling EHRs

Moderator: Michael C. Munin, MD

Each session is offered at various dates and times throughout the meeting. Look for the detailed schedule in the Official Program, which will be distributed onsite at the Assembly, and online at www.aapmr.org/assembly.

Assembly Provides Access to New Research

Learn the latest in PM&R research and offer your feedback during the research events planned for the Assembly.

Scientific Posters in the Poster Hall

Visit the Poster Hall to view the latest research in PM&R. New this year, all posters will be displayed on October 4 and 5: 9 am—2:30 pm.

Your Academy will also host 2 different scientific poster presentations during general poster viewing: October 4; 1:30 pm–2:30 pm and October 5; Noon–1 pm. At these times, lead presenters will be available at their posters. These sessions are designed to facilitate one-on-one discussion with presenters regarding current research, results, and methodologies.

Best Research Presentation Sessions

The top PM&R posters from their respective categories will be put on display for an hour. Sessions are led by an expert discussant who will facilitate a constructive, critically challenging evaluation of the research as well as lead a question-and-answer session for each poster.

801. Best Musculoskeletal Medicine Research Poster Presentation

October 4: 11 am–Noon

802. Best Neurological Rehabilitation Research Poster Presentation

October 5: 11 am–Noon

Accessibility at the 2013 Assembly

To prepare for the 2013 Annual Assembly and to ensure this event will be accessible to all participants, your Academy, including Sam S. Wu, MD, MBA, MPH, MA, a member-at-large for the AAPM&R Board of Governors, worked with a representative from the Paralyzed Veterans of America to tour and assess the Gaylord National Hotel and Convention Center. View the report from the site visit, a map containing accessible points of interest for this year’s venue, and other important accessibility-related information on the Academy’s website at www.aapmr.org/accessibility. Hard copies of this information are also available at the Member Resource Center onsite at the Assembly.

Attend AAPM&R Town Hall Meeting

Friday, October 4: 4:30 pm–5:30 pm
Gaylord National Hotel and Convention Center
National Harbor 8, Level 3
Your AAPM&R Board of Governors sets this time aside to meet face to face with members in a casual environment to answer your questions and to hear your ideas and feedback.

Scientific Podium Presentations

During these sessions, attendees have the opportunity to hear presentations on the methodology, results, and conclusions of completed studies followed by question-and-answer periods. Presentations consist of completed experimental studies or well-controlled epidemiologic studies. Presentations are overseen by an expert moderator who will facilitate a constructive and challenging discussion about the research and educational process.

205. Best Neurological Rehabilitation Research Podium Presentations

October 3: 2 pm–3:30 pm
414. Pediatric Research and Clinical Pearls

October 4: 2:30 pm–4 pm
501. Best Pain and Spine Medicine Research Podium Presentations

October 3: 7:30 am–9 am
A Consumer Health Care Story: An Autopsy of Pitfalls

My wife and I have just finished a 7-month ordeal of medical interventions, diagnostics, second opinions, paraprofessional consultations, and ultimate successful resolution. While my wife was the primarily impacted person, no such story fails to ensnare the family and, certainly, the spouse. She has given me her permission to retell the story as a teaching lesson.

In December 2012, she was walking in our neighborhood, slipped and fell hard on her rear end. About a week later, she developed urinary urgency and burning and even noted a little blood, so she called her physician and was diagnosed with a urinary tract infection based on her symptoms. She started a course of antibiotics, but still had symptoms a week later, so she went in and was diagnosed with a urethral caruncle that was badly inflamed and the source of the bleeding. She continued on antibiotics, and after another week was completely asymptomatic. She had never had prior symptoms of any urologic nature. She was referred to a urologist who recommended an evaluation under anesthesia. The evaluation under anesthesia wound up being a surgical resection, which in retrospect was likely a mistake. This surgery led to several prolonged sessions of indwelling Foley catheterizations, followed by nearly 5 months of ICP. It also led to numerous subsequent diagnostic tests, including 3 VCUGs, several fruitless and misguided physical therapy sessions, a second surgical opinion leading to a video urodynamic study with EMG, a bladder neck resection that was without benefit, and most recently, a third surgical opinion culminating in a distal urethral plastic procedure to resect scar tissue and restore urethral patency.

During these procedures, she also developed an acute reactive depression, a subacute anxiety disorder, saw 2 psychologists (1 who mostly discussed what books she herself was reading), an acupuncturist, a medical hypnotist, and she was treated with a variety of psychometric medications—most of which caused significant side effects. She also had significant side effects to the variety of alpha blockers tried—none of which had been effective in relieving her mechanical outlet obstruction.

So the 7-month journey through this nightmare has been emotionally exhausting, very frustrating, and riddled with opportunity to have avoided the whole process. It is enlightening to review the questions below, as while the pathology is not in our bailiwick, the missed opportunities are common to our field.

1. Was the initial procedure actually necessary? It is hard to make the asymptomatic patient better through surgery. All procedures involve risk, and less intervention would have averted this whole parade.

2. Was the procedure performed done correctly? Again, all procedures carry the risk of technical error. Conservative management rarely carries the same risks.

3. Was the subsequent management optimal? We struggled through multiple delays in care and a 6-hour midnight ER visit because of front-office failures to transmit timely messages and failure of physician responses. How does your office (and how do you) manage such communication?

4. Were the diagnostic efforts performed to best effect? Several of the tests were done with only a technician performing them, and the results transmitted on paper. The correct diagnosis and ultimate fix was based on direct physician oversight of a test that had been done twice previously by techs. A paper report often doesn’t carry the same information that personal reading and oversight does—the major reason why our field fights against EMG techs doing the studies.

5. Did my wife’s emotional struggles cloud medical judgment? The perceptions of an anxiety-ridden patient are not always the product of a neurotic mind. We have all seen depressed and anxious patients reappear as emotionally healthy, grateful individuals once we have successfully treated them.

6. How was the actual pathology missed? Failure of careful listening to the patient’s history was a repeated event, leading to an inappropriate second surgery, which also was based on a faulty understanding of normal physiologic processes. Flawed assumptions led to misguided psychotherapy. Failure of both listening and pharmaceutical knowledge led to misguided medication attempts. The eventual care was based on a physician carefully listening to the initial history of the problem and personal oversight of diagnostic procedures followed by surgical remediation of the then-obvious distal site of pathology confirming exactly what my wife had been telling all her care providers from the beginning. This was followed by close postop oversight and medical reassurance based on the findings at surgery.

It is apparent through the clearer window of hindsight that this unfortunate medical adventure needn’t have been so troubling, expensive, or prolonged.

These problems, while specific to her case, are certainly all relevant to our field as we perform procedures, refer for diagnostic testing, listen to anxious patients, and manage front-office staff that interface with patients daily. The flaws in care are not unique. With a focus on the basics, we can all be better, more caring, and effective physicians. ❖

Be a Proud Physiatrist

I am a proud physiatrist. It seems to me that we as physiatrists are shy by nature and not necessarily willing to publicize what we do as we interact with others. The specialty is complex, focused on multiple areas and not easy to explain. To compound matters, in the last several years, with more physiatrists becoming subspecialists, we have become more focused on identifying ourselves by the subspecialty we practice than as members of the specialty of physical medicine and rehabilitation. In my opinion, we need to let the world know about what we do and how well we do it. By that I mean we need to use the larger envelope of PM&R as the instrument to communicate that information. Many times, I see my colleagues tell their patients that they are sports medicine experts, or that they are pain specialists, or that they practice brain injury rehabilitation, or specialize in pediatric rehabilitation; they tend to forget to tell them that first and foremost they are a physiatrist, trained in the art and science of physical medicine and rehabilitation and, that because of that underpinning, they are good treating individuals with sports injuries or chronic pain or those that have had a neurological injury or childhood-related disability. It seems to me we are our own worst marketing entity because we tend not to tell others about our strength as a specialty.

As physiatrists, we know about team care. We understand clearly the importance of distributing responsibilities to the most appropriate person on the team, to follow up on the efforts made by the full team, and most importantly, to look at the ultimate goal, which is the patient’s functional outcome.

For those of you who have started reading here or elsewhere about the ongoing changes with health care reform, you will see that those characteristics are particularly valuable in the future leadership of health care. As an example, accountable care organizations and other health care reform initiatives are all looking at a team approach to patient care and measuring patient-focused outcomes. Just what we physiatrists are very good at doing.

I encourage you to think openly about how you portray your specialty to your patients, their families, and referring sources. Let me suggest that you use information available through the Academy—both electronic and in print—to educate them all on what PM&R is about. When you tell your patients you are a specialist in a particular clinical area, supplement that information by telling them, “I am a physiatrist who specializes in...” Doing so will give our specialty strength and recognition as a group, and it will inform others about the field of PM&R. It will also allow young physicians who are interested in the field to know where to seek information and guidance on how to become 1 of us.

I want to encourage you to become a marketer, to show what you do, and to let people know about PM&R. To those that proudly call themselves physiatrists first, thank you. You are doing a great service to our specialty, the field of medicine, and more importantly, your patients. ❖
SGR Repeal Bill Adopted Unanimously by House Energy and Commerce Committee

A bill (HR 2810) that would replace the Medicare sustainable growth rate (SGR) won unanimous approval July 31 in the U.S. House of Representatives’ Energy & Commerce Committee. Its next step is likely the House floor when members return to Washington, D.C. after Labor Day. No details on how Congress will pay for the measure have been released, but it is expected that the U.S. House of Representatives’ Committee on Ways and Means will address that issue after the August congressional recess. The Senate Finance Committee is also planning to introduce its own measure this fall.

Since the beginning of 2013, your Academy has answered countless requests by phone, email, and through comments letters, from the House Energy & Commerce Committee to ensure that any quality measure incentive program used to replace the SGR includes the use of cross-cutting quality-of-life measures, which take into account functional status outcomes for persons with multiple chronic conditions and disabilities. Excerpts from the bill are below:

Quality Measures

- Rate updates for years 2014–2018 will be 0.5%.
- Cohort groups, used to measure like physicians against each other, will be listed by the U.S. Department of Health and Human Services (HHS) secretary, in which physicians will self-identify into the most fitting category for their practice. Cohorts may be designated as specialties under American Board of Medical Specialties or as other multispecialty classifications.
- Starting in 2019, each cohort group will be assigned a list of quality measures and clinical practice improvement activities that will be vetted through public comment.
- Specialties will have the opportunity to submit clinical practice guidelines to be worked into both outcome and quality-of-life measures for use in cohort groups.
- All quality measures used in cohort groups will be subject to periodic review and update.
- The U.S. Department of HHS secretary must ensure that quality reporting is aligned with Medicare’s physician compare tool and electronic health records (EHRs).
- If physicians opt out of reporting quality data, they will be paid at 95% of reimbursement levels, according to the fee schedule starting in 2019, unless said physician has a caseload lower than a TBD threshold.

Quality domains are listed as:

1. Clinical care
2. Safety
3. Care coordination
4. Patient and caregiver experience
5. Population health and prevention

The update incentive program will measure quality in a benchmark fashion using a scale between 1 and 100. Incentive payments based on quality are as follows. (This is in addition to the 2019 single conversion factor update of 0.5%):

- Composite scores over 67 = 1% update
- Composite scores between 34 and 67 = 0 update
- Composite scores lower than 34 = –1% update
- Composite score is defined as an average performance across core measure sets within cohort groups.
- The reporting period is 12 months, and each score has no impact on subsequent reporting periods.
- A data portal where physicians could monitor composite scores would be created.
- The U.S. Department of HHS secretary will engage in a nationwide education project regarding the update incentive program.
- The update incentive program would coordinate with both Physician Quality Reporting System and EHR reporting.

Alternative Payment Models

- Physician groups can continue to apply to participate in alternative payment models, such as:
  - Accountable care organizations
  - Primary care medical homes
  - Bundles of episodic payments

Care Coordination

- Centers for Medicare & Medicaid Services will create Healthcare Common Procedure Coding System codes for physicians managing patients with complex chronic conditions.
- Physician eligibility:
  - Is certified as a medical home
  - Is recognized by a patient-centered specialty practice by the National Committee for Quality Assurance
  - Has received equivalent certification (as determined by the secretary)
  - Meets such comparable qualifications as the secretary determines

Bundled Payments

- The U.S. Department of HHS secretary will solicit recommendations from physician societies on appropriate definitions of nonacute episodes of care.
- The U.S. Department of HHS secretary will solicit recommendations from physician societies on payment bundles for chronic conditions and expensive, high-volume services.
- Two years after date of enactment, the U.S. Department of HHS will report to Congress on payment bundle proposals.

Program Integrity

- Both MedPAC and GAO will report on the performance of the update incentive program.

Liability

The bill says, “The development, recognition, or implementation of any guideline or other standard under any federal health care provision shall not be construed to establish the standard of care or duty of care owed by a health care provider to a patient in any medical malpractice or medical product liability action or claim.”

The Physiology of the Effects of Therapeutic Heat on the Body: Uses and Precautions

Pfizer Consumer Healthcare presents

Presented during the 2012 AAPM&R Annual Assembly

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Academy Hosts Stakeholder Meeting Regarding 2010 IRF Medical Necessity Requirements

In June, your Academy hosted a meeting in Washington, DC, for multiple inpatient rehabilitation facility (IRF) stakeholders, including the American Medical Rehabilitation Providers Association, American Physical Therapy Association, American Speech-Language-Hearing Association, American Occupational Therapy Association, Commission on Accreditation of Rehabilitation Facilities, Center for Medicare Advocacy, Inc., the Brain Injury Association of America, and United Spinal Association. The gathering involved analyzing aspects of the inpatient rehabilitation hospital and unit medical necessity criteria set forth by Centers for Medicare & Medicaid Services (CMS) effective January 1, 2010, to provide recommendations for improvement of these regulations from a clinical, administrative, and legal perspective.

Your Academy’s Health Policy and Legislation Committee felt that because the regulations have been in effect for more than 3 years, the time was right to convene key stakeholders and comprehensively review the IRF medical necessity criteria. The goal was to develop a set of recommendations to fine-tune the regulations to reflect the experience of providers since January 2010.

The group examined whether there is consensus on the reasonableness of the documentation deadlines, whether some of the documents could be consolidated to lessen the burden on the IRF and the rehabilitation physician/team, whether the regulations could be strengthened to forbid “less intensive setting” denials in which contractors deny coverage on the assertion that the patient could have received care in a skilled nursing facility, and whether the 3-hour rule should be refined.

In addition, the issue of technical denials was also discussed to examine whether there is consensus on the need to further refine the medical necessity criteria. The goal was to develop a set of recommendations to fine-tune the regulations to reflect the experience of providers since January 2010.

After a full day of intense discussion on these issues, the group decided to put together a consensus recommendation paper addressing some of the refinements needed to ensure the best interests of high-quality patient care that maximizes health and function, maintain program integrity in the Medicare IRF benefit, and provide appropriate access to quality patient care. The goal was to develop a set of recommendations to fine-tune the regulations to reflect the experience of providers since January 2010.

Fiscal Year 2014 Payment and Policy Changes for Medicare IRFs

On July 31, CMS issued a final rule (CMS-1448-F) updating FY 2014 Medicare payment policies and rates for the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) and the IRF Quality Reporting Program (IRF QRP). The FY 2014 changes are summarized below.

Changes to IRF Payment Policies and Rates

- **FY 2014 updates to the payment rates under the IRF PPS:** CMS estimates that aggregate payments to IRFs will increase in FY 2014 by $170 million, or 2.3%, relative to payments in FY 2013. This estimated increase is attributable to a 1.8% payment update, which includes a 2.6% estimated market basket, reduced by a 0.5 percentage point multifactor productivity adjustment and an additional 0.3 percentage point reduction as required by law. Additionally, CMS will update the outlier threshold, increasing IRF PPS payments by an estimated 0.5%.

- **Facility-level adjustment updates:** CMS will update the rural, low-income percentage and teaching status adjustments in FY 2014. To improve the accuracy of the adjustments, CMS will include a new variable in the regression methodology to indicate whether the IRF is a freestanding hospital or a unit of an acute care hospital or critical access hospital. CMS continues to base the adjustments on 3 years of data instead of 1 year of data, which improves the stability of the adjustments over time.

- **“60 percent rule” presumptive methodology code list updates:** To be excluded from the hospital inpatient PPS and be paid at the higher IRF PPS rates, an IRF must demonstrate that at least 60% of its patients require intensive inpatient rehabilitation services for 1 or more of 13 conditions specified in regulation. Most IRFs are first evaluated for compliance with the rule using the “presumptive compliance” method, in which a patient’s diagnosis codes are compared to the presumptive compliance list. If an IRF does not meet the requirements with the presumptive compliance method, it must then be evaluated using medical review. CMS will remove a number of codes from the presumptive compliance list in FY 2014 because the presence of the codes alone does not prove compliance in the absence of additional facts that must be obtained from a patient’s medical record.

The revisions fall in the following categories:

- Nonspecific diagnosis codes
- Arthritis diagnosis codes
- Unilateral upper extremity diagnosis codes
- Some congenital anomaly diagnosis codes
- Miscellaneous diagnosis codes

CMS is delaying the effective date of these changes 1 year in order to give IRFs enough time to adjust to the changes in the final rule. These changes will be effective for compliance review periods beginning on or after October 1, 2014.

Source

What is ZeroG?

ZeroG is a robotic body-weight support system attached to a motorized trolley that rides along a customized ceiling track. It was developed by engineers and therapists as a safe, easy-to-use system to train patients over a wide array of gait and balance activities while providing the ultimate patient-therapist interaction.

Safe. ZeroG tracks the patient and system behaviors at 1000 times per second.
Simple. ZeroG is controlled wirelessly through an Apple iPod or iPad.
Proven. ZeroG’s performance is proven to be accurate (Hidler et al., 2009).
Experience. Aretech is the inventor and manufacturer of ZeroG offering unparalleled expertise.
Look for Commemorative 75th Anniversary Publication During Annual Assembly

To mark AAPM&R’s 75th anniversary, AAPM&R’s History Preservation Committee is creating a special publication that will be placed in all Annual Assembly tote bags this year. Members who do not register for the meeting will receive their copy with the October/November issue of The Physiatrist.

See Pieces of AAPM&R History at www.aapmr.org

Throughout the yearlong observation of the Academy’s 75th anniversary, the history section of the Academy’s website has expanded to include new content uncovered from the Academy’s archives.


Academy Participates in CMS Refinement Panel for EMGs/NCS

Your Academy has been working steadily and diligently since November 2012 to bring clarity to Centers for Medicare & Medicaid Services (CMS) on its decision to drastically cut reimbursement rates for nerve conduction studies (NCS) and electromyography (EMG) studies. Efforts have been varied and have included several direct meetings with CMS leadership, advocacy campaigns, congressional letters, and other avenues of communications.

Recently, CMS granted the Academy’s request to convene a meeting, called a refinement panel, on August 20. This meeting is an attempt to change the FY13 final rule that went into effect on January 1, 2013. This panel was the result of multiple efforts from your Academy and partnering associations in this endeavor: the American Academy of Neurology and the American Association of Neuromuscular & Electrodiagnostic Medicine.

The final outcome of this meeting will be presented when CMS publishes its final rule in early November 2013. Your Academy will continue to provide updates accordingly.

Discussions Continue for Unified GME Accreditation System

Your Academy wants to keep you informed about discussions related to unifying the accreditation system for graduate medical education (GME) for all MDs and DOs in the U.S.

For the last 18 months, both the American Osteopathic Association (AOA) and the American Association of Colleges of Osteopathic Medicine (AACOM) have been exploring ways with the Accreditation Council for Graduate Medical Education (ACGME) to create a unified GME accreditation system. However, to date, AOA and AACOM have been unsuccessful in reaching an agreement with ACGME on a memorandum of understanding to create a single GME accreditation system in the U.S. for both MDs and DOs.

Although no agreement has been made, both organizations have said they are open to additional discussions with the ACGME.

Your Academy will continue to follow these discussions and keep you informed. Stay tuned to www.aapmr.org.

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Physiatry Positions – Johns Hopkins University

The Department of Physical Medicine and Rehabilitation of the Johns Hopkins University School of Medicine is seeking full-time board-certified/board-eligible physiatrists for our growing department. These extraordinary positions offer ample opportunity for clinical practice and teaching in a collegial environment of the highest caliber. Research is encouraged but not required. We offer competitive salary, outstanding benefits, and performance-based bonus. Two positions are available:

**Spine Physiatrist**

This position focuses on physiatric management of spinal disorders in close collaboration with the Departments of Neurosurgery and Orthopaedic Surgery. Participation in interventional spine procedures and EMG is available. Fellowship training in Spine, Pain, or Musculoskeletal Medicine is preferred. This position will be located primarily at Johns Hopkins Bayview and Medstar Good Samaritan Hospitals.

**Medical Director, Musculoskeletal and General Inpatient Rehabilitation**

Medical Director for Musculoskeletal and General Inpatient Rehabilitation at the Medstar Good Samaritan Hospital’s CARF-accredited 51-bed Comprehensive Integrated Inpatient Rehabilitation Program (CIIRP). Based in an outstanding community hospital, this program is a major teaching and practice site for Johns Hopkins. The CIIRP has been under medical direction of Johns Hopkins PM&R for more than 40 years. This leadership position includes attending on the CIIRP service and the active musculoskeletal and neurological rehabilitation outpatient clinics.

For further information contact:

Kenneth Silver, MD
Vice-Chair, Physical Medicine and Rehabilitation
Johns Hopkins University
Send your resume to ksilver1@hmi.edu or (443) 444-4770 (Fax) - Call us at (443) 444-4780

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Frank H. Krusen, MD, Lifetime Achievement Award

The Academy’s highest honor is the Frank H. Krusen, MD, Lifetime Achievement Award. It was established in 1972 in honor of Frank H. Krusen, MD, a founding father and the fourth president of the Academy who was a leader in the development of the specialty of PM&R. Recipients of the Frank H. Krusen Award are selected for their outstanding and unique contributions to the specialty of PM&R in the areas of patient care, research, education, literary contributions, community service, and involvement in Academy activities.

Dr. Reinstein is associate physiatrist-in-chief in the department of PM&R at Sinai Hospital of Baltimore and clinical professor of PM&R at the Medical College of Virginia, Virginia Commonwealth University. In the 40 years of his PM&R practice, he has been on the faculty of PM&R departments in the Schools of Medicine at Temple University, Thomas Jefferson University, the University of Maryland, and The Johns Hopkins University.

Dr. Reinstein has been an active member of AAPM&R for more than 30 years. He was president of AAPM&R from 1992–1993. He has received several AAPM&R awards: the Distinguished Member Award in 2000, Distinguished Clinician Award in 1998, and the Walter J. Zeiter Lectureship in 1995. He has served as a member of the AAPM&R Board of Governors as an AAPM&R delegate to the American Medical Association since 1996, serving as chair of the delegation since 2000. He has also served as an AAPM&R long-term representative to the Council of Medical Specialty Societies (CMSS) since 1993. Currently, he is also a member of AAPM&R’s Health Policy and Legislation Committee and Quality, Practice, Policy, and Research Committee and a member of the AAPM&R Medical Rehabilitation Council. Additionally, he has served as chair for several AAPM&R committees, including the Nominating Committee and the Medical Practice Committee.

Throughout his career, Dr. Reinstein has been involved in other national medical organizations, including the Association of Academic Physiatrists (AAP), and he was president of CMSS from 1999–2000. Additionally, he has authored multiple publications, abstracts, and book chapters, and he has given more than 300 national presentations.

Dr. Reinstein received his MD from the University of Maryland School of Medicine in Baltimore, and he completed his residency in PM&R at Temple University Hospital in Philadelphia, where he was chief resident.

Thank You for Nominating

Thank you to all members who participated in this year’s awards nominations. Didn’t have a chance to nominate a colleague? Plan to participate in 2014. Stay tuned to www.aapmr.org for details.
The Distinguished Member Award was established in 1994 to honor AAPM&R members who have provided invaluable service to the specialty of PM&R, primarily through participation in PM&R-related organizations other than the Academy.

**Dr. Massagli** is a professor of rehabilitation medicine and pediatrics at the University of Washington, where she has been the PM&R residency program director since 1992.

Dr. Massagli is a member of the AAPM&R Pediatric Rehabilitation/Developmental Disabilities Council. Additionally, she is completing a 12-year term as a director and is the past chair of the American Board of Physical Medicine and Rehabilitation (ABPMR). She has chaired several ABPMR committees, including the spinal cord injury exam, the pediatric rehabilitation exam, the oral exam, and the Program Directors’ Advisory Committee. She is currently chair of the Review Committee for Physical Medicine and Rehabilitation for the Accreditation Council for Graduate Medical Education (ACGME). She has been an officer and active participant in the Residency & Fellowship Program Directors’ Council for AAP and served on the AAP Board of Trustees from 2003–2007.

Dr. Massagli received the ACGME Parker J. Palmer Courage to Teach Award in 2005 and has served on ACGME’s portfolio and milestone projects. She has also authored numerous articles with a focus on graduate medical education.

Dr. Massagli received her MD from Yale University, and she completed her pediatric residency at Yale-New Haven Hospital and her PM&R residency at the University of Washington.

The Distinguished Clinician Award is presented by the Academy to honor individual physiatrists who have achieved distinction on the basis of their scholarly level of teaching and their outstanding performance in physiatric patient care activities. Recipients of this award have contributed significantly to the advancement of the specialty through participation in Academy activities.

**Dr. Aseff** is medical director of admissions, director of electrodiagnostic services, and staff physiatrist at the MedStar National Rehabilitation Hospital in Washington, DC. He is also clinical professor of rehabilitation medicine at Georgetown University School of Medicine. He was the founding director of the PM&R residency program at the National Rehabilitation Hospital.

Dr. Aseff is a member of the AAPM&R Central Nervous System Rehabilitation, Medical Rehabilitation, Musculoskeletal Medicine, and Pain Medicine/Neuromuscular Medicine Councils. He is also a member of several medical societies, including the American Association of Neuromuscular & Electrodiagnostic Medicine and AAP. He has received multiple awards and distinctions, including the Dr. John W. Goldschmidt Award for Excellence in Rehabilitation awarded by MedStar National Rehabilitation Network, and he has been named multiple times as one of the area “Top Doctors” by Washingtonian Magazine. He has authored several publications and has given numerous presentations.

Dr. Aseff received his MD from Ohio State University College of Medicine. He completed a residency in PM&R at the Ohio State University Hospitals after having had additional residency training in general surgery and orthopedics at Case Western Reserve/University Hospitals of Cleveland.

The Distinguished Clinician Award was established in 1994 to honor AAPM&R members who have provided invaluable service to the specialty of PM&R, primarily through participation in PM&R-related organizations other than the Academy.

**Dr. Cianca** is the founder of the Human Performance Center in Houston, which was established in 1994. His practice is based on sports medicine treatment principles, and he treats patients of all ages with musculoskeletal disorders using traditional Western medicine and acupuncture. Since 2004, he has developed and maintained a cash and Medicare practice. This allows him to treat patients with sufficient time and energy to maximize his clinical effectiveness and supports his devotion to teaching his patients how to enable their own recovery. He is also a clinical associate professor of PM&R for the Baylor College of Medicine/University of Texas PM&R Alliance and has been the medical director of the Houston Marathon since 1998. He serves on the board of directors for the Houston Marathon Committee. Participant safety and public safety in mass participation events has become an integral part of his work.

Dr. Cianca is a member of AAPM&R’s Medical Education Committee, Musculoskeletal Ultrasound Task Force, and Musculoskeletal Medicine and Pain Medicine/Neuromuscular Medicine Councils. He has been the course director for the musculoskeletal ultrasound preconference course at the AAPM&R Annual Assembly since 2010. Additionally, he has been on the faculty of other musculoskeletal ultrasound courses for AAPM&R and other organizations. He was the program cochairman of the 2004 PASSOR annual meeting, served on AAPM&R’s 2002 Study Guide Committee, and was a PASSOR liaison to AAPM&R’s Practice Guidelines Committee.

Dr. Cianca has authored several abstracts, articles, and book chapters, and he has directed numerous courses and presented numerous lectures. He received his MD from Albany Medical College in Albany, NY, and he completed a fellowship in sports and performing arts medicine at the The Institute for Rehabilitation and Research in Houston.

The Distinguished Member Award was established in 1994 to honor AAPM&R members who have provided invaluable service to the specialty of PM&R, primarily through participation in PM&R-related organizations other than the Academy.

**Dr. Pasquina** is the inaugural chair of the department of PM&R at the Uniformed Services University of the Health Sciences and the director of the PM&R residency program at Walter Reed National Military Medical Center—both located in Bethesda, MD. His current research efforts are focused on exploring new technologies to enhance the recovery, rehabilitation, and reintegration of combat casualties, particularly those with traumatic brain injury and orthopedic trauma, such as amputation. He executes his research as director of the Center for Rehabilitation Sciences Research and coprincipal investigator in the Center for Neuroscience and Regenerative Medicine.

Prior to his retirement from active military service, he served as the chief of the department of orthopedics and rehabilitation at Walter Reed National Military Medical Center. He also served as specialty consultant to the Army Surgeon General and a secretarial appointee for the U.S. Department of Veterans Affairs’ Advisory Committee on Prosthetics and Special Disabilities Programs. He continues to serve as a consultant to the U.S. Department of Defense.

Dr. Pasquina has received multiple military awards, as well as awards for teaching and mentorship, including the U.S. Army’s “A” Proficiency Designation for academic excellence. He has authored multiple book chapters, journal articles, and policy papers, and he is an associate editor for the Journal of Rehabilitation Research & Development.

Dr. Pasquina is board certified in PM&R, electrodiagnostic medicine, and pain medicine. He received his MD from the Uniformed Services University of the Health Sciences, and he completed a fellowship in primary care sports medicine from the Uniformed Services University of the Health Sciences and Georgetown University.
Dr. Press has been an attending physician at Rehabilitation Institute of Chicago since 1988, and in 1989, he founded the Spine and Sports Rehabilitation Centers at Rehabilitation Institute of Chicago, in which he also serves as director. He is also a professor of the Laboratory for the Study and Simulation of Human Movement at George Mason University. Additionally, he is medical director of the outcomes program at Inova Health System’s Betty and Guy Beatty Center for Integrated Research and a special volunteer in the rehabilitation medicine department at the National Institutes of Health (NIH) Clinical Center in Bethesda, MD. He was chief of the rehabilitation medicine department at NIH from 1975–2005, where she constructed the laboratory of biomechanics and was instrumental in helping to develop the subspecialty of rehabilitative rheumatology. She is also the former director of the Center for Study of Chronic Illness and Disability at George Mason University.

Dr. Gerber received the Distinguished Public Service Award from AAPM&R in 2006. She served on the AAPM&R Board of Governors from 2005–2008. She is a member of AAPM&R’s Corporate Relations Committee, History Preservation Committee, and Medical Rehabilitation Council. She has served in various roles in other professional organizations, including diplomate of the American Board of Internal Medicine, and she is a member of the Friends of the Foundation for Physical Medicine and Rehabilitation and the Institute of Medicine of the National Academy of Science.

She has received awards from several organizations and research funding from various institutions, including NIH and National Institute of Disability and Rehabilitation Research. Her research investigates causes of functional loss and disability in chronic illness. Specifically, she studies human movement and the mechanisms and treatment of fatigue. She has also authored or coauthored more than 100 peer-reviewed publications and chapters and has given multiple presentations, and she has served on several advisory boards to national committees and foundations and has been a grant reviewer for several federal agencies and foundations.

Dr. Gerber is board certified in internal medicine, rheumatology, and PM&R. She received her MD from Tufts University School of Medicine in Boston.}

Dr. Press received his MD from the University of Illinois College of Medicine and completed his residency at Northwestern University/Feinberg School of Medicine and Rehabilitation Institute of Chicago.

Dr. Press will present “Looking Back on My First 25 Years: What I Need to Do Better for the Next 25” at the Nadler/PASSOR Award Lectureships on Friday, October 4, 7:30 am–9 am.
The AAPM&R Outstanding Council Service Award is designed to recognize members who have contributed to the success of the Academy, fulfilling its mission and serving members in ways not limited to research, education, and product development.

Central Nervous System Rehabilitation Council
Dr. Horn is chair, PM&R residency program director, and professor of the department of PM&R at Wayne State University School of Medicine at the Detroit Medical Center—Rehabilitation Institute of Michigan. He has mentored many elite brain injury physiatrists in the U.S.
Dr. Horn is a member of AAPM&R’s Central Nervous System Rehabilitation Council. He has served as vice-chair of the Neurological Rehabilitation track for AAPM&R’s Program Planning Committee and was a member of the committee from 2002–2008. He also served on the editorial board for PM&R Knowledge NOW® and as a reviewer for PM&R. Dr. Horn was chair of the Special Interest Group/Section for Rehabilitation of Brain Disorders before AAPM&R created Councils. Additionally, Dr. Horn is an active member of other medical societies, including AAP.
He has published multiple articles and book chapters, served as guest editor for several journals, and was the senior editor for Medical Rehabilitation of Traumatic Brain Injury—the first book dedicated to brain injury medicine. Dr. Horn is a frequent lecturer and course organizer for a variety of national professional conferences, and he has received teaching awards.
Dr. Horn received his MD after completing the honors program in medical education at Northwestern University’s Feinberg School of Medicine. He completed his residency training in PM&R at the University of Washington, where he also received a master’s degree in rehabilitative medicine. He completed a fellowship in brain injury rehabilitation at Santa Clara Valley Medical Center in San Jose, CA.

Medical Rehabilitation Council
Dr. Bartels is chair of the department of rehabilitation medicine at Montefiore Medical Center/Albert Einstein College of Medicine in Bronx, NY.
Dr. Bartels is a member of AAPM&R’s PM&R Knowledge NOW Steering Committee and PM&R Knowledge NOW Editorial Board, and he is the Essentials of Rehabilitation Practice and Science section editor for PM&R Knowledge NOW. Additionally, he is an associate editor for PM&R and a member of AAPM&R’s Medical Rehabilitation Council. Previously, Dr. Bartels was president of AAPM&R’s cardiopulmonary special interest group and has been an active contributor to AAPM&R at Annual Assemblies as a presenter and a contributor to study guides.
Dr. Bartels has published more than 50 scientific papers and reviews and has given multiple presentations on rehabilitation medicine.
He received his MD from Columbia University College of Physicians & Surgeons in New York, and he completed an internship and 2 residencies in internal medicine and rehabilitation medicine at the NewYork-Presbyterian Hospital/Columbia University Medical Center.

Musculoskeletal Medicine Council
Dr. Kennedy is the associate residency program director and the associate spine fellowship director at Stanford University.
Dr. Kennedy serves on AAPM&R’s Medical Education Committee as director of Maintenance of Certification Parts III and IV, and he is a member of the AAPM&R Musculoskeletal Medicine and Pain Medicine/Neuromuscular Medicine Councils. He developed and led multiple pain-related activities on acadeME®, and he also helped develop PM&R Knowledge NOW by serving as the codirector for the task force that outlined the musculoskeletal curriculum and by contributing as an author. He is a member of the editorial boards for both PM&R and Pain Medicine, and serves as coeditor of PM&R’s Point/Counterpoint section. Additionally, he served as the guest editor for PM&R’s supplement on osteoarthritis.

Pain Medicine/Neuromuscular Medicine Council
Dr. Atchison recently became the medical director of the Rehabilitation Institute of Chicago’s Center for Pain Management and professor of PM&R at Northwestern University’s Feinberg School of Medicine in Chicago. He has been in practice at academic medical centers for more than 20 years, and he is a nationally recognized teacher and researcher in PM&R and pain management.

Pediatric Rehabilitation/Developmental Disabilities Council
Dr. Murphy is the medical director for Gillette Children’s Specialty Healthcare’s Northern Minnesota Clinics. He is also medical director of pediatric rehabilitation medicine at Sanford Health in Bismarck, ND.
Dr. Murphy has been a member of AAPM&R for 27 years and is a member of AAPM&R’s Medical Rehabilitation, Musculoskeletal Medicine, and Pediatric Rehabilitation/Developmental Disabilities Councils. He helped develop an online course on acadeME, “Managing the Transition: Adults With Childhood-Onset Conditions.” He is a board member of the Foundation for PM&R. He is also a senior reviewer of the oral examination process and vignette writing and was an oral examiner for ABPMR.
He served in the U.S. Military and U.S. Army for more than 24 years. This service includes Medical Command as Division Surgeon for the 34th Infantry along with 4 active duty combat tours in the Middle East between 2003–2010. He was the U.S. team physician for the Paralympic Games in 1992 and 1996 and is the founder of the Great American Stationary Bike Race for Cerebral Palsy in Bismarck, ND. He has written numerous peer-reviewed publications and has given a multitude of presentations on pediatric and adult rehabilitation.

Intervention Society. He has given numerous lectures for several professional organizations, and he has received multiple teaching awards and has presented numerous courses, lectures, and workshops. Dr. Atchison has published and reviewed numerous research papers, book chapters, and abstracts, and he has led and participated in several research projects, including some funded by the NIH.
He received his DO from Ohio University Heritage College of Osteopathic Medicine, and he completed his PM&R residency at The Ohio State University.

This award was established to honor individuals who, in the course of public service activities, have significantly contributed to the growth and development of services that impact directly the specialty of PM&R.

U.S. Senator Kirk and U.S. Congresswoman Duckworth, through their lives of public service, have brought positive attention to and awareness of the PM&R specialty.
The 2013 AAPM&R Nominating Committee Report
of Member Council Elected Positions

The Central Nervous System Rehabilitation, Medical Rehabilitation, Pain Medicine/Neuromuscular Medicine, and Musculoskeletal Medicine Council Nominating Committees respectfully submit the following Academy fellows for election at their respective annual business meetings to be held in National Harbor, MD, on Friday, October 4:

Central Nervous System Rehabilitation Council
Chair-Elect*
Steven Kirshblum, MD
(Term 2013–2015)

Vice-Chair of Membership
Deborah A. Crane, MD, MPH
(Term 2013–2016)

Vice-Chair of Education
Michael R. Yochelson, MD
(Term 2013–2016)

Member-at-Large, Nominating Committee
Nancy R. Mann, MD
(Term 2013–2014)

Respectfully submitted:
Steven R. Flanagan, MD, Nominating Committee Chair and Council Chair
Kathleen R. Bell, MD, Immediate Past Chair
Richard L. Harvey, MD, Council Member-at-Large

Medical Rehabilitation Council
Vice-Chair of Education
Jean L. Nickels, MD
(Term 2013–2016)

Vice-Chair of Membership
Eric M. Wisotzky, MD
(Term 2013–2016)

Member-at-Large, Nominating Committee
David T. Burke, MD
(Term 2013–2014)

Respectfully submitted:
Michael D. Stubblefield, MD, Nominating Committee Chair and Council Chair
Mary Catherine Spires, MD, PT, Immediate Past Chair
George Forrest, MD, Council Member-at-Large

Pain Medicine/Neuromuscular Medicine Council
Chair-Elect**
Martin Grabois, MD
(Term 2013–2015)

Vice-Chair of Membership
Carol B. Vandenakker-Albanese, MD
(Term 2013–2016)

Member-at-Large, Nominating Committee
Erik T. Shaw, DO
(Term 2013–2014)

Respectfully submitted:
Michael Saffir, MD, Nominating Committee Chair and Council Chair
Jonathan Finnoff, DO, Immediate Past Chair
Kevin R. Vincent, MD, PhD, Council Member-at-Large

Musculoskeletal Medicine Council
Vice-Chair of Education
Arthur Jason De Luigi, DO
(Term 2013–2016)

Vice-Chair of Membership
Kevin R. Vincent, MD, PhD
(Term 2013–2016)

Member-at-Large, Nominating Committee
Mederic M. Hall, MD
(Term 2013–2014)

Respectfully submitted:
Joanne Borg-Stein, MD, Nominating Committee Chair and Council Chair
Jonathan Finnoff, DO, Immediate Past Chair
Kevin R. Vincent, MD, PhD, Council Member-at-Large

Please note: Terms for Council leadership go from Annual Assembly to Annual Assembly.

*The 2013 Central Nervous System Rehabilitation Council Chair-Elect, Joel Stein, MD, will automatically ascend to become the 2013–2015 chair.

**The 2013 Pain Medicine/Neuromuscular Medicine Council Chair-Elect, Deborah A. Veney, MD, will automatically ascend to become the 2013–2015 chair.

2014 Call for Proposals Now Open

The 2014 Call for Proposals opens online on September 23. Each year, the AAPM&R Program Planning Committee (PPC) invites proposals for educational sessions and workshops for the upcoming Annual Assembly. This year, the committee is developing sessions and workshops around the overall theme of exercise. The AAPM&R 2014 Annual Assembly will be held November 13–16, 2014, at the San Diego Convention Center in San Diego.

Submissions should be submitted for 1 of 5 educational tracks:
• Musculoskeletal and Sports Medicine
• Neurological Rehabilitation (includes TBI, stroke, SCI)
• Practice Management and Leadership
• Pain and Spine Medicine
• General Rehabilitation (includes neuromuscular medicine, pediatric rehabilitation, and medical rehabilitation)

The PPC has been working together with the Member Councils in the development of exercise-themed sessions, and the committee would like to continue to receive submissions with an emphasis on that theme in all tracks, including Practice Management and Leadership. We also want to encourage you to submit outstanding nonthemed sessions for consideration in rounding out the diversity of offerings for the 2014 program.

As always, we welcome workshop submissions addressing any physiatry-related topic that provide attendees with an exclusive opportunity to enhance hands-on skills in a small group learning environment.

To submit a proposal, access the AAPM&R online submission site at http://aapmr2014.abstractcentral.com. (This is the only way to submit a proposal.) The deadline to submit proposals online is Friday, November 8, at 11:59 pm (CT).

Questions? Email bstetz@aapmr.org.

Mark your calendars:
The Call for Abstracts opens January 8, 2014!
Know Your Academy Medicare Contractor Advisory Committee Representatives

Because many Medicare policies are established at the local level, Medicare contractors are vested with tremendous authority over payment policies known as local coverage determinations (LCDs). Centers for Medicare & Medicaid Services (CMS) defines LCDs in Section 1869(f)(2)(B) of the Social Security Act (the Act) and states: “For purposes of this section, the term ‘local coverage determination’ means a determination by a fiscal intermediary or a carrier under part A or part B, as applicable, respecting whether or not a particular item or service is covered on an intermediary or carrier-wide basis under such parts, in accordance with section 1862(a)(1)(A).” Within each of the 13 Medicare regions (all 50 states are organized under the regions), there is a Medicare Contractor Advisory Committee (CAC), which consists of at least 1 appointed representative from each medical specialty, along with the medical director and representatives from the insurance company that holds the Medicare contract for that region.

In 1992, CMS established the CAC, which at that time was an acronym for “Carrier Advisory Committees.” CMS has since changed the name. Another purpose of the CAC is to foster better relations and trust between the carriers and providers. CAC is the official mechanism for physicians to be informed on and participate in the development of LCDs and to discuss and improve administrative policies that are within a contractor’s discretion. The CACs hold meetings where physicians have the opportunity to comment on proposed LCDs that impact their specialty, serving in an advisory capacity.

AAPM&R physiatrists advocate on behalf of our specialty for fair reimbursement policies at the local Medicare level. By reviewing and commenting on LCDs and policy changes before implementation, the CACs help ensure physiatrists (and other physicians and health care providers) are appropriately reimbursed for medically reasonable and necessary services provided to Medicare patients.

Why Is It Important to Advocate for Appropriate LCDs?

Your participation in the LCD process gives the specialty the opportunity to influence LCDs and other payment policies that may impact reimbursement for PM&R services. For example, some private payers adopt Medicare policies on a state-by-state basis, and there is a strong influence LCDs and policy changes before implementation, the CACs help ensure physiatrists (and other physicians and health care providers) are appropriately reimbursed for medically reasonable and necessary services provided to Medicare patients.

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Build a Strong Position

It is not enough to just say that you oppose a proposed LCD. Strengthen your position by determining if there is nationally recognized peer-reviewed literature that supports your stance, including whether your position is based on certain benefits such as substantial improved health outcomes, delivery of high-quality care, and possible comparative cost effectiveness of the procedure or device within a targeted patient population. Determine whether government agencies have conducted reviews or assessments (efficacy studies) of the procedure or device. Finally, check whether your Academy has any policy statements or clinical practice guidelines on the procedure/device that you can use to further develop your arguments. Visit www.aapmr.org/advocacy/societies for relevant clinical reviews and data.

To learn more about the Medicare CAC activities in your state or to volunteer as a CAC representative, contact Academy staff at policy@aapmr.org.

How to Get Involved

• Identify your state’s PM&R representative to the Medicare CAC in your region: Contact the Academy to find out who your Medicare CAC representative is or contact your state society president. Questions? Email advocacy@aapmr.org.
• Offer to assist by attending CAC meetings and finalizing comments on LCDs.
• Know your Medicare CAC medical directors: Visit www.aapmr.org/advocacy/societies.
• Post your Medicare CAC’s proposed and final LCDs on your state advocacy group on www.phyzforum.org, where Academy members can post comments and assist with the analyses of LCDs, as well as have access to information on LCDs in effect in your area.

When peak performance counts, wave goodbye to the competition

For more than 60 years, healthcare providers worldwide have relied on the quality and reliability of the Nihon Kohden line of innovative neurodiagnostic instruments to aid in the diagnosis, information and treatment of their patients.

Neuropack 9400A Laptop or Desktop for Portability without Compromise

The feature rich MEB-9400A offers efficient EMG, NCV and EP exams with innovative timesaving technology in either a 2 or 4 channel configuration.

The Newest Member of the Legacy Neuropack EP/EMG Family

Introducing the MEB-2300A, the latest and most advanced EP/EMG system in the Nihon Kohden product portfolio to date. Available with either a 6 or 12 channel amplifier and up to two electrical stimulators, the MEB-2300A is designed with numerous timesaving features to maximize the user’s workflow without compromising the integrity of data acquisition.

Enhanced Multimodality Value

Our MEB system’s value is further enhanced with Nihon Kohden’s gold standard 32-channel EEG option for one of the most flexible multimodality configurations on the market today.

When performance counts, you can rely on Nihon Kohden to make a difference. Contact us today for product information or to schedule a demonstration.

SEPTEMBER 2013

INPATIENT PHYSIATRY BILLING

ALL of our clients are hospital-based physiatrists, and our experience has proven the following:

IF
1. your practice is primarily inpatient, and
2. your patient insurance mix is 80% Medicare, (often true for hospital-based physiatrists)

THEN
3. your practice collection rate will be 98%.

Our exceptional collection rate results from:

• Expert knowledge of Medicare billing guidelines for inpatient physiatric services & procedures (EMG’s, NCV’s, Botox, Baclofen, trigger point injections).
• Vigorous pursuit of outstanding receivables.
• FULL SERVICE practice setup & Credentialing.

Physiatry Billing Specialists, Inc. (800) 835-4482 www.physiatrymedicalbilling.com
Guest Editorial: The Role of State Societies in Today's Health Care Environment

The following guest editorial is submitted by Anthony Lee, MD, chair of AAPM&R’s Presidents’ Council Executive Committee.

“Why should I join a state PM&R society if I’m already a member of AAPM&R?” That is a question, which unfortunately, I hear way too often. The role AAPM&R plays in national advocacy, in member education, and in leading PM&R into the future cannot be undervalued. In fact, AAPM&R and the state societies work in tandem on a range of policy issues that impact the specialty. However, state PM&R societies provide a great benefit to physiatrists, with opportunities to participate in grassroots’ advocacy by collaborating with state medical associations and other state specialty societies on important legislation and proposed regulations.

With the ongoing implementation of the Patient Protection and Affordable Care Act, the state PM&R societies have a role in monitoring essential health benefits and health insurance exchanges in each state. Because physiatrists coordinate care for patients with acute and chronic illness and disabling conditions, we are the “go-to” physicians to align quality improvement and reimbursement strategies across diverse health purchasers.

Your Academy recently formed a work group to conduct a pilot study of state societies to examine those societies’ capacity to advocate for rehabilitation-friendly essential health benefits and state insurance exchange implementation. State societies are also participating in the health insurance exchanges’ process by getting involved in discussions on functional status assessments and interventions that provide improvements in human functioning, which should be part of the dialogue that informs consumer choice. In this way, state societies can help drive quality improvement. I encourage you to listen to an Academy webinar designed to provide key information on health insurance exchanges and essential health benefit plans, including advocacy tools, and to help guide your involvement in this effort. Access the webinar at www.aapmrm.org, type “Federal Health Care Reform” in the search box.

Because many reimbursement decisions are based on Medicare local coverage determinations (LCDs), having a viable state society allows physiatrists to participate in these coverage decisions before implementation. State societies participate in an advisory role with the Medicare Contractor Advisory Committees (CACs)—a forum for physicians and other providers to participate in the development of LCDs. (Read more about CACs on page 14.) I urge physiatrists to work with other stakeholders in the various Medicare jurisdictions in opposing LCDs that, among other things, seek to deprive physicians from assessing and treating their patients. Check your Medicare CAC website for information on LCDs and post links on your state advocacy groups on PhyzForum—www.phyzforum.org—to the LCDs so that other members can provide clinical comments regarding these payment policies.

In the current evolving health care environment, it is important to be up to date with issues that are emerging in our communities. Our focus at the state level should also include advocacy around nongovernmental entities. Private payers are also utilizing new health care delivery models to control spiraling health care costs. Each state society will benefit from having physiatrist volunteers to help foster positive working relations within the private sector to ensure the development of coverage and payment policies that facilitate quality PM&R services. It is our responsibility to advocate for changes to restrictive policies that limit PM&R services as we strive for improved payment, fairer contracts, and less administrative hassle.

In recent years, PM&R has met the challenge of advocating for passage of concussion laws modeled after Washington state’s Zackery Lystedt Law. If your state recently passed a law, your state society should monitor the regulatory phase of implementing that law—making sure that the concussion regulations adequately comply with the statute. By being better advocates for our specialty and our patients, through the state societies, we are able to increase awareness and get the PM&R message to others. Let’s in turn use these opportunities to build stronger societies that protect the practice of PM&R.

With active state societies, our specialty is better positioned to address current changes in health care, inform legislators and policymakers on the needs of our patients, and contribute to the development of best practices and quality of care, as well as advocate for improvements in efficiency and quality. Why then would a physiatrist not want to be a part of a state PM&R society?

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Log On to PhyzForum, Get Acquainted With Your State Advocacy Group

Your state advocacy group is designed to assist members with legislative and regulatory advocacy and practice and can be utilized to help build grassroots’ campaigns. Members can post links to legislation, draft regulatory proposals and reminders about Medicare CAC activities. Email or PhyzForum-based discussion options are easy to access, and subscription options include immediate, daily, or weekly digests. PhyzForum allows for a productive interface among peers on these issues and can be a reliable source of information.

It’s easy to participate in your state advocacy group on PhyzForum. Visit www.phyzforum.org; membership in state advocacy groups is automatic and will appear in the “My Groups” section on the left-hand side.

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With affiliation opportunities in 26 states, we’re growing every day and making a difference in the new era of rehabilitation medicine.

U.S. Physiatry has openings across the country in Florida, Georgia, Texas, Arizona, Pennsylvania, Missouri, Nevada and North Carolina with competitive compensation + benefits. For more information on U.S. Physiatry visit www.usphysiatry.com or call us toll-free at (877) 749-7428.

Come see U.S. Physiatry in Washington D.C. at the Job Fair and Booth 711 during the 2013 AAPMR Annual Assembly.
Verify Your NPI Number

With the Sunshine Act now in place, AAPM&R members are encouraged to verify the information on file associated with their national provider identifier (NPI) number. Your Academy is providing you with the links to make this process simple.

Certain payments and transfers of value from industry to physicians will be tracked and recorded using your NPI number. Your NPI number is neither your license number nor your DEA number. NPI numbers are publicly available and can be found on the web. Payment information will be reported to the Centers for Medicare & Medicaid Services (CMS) by pharmaceutical and device companies that will then post this data on a website that can be searched by the public. Physicians will have a period of time to review the information on the website before it is released to the public. This website is expected to be launched September 30, 2014; however, collection of reportable “transfers of value” began August 1, 2013.

To ensure that the proper information is attached to your NPI number before any reporting begins, you are encouraged to visit the CMS website to verify your information. Your Academy’s website explains the Sunshine Act and provides instructions for how to verify your NPI number as well as links to more detailed information. Visit www.aapmr.org and type “NPI” in the search box.

2013 Annual Assembly Attendees: Your Academy is including NPI numbers in members’ records and is also including them in the information provided in the barcode on attendees’ badges. This information will be accessible to companies that scan badges with lead retrieval systems at the Annual Assembly. As a reminder, this information is publicly available through a web search, and we encourage members to ensure the accuracy of information associated with your NPI numbers by visiting https://nppes.cms.hhs.gov. We also invite members to review their member profile and verify all of their profile information, including their NPI number.

AAPM&R Recognizes the Korean Academy of Rehabilitation Medicine

AAPM&R would like to thank the Korean Academy of Rehabilitation Medicine for supporting PM&R—your Academy’s official scientific journal. In light of the announcement of the impact factor this summer, the Korean Academy of Rehabilitation Medicine let their members know that PM&R now has an impact factor and is included among acceptable journals for their submissions.

In turn, AAPM&R would like to recognize the Korean Academy of Rehabilitation Medicine’s journal—Journal of Korean Academy of Rehabilitation Medicine. Thank you for the continued relationship!

New Clinical Education Coming Soon

Your Academy will have 2 new educational resources available at the end of September.

Musculoskeletal Medicine SAE-P:
- Based on PM&R Knowledge NOW content
- Contains more than 20 questions
- Available for up to 8 AMA PRA Category 1 Credits™

Stroke Online Review Course:
- Was developed by a stroke expert
- Provides a comprehensive overview
- Is eligible for AMA PRA Category 1 Credits™
Register Now!
This 2-and-a-half-day course offers hands-on diagnostic and interventional training, lectures, and independent scanning time to prepare you for immediate application in practice.

Diagnostic and Interventional Musculoskeletal Ultrasound of the Lower Extremity

March 7–9, 2014
Tampa, FL

Learn more at www.aapmr.org/2014US.
WEST

Boise, Idaho: Boise Physical Medicine and Rehabilitation Clinic is seeking a BC/BE physiatrist to join our team of providers. Boise provides a wide variety of resources, including an active academic medical center, excellent schools, and amenities of a metropolitan center – professional sports, museums, parks – and provides a work/life balance. Boise has a strong emphasis on veterans affairs, working closely with other surgical and non-surgical teams to provide the highest level of care to our military patients. Boise VA Medical Center is a regional referral center for the State of Idaho. We are also looking to expand our services with a new VA Outpatient Clinic.

FT/PT, Parkinson's Disease Program, $240,000 - $360,000. The position will provide inpatient, outpatient and consultative services focusing on patients with Parkinson’s Disease. We are seeking an experienced and energetic provider with an interest in Parkinson’s Disease. The individual must be skilled in non-invasive and invasive diagnostic and interventional procedures. For more information please contact: Larry J. Shepherd, MD, Department of Neurology, 2221 South Parkway, Boise, ID 83720; phone: (208) 426-2928; fax: (208) 426-2927; email: Larry.Shepherd@bomahi.org.

Boise Physical Medicine and Rehabilitation Clinic is seeking a BC/BE physiatrist to join our team of providers. Boise provides a wide variety of resources, including an active academic medical center, excellent schools, and amenities of a metropolitan center – professional sports, museums, parks – and provides a work/life balance. Boise has a strong emphasis on veterans affairs, working closely with other surgical and non-surgical teams to provide the highest level of care to our military patients. Boise VA Medical Center is a regional referral center for the State of Idaho. We are also looking to expand our services with a new VA Outpatient Clinic.

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We have two immediate openings: 1: We are seeking a BC/BE physiatrist to join our premier physician owned PM&R practice in Central Pennsylvania. We are seeking a candidate with a diverse practice mix including complex medical and surgical cases as well as outpatient stroke program. Good communication and leadership skills are required. You will be joining a growing physiatry practice in a county which is experiencing rapid population growth. We provide excellent benefits and compensation. Email: soaresp@mlhs.org.

SOUTH

Boise, Idaho: Boise Physical Medicine and Rehabilitation Clinic is seeking a BC/BE physiatrist to join our team of providers. Boise provides a wide variety of resources, including an active academic medical center, excellent schools, and amenities of a metropolitan center – professional sports, museums, parks – and provides a work/life balance. Boise has a strong emphasis on veterans affairs, working closely with other surgical and non-surgical teams to provide the highest level of care to our military patients. Boise VA Medical Center is a regional referral center for the State of Idaho. We are also looking to expand our services with a new VA Outpatient Clinic.

FT/PT, Parkinson's Disease Program, $240,000 - $360,000. The position will provide inpatient, outpatient and consultative services focusing on patients with Parkinson’s Disease. We are seeking an experienced and energetic provider with an interest in Parkinson’s Disease. The individual must be skilled in non-invasive and invasive diagnostic and interventional procedures. For more information please contact: Larry J. Shepherd, MD, Department of Neurology, 2221 South Parkway, Boise, ID 83720; phone: (208) 426-2928; fax: (208) 426-2927; email: Larry.Shepherd@bomahi.org.

We have two immediate openings: 1: We are seeking a BC/BE physiatrist to join our premier physician owned PM&R practice in Central Pennsylvania. We are seeking a candidate with a diverse practice mix including complex medical and surgical cases as well as outpatient stroke program. Good communication and leadership skills are required. You will be joining a growing physiatry practice in a county which is experiencing rapid population growth. We provide excellent benefits and compensation. Email: soaresp@mlhs.org.

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Take Advantage of Your Academy’s Career Services

Helping Job Seekers and Employers Connect

Physiatrists’ Job Board—Available 24/7/365

1 ATTEND THE JOB FAIR AT ANNUAL ASSEMBLY!

Make Meaningful Connections
Employers, reserve your space today!

October 2, 2013, 6–9 pm
Gaylord National Hotel and Convention Center
National Harbor, MD
For more information, please visit www.aapmr.org or e-mail careerservices@aapmr.org.

2 JOB SEEKERS

Make the Most of Your Job Search—http://jobboard.aapmr.org
Visit the Physiatrists’ Job Board today and take advantage of the many tools to help advance your career.

• Free online Job Search
• ResumBuilder
• Post your resume so employers can find you
• And more!

3 EMPLOYERS

Make the Most of Your Recruitment Efforts
The Physiatrist’s Job Board is economical, improves efficiency, and streamlines your hiring process.

• Upgrade with the National Healthcare Career Network (distributes your job posting beyond AAPM&R)
• Search database of resumes
• Post your job to AAPM&R’s Facebook page automatically!
SGR repeal bill was recently adopted unanimously by House Energy and Commerce Committee. Learn more on page 3.

Why is it important to know your Academy Medicare Contractor Advisory Committee representatives? Find out on page 14.

There’s still time to register for the 2013 Assembly. Don’t miss out on this year’s meeting. Details on page 1.