THE FORUM

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The Official Magazine of The Collier County Medical Society

WHAT'S INSIDE:

Dr. Jackie A. Kawiecki,
Medical Director, NCH Brookdale Inpatient Rehabilitation Center, and NCH Physician Medicine & Rehabilitation Department

Photos of
PLAN: Open House
CCMS: New Member Reception

Welcome New Members

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Physical Medicine & Rehabilitation, Pain Management
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Board Certified: Physical Medicine & Rehabilitation

Daniel Deutschman, M.D.
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1415 Panther Lane
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591-6736 Fax: 239-591-6737
Board Certified: Psychiatry, Geriatric Psychiatry, Psychopharmacology, and Adolescent Psychiatry

Mary J. Foley, D.O.
Family Medicine & Forensic Medicine
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Board Certified: Nuclear Medicine

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1855 Veterans Park Drive, Suite 101
Naples, FL 34109
593-0918 Fax: 239-593-0927
Board Certified: Pain Management & Rehabilitation

CCMS Member News

Vivian Ebert, D.C., was honored by The Florida Chiropractic Association (FCA) as the distinguished chiropractic physician of the year in Southwest Florida. Congratulations to Dr. Ebert.

David Greene, M.D., Otolaryngology, has named his new practice, Florida Sinus Institute, 1112 Goodlette Road N., Ste. 203, Naples, FL 34102, tel: 263-8444, fax: 263-6120.

Thanks to **Dr. William Laskowski** who has retired from the Board of the Physician Led Access Network (PLAN) after serving since 2004. Dr. Laskowski was one of the founding members of Collier WeCare program that was an initiative of CCMS started in 2003.

David Whalley, M.D., Chief of Anesthesiology at Physicians Regional Medical Center retired in December after 40 years in practice. We wish David and his wife Theresa many happy years of retirement.

What's on Your Mind?

Help us make this magazine more valuable!
Send your letters to the editor or e-mail comments to Dr. Richard Pagliara at rpagliara@hotmail.com.

Get Involved!

Discover the benefits of being a physician leader.
Contact Margaret to discuss board leadership openings in 2012.

Dr. Madwar Meets with Reinhold Schmieding of Arthrex

Dr. D. Scott Madwar, CCMS President and Margaret Eadington, Executive Director, along with County Commissioner Jim Coletta met recently with the President and Founder of Arthrex, Reinhold Schmieding, and CCMS member Paul Hobaica MD, who is the Medical Director of the Arthrex medical clinic. Arthrex is a world leader in medical device technology bringing innovative technology to orthopedic specialists in athroscopic procedures. They bring an economic impact of 1.2 billion dollars to Collier County annually.

Mr. Schmieding is forthright and sincere in his desire to strengthen the bonds between the professional and industrial delivery of expert medical care. There appears to be no better place to start that right here in Collier County where he has made his headquarters. The synergies can include educational support for all physicians in the goal to remain current and relevant in the fields of sports medicine and orthopedic surgery. Arthrex will be generously hosting the CCMS Spring General Membership meeting at their Headquarters on Thursday, March 15th. The topic will be "Advancing orthopedic medicine in the community and around the world. The latest surgical treatment innovations, advances in orthobiologics, medical education, biomechanical/clinical research and more."

Pictured (l-r): Paul Hobaica, M.D., Arthrex Medical Director; Commissioner Jim Coletta, D. Scott Madwar, M.D., CCMS President; and Reinhold Schmieding, Arthrex Founder and President.

CCMS Alliance Report

The CCMSA has been busy with some great events this year. We recently held a Ladies Night Out cooking event at the home of Beth Schultz. We held our holiday playdate at the Pelican Bay Community Park Playground on November 21st. At both of these events we collected donations for holiday gifts for the Immokalee Child Care Center. We also used the Ariel Goldman Grant awarded to us for purchasing holiday gifts for the Children's Advocacy Center.

Please look out for our next Couples Night Out fundraiser which will be held at the end of January. This event will be a special dinner at Mercato followed by a movie at Silverspot. All proceeds from the event will go to our scholarship foundation. Invites will be sent just after the New Year.

Please don't hesitate to contact us (my e-mail below) if you have any questions about membership or getting involved with volunteering on our many committees. On behalf of the CCMSA, we wish you a great holiday season!

-Wendy Jeanne Grossman, CCMSA President
wjpueschel@msn.com

PLAN Open House

The Physician Led Access Network hosted an open house at their new office location at **2500 Tamiami Trail North, Suite 212, Naples,** on Thursday, December 8th. For more information on volunteering for the program call Michelle Jay at 776-3016.

PLAN staff welcome Connie Dillon, Executive Director of CHS Healthcare

Margaret Eadington, PLAN Chair with Dr. Metka

Dr. Joan Colfer, Commissioner Jim Coletta, Connie Dillon, Kelly Daly, Dr. Carron and Deb Cecere congregate in the new conference room

Dr. Michael Carron, Radiology Regional Center and PLAN Board member with Deb Cecere, PLAN Executive Director

President's Message:

The Fifth Vital Sign: A Badge of Dishonor

by D. Scott Madwar, M.D., President of CCMS

The Collier County Commission extended a moratorium December 13th against new pain management clinics from opening in an effort to crack down on "pill mill" operations. The vote was apparently unanimous and without discussion. The basis for the moratorium is a perceived need by state lawmakers to address a drug database monitoring program to crack down on pill mill operations and pain drug abusers. This occurs on the coat tails of more stringent state regulations in House Bill 7095 for those physicians prescribing narcotic analgesics to those patients with non-narcotic malignant pain.

We are aware of the intended consequences. But what about the unintended consequences of these two simultaneous events.

We have now decided to segregate patients into two broad categories: those with cancer and those without. Apparently if you do not have cancer, there may be a significant chance that your pain is illegitimate. Conversely, the prescribing patterns of your care provider may be illegitimate. **Is it ever possible for a patient with cancer to have illegitimate pain?** This is the fundamental conflict within House Bill 7095.

The logic of a pain clinic moratorium will be similarly flawed if it equates legitimate with illegitimate practices. Legitimate practices will be too busy to comply with the new regulations and will simply pass the care of non-malignant pain on to the existing interventional pain physicians. These doctors will, in turn, prioritize to the care of those likely to benefit from procedural interventions (i.e., epidural injections) and will have to turn away those requiring care with their newly stigmatized illness. Where will these patients then turn? What was once "the fifth vital sign" has now become a badge of dishonor.

Are deaths associated with alcohol use similarly evaluated? Will we place a moratorium on future wine festivals? Are deaths related to cell phone use similarly evaluated? Can you envision the recommendation of the NTSB that we ban all cell phone use of any kind while operating a motor vehicle?

The reality of our dilemma is that once again we doctors (from the Latin "docere" meaning to teach) have failed. We have in our power the ability to teach our patients the safe and appropriate use of medications. Since the 5th Century BC we have pledged "I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone". It appears that now we have deferred the nuance of our craft to legislators and will have unintended consequences to bear.

Reactions from a Board Certified Pain Physician

As a practicing pain physician *I am worried that the new state laws concerning prescribing controlled drugs (narcotics and sedatives) are so onerous on primary care physicians that they will send all their pain patients to us board certified specialists. It will inundate us with so many patients who have been helped over the years with low doses of daily pain medicine, well-cared for by their primary care doctors.*

For years we have tried to stop the "pill mills" in Florida, those dishonest doctors who sell narcotics to bogus patients for a big profit. The new state laws are helping to do that with many being shut down.

One of the unintended consequences is that pharmacies are under much closer scrutiny by the State and there is a reluctance by many to fill narcotic prescriptions, even for legitimate patients who have been on stable doses for years.

The Drug Enforcement Agency, on a national level, of course, wants to get controlled drugs "off the street", so they have pressured manufacturers to reduce the supply. This results in my patients telling me "I've been to four pharmacies and can't get my prescription filled." It requires me to write a different prescription and the patient to transition to a different drug which may not be as tolerable as the original.

These are prices we pay to try to reduce the prescription drug deaths, 40% of which victims are under 18, and this year are estimated by a group of State medical examiners to be between 10-15 deaths PER DAY in Florida, up from 7 per day five years ago. This is far higher than deaths from heroin and cocaine combined.

We'll watch how the experienced pain physicians have dealt with the new law, and perhaps lobby the legislature to amend it if there are portions too burdensome, but it is a good start to try to get rid of the "bad guys pushing drugs", and the horrendous numbers of accidental drug overdose deaths in this State. - James Worden, M.D.

Pictures from the New Member Welcome Event

Mr. and Dr. Aleksandra Granath and Mrs. and Dr. Marc Guttman

Wendy Grossman CCMSA President and her husband Dr. Joel Grossman

Dr. James Lim and his wife, Doris

Dr. Timothy L. Kerwin, new member, CCMS President Dr. D. Scott Madwar, Sue Gauta and CCMS Past President Dr. Joseph Gauta

Dr. Cesar De Leon, Milly De Diego and Mrs. and Dr. David Ornstein

Dr. Lindita Hobdari, Mrs. Lugo, and Dr. Gerardo Lugo

Dr. Jaime Weaver and guest with Dr. Jonathan Sonne and Dr. Rebecca Lambert

Circle of Friends – A Program of Preferred Vendors

Welcome New Circle of Friends Members

With more than $5 billion in assets, **Mutual of Omaha Bank** is a full-service community bank providing financial solutions to individuals and businesses in communities across the United States. For more information please contact Kris Scoone, 687-5241, Fax: 687-5252, kris.scoone@mutualofomahabank.com.

Markham Norton Mosteller Wright & Company specializes in tax, accounting and business consulting services for physicians and health care providers. Serving Southwest Florida since 1979, our experienced team can improve your profits and sharpen your competitive edge with a variety of services related to practice operations, strategic planning, human resources, tax planning and accounting services. www.markham-norton.

CCMS Circle of Friends

CCMS Circle of Friends program is open to businesses that can offer member only benefits and discounts. We encourage our members to patronize these businesses that have been selected by CCMS for their outstanding services and products.

Calendar of Events

Thursday, January 26, 2012
A Taste of Italy & Financial Planning Workshop
5:30pm - 7:30pm
Enjoy an Italian wine tasting and heavy hors d'oeuvres followed by a special presentation arranged by Peter Montalbano, CFP, Harris Private Bank with John Gast, Esq., Managing Partner at Brennan Manna & Diamond LLC, and Daniel A. Mendoza, CIMA®, Senior Vice President and Senior Portfolio Manager, M&I Wealth Management
Anthony's Trattoria
7935 Airport Pulling Road, North Naples, FL 34109
RSVP Carol Whitlock by January 23, 2012 at 239-390-5186 or carol.whitlock@micorp.com

Friday, February 10, 2012
Women Physicians Lunch
12:00pm
McCormick & Schmick's (Mercato)
9114 Strada Place, Naples, FL 34108

Thursday, March 15, 2012
General Membership Meeting
"Advancing orthopedic medicine in the community and around the world. The latest surgical treatment innovations, advances in orthobiologics, medical education, biomechanical/clinical research and more."
6:30pm
Sponsored by Arthex and held at their corporate headquarters on 1370 Creekside Blvd.
Naples, FL 34108

Thursday, April 19, 2012
Spring Seminar, TBA

Saturday, May 5, 2012
Annual Meeting and Installation of Officers
6:30pm
Grey Oaks Country Club
2400 Grey Oaks Drive
Naples, FL 34105

Register for these events at (239) 435-7727 or info@ccmsonline.org

Medical Staffs & Conflicts of Interest

by Jeffrey L. Cohen & Albert R. Meyer, The Florida Healthcare Law Firm

Medical staffs are increasingly frustrated with the financial relationships their medical executive committee (MEC) members have with the hospitals where they work. These financial relationships can be the cause of troubling conflicts of interest (COI). Medical staffs need to be proactive about the issue.

A hospital based physician's livelihood (and the economic welfare of his/her family) depends in part on having a good relationship with the administration of the hospital where he or she works. It is easy, therefore, to see how the physician would be hard pressed to go against the hospital on controversial matters. The same goes for a full time employed physician of a hospital and even a medical director who may derive significant compensation from his or her relationship with the hospital.

But what about a physician who staffs a hospital based department at hospital #1 who wants to get on staff at competing hospital #2? What about the physician who is employed by hospital #1 becoming a member of hospital #2 and who wants to become president of hospital #2's medical staff?

The complexity of this evolving business model brings hospitals and physicians closer, which creates COIs. MECs must take a good look at what circumstances constitute a COI and develop methods to counteract them.

A COI basically exists for an MEC member when the member has a relationship with a party which causes the member to place his or her personal interests before those interests of the medical staff as a whole. A classic COI is a financial relationship with the hospital. If an MEC member receives money from a hospital for providing a service to or on behalf of a hospital, a COI exists. But the inquiry does not stop there. Simply having a COI is not dispositive. The question is what to do about it.

There is essentially a two step process involved for an MEC member with a COI. First, the COI must be disclosed. This ought to be done annually and at each MEC meeting. Second, on any matter where the COI is implicated, the MEC member ought to recuse himself or herself from a vote on the matter. They can participate in the MEC consideration, but should leave the room when the vote is taken.

There is a third option, a poison pill of sorts. If an MEC member find that the COI has him or her bouncing in and out of the MEC meeting room regularly, there ought to be consideration given to the person's resignation.

At the very least, medical staffs must develop policies and procedures regarding COIs. COIs ought to be defined and handled on a predetermined basis. Moreover, medical staffs should give serious consideration to ensuring that at least a majority of the MEC members do not have a COI that would prevent them from doing their job, which is to ensure the integrity and proper functioning of the medical staff.

Mr. Cohen is board certified by The Florida Bar as a specialist in healthcare law. Mr. Cohen can be reached at www.floridahealthcarelawfirm.com and also by calling (888) 455-7702.

Summary of Actions: 2011 AMA Interim Meeting

by Corey Howard, M.D., F.A.C.P., Chair, FMA Delegation to the AMA; Vice Speaker, FMA House of Delegates

Your FMA Delegation to the AMA attended the 2011 Interim Meeting of the AMA House of Delegates in New Orleans, November 11-15. We submitted 12 resolutions on behalf of the physicians in Florida. These resolutions and their final actions are noted in the table provided below.

The most important resolution for the FMA at this meeting was initially titled: "AMA to Make Private Contracting Its Highest Priority" as submitted to the FMA House of Delegates by the South Florida Caucus. During the AMA Interim Meeting the resolve clauses were modified for clarity and to make an additional point as the resolution in its original form was destined for reaffirmation. This change and the recommended title change were as follows:

Substitute Resolution 203: A Grassroots Campaign to Earn the Support of the American People for the Medicare Patient Empowerment Act

RESOLVED, That our AMA now initiate and sustain our well-funded grassroots campaign to secure the support of the American People for passage of the Medicare Patient Empowerment Act in Congress as directed by the I-2010 HOD meeting through policy D-390.960.

The recent AMA policy listed was in support of the Medicare Patient Empowerment Act, now called HR 1700 as introduced by Tom Price, M.D., Member of the U.S. House of Representatives from Georgia. During the Interim Meeting the executive committee of your FMA Delegation to the AMA met with leaders from state and national specialty organizations in order to gain support. There was an uphill battle initially. However, we were able to have open and honest debate as to the merits of this important resolution. A strategy was developed and implemented when the resolution was presented (it was the last item of business). Since the AMA had policy on this subject, your FMA Delegation thought that it was time to move to the next level and have a directive to take action. This resolution passed with over 90% voting in the positive. This was a major win for our patients and for the physicians of the FMA.

This was a coordinated action through many large states such as California, Texas, and New York. I am very proud of how effective your FMA Delegation was during this meeting.

In addition to this very important policy, your Delegation made it clear that Florida was going to lead the way for the practice of medicine. As always our goal is to help physicians practice medicine. That is exactly what we did. We will continue to provide valuable input into the process on behalf of our members and the people of the State of Florida.

Resolution 810: Empowering State Choice

RESOLVED, That our American Medical Association advocate that state governments be given the freedom to develop and test different models for covering the uninsured, provided that their proposed alternatives a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b) ensure and maximize patient choice of physician and private health plan and, c) include reforms that eliminate denials for pre-existing conditions.

Importantly, the AMA House of Delegates also adopted Substitute Resolution 216: Stop the Implementation of ICD-10 to mandate that the AMA vigorously take action to stop implementation of ICD-10 (The International Classification of Diseases and Related Health Problems, 10th Revision). ICD-10 has about 69,000 codes and aims to replace the 14,000 ICD-9 diagnosis codes currently in use. This resolution requires the AMA to work with other national and state associations to assess an appropriate replacement for ICD-9.

CCMS Past President Corey Howard, M.D., FMA Vice Speaker and AMA Delegation Chair speaks to delegation members at the July 2011 FMA annual meeting.

SPOTLIGHT ON NEW MEMBER

Never Stop Training: What Drives Dr. Jackie A. Kawiecki

by Mollie Page

During her fourth semester at medical school, Dr. Jackie Kawiecki experienced a personal tragedy that would impact her direction in medicine. The victim of a severe car accident, Dr. Kawiecki suffered serious spine injuries that set her training back nearly four years.

Faced with hours of extensive rehabilitation each day, she was forced to resign from her orthopedic internship at the University of Minnesota. The injuries also delayed her ability to start clinical practice at the University's Trauma 1 hospital in St. Paul. With her original career path obstructed, Dr. Kawiecki had to find a new direction.

In less than two years she obtained a masters in Healthcare Administration, did coursework toward an MBA in Finance and Operations, and pursued a fellowship in clinical outcomes research. Then in June 1998, Dr. Kawiecki went back to finish her clinical internship. During all this training, the headstrong physician somehow also found time to work in the University's Physical Medicine department.

"I finally got everything done in 2002," said Dr. Kawiecki, who was simply referring to her scholastic goals.

Like many colleagues, Dr. Kawiecki is highly driven. She quickly went to work for the Social Security Administration in Minnesota; reviewing patient charts and cases involving disability. I later find out she also wed and birthed a son during this period.

A year-long pediatric rehabilitation fellowship at the University's Gillette Children's Specialty Healthcare in St. Paul rekindled Dr. Kawiecki's interest in Physical Medicine.

"We had a child here [NCH downtown] last year that was a near drowning victim," said Dr. Kawiecki. "She went without oxygen for almost 20 minutes. It took three days of guided physical, occupational, and speech therapy to get her stabilized."

In 2004 she began working in a neuro rehab program, where she could cultivate her interest in advanced rehab therapies.

"This is where I learned about spasticity management," said Dr. Kawiecki. This was at a time when Botox injections were just starting to be used for pain management. The next year she transferred over to Region's Hospital where she worked in its 24-hour trauma center.

All her administration and medical training kicked in when she was recruited in January 2006 to be the Corporate Medical Director at the Courage Center in Minnesota, a non-profit rehabilitation center that uses a holistic approach to physical medicine to include services ranging from transitional rehabilitation to community reintegration.

The Center opened Dr. Kawiecki's eyes to even more new therapies for chronic pain rehabilitation. She opened a spasticity clinic within the center and in the evenings finished dual boards in Physical Medicine and Rehabilitation and Spinal Cord Injury Medicine (plus some more work in pediatric rehab).

December 1st marked her first anniversary as the Medical Director of the Brookdale Center for Health Aging & Rehabilitation, a division within NCH Healthcare. The 54-bed facility is just behind North Collier Hospital, but you'll find Dr. Kawiecki in her office at NCH Downtown because she's also the medical director of the 60-bed Physical Medicine and Rehabilitation hospital located at the Downtown campus.

Staying busy fits Dr. Kawiecki. Her focus now is to custom build patient rehab plans in a comprehensive multi-disciplinary atmosphere.

"There's no 3-day hospitalization requirement to admit your patients into the acute inpatient rehab center," said Dr. Kawiecki. "We manage their rehabilitation while you manage their medical diagnosis."

"Early consultation with PM&R in the hospital allows us to partner with the primary physician, attending physician, and specialists as early as an ICU setting. This helps prevent complications including skin breakdown, bowel dysfunction, joint contractures, and peripheral pressure neuropathy. We want to initiate rehab therapies early in the hospital for best outcomes."

Outcomes are important to Dr. Kawiecki. Still in discomfort herself, her busy days keep her moving. "I live with what my patients experience, so I'm always searching for new therapies or ideas."

For this reason, Dr. Kawiecki will never stop training. In fact, she's currently working with FGCU research. The "Body Supported Treadmill Training" program aims to rebuild a patient's natural gait.

"It's good for stroke patients and also helps rebuild motor planning and control. This is very important knowledge for my stroke patients."

In fact, she was instrumental in obtaining a special accreditation in stroke rehabilitation for the Center, and it now enjoys a 68 percent success rate for patients returning to their regular community lives.

New Laws for Prescribing Controlled Rx

by Mollie Page

On December 13, 2011, Collier County Commissioners voted unanimously to extend an existing moratorium on pain management clinics until December 2012. The decision comes on the heels of a new state law, which goes into effect on January 1st, that enacts a series of new requirements for doctors prescribing pain medications to patients with a diagnosis of chronic, non-malignant pain.

To help members understand how to comply with the law, as well as its ramifications, your medical society hosted an informative CME event in early December that featured Dr. Deborah H. Tracy, MBA and Brent Hoard, Esq.

Chronic nonmalignant pain: As defined by the State of Florida. *Pain unrelated to cancer or rheumatoid arthritis which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery.*

Dr. Tracy is the current President of the Florida Society of Interventional Pain Physicians, President of Hernando County Medical Society, is on the Medicare Contractor Advisory Committee, is a member of the FMA Council on Medical Economics, and an expert panelist for the Florida Board of Medicine. After revealing some startling statistics on prescribed medications in Florida, Dr. Tracy and Mr. Hoard spent two hours discussing the new law and what physicians can expect to face on January 1, 2012.

It all started this past July (7/1/11), under HB 7095, a physician (licensed 458, 459, 461, 466), who prescribes **ANY** controlled substance (CS) for chronic non-malignant pain must:

- Designate himself a CS prescriber on the Physician's Practitioner Profile
- Comply with applicable Board Rules

NOTE: Any physician who prescribes any CS (including schedule V) for chronic non malignant pain, even those who are exempt (see box), **MUST** register, on their practitioner profile.If you plan to adhere and implement this service, you must follow these newly expanded standards of practice. For documentation purposes, your medical record must include:

Who is Exempt

- Board Certified Anesthesiologist
- Board Certified Physiatrist
- Board Certified Neurologist
- Board Certified Physician:
  -Surgical privileges at Hospital or ASC and primarily provides surgical services
  -Fellowship in pain medicine (ACGME or AOA approved)
- Board Certified in Pain Medicine (ABMS or AOA) and perform procedures of the type billed using surgical codes

- History and PE
- Drug abuse or dependence *
- Diagnostic, imaging, therapeutic and lab results
- Evaluations and consultations *
- Treatment objectives, periodic review
- Risks and benefits
- Treatments
- Medications, date, type, dosage, # prescribed
- Instructions and agreements *
- Periodic reviews *
- Drug testing results *
- Copy of patient's government-issued photo ID *
- Duplicates of prescriptions, with physicians name

Each physician must develop a written treatment plan for each patient. The treatment plan must state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and shall indicate if any further testing is needed.

Physicians must also have a written agreement with the patient explaining and outlining the risks and benefits, potential for addiction and physical dependence, the number and frequency of refills, patient compliance and violations for termination.

You must see the patient every three months and create a new written agreement further including details on the drug's efficacy, any indications, progress to objectives, adverse effects, review etiology, modifications, and revaluate appropriateness of treatment, as well as note the patient's compliance.

The penalties for violations of the new standards of practice are severe and include: **The physician shall be suspended for a period of not less than 6 months and pay a fine of not less than $10,000 per count.**

GET SET TO USE E-FORSCE

The new law includes a provision that requires doctors assess and review a patient's current medication regimen. Access to E-FORSCE, the State of Florida's Prescription Drug Monitoring Program (PDMP), helps this process. As a registered CS prescriber, you are required to report to the PDMP each time a controlled substance is dispensed to an individual.

However, as revealed during Dr. Tracy's presentation, pharmacies may take up to 10 days to update dispensing data into the system. This delay is of major concern to local physicians utilizing the program because it does not provide real-time data necessary to successfully identify duplicate prescribing. Efforts are being made to address this. Access E-FORSCE at http://www.hidinc.com/flpdmp.

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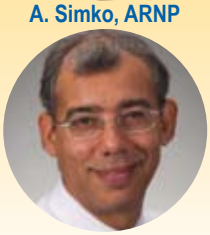
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Message from the Florida Board of Medicine

by George Thomas, MD, FACC, Chair, Florida Board of Medicine

It appears that there is some apprehension by many physicians about the Board's work and changes in Florida Statutes. Below is a summary of the key areas each physician should be familiar with:

1. You must update your practitioner profile within 15 days of any change. You can do this by going online to http://www.doh.state.fl.us/mqa/ and clicking on Practitioner Profile.

2. Do not pre-sign prescriptions. This is a violation of the law.

3. You must keep charts on the family, friends, and employees that you treat. Prescribing to your family members, friends and employees is not against the law. However, you are required to maintain medical records just like you would any other patient. You are not permitted to prescribe controlled substances to yourself under any circumstance.

4. Internet prescribing. Florida Rule 64B8-9.014 outlines acceptable telemedicine practice in Florida.

5. Patient Boundaries. The patient-physician relationship is built on mutual trust. Sexual misconduct in the practice of medicine is prohibited by law. The Board of Medicine has zero tolerance for sexual misconduct.

6. Relocate practice. There are steps you must follow when closing or relocating your office practice. You can find these steps in Rule 64B8-10.002, Florida Administrative Code.

7. Help for Impaired practitioners. The Professionals Resource Network (PRN) is available to help physicians as well as applicants for licensure and medical students. PRN can be contacted at (800) 888-8776.

8. Pain Management and Controlled Substances. There have been a lot of changes to pain management in Florida:

- Prescription Drug Monitoring Program (E-Forcse) – in effect now
  - –If you dispense controlled substances, you must register
  - –May use to look up patient before prescribing
  - –Register online at www.doh.state.fl.us/mqa
- Register by January 1, 2012 on your profile as a controlled substance prescriber if you prescribe controlled substances for chronic nonmalignant pain [s. 456.44, FS]
- Must use counterfeit proof prescriptions pads from approved vendors for all controlled substance prescriptions
- No dispensing of Schedule II and III controlled substances
- New laws for pain-management clinics [s. 458.3265, FS]

9. At license renewal.

- Florida physicians must renew their license every two years and can do it ONLINE at www.doh.state.fl.us/mqaservices
- To renew a Florida license, physicians are required to obtain the required CME, attest to financial responsibility coverage, and complete the Physician Workforce Survey
- Recent reduction of renewal fee to $391 (includes background check fee and unlicensed activity fee)

10. CME requirements. You are required to complete 40 hours CME every two years. Of the 40 hours, two hours must be in the prevention of medical errors. Every six years, the 40 hours will include the two hours in the prevention of medical errors as well as a 2-hour course in domestic violence. Maintain your CME certificates for two licensing bienniums in case you are audited.

STAY IN TOUCH

Join our Mailman System (Interested Parties List). It's a simple way to stay informed on changes in the laws and rules and updates from the Board. You will receive up to the minute information. To subscribe, log on to www.doh.state.fl.us/mqa/medical. Once there, follow these quick and easy steps:

- Click on Interested Parties (Mailman) in the blue box in the upper left-hand corner
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I would like to congratulate Dr. Jason Rosenberg, Chair, Dr. Zach Zachariah, Vice-Chair and Dr. Nabil El Sanadi, First Vice-Chair for 2012. We are honored to have these talented individuals to the serve as Board's leadership.

Medicine is a profession that demands the best in us. There are close to 60,000 physicians holding active licenses from the State of Florida. Millions of Floridians depend, everyday, on your labor and commitment for their wellbeing. I would just like to remind each of you to be familiar with the laws and rules affecting your practice of medicine in Florida. The citizens of the Sunshine State need you, and on behalf of the Board, we truly appreciate your good work and dedication.

Estate Tax Changes Under the 2010 Tax Act

by Peter Montalbano, CFP, Director/Wealth Advisor, Harris Bank, a CCMS Preferred Vendor

The Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (the 2010 Tax Act) was signed into law in December 2010. This law contained **dramatic changes to the federal gift and estate tax and the federal generation-skipping transfer (GST) tax**. **These changes are only temporary – for 2011 and 2012 only!** Unless Congress enacts further legislation, the rules that were in effect in 2000 are scheduled to be reinstated in 2013.

The Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) significantly changed the federal gift and estate tax and the GST tax for the years 2001 through 2010. The maximum tax rates gradually decreased from 55 percent to 45 percent (35 percent for gift tax) and the exemptions gradually increased from $675,000 to $3.5 million ($1 million for gift tax). The provisions of EGTRRA repealed the estate and GST taxes (but not the gift tax) for 2010; then, for 2011, reinstated the tax rules that were in effect prior to EGTRRA. Also, from 2004 through 2010, the gift tax was "dis-unified" from the estate tax.

Modified Carryover Basis in 2010

Generally, for tax years prior to 2010, a taxpayer's income tax basis in property acquired from a decedent was stepped up (or stepped down) to the property's fair market value on the date of death. If the property acquired from the decedent had increased in value, the unrealized gain permanently escaped income taxation. Conversely, if the property had declined in value, the unrealized loss was not recognized either by the decedent or the heir. In addition, the long-term capital gains holding period applied automatically. Because of this, taxpayers generally did not need to maintain basis information for assets that would be distributed at death.

Under EGTRRA, for deaths occurring in 2010 only, a modified carryover basis regime was substituted for the stepped-up basis rules. Under these rules, a recipient of property transferred from a decedent received a basis equal to the lesser of the decedent's basis or the fair market value of the property on the decedent's date of death.

This carryover basis is then stepped up by an aggregate amount of $1.3 million, and property passing to the spouse of the decedent is stepped up by an aggregate amount of $3 million (but no interest in property acquired from the decedent is stepped up above its fair market value). There is also a carryover of the holding period. Thus, documentation of cost basis and acquisition dates is necessary.

Caution: Under both the modified carryover basis and the stepped-up basis rules, income in respect of a decedent does not receive a step-up in basis. Thus, for example, distributions from a qualified plan or a traditional IRA that you received from a decedent may be fully taxable to you.

Repeal of State Death Tax Credit

In addition to federal estate taxation, some states impose their own estate taxes. In order to reduce the dual burden, federal law provided for the sharing of revenue with states through the state death tax credit. EGTRRA gradually reduced and then eliminated the state death tax credit in 2005, replacing it with a state death tax deduction. Many states that tied their death tax to the federal credit (i.e., by imposing a "pick-up" or "sponge" tax) have since "decoupled," and now impose a separate estate or inheritance tax.

The 2010 Tax Act

Just days before the sunset provisions of EGTRRA were to take effect, the 2010 Tax Act became law. Among other things, the 2010 Tax Act repealed the repeal of the estate and GST taxes for 2010, and, for the next two years, set the maximum tax rates at 35 percent, increased the gift and estate tax applicable exclusion amount to $5 million (and increased the GST tax exemption to $5 million as well), made the applicable exclusion amount "portable," and extended the repeal of the state death tax credit and the allowance of the state death tax deduction.

Repeal of the *Repeal*

The 2010 Tax Act retroactively reinstated the estate and GST taxes for 2010, along with the step-up in basis rules. For the estate tax, a top tax rate of 35 percent was imposed and an applicable exclusion amount of $5 million was established. For the GST tax, a top rate of 0 (zero) percent was imposed and a separate $5 million exemption was allowed. This presented a narrow window during which taxpayers could make gifts to grandchildren and other skip persons, without having to pay any GST tax; however, that window closed December 31, 2010. The gift tax, which had remained in effect, was "re-unified" with the estate tax: a top tax rate of 35 percent was imposed and the applicable exclusion amount of $5 million for gift and estate tax applied.

Election OUT of the Estate Tax for 2010

Under the 2010 Tax Act, executors of estates of persons dying in 2010 were given the choice of either the estate tax regime (with the step-up in basis rules) or electing out of the estate tax (with the modified carryover basis rules).

Executors had to make an affirmative election to opt in to

carryover basis. Absent such an election, the traditional automatic basis step-up rules will apply to assets passing as a result of deaths occurring in 2010.

The due date of estate tax returns for decedents dying between January 1 and December 16, 2010, is September 17, 2011 (nine months from December 17, 2010). For deaths on or after December 17, 2010, the return is due nine months from the date of death.

Estates that elect to opt out of the estate tax are also required to file Form 8939, Allocation of Increase in Basis for Property Acquired From a Decedent. Originally, the IRS stated that generally Form 8939 was to be filed along with the decedent's final Form 1040 no later than April 18, 2011. Subsequently, the IRS said Form 8939 must be filed within 90 days after Form 8939 is finalized.

Tip: Executors should do an analysis comparing the potential estate tax liability to the potential capital gains tax liability to determine which option is better for the estate. Projecting potential capital gains tax liability requires the prediction of several factors, including: (1) the character of the gain, (2) the applicable tax rate, and (3) the applicable holding period.

Tax Rates and Exemptions

Mr. Montalbano will share a table that illustrates the status of the federal transfer tax rates and exemptions at his presentation to CCMS members on January 26th (see page 2 for details).

Portability of the DSUEA

The surviving spouse of a person who dies in the year 2011 or 2012 can now use the deceased spouse's unused exemption. When the surviving spouse dies, his or her executor can combine the estate tax exemption of the last spouse to die with the unused exemption of the first spouse to die. The ability to transfer the estate tax exemption to the surviving spouse is referred to as " portability." Portability gives married couples the ability to exempt up to $10 million of assets from gift and estate tax. Before the 2010 Tax Act created the concept of the deceased spouse's unused exemption (or exclusion) amount (DSUEA), a married couple would often preserve the estate tax exemption of the first spouse to die by setting up a bypass trust arrangement (often referred to as an A/B trust arrangement).

The executor of the estate of the deceased spouse must file an estate tax return (Form 706) with the IRS and claim the deceased spouse's unused exclusion amount, even if no tax is due. Generally, the estate tax return must be filed within nine months after death. The IRS is expected to create a short Form 706 to make it easier to file and claim the DSUEA. If the estate of the deceased spouse does not file Form 706, the surviving spouse loses the right to portability. If a surviving spouse remarries and is predeceased by the second spouse, the surviving spouse must use the DSUEA of the second spouse, even if the unused exemption of the second spouse is less than the unused exemption of the first deceased spouse.

Example(s): *Assume that Spouse 1 dies in 2011, having made taxable transfers of $3 million and having no taxable estate. An election is made on Spouse 1's estate tax return to permit Spouse 2 to use Spouse 1's DSUEA. As of Spouse 1's death, Spouse 2 has made no taxable gifts. Thereafter, Spouse 2's exemption is $7 million (his or her $5 million "basic" exclusion amount plus $2 million of Spouse 1's unused exemption), which Spouse 2 may use for lifetime gifts or for transfers at death.*

For many couples, the simplicity of portability along with the second step-up in basis for appreciated assets (which a credit shelter trust does not receive) may seem attractive. However, portability does have certain drawbacks that the married couple must consider when creating their estate plan.

- The DSUEA is not indexed for inflation. In contrast, if assets are left in a bypass trust, the appreciation of those assets will not be subject to estate tax at the death of the surviving spouse. For example, say a bypass trust is funded with $5 million at the death of the first spouse, and the bypass trust grows in value to $6 million by the time the second spouse dies. That $1 million increase in value will not be subject to the estate tax. Under the DSUEA rules, the entire $6 million would be part of the surviving spouse's estate, with only a $5 million DSUEA to shelter those assets from estate tax. The same $1 million increase in value would be taxable at the surviving spouse's death. Keep in mind, however, that the estate tax savings from using a bypass trust could be offset by the capital gains taxes that may be owed on the trust assets when they are sold (the bypass trust will not get a step-up in basis at the survivor's death).

- The GST tax exemption is not portable. If a married couple wants to fully utilize their combined $10 million GST tax exemptions, they must still create a bypass trust at the death of the first spouse to use his or her $5 million GST tax exemption.

- This portability feature is scheduled to sunset, or expire, after 2012. Unless and until portability is made permanent, it is problematic to rely on it in creating a successful estate plan.

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