THE PHYSIATRIST

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aaPM&R

In the December 2012/January 2013 issue of *The Physiatrist*, your Academy explained how it has recently challenged proposed nerve conduction studies (NCS) and electromyography (EMG) cuts. This is part of a multipart series that takes a closer look at health care economics. Part 5 of this multipart series details the timeline of events that led to the drastic NCS and EMG cuts.

NCS and EMG Cuts: How Did They Happen?

A Detailed Look at the Timeline of Events That Led to the Drastic NCS and EMG Cuts

Your Academy understands and is aware of the drastic NCS and EMG cuts that are currently impacting many of our members. Our work is not over on this extremely important issue! We continue to be engaged with Centers for Medicare & Medicaid Services (CMS) and are working on setting another meeting date with CMS leaders. The goal of the meeting is to determine the impact of these cuts—not only on physician practices, but also on patient access.

Your Academy is working with other stakeholders in selecting data points from early 2013 claims that will not only demonstrate the impact of these cuts on physician reimbursement, but more importantly patient access. Ultimately, patients will be impacted because physicians in the different specialties are being forced to close their practices due to the drastic and severe cuts in the reimbursements for these specialty studies. Your Academy's intent is to show that the impact of these cuts runs far and deep—not only impacting physicians, but also the population that CMS is working to protect (eg, Medicare participants who are 65 years old and older, patients with certain disabilities, etc). The unintended consequences of these cuts will be delays in diagnosing and treating patients at the proper time, with the potential of creating larger expenses in long-term care for patients with complex diagnostic illnesses. Unanticipated consequences may also include an increase in unnecessary surgical procedures and expenditures when these specialty studies are performed inappropriately and patients being diagnosed without the proper studies in place.

Many members have reached out to the Academy for additional information regarding the NCS and EMG cuts. Below is a high-level timeline of events that ultimately led to the reimbursement cuts. Your Academy understands the impact of these cuts on you and your patients and will continue to work diligently to inform CMS as well as represent the interests of physiatrists and their patients.

2010

- >> NCS and EMGs are identified as being done together more than 75% of the time.
- >> The CPT® and the American Medical Association's Specialty Society Relative Value Scale Update Committee (RUC) task force ask participating societies to review these codes as it is believed that when codes are routinely reported together, there is duplication of work.
- >> Specialty societies AAPM&R, American Association of Neuromuscular & Electrodiagnostic Medicine, and American Academy of Neurology (AAN) present several code change proposals for EMGs and NCS during a CPT Editorial Panel meeting.
- >> CPT Editorial Panel approves the creation of three EMG codes, which went into effect in January 2012. The next step for these three codes is to go to the RUC panel for determining recommended values. Proposed NCS codes were not accepted. The societies continue to work on proposals for these codes.

2011

- >> The three proposed EMG codes are surveyed by AAPM&R, AANEM, and AAN, and the data collected are presented at the RUC panel.
- >> CMS accepts the RUC panel recommendations and moves forward with the creation and value assigned to the three new interim EMG codes.

2012

- >> The three interim EMG codes go into effect on January 1.
- >> The societies present a new code change proposal to the CPT panel for the NCS codes and it is rejected once more.
- >> CPT and RUC advisors from the specialty societies come up with the final NCS code tree couplets at the insistence of the CPT and RUC committees. Complex surveys are sent to several hundred participants from each of the societies. The codes are closely scrutinized by the RUC.
- >> PROPOSED DECISION: In July, CMS publishes its proposed Physician Fee Schedule for 2013. There is no mention of the codes surveyed at the last RUC meeting.
- >> In September, your Academy begins informing its members about the upcoming changes to NCS tests as presented at the RUC panel.
- >> FINAL DECISION: On November 1, CMS releases its final rule on the Physician Fee Schedule. In final valuation of codes, CMS further reduces values proposed by the RUC, and NCS codes are cut substantially. At this time, it becomes evident that the proposed cuts are projected to be about 60% due to further cuts to practice expense.
- >> On November 26, your Academy and AANEM distribute a survey to members of both organizations to determine impact of cuts on practicing physicians.
- >> On November 28, representatives from your Academy and other society stakeholders participate in a CMS conference call with CMS Deputy Director of the Hospital and Ambulatory Policy Group Marc Hartstein to discuss drastic projected cuts.
- >> In early December, your Academy and other stakeholders draft a "Dear Colleague" letter to be circulated in Congress. The letter was endorsed and sponsored by Reps. Peter Roskam (R-IL) and Dutch Ruppersberger (D-MD), and by 11 other members of Congress.
- >> In mid-December, your Academy distributes a coalition letter to members of Congress signed by nearly 75 patient, provider, physician, and academic groups urging them to support this effort.
- >> In mid-December, your Academy sends an Academy-wide action alert, which garners record member participation, to urge members to write their representatives to ensure their support on the "Dear Colleague" letter.
- >> On December 20, your Academy participates in a face-to-face meeting with Deputy Administrator and Director for the Center for Medicare at CMS Jonathan Blum. The meeting was initiated to discuss the recent NCS/EMG cuts, which were released as part of the sustainable growth rate final rule. Barry Smith, MD, and Andrea Boon, MD, represent AAPM&R. The goal is to express the impact of the cuts on patients and physician practices.

2013

- >> On January 1, new NCS and EMG codes go into effect.
- >> On April 1, your Academy met with CMS to move forward with the claims data project and also to request a refinement panel to be conducted this summer. ❖

FROM THE EDITOR

Medical Errors and Physiatric Practice

BRUCE E. BECKER, MD, MS

"You must never feel badly about making mistakes…as long as you take the trouble to learn from them. For you often learn more by being wrong for the right reasons than you do by being right for the wrong reasons."

—Norton Juster, *The Phantom Tollbooth*

My wife and I have been very actively exposed to the world of health care as consumers during the past six weeks. While these recent experiences have been generally positive, my career-bred tendencies toward paranoia have predictably colored my thoughts about life as a vulnerable patient. They have also led to reflection on where our field is relative to the current focus on reducing medical error.

Since the 1999 Institute of Medicine (IOM) report, "To Err is Human: Building a Safer Health System,"[1] there have been considerable efforts to reduce medical error, much of which have been centered in inpatient settings. While the many hospital-based efforts have achieved some success, it is generally conceded that the efforts to date have fallen short of the hopes of that early report.[2] Nearly all of us with inpatient exposure have sat in committee meetings, medical staff meetings, and read administrative bulletins *ad nauseum* regarding the systemic efforts to reduce errors. Those of us with administrative roles have had substantially higher doses of the same, potentially requiring large prescriptions of Zofran™. Certainly, the problem is critically important, but the solutions have rarely centered directly within our sphere of influence.

Yet medical errors are often visible to us given our frequent cleanup position behind the elephants in the circus parade of care, allowing us a marvelous retroscopic view of that care. Despite that perspective, I suspect that few of us have routinely reported such errors in the prior events. There are many reasons for failing to report. A 2008 survey of physician practices (faculty and residents both) within teaching hospitals revealed a general willingness to report medical error, especially within the categories of hypothetical major or minor harm (92% and 78%, respectively) but only rare actual reporting of real events (17.8% and 3.9%, respectively).[3] Reasons for failing to report revealed that nearly half of survey respondents didn't know how to report or were uncertain as to which types of errors needed reporting. More than half the respondents agreed that it was difficult to be certain about the true causes of adverse events in clinical medicine. More than half were concerned about professional discipline when reporting adverse events. So two main reasons for failing to report were given in this article: ignorance over error types and reporting mechanisms, and fear of repercussions. Most of this article, however, dealt with issues of personal responsibility for the real or hypothetical error.

Life is unfortunately more complicated than that. Variances in physician perceptions of what constitutes an error permeate medicine.[4] Was the outcome clearly adverse or simply a variation of possible outcomes? Was the adverse result a matter of a missing or misfiled report or lab test? Was it a failure of listening or remembering facts in the midst of an unrelated crisis? In the initial IOM report, an error is defined as "failure of an action to be completed as intended, or use of a wrong plan to achieve an aim" (ie, errors of execution or planning). Despite much discussion to the contrary, for most physicians, blame remains as a real emotional response to errors, both personal and in colleagues. For me, it would be far more comfortable to report my own errors than those of a close colleague or a mentor/professor, and of course there is also concern when reporting an error made by a critical referral source. So ethics raises its fog-shrouded head in a great many ways, requiring an assuredness that is not often based on clinical certainty. It came as a real surprise to me that in my research in writing this editorial, I was unable to find a single journal article that spoke to these very real-world concerns.

In our professional roles, we certainly have a place in reducing medical errors, but defining the specific actions that achieve that goal are often less than clear. The ethics and logistics of reporting actual or potential upstream errors in care are complex. Would earlier mobilization of an intensive care unit patient have prevented a deep vein thrombosis? Was thromboprophylaxis prematurely discontinued or poorly managed causing a complication? Doing a root cause analysis of every adverse event is impractical, and fault is often ill-defined and shrouded in the bureaucratic complexity of contemporary hospital practice. "What would Osler do?" is a very hard question. ❖

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FROM THE PRESIDENT

Education Is a Key Element of Physiatric Practice

ALBERTO ESQUENAZI, MD

Education is part and parcel of what we as physiatrists do every day. We consistently educate patients and their families, but this activity can expand much beyond that. We educate our colleagues, referral sources, and insurers, and let's not forget your continuous and ongoing efforts to try to keep up with your own professional education that has become more complex and extends to maintaining professional licensure and certification.

Your Academy is the largest source of educational activities specific to the field of PM&R. Resources are heavily invested through AAPM&R's Medical Education Committee and all of the subcommittees to develop excellent educational programs that reflect the needs in the field and are delivered through the Annual Assembly and other programs throughout the year—either in person or through acadeME.® Additionally, AAPM&R's new initiative—Unique Delivery Models of Patient Care for the Future—which was launched by AAPM&R's Public and Professional Awareness Committee, asks members who are involved in unique or innovative health care delivery models to share their experiences as an educational opportunity for other members. This initiative will help AAPM&R position PM&R within the future of the changing health care environment and emphasize how it meets the Triple Aim. The excellent content in *PM&R* nicely complements these educational efforts.

The reason I bring this topic to your attention is my view that our role as educators needs to expand beyond the receiving part. To achieve its full potential, we need to think about how to educate others. Educate referral sources about the benefits of PM&R—not only to their patients, but also to the practitioners and the larger health care system infrastructure. In institutional settings, physiatrists need to reach out and educate colleagues, clinical staff, and administrators on the value of physiatric practice as a model of care. We need to continue to grow our specialty, so educating medical students and residents is key to achieving this growth. Overall, PM&R is a small part of the health care dollars, but we play a key role in improving function, reducing comorbidities, and improving satisfaction—all key components of health care reform.

As a field, we need your help to expand education. Your participation in response to requests for developing topic lists for our Councils, participating in case discussions through PhyzForum, writing and sharing materials in which you have clinical expertise, and sharing your unique delivery model of patient care (which meets the Triple Aim) for the future are all important to enhance the visibility of our field. Maybe you have ideas on how effectively we can incorporate technology to expand our educational reach or ways to reach out to insurance companies and help them realize that there is more than rigid policies that need to be taken into consideration when a patient is in need of care. Examples are lecturing in your community, helping patient support groups, and responding to calls for educational requests. We need to showcase what we know, and through education in the widest sense of the word, demonstrate our contributions and form strong working bonds around us and proudly state that we are physiatrists.

As part of my day-to-day activities, I interact with many clinicians, colleagues in other specialities, medical students, residents, and administrators. I know education takes effort and time, but without it, we are isolating the specialty. This is particularly important in our interactions with insurance companies and health care administrators.

Education can be rewarding in many ways, and when done effectively, it will improve your standing as a clinician and care delivery to your patients. I encourage you to use your skills to educate and to understand the value and influence that you can have through it.

I invite you to take advantage of the many materials that your Academy offers. When the time comes for responding to requests for ideas or providing help in the development of educational materials, offer your time and expertise. Education is important for everyone, and your Academy wants to help. ❖

Guest Editorial: **Value of Council Input for Academy Planning Continues to Grow**

The following guest editorial is submitted by Kurtis M. Hoppe, MD, who serves as president-elect on the AAPM&R Board of Governors.

KURTIS M. HOPPE, MD

As president-elect, I serve as a liaison between AAPM&R's Board of Directors and the Member Councils.

In January, the Academy held its Council Advisory Panel (CAP) meeting and Council Leadership Committee (CLC) meeting in Rosemont, IL. Both meetings are annual gatherings designed to encourage discussion of key Academy strategic priorities. At this year's meetings, the energy and level of engagement and active dialogue among all of the Academy leaders was evident and extremely encouraging.

The CAP meeting is designed so that Council leaders may bring input, received from surveying the entire Council membership in the fall, to discuss with Academy strategic coordinating committee (SCC) chairs before AAPM&R's Board of Governors begins the process of setting priorities for the Academy in the spring.

This year's CAP meeting was organized in a workshop format, where attendees participated in numerous breakout sessions to encourage face-to-face discussions. While a brief discussion of overall goals took place at the beginning of the meeting, the bulk of the day's discussion was based on feedback from Council members.

Each Council leader had the opportunity to meet with each SCC chair to review important details from the Council surveys. At the end of the meeting, attendees reconvened to discuss key findings, insights, and opportunities from the meeting to assist in multiyear planning for the Academy.

This year's CLC meeting was similar in format to previous years, where the Council executive committees engaged in planning for the coming year as well as cross-Council dialogue. Council leaders spent the day developing their work plans for 2013 and shared ideas for new opportunities to engage and communicate with Council members.

Both meetings are wonderful examples of how Council leaders gather input from Council members and provide this input to committees (and the Academy's strategic planning process as a whole), as well as how Academy volunteer leaders work together in multiple capacities across the organization.

I extend a sincere thank you and congratulations to each Academy leader who participated in these successful meetings. ❖

Who Attends the CAP/CLC Meetings?

CAP meeting attendees include:

- Academy president
- Academy president-elect
- Academy vice president
- Council chairs
- Council chairs-elect
- Council vice-chairs
- Strategic coordinating committee chairs
- Resident Physician Council Board president
- *PM&R* editor-in-chief

CLC meeting attendees include Academy Council leaders:

- Academy president-elect
- Academy vice president
- Council chairs
- Council chairs-elect
- Council vice-chairs of membership development
- Council vice-chairs of education
- Council vice-chairs of communication

For the full list of names of your current Academy Council leaders, visit the AAPM&R Web site at www.aapmr.org, and type "Council Executive Committees" in the search box. For the list of current strategic coordinating committee chairs, type "AAPM&R Committees & Councils" in the search box on the AAPM&R Web site.

Attendees of the CAP/CLC meetings gather in January to discuss key Academy strategic priorities.

Academy Hosts Evidence-Based Practice Committee Meetings

Back row from left to right: Gregory Park, MD; Elliot Roth, MD; M. Elizabeth Sandel, MD; Elissa Charbonneau, DO; Joseph Hornyak, MD, PhD; Deepthi Saxena, MD; Dexanne Clohan, MD

Front row from left to right: Thiru Annaswamy, MD; Amy Houtrow, MD, PhD, MPH; Richard Zorowitz, MD; Alan Novick, MD; Kurtis Hoppe, MD; Peter Flemister, MD

Not pictured: Raj Mitra, MD; Joseph Feinberg, MD; John Melvin, MD; David Berbrayer, MD; Gwendolyn Sowa, MD, PhD; Itala M. Wickremasinghe, MD; Karen Nelson, MD, PT; Lisa Lombard, MD; Kevin Fitzpatrick, MD

AAPM&R's Evidence-Based Practice Committee, Evidence Committee, Clinical Practice Guidelines Committee, and Performance Metrics Committee met for three days in February in Rosemont, IL. All four committees met jointly the first day and a half and then broke up into their respective committees to meet separately for the remainder of the time.

With the Academy's new vision statement in mind—**AAPM&R will transform the focus of health care to value function**—the primary objective of the joint meeting was to develop consensus on a quality business plan, which was presented to AAPM&R's Board of Governors in April.

Stay tuned for updates from these four productive committees. Explore the work products from these committees, such as performance measures sets, endorsed clinical practice guidelines, and evidence tools, which are available under the "Clinical Quality & Research" tab at www.aapmr.org. ❖

Keep on Track With MOC

Maintenance of Certification (MOC) diplomates going through American Board of Physical Medicine and Rehabilitation (ABPMR) MOC need to complete certain requirements throughout their 10-year cycle. Stay up-to-date on your requirements with Academy resources that fulfill Parts II and IV requirements. (Note: If you are in year 10 of your MOC cycle, remember that the ABPMR deadline to complete MOC requirements is June 30!)

MOC 4

Self-Guided PIPs

Practice improvement projects (PIPs) are interactive, self-directed projects aimed at improving specific areas within your practice where there is an identified performance gap. Completing an AAPM&R PIP fulfills Part IV of ABPMR MOC, and you can earn up to 20 *AMA PRA Category 1 Credits*™. For a full list of PIPs, visit acadeME® at www.me.aapmr.org, and click **MOC|4 PIPs** in the left navigation.

MOC 2

SAE-Ps

Self-assessment examinations for practitioners (SAE-Ps) help learners identify their knowledge gaps on a focused topic. Completing an SAE-P fulfills Part II of ABPMR MOC, and you can earn up to 8 *AMA PRA Category 1 Credits*™. For a full list of SAE-Ps, visit acadeME at www.me.aapmr.org, and click **MOC|2 SAE-Ps** in the left navigation.

New and Coming Soon!

SAE-Ps on a variety of clinical topics will be launched throughout the year. Available now is an SAE-P on brain injury. Coming next month is a new SAE-P on electrodiagnosis.

Not sure which MOC requirements you need to fulfill? Access your personal MOC plan to view your requirements as well as suggestions on where you should be in meeting the requirements based on your certification year. For more information, visit the newly enhanced acadeME and click What is MOC? in the left navigation. ❖

MOC

Impact the Future of PM&R: Sign Up to Mentor a Medical Student

Mentorship has long been acknowledged as the key to successful and satisfying careers in medicine. The AAPM&R Medical Student Mentor Program is your opportunity to give back to the specialty in which you have chosen to dedicate yourself, and in doing so help empower the next generation of physicians entering the world of health care.

All AAPM&R members are invited to participate as volunteer mentors in the AAPM&R Medical Student Mentor Program, which serves first-through fourth-year medical students expressing an interest in physiatry. Choose your level of involvement—ranging from simply answering brief e-mail questions during your down time, to allowing a medical student shadow you in your practice, to working closely with a medical student as their faculty advisor. Even brief interactions can help not only attract the best and the brightest students to the PM&R specialty, but also raise awareness of PM&R among future members of the health care community to understand the role of the specialty and its importance.

It's easy to get involved—and even easier to sign up! Complete your mentor profile today. Visit www.aapmr.org, and type "Medical Student Mentor Volunteer Form" in the search box.

Questions? Contact medstumentors@aapmr.org. ❖

Volunteer. Participate.

The medical student mentor volunteer opportunity is just one of the volunteer opportunities offered by your Academy. Your Academy offers several other opportunities to get involved and make a difference in the specialty. Check out the AAPM&R Volunteer Match Tool on our Web site—new volunteer opportunities are added periodically!

Don't see something specific that interests you? Your Academy can still match you to other opportunities. Tell us your volunteer interests and preferences by updating the volunteer section of your AAPM&R member profile. If an opportunity arises that matches your preferences, you will be contacted by a staff member.

Visit www.aapmr.org, and type "AAPM&R Volunteer Match Tool" in the search box for more information.

"This is a great tool for expanding our field, getting to know young physicians, and helping them make an informed decision to join the ranks of PM&R."

—Luis A. Guerrero, MD

Prepare for the Future With the 2013 Annual Assembly Educational Program

Get ready to celebrate movement and celebrate progress at the AAPM&R 2013 Annual Assembly. AAPM&R's 75th anniversary is a milestone event that provides the opportunity for members to reflect on how far the Academy has come since its humble beginning in 1938. Through the years, the Academy has continued its commitment to educating its members from all corners of the specialty.

The 2013 Annual Assembly will be held October 3–6, 2013, in National Harbor, MD. Online registration for the meeting is now open at www.aapmr.org. All members recently received the *Advance Program* in the mail, and more detailed information is available online.

Each day of the meeting includes a plenary session to bring all registrants together for a lecture, while the rest of the day provides a selection of sessions that fall into five topic tracks:

- Musculoskeletal and Sports Medicine
- Neurological Rehabilitation
- Practice Management and Leadership
- General Rehabilitation
- Pain and Spine Medicine

One registration fee for the meeting allows access to all of these sessions. Additionally, there are ticketed workshops and preconference courses available at an additional fee for even more focused learning.

This year, the Program Planning Committee has a new workshop format for registrations. Workshops Director Christopher J. Visco, MD, has assembled a selection of three-hour workshops:

- Hands-On Introduction to Ultrasound Applications in Musculoskeletal Medicine
- Hands-On Introduction to Ultrasound Applications in Neuromuscular Medicine
- Hands-On Introduction to Ultrasound Applications in Spine and Pain Medicine

There are a limited number of spaces in all workshops. So, register early if you'd like to take advantage of this format.

Regenerative Medicine Symposium on Friday

Academy members Casey Childers, DO, PhD; Michael Boninger, MD; Joel Stein, MD; and Carmen Terzic, MD, PhD, have developed an exciting new symposium on the fascinating field of regenerative medicine. Keynote speaker Anthony Atala, MD, presents Friday's plenary session, "Regenerative Medicine: Current Concepts and Changing Trends." Four additional sessions in the symposium cut across clinical topics:

- Stem Cells, Drug Discovery, and Gene Replacement: New Tools for Combating Muscular Dystrophy, Congenital Myopathies, and Muscle Damage
- Stem Cells, Robotics, and Brain-Computer Interfaces: Emerging Role in Neurorehabilitation
- Stem Cell Therapy in Cardiovascular Diseases
- Stem Cells in the Nervous System and Muscles: Tools or Treatments

Pediatric Day on Saturday

Sessions with a pediatric focus have been planned for all four days of the Assembly in multiple tracks. Additionally, Saturday will offer a full day of sessions dedicated to pediatric spinal cord issues.

"Spinal Cord Dysfunction in Youth and Young Adults: Bench to Bedside" is being developed by David Pruitt, MD, of the Cincinnati Children's Hospital Medical Center. Sessions will focus on:

- Clinical and Translational Research in Pediatric Spinal Cord Injury
- Neuroimmunologic Pediatric Spinal Cord Injury
- Therapeutic Interventions in Pediatric Spinal Cord Injury

All Annual Assembly registrants may attend any or all of these sessions. Register before August 5 to take advantage of discounted registration rates for the meeting. Don't forget to keep your membership current for additional savings.

Academy Brings PM&R to Capitol Hill This October

Join AAPM&R members on October 2, 2013, for "PM&R on Capitol Hill." Your Academy is presenting this advocacy opportunity for members to coincide with the 2013 Annual Assembly.

Members can register now for this free event. Register using the 2013 Annual Assembly online registration form at www.aapmr.org. You do not need to register for the Annual Assembly to register for "PM&R on Capitol Hill." There are only 100 spots available, so register early.

An advocacy training webinar will be held prior to the event for all registered member attendees. Policy briefing documents on the key issues will also be provided. On October 2, in National Harbor, MD, registrants will have a morning legislative briefing at the Gaylord National Hotel and Convention Center, have lunch, and board buses for the short ride to Capitol Hill. They'll attend scheduled meetings with members of Congress and their staff. AAPM&R policy staff will also be on hand to answer questions and attend meetings. Registrants will return to the Gaylord National Hotel and Convention Center later that afternoon by bus.

Don't miss this opportunity to meet with your members of Congress and their staff to discuss a range of priority health policy issues. With your help, our specialty can continue to expand PM&R awareness with lawmakers and regulators as well as increase national recognition of the needs of our unique specialty. Along with striving to provide a high standard of care in your professional pursuits, at a pivotal time in health policy history, we need your commitment to enhance the Academy's ability to advocate for PM&R interests.

Make a difference! "PM&R on Capitol Hill" is an opportunity for you to let your members of Congress hear PM&R-related concerns. Register now at www.aapmr.org. ❖

2013 Annual Assembly registration now open at www.aapmr.org.

75 YEARS aaPM&R
annual assembly
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Judge Approves Settlement Agreement in Improvement Standard Lawsuit

Medicare Will Cover Skilled Maintenance Services

AAPM&R is pleased to inform members that the US district court judge has approved the settlement agreement in the watershed case *Jimmo v. Sebelius,* marking a historical step toward essential health care coverage for thousands of beneficiaries nationwide. The case settles once and for all that the determining issue regarding Medicare coverage is whether the skilled services of a health care professional are needed, not whether the Medicare beneficiary will "improve." Pursuant to Jimmo, medically necessary nursing and therapy services, provided by or under the supervision of skilled personnel, are coverable by Medicare if the services are needed to maintain the individual's condition, or prevent or slow the individual's decline.

Your Academy would like to acknowledge the dedication and hard work of the Center for Medicare Advocacy, Inc. (CMA), along with its cocounsel Vermont Legal Aid, in litigating the case that was filed on behalf of a class of Medicare beneficiaries. Other plaintiffs in the case were the National Multiple Sclerosis Society, the Paralyzed Veterans of America, the Parkinson's Action Network, and the National Committee to Preserve Social Security and Medicare. Your Academy played an important role in this case as AAPM&R was an original plaintiff until it was dismissed by the court for lack of legal standing to sue.

Next Steps

With the settlement now officially approved, Centers for Medicare & Medicaid Services has a year to:

- Revise its Medicare Benefit Policy Manual and numerous other policies, guidelines, and instructions to ensure that Medicare coverage is available for skilled maintenance services in the home health, nursing home, and outpatient settings.
- Develop and implement a nationwide educational campaign for all who make Medicare determinations to ensure that beneficiaries with disabilities and chronic conditions are not denied coverage for critical services because their underlying conditions will not improve.

What Physiatrists Can Do to Help

There are anecdotal reports from beneficiaries of continued Medicare coverage denials based on the improvement standard.

- **Be informed:** Because of *Jimmo v. Sebelius,* improvement is no longer required for Medicare coverage. Emphasize with your billing staff and your patients that coverage is available for people who need skilled maintenance care and meet any other qualifying Medicare criteria. To review other Academy resources on this issue, visit www.aapmr.org, and type "Jimmo vs. Sebelius" in the search box.
- **Help inform patients:** You may be called on to assist your patients by explaining in writing why skilled nursing or therapy is required, and you should be as specific as possible in explaining why skilled care is needed given your patient's unique medical condition.
- **Display printed information in your office:** Place copies of an Academy patient brochure in your office. The brochure is available at www.aapmr.org. Type "Jimmo patient brochure" in the search box.
- **Include updates in your state PM&R society newsletter:** Ask your state medical association to include updates on this issue in its newsletter.
- **Post a discussion on your state advocacy group at PhyzForum (member login required):** Engage in discussions with colleagues about how this may impact patients.
- **Use social media:** Use social media to spread the word about the decision. Include a link to the CMA Web site, which contains relevant self-help information to assist patients with appeals when services are denied. Visit www.medicareadvocacy.org, and type "self-help packets" in the search box.

Thank you for your help in eliminating the improvement standard for good! For more updates on this issue, visit www.aapmr.org, and type "health policy updates and advocacy" in the search box. ❖

Academy Leadership Program Applications Due April 30

The deadline to apply for the Academy Leadership Program is quickly approaching. This program provides an opportunity to identify and train future leaders who have limited volunteer experience and immerse them in the culture of volunteerism at the Academy. Academy members selected to participate in the program will be taken through a two-year curriculum that introduces them to association leadership, strategic planning, media skills, Academy governance, products and services, and volunteer leadership.

For more information about the program and to apply, visit the AAPM&R Web site at www.aapmr.org, and type "Academy Leadership Program" in the search box. ❖

Attend ISPRM 2013 Meeting

Academy members are invited to attend the 7th World Congress of the International Society of Physical and Rehabilitation Medicine (ISPRM), which is being held June 16–20 in Beijing, China.

The theme of this year's ISPRM meeting is to ENJOY the process of rehabilitation; ENRICH the knowledge for rehabilitation professionals, patients, and their families; and ENABLE a better quality of living for everyone.

William Micheo, MD, AAPM&R's liaison to ISPRM, encourages Academy members to attend the meeting. He said, "You will have the opportunity to learn from more than 150 invited faculty experts from around the world, interact with physiatrists from every corner of the globe, and visit the great city of Beijing, as well as being exposed to the historic sites and cultural heritage of China. Don't miss this opportunity!"

Your Academy supports ISPRM as ISPRM is a catalyst for international PM&R research.

Visit the ISPRM Web site at www.isprm2013.org/en to register for the ISPRM 2013 meeting. ❖

Engagement on PhyzForum Can Impact PM&R's Concussion Legislative Efforts

Last year, we brought attention to the fact that seven states—Arkansas, Georgia, Mississippi, Montana, South Carolina, Tennessee, and West Virginia, had not yet passed concussion legislation. At the time of this writing, we are pleased to share with you that Academy members in both South Carolina (H3061) and Tennessee (SB0882) are working to get concussion legislation passed.

For members involved in concussion advocacy, your Academy offers two indispensable tools on PhyzForum—the concussion/mild TBI group and the state advocacy groups. Each is designed to assist members with advocacy for concussion legislation and practice.

The concussion/mild TBI discussion group covers clinical, legislative, and practice management components of concussion/mild TBI management and prevention and can be a resource for getting insight on concussion issues, such as the psychosocial symptoms associated with concussion or the possible educational issues that arise in youth after a concussion.

The state advocacy groups can be utilized to build grassroots' campaigns for concussion legislation. Members can post information regarding legislative hearings and drafts of concussion testimony for comment before submitting to a legislative committee. E-mail 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.

1. Concussion/mild TBI group: Go to www.phyzforum.org, click on "Groups," and scroll to the Concussion/Mild TBI group.
   You will find:
   - Timely concussion discussions
   - Advocacy toolkit
   - *PM&R* articles
   - Member share library
   - acadeME® resources
2. State advocacy groups: Go to www.phyzforum.org and click on "My Groups" to get to your state advocacy group.
   - Membership in state advocacy groups is automatic and will show in the "My Groups" view.
   - Members can post information regarding legislative hearings and drafts of concussion testimony for comment before submitting to a legislative committee.

Your Academy has integrated its Advocacy Action Center software on PhyzForum to help members communicate regarding their specific advocacy priorities to state legislators. For more information on how you can become a physiatrist advocate on concussion issues, e-mail us at policy@aapmr.org. ❖

phyzFORUM

Have You Visited Your State Advocacy Group?
Starting a new discussion in your state's advocacy group works the same way as other groups in PhyzForum. To find your state advocacy group, log in at www.phyzforum.org as you normally would. On the left side of the screen under "My Groups," you will see your state listed. From here, it is easy to take part in one of the active discussions or start your own.

Are you interested in what your colleagues in other states are saying? Join one of the other state advocacy groups by selecting "Groups Directory" at the top of the page. Choose the state from the list, and then click the large blue button marked "Join This Group."

As with other PhyzForum groups, you can use member resource libraries and manage your subscription options. Log in today, and let your voice be heard in your local communities.

Academy Member Speaks Before National Academy of Sciences Committee
In February, AAPM&R member Stanley Herring, MD, spoke before an ad hoc committee of the National Academy of Sciences that is studying and preparing a report on sports-related concussions in youth. During the session, "Diagnosis and Management of Sports-Related Concussion in Youth: The Roles of Pediatric Neurologists and Family and Rehabilitation Medicine Physicians," Dr. Herring emphasized the physiatrist's role in comprehensive rehabilitation of concussion, reflecting on the specialty's training in TBI and musculoskeletal injury.

He spoke about how physiatrists work with an interdisciplinary team of providers and said physiatrists understand the psychosocial symptoms associated with concussion (often confused by others as persistent problems due to the concussion itself). The importance of health care providers having the education, knowledge, and experience to manage sports concussions from the acute injuries on the field of play to the follow-up visits in the examination room, including access to a health care team that can provide comprehensive care as needed, was also discussed. For more information, visit the National Academy of Sciences Web site at www.nasonline.org.

Visit www.phyzforum.org today!

New Consensus Statement on Concussion in Sport in April *PM&R*

The new Consensus Statement on Concussion in Sport will appear in the April 2013 issue of *PM&R.* This paper is a revision and update of earlier recommendations and is based on the deliberations at the 4th International Conference on Concussion in Sport held in Zurich, Switzerland, in November 2012.

This document is developed for use by physicians and health care professionals involved in the care of injured athletes, whether at the recreational, elite, or professional level. Accompanying the consensus statement will be updated concussion assessment tools, including the concussion recognition tool, the sports concussion assessment tool version 3 (SCAT3), and the child SCAT3 card.

Watch for the April issue of *PM&R,* which should be hitting mailboxes soon. ❖

RAC Audits: Accurate or Egregious?

In early February, the Congressional Budget Office (CBO) lowered spending projections for Medicare, noting that the program's bills have been "significantly lower" than predicted for three years straight. CBO revised its 10-year spending projection for Medicare by $137 billion, or 2%, in its latest long-term economic forecast. Some of these projected savings can be attributed to the work of the Medicare Recovery Audit Contractors (RACs). In fiscal year 2011, RACs identified nearly $1 billion of improper payments. However, of the nearly 61,000 appeals sought by providers, 43% were successful. The question that many physiatrists have asked the Academy is "Are Medicare contractors required to compensate providers for money spent in appealing denials that are ultimately ruled in favor of the physician or provider?" The answer is no.

Although your Academy supports the intent to combat true fraud and abuse, it does not support the lack of transparent oversight of the program by Centers for Medicare & Medicaid Services (CMS) to ensure that medically necessary treatment is not denied after the fact, forcing physicians to endure a lengthy appeals process. Currently, Medicare contractors are not required to examine the outcomes of appeals of particular types of cases and factor those administrative law judge decisions into future auditing activities. Although RACs do have to refund their incentive payment as well as the amount of the claim to the physician when a case is overturned in the physician's favor, in most cases, physicians spend valuable resources in the appeals process, with no hope of recouping those costs.

Your Academy is doing something about it. In June 2012, the US Senate Committee on Finance solicited input on how a better balance could be reached between stamping out fraud and paying legitimate claims. Your Academy submitted the following cost-effective recommendations:

1. Physician education series: Your Academy feels that the physician community must take on the responsibility of educating its members about appropriate documentation of medical care provided to avoid audit denials. CMS plays an important role in this process by participating in physician education sessions, providing clear coverage rules, and being available to answer questions from the provider community on an ongoing basis.

2. Transparency and public input: Your Academy proposes that performance standards for the RAC Validation Contractor be developed, published, and open for public comment. Additionally, a clinical advisory panel of physicians and appropriate practitioners should be established by CMS to provide oversight into Medicare contractor operations.

3. Penalties: Failure of Medicare contractors to achieve appropriate standards on claims auditing and appeals should result in financial penalties, such as reduced contingency fee rates for a given period of time until accuracy improves and/or, in persistent and extreme cases, loss of contract.

In January 2013, your Academy met with CMS to discuss the possibility of partnering to provide information on documentation as a preemptive strike to avoid RAC audits. CMS staff agreed to play a large role in providing information, participating in educational webinars, and speaking to members at the AAPM&R 2013 Annual Assembly.

Furthermore, on February 1, 2013, the US Senate Committee on Finance released a summary of their findings from the June 2012 request for comment regarding this issue. As part of the process, the committee compiled various concerns about Medicare contractors, which were submitted by consumer, provider, and supplier groups. Of the important recommendations noted in the correspondence, of which there were eight, two were taken directly from the submission crafted by the Academy. Both the transparency and public input and the penalties proposals were singled out by the committee for further review as they move toward potential legislation.

Your Academy will be working with the committee moving forward to ensure that patient care continues to be at the forefront of physicians' minds—not paperwork and the arguing of appeals of denied claims. ❖

Now available exclusively through Aretech, the inventors of ZeroG!

The ZeroG Gait and Balance Training System

Developed by a team of engineers and therapists, ZeroG is a state-of-the-art gait and balance training system that allows patients to practice a wide range of rehabilitation activities safely and progressively. Therapists can adjust the amount of body-weight support, set safe walking speeds, setup fall protection and monitor their patient's progress all through a simple to use computer interface.

Why ZeroG?

Versatility:

- Because ZeroG rides along a custom-designed ceiling track, there are no barriers when interacting with patients.
- Patients can practice the types of activities they will use at home and in the community, such as walking up steps, getting off the floor, and standing up.

Safety:

- ZeroG monitors patient and system behaviors at 1000 times per second, safely catching a patient in the event of a fall.

Ease of Use:

- Setup takes minutes, meaning longer training sessions for patients.
- ZeroG is controlled wirelessly through an Apple iPod and iPad.

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- ZeroG has been used by 1000+ patients in 32 centers in the United States and Canada without a single reported injury.
- ZeroG has been in clinical use for 5 years and under development for 8 years.

Customer Service:

- As the inventor and manufacturer of ZeroG, Aretech provides the highest level of expertise during the manufacturing process, the installation, therapist training, and long-term service.

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To see patients using ZeroG, visit us at www.aretechllc.com

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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 opportunities are available and are encouraged. We offer competitive salary, outstanding benefits, and performance-based bonus. The following positions are available:

General Outpatient/Inpatient Physiatrist

At the Johns Hopkins Hospital, this position primarily involves our outpatient PM&R clinics serving a large variety of patients. You will serve as Attending Physiatrist for several months per year on our 14-bed Inpatient Rehab Unit as well as the Inpatient Consultation service.

Spine Physiatrist

Located primarily at the Johns Hopkins Hospital, this position, in close collaboration with the Departments of Neurosurgery and Orthopaedic Surgery, focuses on conservative management of spinal disorders. Limited participation in interventional spine procedures and EMG is available. Fellowship training in Spine or Musculoskeletal Medicine is preferred.

Musculoskeletal Outpatient/Inpatient Physiatrist

At Johns Hopkins Bayview Medical Center (a member of the Johns Hopkins Health System), this position offers a Musculoskeletal Outpatient Clinic, with limited participation in comprehensive inpatient rehabilitation and inpatient consultation. Additional opportunities include participation in Burn and Wound Care services.

Medical Director of Stroke and Brain Injury Rehabilitation

Medical Director for Stroke and Brain Injury 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 Stroke service and the outpatient Stroke and Brain Injury Clinic.

Medical Director of Interventional Pain Management (IPM)

This leadership position requires fellowship training in an ACGME-approved program in Pain Medicine. Duties include performing IPM procedures, holding outpatient clinics, and leading our IPM program at two Johns Hopkins-affiliated sites, each with facilities for fluoroscopically-guided injections. There is an opportunity for academic collaboration with the Johns Hopkins Division of Pain Medicine in the Department of Anesthesiology.

FOR FURTHER INFORMATION CONTACT:

Kenneth Silver, MD
Vice-Chair, Physical Medicine and Rehabilitation
Johns Hopkins University

(443) 444–4780 – Office
Email: ksilver3@jhmi.edu

JOHNS HOPKINS
MEDICINE

Positions Available

EAST

Hartford, Connecticut: Outstanding opportunity for a full-time BC/BQ physiatrist to join a dynamic, growing PM&R practice affiliated with a major hospital system and a 60-bed acute rehab hospital located in Hartford, Connecticut. The ideal candidate will have an interest in both inpatient rehabilitation and outpatient care with an opportunity for inpatient acute care consultations as well. Excellent compensation and benefits offered. Our hospital system completed a major expansion that includes a new ED and patient care tower that houses the Connecticut Joint Replacement Institute, the 7th largest such program in the nation. Mount Sinai Rehabilitation Hospital is the only freestanding acute rehab hospital in CT and the largest provider of stroke/BI acute rehab in the state. The Mandell MS Center, housed within our rehab hospital is one of the nation's most comprehensive programs dedicated to the treatment and research of multiple sclerosis. Newer initiatives moving forward include the creation of a comprehensive interdisciplinary spine program. If you are an energetic, talented physiatrist interested in an excellent career opportunity located in beautiful New England, please contact Christine Bourbeau, Director of Physician Recruitment, at (860) 714–1090, or fax/email a letter of interest and CV to (860) 714–8894. Email address: cbourbea@stfranciscare.org. Visit The Rehabilitation Hospital of Connecticut website www.rehabct.com. Visit Saint Francis at www.joinsaintfranciscare.com/Phys/AAPMR. EEO/AA - M/F/D/V, pre-employment drug testing.

Williamsville, New York: Buffalo Spine and Sports Institute is actively recruiting a Board Certified Physiatrist to join our nationally recognized, highly respected, non-surgical outpatient practice. This physician owned practice is the largest PM&R practice in the area and was established in 1988. We are seeking a physiatrist who shares our philosophy which emphasizes the medical exam, medical history, performance enhancement and functional improvement. Our practice is dedicated to enhancing outcomes with electrodiagnostic testing and ultrasound visualization and treats spine injuries and conditions, sports injuries, degenerative and painful joint/muscle conditions, chronic migraines, women specific musculoskeletal conditions and spasticity and dystonia. This busy 4 physician practice is open to newly trained or experienced physicians familiar with EMRs or willing to learn ours. Training in the modalities we offer in diagnostics and interventional pain alleviating injections will be provided. Excellent salary, production bonus and benefits will be provided. The practice is nestled in the heart of the Buffalo Niagara region, which is situated on Lake Erie, where you can enjoy a wealth of waterfront activities. The region is widely recognized for its reasonable real estate, enriching cultural attractions and architectural treasures. For more information, please contact Gerry Nannen at (716) 650–3100 or gnannen@buffspine.com.

Yardley, Pennsylvania: Established and respected PM&R practice of 1 MD and 1 Midlevel seeking to add a full-time Board Certified /Eligible physiatrist to its growing practice. Candidate must be interested in general PM&R, including inpatient rehab, consultations in the acute care and nursing home settings, EMG's, and outpatient office. Interest in TBI and non-spinal musculoskeletal injections preferred. Motivation, strong work ethic, excellent clinical skills and great interpersonal skills required. New grads welcome. Competitive salary/benefits package. Please send CV to administrative_brs@comcast.net or fax to (215) 968-9718.

New Hampshire: Network of over 150 providers seeks a well trained, fellowship trained PM&R interventional spine physician to join existing provider. Very busy practice that is expanding rapidly and will be moving into a new muscular/skeletal center that is being constructed now that is adjacent to hospital. Full EMR, 24/7 hospitalist service, very competitive salary and benefits package. Located only one hour from Boston, Amtrak train service 5 times per day to Boston, 403B plus variable company match, 100% of moving expenses covered, 6 weeks of vacation, liberal CME allowance. Great four season recreation, Phillips Exeter Academy, no state sales or income taxes. Please visit us on the web at www.corephysicians.org. Forward CV's to Ron Goodspeed at rgoodspeed@ehr.org.

Virginia: Established physiatry practice in the northern Virginia/Wash.D.C. area seeks BC/BE physiatrist who is motivated and interested in a diverse physiatric practice, including inpatient rehab care, inpatient consultation, outpatient evaluations and EMG. Several offices with 6 physicians, who manage a CARF-accredited, acute inpatient rehab unit, located within a full service med/surg hospital. Benefits including malpractice and health insurance. Competitive salary. Highly desirable urban/suburban area, with downtown D.C. and Reagan National Airport 20 minutes away, and Old Town Alexandria 10 minutes away. Please send CV to: ccampbell49@cox.net.

WEST

San Francisco, California: PM&R Specialist immediately needed: A busy multi-specialty group in San Francisco, specializing in treatment of worker's comp injuries is looking to immediately hire a full time Physiatrist. Must have a California license. California workers' compensation experience a plus. Willing to travel 2 days per week to our Sacramento clinic. We offer a competitive salary and attractive benefit package. Please email a brief introduction letter with curriculum vitae or questions to cynthia@sfmmg.com or call Cynthia Twomey, Practice Administrator at (415) 294–4467.

Washington: PeaceHealth Medical Group seeks physiatrists in Longview and Vancouver, WA. In Longview, join a well-established Musculoskeletal Clinic of experienced, board certified physicians. Vancouver, WA offers a well-established practice providing services in an inpatient and outpatient setting. Southwest Washington offers all the qualities of the Pacific Northwest including excellent schools, low crime rate and no state income tax. Longview (40 minutes) and Vancouver (20 minutes) from Portland, OR. If you are looking for a career that engages your heart and spirit as well as your mind, please call for more details: Sheila Bixler, Jordan Search Consultants, (636) 294–6082 or sheila@jordanmc.com.

MIDWEST

Grand Blanc, Michigan: Dynamic and growing PM&R practice in Grand Blanc, MI seeking bright, motivated team player to join 4-person physiatry group. Our practice includes outpatient musculoskeletal and spine care, interventional pain management and inpatient rehabilitation services. We are seeking a physiatrist, BC/BE in interventional spine care. Opportunity includes the majority of time spent in outpatient spine care and interventional pain management with occasional inpatient rehabilitation and consulting. Excellent work environment. Close to several area lakes, great golf, excellent schools, excellent location for families and close to Detroit and Ann Arbor. Please contact Practice Manager, Margaret Flesher ph: (810) 606–7182; fax: (810) 606–5803; Email: MFlesher@genesys.org. NOTES: Employer will assist with relocation costs. Additional Salary Information: Excellent vacation, health care, pension plan/401K, partnership track.

Illinois: Illinois Spine Institute, S.C. is seeking a PT/FT Board Certified or Board Eligible physiatrist to join our busy, established spine surgery practice. Our practice consists of Orthopedic Spine Surgery, Interventional Pain Management, and Physical Therapy. Currently we have 2 locations in Chicagoland. We are seeking a physiatrist to provide inpatient and outpatient services. Our practice focuses on treatment of spinal conditions. The clinical staff includes two (2) board certified orthopedic spine surgeons, one (1) interventional pain management anesthesiologist and physical therapists. Compensation package includes a competitive salary and benefit package (including a profit sharing/401K). Background screening is required. Please send CV to: Nisa Lami, Executive Director, nlami@ilspine.com.

Ohio: The Department of Neurology and Physical Medicine and Rehabilitation is seeking BC/BE physiatrists to join our growing Department in the Neuroscience Institute at the University of Cincinnati College of Medicine. Our expanding clinical programs currently include dedicated inpatient units for stroke, spinal cord injury and brain injury, as well a busy outpatient practice at The Drake Center. Consult services are provided at University Hospital, the only level 1 adult trauma center in Cincinnati. Faculty candidates must have excellent clinical skills and a strong commitment to teaching residents and medical students. Opportunities for research and administrative leadership are also available. Salary and faculty rank will be commensurate with experience and academic qualifications. The University of Cincinnati Neuroscience Institute - The University of Cincinnati Neuroscience Institute (UCNI) is a leading treatment, research and teaching center for complex neurological conditions. Based at the University Hospital and the University of Cincinnati, its physicians and researchers have achieved national benchmarks in the collaborative treatment and investigation of ischemic and hemorrhagic stroke, brain aneurysms, brain and spinal cord trauma, Parkinson's disease, brain tumors, seizures, trigeminal neuralgia, Alzheimer's disease and memory disorders, mood disorders, and neuromuscular disorders. UCNI's team includes more than 100 faculty members from 14 clinical specialties who collaborate across disciplines to provide the most comprehensive diagnosis and treatment possible. Interested candidates should contact: Mark Goddard, M.D., Associate Professor and Chief, Division of Physical Medicine and Rehabilitation University of Cincinnati Academic Health Center. PO Box 670530, Cincinnati, OH 45267–0530; Email: Mark.goddard@uc.edu. Phone: (513) 558–2919.

SOUTH

Plano, Texas: Rehabilitation Institute of Texas is looking for a BC/BQ Physiatrist to work at Plano, Texas. The main service is outpatient care. Inpatient pain consultation service is required. Skills in office-based injections are required. Efficiency in EMGs is preferred. Interventional spine injections are optional. We are looking for someone who is self motivated, dependable, and with good people skills. Plano is about 10 miles north of Downtown Dallas, Texas. It has affordable housing, low living costs (no state income taxes), excellent schools, and diverse outdoor activities. Send your CV to ritcare@yahoo.com or (888) 789-6471 (fax).

Florida: Busy spine practice seeks a PM&R physician to provide medical care. Fellowship trained in Interventional Procedures and EMG required. Excellent salary and benefits package available, full time, Monday-Friday. Send resumes to info@mjspine.com.

THE PHYSIATRIST

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PRESIDENT, AAPM&R
Alberto Esquenazi, MD

EXECUTIVE DIRECTOR
Thomas E. Stautzenbach, MA, MBA, CAE

EDITOR-IN-CHIEF, *THE PHYSIATRIST*
Bruce E. Becker, MD, MS

CONTACT
The Physiatrist: submissions@aapmr.org

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American Academy of Physical Medicine and Rehabilitation

9700 W. Bryn Mawr Ave., Suite 200
Rosemont, Illinois 60018
www.aapmr.org

phone 847/737.6000
fax 847/737.6001
info@aapmr.org

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A Year of Celebrations

2013 Marks the Fifth Anniversary of acadeME®!

Since the acadeME Web site went live in 2008, your Academy has doubled the number of educational activities and is preparing to launch more this year. New content is constantly being developed to ensure physiatrists have access to clinically relevant information.

Activities are now organized by clinical topic and by Maintenance of Certification requirements for quick and easy navigation.

acadeME is your go-to resource for PM&R education. Check out the newly enhanced site; visit **www.me.aapmr.org today!**

PM&R: A Young Journal With Numerous Achievements

PM&R—your Academy's scientific journal—is in its fifth year of publication. Each year, the journal continues to make significant progress. From becoming a leading source of PM&R research to awaiting the announcement of its first impact factor this June, *PM&R* has reached several exciting milestones in its young life. The journal continues to grow in circulation, stature, and recognition from the scientific community.

Help continue the positive momentum. Submit your research to *PM&R* today at **www.ees.elsevier.com/pmrjournal.** ❖

Celebrate Academy's 75th Anniversary: Walk Through the History of PM&R

Take a journey through the history of PM&R during this year's AAPM&R Annual Assembly. As part of the AAPM&R History Preservation Committee's yearlong commemoration of the Academy's 75th anniversary, the committee has assembled a series of poster presentations for this year's meeting. Through the enthusiastic participation of the larger PM&R community, including PM&R residency programs and institutions from across the country, Annual Assembly registrants can literally walk through history at this year's Assembly.

In addition to individual case histories of PM&R departments and institutions, the more than 35 poster topics submitted also include the history of women in PM&R, the development of polio rehabilitation, and rehabilitation research.

AAPM&R's History Preservation Committee and its chair Robert Conway, MD, wish to thank the following participants in this endeavor:

- Carolinas Rehabilitation
- Case Western Reserve University School of Medicine
- Emory University School of Medicine
- Harvard Medical School/Spaulding Rehabilitation Hospital
- Helen Hayes Hospital
- Jefferson Medical College of Thomas Jefferson University
- Kessler Institute for Rehabilitation
- LSU Medical Center
- Marianjoy Rehabilitation Hospital
- Medical College of Wisconsin
- MedStar National Rehabilitation Network
- Montefiore Medical Center/Albert Einstein College of Medicine
- Mount Sinai Medical Center
- National Institutes of Health
- NewYork-Presbyterian Hospital
- The Brody School of Medicine at East Carolina University
- The Ohio State University Wexner Medical Center
- Northwestern University Feinberg School of Medicine/ Rehabilitation Institute of Chicago
- Rehabilitation Institute of Michigan/Detroit Medical Center
- Shepherd Center
- University of California, Davis
- University of Miami Miller School of Medicine
- University of Minnesota
- University of Missouri-Columbia
- University of Rochester
- University of South Florida/James A. Haley Veterans' Hospital
- University of Texas-Houston
- University of Washington
- UT Southwestern Medical Center
- University of Utah
- Wayne State University ❖

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