



THE FORUM

HAPPY DOCTORS DAY / MARCH 30th

March/April 2012 ♦ Volume 11, No. 2

THE OFFICIAL MAGAZINE OF THE COLLIER COUNTY MEDICAL SOCIETY

The Wonderful World of Digital Health

What You Need to Know About the Health Information Exchange (HIE)



Dr. Carlos Portu,
Internal Medicine
Physician Regional Medical Group

WHAT'S INSIDE:

Are You a Target for Embezzlement?

What You Need to know about LIFE INSURANCE

Employer Tips for Surviving Health-Care REFORM

IMMUNIZE Your Patients

WELCOME NEW MEMBERS



NURUDDIN JOOMA, M.D.
Oncology & Hematology
Premiere Oncology
955 10th Avenue North
Naples, FL 34102
325-1440 Fax: 325-2287
Board Certified: Oncology, Hematology
& Internal Medicine



JEFFREY WILLIG, M.D.
Ophthalmology
Florida Eye Health
2100 Tamiami Trail North
Naples, FL 34102
430-3939 Fax: 274-0388
Board Certified: Ophthalmology



RONALD T. PURCELL, M.D.
Allergy, Asthma & Immunology
Allergy, Sinus and Asthma Specialists
1000 Goodlette Road N., Ste. 200
Naples, FL 34102
434-6200 Fax: 434-5741
Board Certified: Internal Medicine, Allergy
Immunology



JAY WANG, MD
Medical Oncology
Premiere Oncology
955 10th Avenue North
Naples, FL 34102
325-1440 Fax: 322-5605
Board Certified: Medical Oncology &
Hematology



MONICA ROBLES, M.D.
Psychiatry
David Lawrence Center
6075 Bathey Lane
Naples, FL 34116
455-8500 Fax: 455-6561
Board Certified: American Board of
Psychiatry/Neurology: Psychiatry and Child
and Adolescent Psychiatry



DAVID A. SCOTT, D.O.
Family Medicine
Naples Medical Center
400 8th Street North
Naples, FL 34102
649-3347 Fax: 430-5597
Board Certified: Family Medicine



ALBERTO F. VERA, M.D.
Internal Medicine
1048 Goodlette Road N., Ste. 102
Naples, FL 34102
692-8719 Fax: 692-8856

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 committee leadership openings.

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through the resources provided by your Medical Society.

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CCMS MEMBER NEWS

Emily Clements, D.O., Obstetrics & Gynecology, has joined Physicians Regional Medical Center, Complete Women's Care of Naples, 8340 Collier Blvd., Suite 301, Naples, FL 34114, telephone: 348-4098 and fax: 354-6569.

Dean Hildahl, M.D., Obstetrics and Gynecology, has moved his office to 6610 Willow Park Drive, #102, Naples, FL 34109, telephone: 593-5510.

Lindita Hobdari M.D., Family Medicine, will open her new office April 1st, Hobdari Family Health, 1890 SW Health Pkwy., Naples, FL 34109, telephone: 260-1033 and fax 260-1491.

Congratulations to **Dr. Paul Jones** and **Dr. Jerry Williamson**, who were both recipients of the Naples Daily News Heroes in Healthcare.

Congratulations to **Dr. William and Nancy Lascheid** on receiving Hodges University's 2012 Humanitarian Award.

Suzy Pope Lee, M.D., Dermatology, has opened her new office, Bonita Dermatology PA, 9411 Fountain Medical Court, Bldg. E. Suite 100, Bonita Springs, FL 34135, telephone: 221-8516 and fax: 221-8787.

Dean Rackleff, M.D., Infectious Diseases, has moved his office to 3467 Pine Ridge Rd., Ste. 103, Naples, FL 34109, telephone: 455-9946 and fax: 455-9947.

Mitchell Petusevsky, M.D., Pulmonary Medicine, suite number correction: Suite #305.

Igor Levy-Reis, M.D., Neurology, is now **Board Certified in Geriatric Neurology**.

Nilsa Rivera, PhD., Clinical Psychologist, has relocated her offices to 681 Goodlette Rd. N., Suite 150, Naples FL 34102, telephone: 434-2425 and fax: 649-6085 and 1560 Matthews Drive, Unit F., Ft. Myers, FL 33907, www.nrphd.com.

Rebecca Rock, M.D., Internal Medicine, has opened her new office at 1400 Gulf Shore Blvd., Suite 166, Naples, FL 34102, telephone: 325-5350 and fax: 352-5545, www.rebeccarockmd.com.

Argyrios Tzilinis, M.D., Surgery-Vascular, has changed his office numbers. Telephone: 348-4212 and fax: 348-4213.

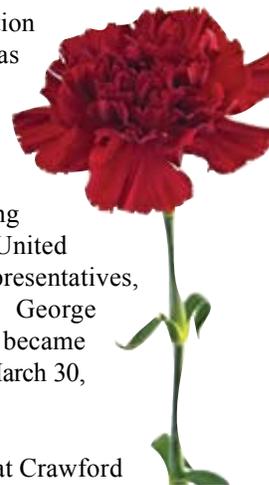
Roland Werres, M.D., Cardiology, has changed his telephone number to (239) 348-4309.

D.A. Zafar, D.P.M., Podiatry, SW FL Ankle and Foot Care Specialists, has relocated his office to 7151 Radio Road, Naples, FL 34104, telephone: 732-5585 and fax: 732-1382, www.ankleandfoot.net.

THE HISTORY OF DOCTORS DAY

The first Doctors Day observance was March 30, 1933 in Winder, Georgia. Eudora Brown Almond, wife of Dr. Charles B. Almond, decided to set aside a day to honor physicians. This first observance included the mailing of greeting cards and placing of flowers on graves of deceased doctors. The red carnation is commonly used as the symbolic flower for National Doctors Day.

On March 30, 1958, a Resolution Commemorating Doctors Day was adopted by the United States House of Representatives. In 1990, legislation was introduced in the House and Senate to establish a national Doctors Day. Following overwhelming approval by the United States Senate and the House of Representatives, on October 30, 1990, President George Bush signed S.J. RES. #366 (which became Public Law 101-473) designating March 30, 1991 as "National Doctors Day."



Doctors Day also marks the date that Crawford W. Long, M.D., of Jefferson, GA, administered the first ether anesthetic for surgery on March 30, 1842. On that day, Dr. Long administered ether anesthesia to a patient and then operated to remove a tumor from the man's neck. Later, the patient would swear that he felt nothing during the surgery and wasn't aware the surgery was over until he awoke.

The most common recognition on National Doctor's Day is a handwritten note or greeting card signed by the doctor's staff.

Source: Wikipedia

NEW BABY

Congratulations to **Dr. Joel Grossman** and his wife Wendy on the safe arrival of Ruth Helene who arrived on December 19, 2011.

Congratulations to **Dr. Carlos Portu** and his wife Jenny on the safe arrival of Hadley Rae, born at 5:17pm on February 20, 2012.

OBITUARY

Steven Nguyen, M.D., a local Allergist, passed away after a struggle with cancer. We extend our sincere condolences to his family.



A MESSAGE FROM THE TREASURER: HEALTH INFORMATION EXCHANGE IS COMING

by Richard Pagliara, D.O., CCMS Treasurer, HIE Committee Chair

*The voyage of discovery is not
in seeking new landscapes, but
in having new eyes. - Marcel Proust*

Imagine the independent internist who has real-time access to hospital documentation from a recent stay of one of his patients. Imagine the emergency room physician who can fully access an unfamiliar nursing home patient's medical chart from their long-term care facility. Imagine the orthopedic surgeon who is fed up with radiology CD's and now can access full MRI studies on her office computer from any imaging facility. Imagine a physician looking to satisfy the meaningful use requirement, now being able to acquire an EMR product at little cost while satisfying such requirement. This transformation of medicine is underway in many parts of the country and will soon be a reality here.

Health Information Exchange (HIE) is simply the ability to exchange patient data between health care facilities including physicians, hospitals, health departments, outpatient imaging facilities, laboratories, and pharmacies, just to name a few. HIE provides many well-documented benefits including access to more complete patient information, reduced duplication of exams, easier transition of patient care between facilities, and more accurate prescriptions. For example, if patient A has her doctors X, Y and Z on the HIE, all her physicians will know what health care has been provided with no faxes or phone calls in a shorter timeframe. If patient A is admitted to hospital B, the hospitalist can fully access her medical history from doctors X and Y, and even non-hospital privileged doctor Z. These are simple scenarios; however, the main purpose for this endeavor is to improve communication throughout the medical industry, ultimately reducing medical errors, lowering costs and improving patient outcomes.

Currently, both PRHS and NCH are working on HIE solutions which are slated to be operational in the coming months of 2012. CCMS has been involved in this arena for over a year and is currently working with PRHS and HMA to help support HIE implementation and its expansion. Details about the HIE platform, software including EHR Lite, governance, cost structure and sustainability are currently being worked out and more information will be available shortly. I foresee HIE educational seminars dotting the spring and summer months and encourage you and your office managers to attend.

This truly is an exciting time for healthcare in our community. I believe HIE will be a paradigm shift in how healthcare professionals and facilities handle patient data. I can imagine a time, in the not so distant future, when we'll be wondering why we didn't get rid of the fax machine sooner.

Read more about Collier's HIE plans on page 6.

We hate lawsuits. We loathe litigation. We help doctors head off claims at the pass. We track new treatments and analyze medical advances. **We are the eyes in the back of your head.** We make CME easy, free, and online. We do extra homework. We protect good medicine. We are your guardian angels. **We are The Doctors Company.**

To learn more about our medical professional liability program, call us at (800) 352-0320 or visit www.thedoctors.com.



CALENDAR OF EVENTS

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

THURSDAY, MARCH 15, 2012

General Membership Meeting

“Advancing orthopaedic medicine in the community and around the world. The latest surgical treatment innovations, advances in orthobiologics, medical education, biomedical/clinical research and more.”

6:00pm

Sponsored by Arthrex and held at their corporate headquarters on 1370 Creekside Blvd.

Naples, FL 34108

Last minute RSVPs call Margaret at 435-7727

THURSDAY, APRIL 12, 2012

“Preventing employee theft and embezzlement”

6:30pm

Sponsored and presented by

Brett Nesbit of Rehmann Healthcare Advisors

& Richard Annunziata of Brennan, Manna & Diamond, PL

Venue TBA

SATURDAY, MAY 5, 2012

**Annual Meeting and Installation of Officers
Speaker: FMA President Dr. Miguel Machado**

6:30pm - 9:00pm

Naples Beach Hotel & Golf Club

851 Gulf Shore Boulevard North

See “Save The Date” at right

SAVE THE DATE

*Annual Meeting
& Installation*
*of 54th President, Rolando Rivera, MD
& Officers*

Saturday, May 5, 2012
Naples Beach Hotel & Golf Club
851 Gulf Shore Boulevard North

Guest Speaker
President of the Florida Medical Association
Dr. Miguel Machado

Register for this event via a link at
www.ccmsonline.org

*This is a complimentary event for CCMS members and a spouse or guest.
Sponsorships available - call Margaret at 435-7727.*



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ARE WE READY TO SHARE?

Q&A ANALYSIS OF HEALTH INFORMATION EXCHANGE

by Mollie Page

As your voice in many matters that affect the practice of medicine, your Medical Society set the wheels in motion to bring a Health Information Exchange to Collier County.

Historically, health information has been treated like a commodity. Arguably, the data is as precious as gold; and just like the metal, its value continues to grow amidst perceived and real dangers in the mining process. For many doctors, access to patient information is a proprietary privilege. Time spent gathering histories, performing procedures and attending to disease management is a highly guarded commodity. Therefore, the idea and eventual mobilization of this data has many health providers concerned. In an ideal digital environment, sharing this information will enable more informed decision making. But then there are the elephants in the room: security, ownership, and liability.

The following article includes answers and feedback from members of Collier County's HIE committee. *(see key at right)*

What value do you think an HIE will bring to doctors in the community?

DELEON: It will be a great service to patients when our medical records are integrated into one system. As primary care doctors, we could be well aware of the care our patients are receiving by specialists and it will help expedite referrals and outpatient services.

HACISKI: Right now we rely on different traditional methods that tend to slow down our ability to understand what care our patients are receiving. Referring patients to specialists would also be easier as it could be just a matter of connect and go. **SALMON:** The HIE will allow physicians, hospitals, ancillary service providers and patients/consumers to exchange clinical data and create a patient centric longitudinal clinical record containing data from multiple sources throughout the continuum of care. It will also allow physicians to electronically order tests and receive these results back in their EHR or through the HIE portal. An HIE will provide practices a means to streamline referral coordination and to track the status of referrals. The HIE allows physicians to securely send messages to others within the HIE.

Do you think this will also benefit patients?

DELEON: Patients with complicated medical issues will be best served as they may have multiple physicians caring for them. With the HIE, all records are easily accessible at all times by all physicians involved in the care. **HACISKI:** Imagine this scenario: A patient presents and you want to know his Vitamin D level. Ask

the patient, and they usually have no idea, even if they recently had it tested. With reimbursement down, this could save us and the patient money as we'd avoid doing duplicate tests. **SALMON:** The HIE will also provide a vehicle for physicians to communicate with patients and care givers by providing patient instructions, test results, centralized medication lists, and patient specific educational materials. For example, by having access to all of the patient's medications in one view, the provider can spend more time with patients reviewing their health issues. Patients and their care teams (friends and family) will also be able to view the patient's health information (medications, discharge instructions) through the HIE's patient portal. They can also view how well they are managing their health and have access to educational materials that are targeted to the patient's current medical condition.

What value will this bring to patients in Naples that only spend half the year here?

HACISKI: Right now we are focused on getting this implemented in just our county. But it's likely to spread as part of the Health Information

Technology for Economic and Clinical Health (HITECH) Act. **SALMON:** Our HIE will enable providers in Naples to connect and communicate with physicians that are outside of the community. For example, a physician in Naples will be able to share clinical information with a patient's specialist in Ohio through the HIE. Patients will also be able to access their patient portal from anywhere that they have an internet connection and they can continue to use the patient portal to update their health information and manage their health conditions.

CONTRIBUTORS

D. Scott Madwar, M.D., independent concierge practice owner and president of Collier County Medical Society.

Carlos Portu, M.D., internist with Physicians Regional Medical Group.

Cesar DeLeon, D.O., independent family practitioner with Naples Medical Center and director at large of Collier County Medical Society.

Rafael Haciski, M.D., gynecologist, solo practitioner with Advanced Gynecology, Inc.

Paul Salmon, Meaningful Use Program Manager/HIE Program Manager, Health Management Associates.

David Greider, M.D., head of pathology, Naples Pathology Associates.

What's the difference between an EHR and an HIE?

MADWAR: A good quarterback requires a good team! **HACISKI:** An EHR is my own electronic chart of a patient. It resides on my computer or server in my office. An HIE is that same record – but now encompassing all other physicians' records: **The super chart.**

Do doctors need an EHR to participate in an HIE?

According to a recent Medical Society survey, 50% of local physician members currently use an EHR system. **DELEON:** A physician can log in and view, and input data – but in order for full integration, the doctor needs to use an EHR. Having an EHR will make it much easier to share data. For example: If a patient ends up in ER, then the ER doctors will have vital info at their fingertips in order to provide the best care possible. **SALMON:** Physicians can participate with the HIE if they have an EHR or if they do not. There are over 350 EHR vendors, and we are working with the top 10 to negotiate HIE interfacing discounts. Plus, physicians can qualify for Meaningful Use incentive funds through the HIE's Certified EHR Lite module. (See box on page 8).

What security problems may be encountered in the sharing of medical records through an HIE?

MADWAR: The Medical Society has researched and worked with vendors on finding an HIE for the county as our highest concern has been the safety of our patient's medical records. **DELEON:** Yes. We are working with the hospitals to make sure physicians are represented and records will always belong to physicians. **HACISKI:** Physicians will not be allowed to adjust any data in an HIE that was input by other doctors. Some areas will be read only, and all data will be password protected with varying levels of permissible access. Other

An EHR is a folder that houses all the information I input in my office. The HIE acts like a bridge that takes all my information and combines it with other physicians that have helped my patients.

-Dr. Carlos Portu

issues to discuss will be: How to identify each data generator; whether this will be used to report to Medicare; whether to share this data with the Health Department and CDC; and how to use it to track health outcomes. **SALMON:** Security controls are in place so that unauthorized providers cannot view a patient's medical record without passing a "security check point". We are working with your Medical Society to create a multidisciplinary group of stakeholders from the community to oversee the governance of the HIE.

Will doctors need to participate in both hospital systems' HIEs?

HACISKI: The objective is to get both hospital systems to collaborate and interconnect. **DELEON:** Ideally, both hospital HIE systems will talk to each other so there will be no need to access both.

What obstacles do you see an HIE needs to overcome in the next year? Next 5 years?

DELEON: An obstacle I see is the integration of multiple different health records into an HIE as it could be costly to each physician and may discourage some independent doctors from participating.

HACISKI: I hope we can avoid many of the mistakes made by EHR developers like designing a system without the end user in mind. With constant physician committee oversight, we can keep an eye on the process so we can overcome the perception that hospitals will use the information in the HIE nefariously. **SALMON:** A major obstacle to the success of the Collier County HIE is lack of physician adoption. In order to realize the full community benefits of the HIE to patient care and quality we must reach critical mass of adoption and sharing of physician's patient data with other physicians. Physician practice cost to interface their EHR to the HIE will depend on the practice EHR vendor and the level of integration desired. Some physician practices will not have any costs attributable to interfaces depending on the EHR vendor.

What is the role of the HIE Committee moving forward?

GREIDER: I was glad to chair the Collier County Medical Society HIE committee at its inception in 2010. Our mission has been to search for an HIE that would meet the needs of all doctors in the community. We looked at a number of solutions and heard testimony from vendors, end users, doctors and administrators. It was clear that there were many players and without full participation by NCH and PRMC it would not be a success. Dr. Richard Pagliara has ably chaired the committee since 2011 and is pleased to be working with our colleagues at PRMC to review a proposal from HMA to provide an HIE solution to not only serve their physicians but every doctor in Naples. NCH is also committed to find a solution using their current Cerner technology.

All transactions are tracked by the HIE and audit reports can be run to determine who has accessed a patient's record and when it was accessed.

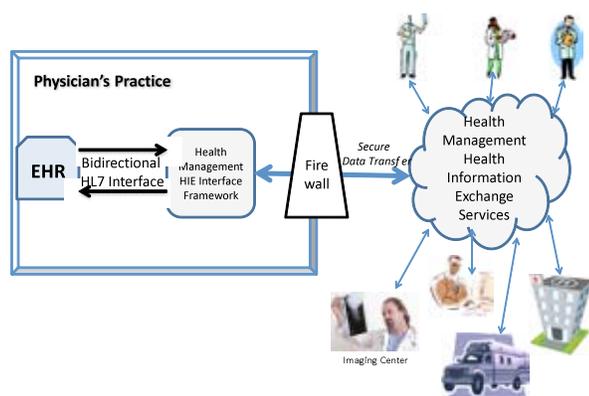
-Paul Salmon

We feel that both systems can work side by side bringing our physicians the tools they need to provide the best healthcare in Florida.

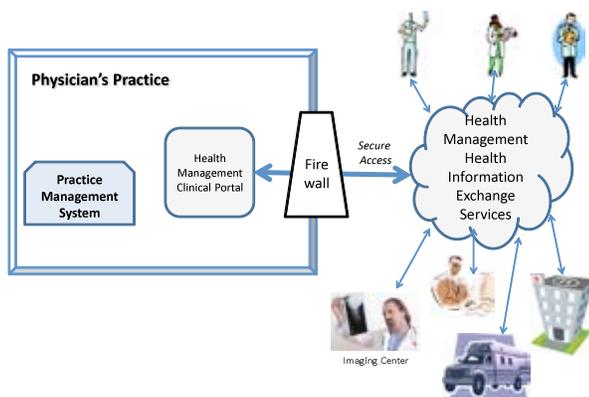
-Dr. David Greider

HOW EHRs WORK WITHIN AN HIE

The figure below depicts physician's using the HIE through integration with the practices EHR system. The HIE interface framework securely exchanges data with the HIE and the care team treating the patient. The software that is installed in the physician practice also contains a copy of the patient's record that can be accessed even if the connection to the HIE is temporarily unavailable.



In the figure below, the practice does not have an EHR but can access all the longitudinal patient data via the clinical portal. Data can be exchanged using upload and download capabilities eliminating faxing and scanning. Both options include additional Health Management HIE services such as Electronic Diagnostic Test Orders and Results Reporting; Electronic Referrals; Secure Messaging; Creation of Continuity of Care Document (CCD); Exchange of CCD with providers not part of the Health Management HIE; Access to Patient Communication and Portal Tools.



Source: Paul Salmon, Program Manager, Health Information Exchange and Meaningful Use, Health Management Associates

RE-EXAMINING THE ROLE OF LIFE INSURANCE

by Diane K. Layton, Northwestern Mutual Financial Network,
a CCMS Preferred Vendor

While the '90s were a time of economic prosperity and wealth accumulation for many, the 2000's have reminded people of the importance of diversification and protection. Certainly, economic and world events have caused many of us to refocus on a larger and more challenging financial picture.

For these reasons, it is more important to work with a qualified financial professional. And, wisely, many financial professionals are preaching the need for diversification as a means of better managing risk. But how many of them are suggesting that their clients take a second look at an old reliable tool – life insurance – as an essential element for a sound financial strategy?

Arguably, the biggest issue with life insurance is the tendency to oversimplify the whole process of buying it. It's either term or permanent, some "experts" will say. Furthermore, these same experts will often advise that term is the only way to go for everyone.

Truth is, buying life insurance cannot be reduced to a simple either/or decision. It is much more than a simple commodity; it's not like buying a book online or using the latest technology tool. And it will depend upon each person's circumstances. There are issues of:

- How much insurance you need and how long you'll need it.
- How the actual contract is designed: what types or combination of types are best for your needs; how your insurance needs might change over time; the extent to which you are prepared to pay premiums over an extended period.

It follows that the life insurance policy a person owns should reflect that individual's unique needs – there are no one-size-fits-all solutions when developing a financial security plan. For some this could mean term life insurance; for others, it could mean permanent life insurance. For others, still, it could mean a blended policy of both term and permanent insurance, or a combination of several types.

Whenever you get into the issue of term or permanent, it's important to understand the fundamentals. With permanent insurance, the insurance proceeds are paid to your beneficiaries whenever you die, as long as the premiums continue to be paid. Permanent insurance has level premiums and a cash value that grows on a tax-deferred basis. Term insurance, on the other hand, provides a payout only if you die within a certain period of time. The premiums typically increase each time you renew your policy and it has no cash value. Initially, the premium for term insurance is considerably lower than that of a permanent policy. But, in the long-run, the net cost may eventually be lower with the permanent plan.

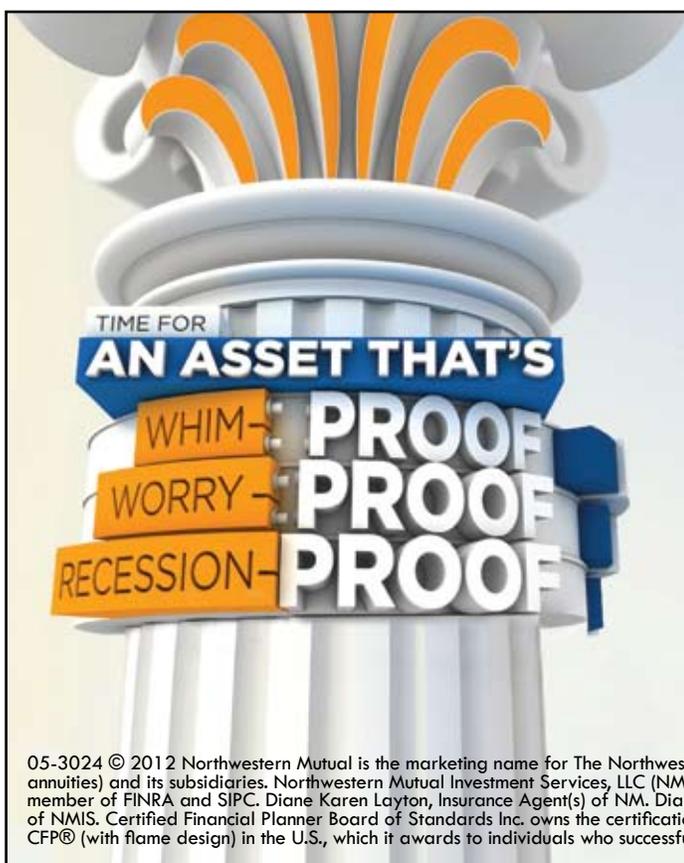
Life insurance should be considered the foundation and most conservative element of any personal plan – the money that absolutely has to be there, no matter what the economic cycle or climate. Furthermore, choosing the right amount of insurance is more important than finding the right kind. After that, the type you buy depends on your timetable and budget.

A good financial representative will make sure you consider life insurance as part of your overall financial strategy. This is someone who can help you understand your insurance needs and help identify which products offer innovative solutions in a particular situation.

Rather than push a product, a good financial representative will do these things:

- Ask questions about your goals and objectives and your long- and short-term needs.
- Analyze the information to determine the feasibility of these goals, objectives and needs.
- Make a recommendation to help meet your financial goals.
- Provide good service year after year, by letting you know how your plan is performing relative to your objectives – it's a long-term relationship.

Article prepared by Northwestern Mutual with the cooperation of Diane Layton, a Financial Advisor with Northwestern Mutual Financial Network, the marketing name for the sales and distribution arm of The Northwestern Mutual Life Insurance Company (NM), Milwaukee, Wisconsin, its affiliates and subsidiaries. Financial Advisor is an agent of NM based in Estero, FL. Contact Diane Layton at 239-676-2309, e-mail her at diane.layton@nmfn.com. Web site at www.nmfn.com/dianelayton.



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HOW TO AVOID EMPLOYEE FRAUD & EMBEZZLEMENT

by Brett W. Nesbit, CPA, MBA, MSA, Principal in Charge, Rehmann Healthcare Advisors, a CCMS Preferred Vendor



Medical practitioners, including doctors, dentists, and other care providers, have long been an easy target for dishonest employees. Traditionally, medical professionals have had little training or awareness of embezzlement issues and fraud detection. As you might imagine, their focus has been on providing patient care, and the details about the money and the administration of the practice have left to others.

Left largely unchecked, employees of medical practices often have greater opportunities to commit and conceal fraud. Add to this the complicated billing codes and procedures, the ever-changing insurance reimbursements, and the proliferation of co-pays and write-offs, and medical providers are at an increased risk for fraud and abuse by employees.

There are many ways to embezzle money from a medical practice. The methods can be as simple as stealing a cash payment made by a patient, to as complex as overbilling an insurance company and stealing the excess funds.

Whatever the method of fraud, it often involves the manipulation of billing records and patient accounts. This can be accomplished with write-offs or alterations to account balances. However, the good news is this creates a paper trail which may later be discovered by anyone who examines the documentation.

It is helpful to get outside professionals involved in the management of the practice. An outside accountant can independently review the books in order to help look for improprieties. The accountant might also review high-risk accounts, such as a write-off account, to look for unusual activity or a high level of adjustments.

In our judgment, the best way for doctors, dentists and other medical providers to reduce the instance of internal fraud is by becoming more actively involved in the administration of the practice and implementing reasonable but sound internal controls regarding the originating, approving, entering and documenting transactions. This doesn't mean that the medical professional should be keeping the books or examining each insurance reimbursement. It means that the owner of the practice must take a more active role in the oversight the practice's daily operations.

By making employees aware that you are taking an active role in overseeing the day-to-day accounting functions will improve employee integrity and reduce the risk of fraud.

Let them know that you're going to be examining bank statements, reviewing the numbers, and occasionally looking at detailed documentation.

Additional oversight should help reduce the risk of employee theft, because many employees will be deterred from committing fraud simply because they know someone is watching.

In closing, there are several reasons for the increased focus on internal control within the health care industry. First, there is a continuing belief among many individuals and groups that effective internal control is what ultimately safeguards a practice's assets from fraud, illegal acts, or other transgressions by employees. Because of the frequency of such events and the huge potential dollar amounts of resulting losses, the health care community should demand more scrutiny within their profession.

Rehmann Advisors are speaking on the topic of employee fraud at an April 12th seminar for CCMS members. Discover more about the seminar in the "Calendar of Events" on page 5.

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Clifford Medical Billing helped us streamline the reimbursement process by reducing coding errors which led to a reduction in returned or unpaid claims. — James J. Talano, MHA, Administrator, SWICFT Institute

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SPOTLIGHT ON NEW MEMBER

FLORIDA GROWN: HOW DR. CARLOS PORTU IS CONNECTING GENERATIONS

by Mollie Page

For many physician members, juggling work and family is a talent that demands careful coordination of schedules and a very supportive staff and family. When I interviewed Dr. Carlos Portu, he was three days away from expecting his first child.

Now the proud father of a beautiful 8-lb, 3-oz baby girl, Hadley Rae, born at 5:17pm on Friday, February 20, Dr. Portu is one of the new generation of physicians that will rely on technology to capture and coordinate his life.

Dr. Carlos Portu was born and raised in Ft. Lauderdale. The second son of Cuban immigrants, the entire family now lives on Marco Island. His brother commutes to Miami everyday to his job in Homeland Security, and his parents are happily retired and ready to spoil their newest grandchild.

“My father loves to fish Cape Romano,” said Dr. Portu, who adds that on most weekends, the Portu family enjoys some sort of boating or fishing activity together.

A graduate of the University of Miami, Dr. Portu is board certified in Internal Medicine and began his career as a director for the Mitchell K. Wolfson Sr. Department of Community Service, where he helped develop and implement innovative modalities for improving the health and wellness for over 2,000 underserved residents living in Miami each year.

Dr. Portu was a hospitalist at Baptist Hospital in South Florida before he came to Physicians Regional Medical Group in January 2011. The majority of his patients are over 60 years of age.

Looking around Dr. Portu’s office, it became apparent that he likes technology (see cover image). With a desktop, tablet and smart phone always within reach, Dr. Portu is embracing the digital revolution and has a strong grasp and opinion on how technology and medicine can be safely integrated. He also thinks the benefits of utilizing new technologies (see his contributions to the HIE article on page 18) can help both doctor and patient.

“When I did training at a VA Hospital in Miami, it was completely paperless,” said Dr. Portu. “Having to go back to using paper charts and the old system of faxing and waiting was frustrating.

I’m really eager to see this HIE system get under way because it will greatly improve my patients’ care. Many of them are at a point in life where they require attention from multiple specialists and we, as doctors, must have access to real-time data in order to make decisions and in many cases intervene before a life-threatening issue arises.”

For his patients, Dr. Portu likens himself as being their quarterback. He has a calm demeanor and genuine smile; two qualities alone that probably explain why the majority of his new patients come from word-of-mouth.

He recently completed a Hyperbaric Oxygen Chamber Certification for Wound Care and has first-line access to refer patients to six ongoing studies within the Medical Group. The studies provide some cost coverage for patients and are for the following conditions/diseases: Rheumatoid Arthritis, Diabetes, Angina, Post MI, Depomed Post Herpetic Neuralgia, and COPD.

Dr. Portu is also very excited that his medical group is looking into opening a clinic on Marco as early as this summer.

“Being able to serve my patients living in Marco and being closer to my family would be great,” said the new father.

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HEALTH-CARE REFORM: CONSIDERATIONS FOR EMPLOYERS

by Peter Montalbano, CFP®, Director-Wealth Advisor, Harris Private Bank, a CCMS Preferred Vendor

You may have heard that the health-care reform legislation passed in 2010 requires all employers to provide health insurance to their employees. That is not the case. But the law does try to encourage employers to offer health insurance by imposing penalties on larger employers that don't offer affordable health insurance coverage, and by offering incentives in the form of tax credits to smaller employers who do provide their workers with affordable health-care coverage.

GRANDFATHERED PLANS

Employer plans that were in existence on the date the health-care law was enacted (March 23, 2010) are considered grandfathered and are subject to some of the provisions of the health-care reform law. Provisions of the new law that affect grandfathered plans include:

STARTING IN 2010...

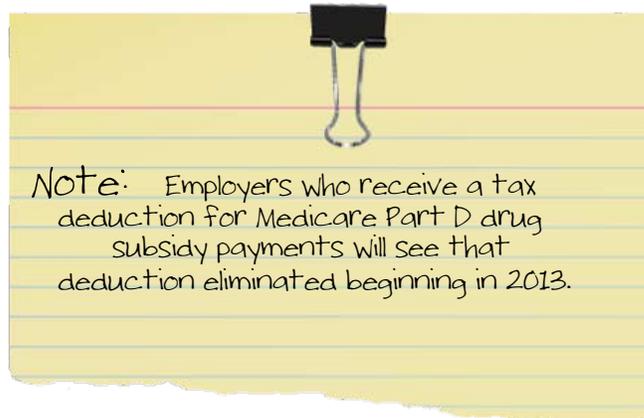
- Plans must extend dependent care coverage (if offered by the plan) to adult children up to age 26
- Plans can no longer impose lifetime coverage limits
- Plans can no longer include pre-existing condition exclusions for children

STARTING IN 2014...

- Plans can no longer apply annual limits on coverage
- Plans can no longer impose pre-existing condition exclusions for adults
- Plans cannot extend coverage waiting periods beyond 90 days

TAX PENALTY BEGINS IN 2014

Beginning in 2014, large employers that do not offer health insurance coverage to employees will generally be subject to a tax penalty if even one full-time employee buys coverage through a state exchange and is entitled to a tax credit or cost-sharing reduction. You're considered a large employer if, in the prior year, you had an average of at least 50 full-time employees. (The rules for calculating average full-time employees can be a little tricky though.



Part-time employees are factored in as part of the determination, for example.) The penalty can be up to \$2,000 per year for every full-time employee after the first 30 full-time employees.

If you're a large employer and do offer health insurance coverage to your employees, but the coverage isn't considered affordable, a separate penalty calculation applies--this penalty can amount to up to \$3,000 per year for each employee who purchases health insurance coverage through a state exchange and is entitled to a tax credit or cost-sharing reduction, but it's capped at the amount of penalty that you would pay if you offered no insurance coverage at all. The coverage you provide may be considered unaffordable if it doesn't cover at least 60 percent of the cost of covered services, or the premium for an employee's coverage exceeds 9.5 percent of the employee's household income.

SMALL BUSINESS TAX CREDIT

The health-care reform law does provide an incentive in the form of tax credits to certain small businesses (generally those with fewer than 25 full-time employees) that pay at least half the cost of health insurance for their employees.

The credit is available in two phases. For years 2010 through 2013, the maximum credit can be up to 35 percent (25 percent for eligible tax-exempt small employers) of the employer's premium expenses. For tax years 2014 and later, the maximum credit increases to 50 percent for employers that purchase coverage for employees through a state exchange (35 percent for eligible tax-exempt employers).

...continued on next page

To be eligible for the maximum tax credit, the employer must have 10 or fewer employees and average annual wages not exceeding \$25,000. The credit is phased out for employers with between 10 and 25 full-time employees, and for employers whose full-time employees have average annual wages between \$25,000 and \$50,000. In addition, the credit is capped based on the average cost of health insurance in the area where the small business is located.

RETIRED EMPLOYEE REIMBURSEMENT

Employers who provide insurance for retired employees who are over age 55 but not yet eligible for Medicare may receive reimbursement for up to 80 percent of the combined retiree claims costs for health benefits between \$15,000 and \$90,000. This program is intended to make it easier for employers to provide coverage to early retirees. This temporary reinsurance program began in 2010 and is available until 2014, or the date when the funds allocated to the program are exhausted.

SHOP EXCHANGES TO BE ESTABLISHED IN 2014

Small businesses with 100 or fewer employees should be able to purchase health insurance through state-based Small Business

Health Options Program (SHOP) exchanges by 2014. The exchanges will offer at least four benefit categories of plans based on covering an increasing percentage of benefit costs, and allow employers to more easily compare plan prices and benefits. In 2017, states may elect to allow employers with more than 100 employees to buy coverage through SHOP exchanges.

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NEWS FROM THE HEALTH DEPARTMENT

VACCINATION GUIDELINES & REMINDER

by Laura Levine, MSN, RN., Collier County Health Department

The advent and global application of immunizations has changed the course of human mortality and morbidity and is often touted as one of the most successful public health interventions in history. When high percentages of a population are immune to a specific disease, the chances of contacting and infecting another non immune person are statistically lowered and disease is often contained. Although great reductions in vaccine preventable diseases have been realized in the United States and around the world, low rates of adult vaccine coverage, increases in global travel and immigration, and individual choices to decline available vaccinations requires diligence on the part of primary care providers and public health providers not only to assure individual patients are protected but to maintain adequate community immunization levels to prevent larger outbreaks.

Adult vaccination coverage rates remain low across the United States. *See box at right.*

Updated Advisory Committee on Immunization Practices (ACIP) recommendations (<http://www.cdc.gov/vaccines/recs/schedules/default.htm>) note the following routine vaccinations unless allergy or medical complications exist:

- Adults who are close contacts with children under the age of one year and did not receive a Tdap booster as an adolescent should receive one Tetanus, diphtheria and pertussis (Tdap) booster to assure continued immunity to Pertussis. Pregnant women should receive the vaccine at the end of pregnancy (> 20 weeks gestation) or prior to leaving the hospital after delivery.
- Seasonal vaccination against influenza is recommended for all persons over the age of 6 months.
- Both male and female adults under the age of 26 should receive 3 doses of Gardasil® which protects against human papillomavirus (HPV) and can decrease the risk of genital warts, and cervical anal and penile cancers later in life.
- Adults < age 60 who are newly diagnosed with diabetes should receive the three doses of Hepatitis B vaccine as soon as possible after diagnosis. Diabetics > age 60 should be provided the vaccine at the discretion of their healthcare provider.

Collier County Health Department encourages all physicians to routinely assess each client for gaps in vaccination coverage and advise patients of the importance not only for their own health but for the health of others in the community to receive all recommended vaccines. Many physicians have a wide range of vaccines in their office, however, some vaccines like Zostavax® are more difficult to obtain due to shortage or back order or require special storage and handling.

We encourage physicians to advise patients that routine child and adult vaccinations are available Monday through Friday at the Collier County Health Department. Childhood vaccines through age 19 are available at no charge through the Vaccines For Children (VFC) program. Adult vaccinations do have a charge but the Health Department also assists financially eligible patients to apply for vaccine assistance programs which can help offset this cost. Please call (239) 252-8207 for appointments.

2010 ADULT VACCINE COVERAGE RATES

ADULT VACCINE:	COVERAGE RATES:
Pneumococcal	
High risk age 19-64	18.5%
Age > 65	59.7%
Hepatitis A > 2 doses	10.7%
Hepatitis B > 3 doses	42%
Tetanus	
Age 19-49	64%
Age 50-64	63.4%
Age > 65	53.4%
Tdap Adults 19-64	8.2%
HPV > 1 dose	
Women age 19-26	20.7%
Males age 19-26	< 1%
Zoster Age > 60	14.4%

CDC, *Morbidity and Mortality Weekly Report*, February 3, 2012/61(04); 66-72

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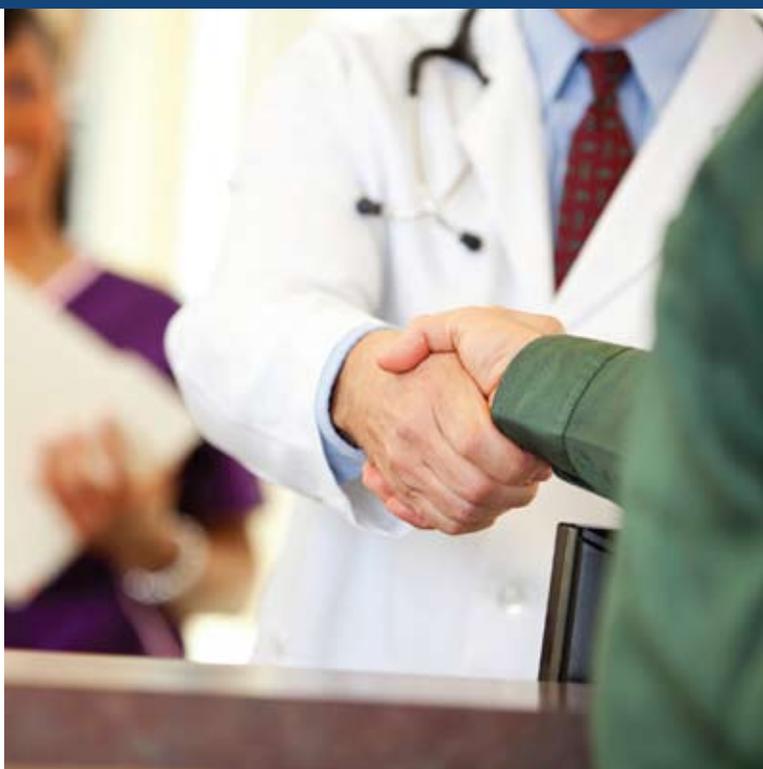
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PHYSICIAN OWNED DISTRIBUTORSHIPS (PODS)

by Jeffrey L. Cohen, P.A., The Florida Healthcare Law Firm

Physician owned distributorships (PODs) have been the source of considerable controversy for years, but now they've caught the attention of Congress!

PODs distribute various things, most commonly surgical implants and devices, that are reimbursed by insurers. A patient needs a spinal rod, a surgical implant/device company makes it and a distributor rep distributes it. Device/implant companies usually contract with distributorships to sell their products. Distributorships contract with reps who are paid commissions for sales. Surgeons, who actually order the devices, sometimes think "Since I'm the one doing the surgery and ordering all this stuff, why don't I make something from the selling it?" PODs are one way for physicians to financially benefit from the sales of devices and items their patients need, but they have never been more controversial than now.

Conceptually speaking, PODs are controversial because government regulators think physicians who have an economic stake in health care items or services will tend to over utilize them. Moreover, there is a specific concern that allowing physicians to profit from the devices their patients need violates federal anti kickback laws or the Stark prohibition on compensation arrangements.

In 2006, the Office of the Inspector General of HHS and CMS expressed major concerns about PODs, and cited concerns about "improper inducements." At that time, the OIG stopped short of prohibiting them, but called for heightened scrutiny. CMS itself has stated that PODs "serve little purpose other than providing physicians the opportunity to earn economic benefits in exchange for nothing more than ordering medical devices or other products that the physician-investors use on their own patients."

Implantable medical devices are unusual in the way they come into use. Unlike DMEPOS, for instance, medical devices are not sold to distributors. They're sold from the manufacture to the medical facility where the surgery will take place. So, the argument goes, physicians are not actually in a position to drive the sales volume of the implants. The counter: physicians invested in a POD can leverage their hospital admissions to influence the device choice of hospitals and surgery centers.

The biggest legal hurdle for PODs is the federal Anti Kickback Statute, which carries both criminal and civil penalties. Simply put, if even one purpose of an arrangement is to pay for patient referrals, the law is violated. So, the law is arguably violated if one purpose of the POD is to induce physicians to order implants for their patients. Looked at another way, the law is

violated if one purpose of a hospital doing business with a POD is to ensure patient referrals by the physician POD investors.

A 1989 OIG Special Fraud Alert on fraudulent physician joint ventures is especially interesting on the fraud and abuse issues in pointing out that the following would indicate unlawful intent to induce patient referrals—

INVESTOR CHOICE

If the only investors chosen are surgeons with an opportunity to refer and if they lack any business or management expertise, the arrangement appears to be a cloaked way to incentivize unlawful referrals (i.e. ordering implants). The key question is whether the business, in selecting investors, is looking to raise capital or to lock in referral sources.

RISK

If the POD investment involves little or no financial risk, the OIG would likely take issue with it.

The bottom line seems to be that if there isn't a real business, with real financial risk and qualified investors, a POD will likely be viewed as a suspicious arrangement based on locking in patient referrals or physician admitting pressure by physician investors.

In its June, 2011 Inquiry "Physician Owned Distributors (PODs): Overview of Key Issues and Potential Areas for Congressional Oversight," the U.S. Senate Finance Committee Minority Staff, the Committee reports "A number of legal and ethical concerns have been identified as a result of this initial inquiry into the POD Models." The Committee reviewed over 1,000 pages of documents and spoke with over 50 people in preparing its report. The Committee cited long-held concerns regarding PODs, and leaned heavily on the 2006 Hogan Lovells (previously Hogan & Hartson) law firm's anti-POD analysis.

With the Committee's call for greater OIG and CMS involvement, one thing seems clear: the future of PODs is uncertain. In this era of cost-cutting, it seems clear that PODs are gonna get a haircut and may even lose their head.

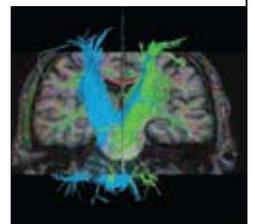
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Richard Pagliara, D.O., Editor
Eric Hochman, M.D., Associate Editor
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