New York Physicians Boost the State’s Economy

Physicians add opportunity, growth and prosperity to the New York economy by creating 688,760 jobs and generating $141.2 billion in economic activity, according to a new report, The Economic Impact of Physicians in New York, released today by the Medical Society of the State of New York (MSSNY) and the American Medical Association (AMA).

The study quantifies the economic boost that 60,444 New York physicians provide to the state’s economy, producing a ripple effect that is felt statewide. The study measures physicians’ impact using four key economic indicators:

- **Jobs:** Physicians support 688,760 jobs in New York – 11.4 for each physician on average.
- **Economic activity:** Physicians generate $141.2 billion in economic activity.
- **Economic output:** Physicians add $141.2 billion in economic output.
- **Tax revenue:** Physicians generate $27.3 billion in tax revenue.

See full story on page 5.

Council Notes - January 18, 2018

- Council discussed concerns over the proposed CVS takeover of Aetna. Specifically, they addressed the adverse implications for patients if this merger goes forward. The leadership is concerned with burdensome and excessive prior authorization barriers for prescription medications. There are also concerns with potential advancement of “minute-clinics” and patients being treated by non-physicians. The Council is wary of CVS’s ultimate intent. Following the discussion, Council approved the following resolution:

  MSSNY, along with other state medical society allies, will communicate our opposition to the Aetna/CVS merger to appropriate federal agencies. MSSNY will then communicate that information to the AMA, seeking that they take similar action in opposition to the merger.

- On behalf of MSSNY General Counsel Garfunkel Wild, Don Moy, Esq., addressed the question concerning whether a physician can consult the Prescription Monitoring Program Registry (PMP) to access the controlled substance history of a potential patient for the purpose of deciding whether to accept or decline the individual as a patient. Following an explanation regarding what a practitioner must attest to after accessing the PMP, Garfunkel Wild’s conclusion is as follows: “It appears that accessing the PMP to learn the controlled substances history of a potential patient, not for the purpose of diagnosis or (Continued on page 9)
By Andrew L. Zwerling, Esq.

It’s a common scenario. A medical practice hires a new employee to serve as an administrative assistant and, because it pays the employee an annual salary (for example, $35,000), rather than an hourly wage, assumes that it does not have to pay the employee any overtime. The employee is terminated 15 months later for performance issues, and then sues claiming that he or she was wrongfully classified as exempt employee and consequently denied overtime pay based on the allegation that the employee regularly worked an hour of overtime each day for 15 months. Because the medical practice had wrongfully classified the employee as exempt under the overtime laws, it had no payroll records to refute the employee’s overtime allegations.

The likely result: the medical practice will pay: 1) approximately 300 hours of back pay at time and a half for the denied overtime; 2) liquidated damages in the amount of the back pay; 3) the employee’s attorneys’ fees; and 4) statutory damages based upon wage notice violations. All told, the medical practice will likely pay the employee overtime dollars that will far surpass her annual salary. Moreover, the cost would be magnified exponentially if a class action or collective action was instituted against the employer on behalf of similarly situated employees.

The reason for such results rests in codified law. The federal overtime provisions in the Fair Labor Standards Act (FLSA) provide that, unless an employee is characterized as exempt, the employee must receive overtime pay for hours worked over 40 in a workweek at a rate not less than time and one-half their regular rates of pay. (New York State has its own overtime codified law.) The FLSA provides an exemption from overtime pay for employees employed as bona fide executive, administrative, professional and outside sales employees, and also exempts certain computer employees. To qualify for an exemption, however, employees generally must meet certain tests regarding their job duties and be paid on a salary basis. Significantly, job titles do not determine exempt status. In order for an exemption to apply, an employee’s specific job duties and salary must meet all of the requirements for such exemptions. For example, to qualify for the “Administrative Exemption,” the employee’s primary duty must be the performance of office or non-manual work directly related to the management or general business operations of the employer or the employer’s customers, and, very importantly, the employee’s primary duty must include the exercise of discretion and independent judgment with respect to matters of significance. If an employee is misclassified by the employer because any of the criteria are unsatisfied, then the employee must be paid overtime and a failure to do so will expose an employer to the outcome described above.

How does a medical practice avoid this painful scenario? Simply put, err on the safe side when assessing whether to classify an employee as exempt or non-exempt, meaning, when in doubt, classify that employee as non-exempt and therefore subject to the overtime laws. Moreover, don’t be penny wise and pound foolish. The cost of the brief time spent conferring with your attorney in determining a classification issue upon hiring an employee will represent a fraction of the cost of defending a wage and hour litigation.
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Why Should You Come to Albany on March 7?

This is your allotted time for a face-to-face with Health Committee Chairs and your own legislators.

You should feel compelled to come to our Annual Lobby Day because Government Affairs cannot do their jobs without some support from members. MSSNY needs a good showing to demonstrate to your own legislator that you care about your profession.

It shows your commitment and that you are part of an organization that is bigger than one practice. You are telling your legislators that physicians can unite on the most important issues as one force for the good of all.

Government Affairs goes to bat for you every day. On March 7, you should be in the line up! You and I have to make our case to the legislators about how difficult it is to deliver quality care in New York (the worst state in which to practice!).

When you come to Albany yourself, your legislator no longer doubts your commitment and that you are, in fact, the voice of MSSNY.

Join us to lobby your legislators to keep our issues in mind during this legislative session.

This year’s most pressing issues are to:

- Reject burdensome mandates that interfere with patient care
- Preserve opportunities for our medical students and residents to become New York’s future leaders
- Preserve choice of physicians for our patients
- Reduce excessive health insurer hassles that delay patient care
- Reduce the cost of medical liability insurance
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- Preserve choice of physicians for our patients

MSSNY-PAC

Clout at the Capitol Matters

While February is the shortest month of the year, it is also one of the busiest at the New York State Capitol.

Governor Cuomo recently released his proposed 2018-19 Executive Budget. His Budget proposal seeks to close a $4.4 billion Budget gap and has numerous proposals that impact the practice of medicine.

The enormous Budget deficit presents a significant challenge for our State, particularly at a time when continued federal funding for many programs is being threatened.

While there are some positive provisions in the proposed Budget, there are also several proposals of significant concern. These include proposals to expand the scope of practice of various non-physicians, and proposals to enable drug stores and grocery stores to open clinics staffed by physician extenders to deliver care to the public.

Scary? You bet it is.

The hallways of the Capitol will be bustling as lawmakers determine their own spending priorities and try to complete a $168 billion budget before the April 1st deadline. While MSSNY’s input is valued by many of our elected officials, various interest groups will also be lobbying for their respective interest, often diametrically opposed to the physician agenda.

Hearings will take place throughout the month on the various aspects of the Budget proposal. Protestors will be ever-present on the steps and in the halls of the Capitol.

Which makes our being visible more important than ever.

Like it or not, advocacy and political activism are essential to making a difference in Albany. MSSNY needs resources and activists like you to so that legislators will know our concerns, and take

(Continued on page 10)
As rates of physician employment by hospitals rise dramatically, costs for Medicare beneficiaries and programs may increase as a result of patients being seen in higher cost settings of care.

Physician Employment by Hospitals Increased Medicare Costs for Four Services by $3.1 Billion from 2012-2015

A 49 percent increase in physician employment by hospitals caused Medicare costs for four healthcare services to rise $3.1 billion between 2012 and 2015, according to a new study released by the Physicians Advocacy Institute (PAI).

The analysis, conducted by Avalere Health, shows that for four specific cardiology, orthopedic, and gastroenterology services, Medicare paid $2.7 billion more for services performed in hospital outpatient settings, with beneficiaries facing $411 million more in financial responsibility for these services than they would have if they were performed in independent physicians’ offices.

"Hospital consolidation pushes healthcare costs upward," said Robert Seligson, PAI president. "The impact of hospitals owning outpatient practices places a greater financial burden on Medicare beneficiaries and on taxpayers."

Researchers analyzed certain cardiology, orthopedic, and gastroenterology services and found that practice patterns for hospital-employed physicians resulted in up to 27 percent higher costs for the Medicare program and 21 percent higher costs for patients.

The study looked at practice patterns and found that physicians employed by hospitals deliver a higher volume of services in the more costly hospital outpatient setting than independent physicians.

Avalere researchers then analyzed how costs of care for patients treated by hospital-employed physicians would change if they had the same practice patterns as independent physicians in their geographic area, and assumed the same patients would receive the same procedures, just in a different setting. Once the costs were determined, researchers calculated the difference in costs to Medicare and costs shared by the patient.

(Continued on page 14)
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At Park Avenue
Size: 1228 - 37,579 SF +/- for lease

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Size: 1,500 - 18,602 SF +/- for lease

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Between 1st & Second Avenue
Size: 25,000 SF +/- for lease

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Size: 3,257 SF +/- for sale

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Size: 985 - 47,35 SF +/- for lease

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PRIME MEDICAL ON UPPER EAST SIDE
1041 Third Avenue
Between East 61st & East 62nd Street
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SUTTON AREA MEDICAL
333 East 57th Street
Between Fifth & Sixth Avenue
Size: 1,200 SF +/- for sale

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800A Fifth Avenue
At East 61st Street
Size: 950 SF, 1,860 SF & 4,293 SF +/- for lease

SMALL GEM ON FIFTH
1056 Fifth Avenue
Between East 86th & East 87th Street
Size: 678 SF +/- for sale

FABULOUS PARK AVENUE LOCATION
700 Park Avenue
Between East 69th & East 70th Street
Size: 1,800 SF +/- for sale

EAST END SURGERY SUITE
200 East End Avenue
Between 89th & 90th Street
Size: 4,770 SF +/- for sale

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Between CPW & Columbus Avenue
Size: 1,276 SF +/- for sale

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Diabetes affects more than 25 percent of Americans aged 65 or older, and its pervasiveness is projected to increase approximately two-fold for all U.S. adults (ages 18-79) by 2050 if current trends continue.

As part of ongoing work to reduce the incidence of type 2 diabetes nationwide, the American Medical Association (AMA) has commenced a multi-state effort to reach more of the estimated 84 million Americans who unknowingly live with prediabetes. MSSNY has proudly partnered with the AMA to launch this proactive initiative to educate New York State physicians on how to initiate clinical practice change and prevent diabetes in patient population. In addition, MSSNY is working to identify health systems, private and/or group practices who are interested in implementing the Center for Disease Control’s (CDC) National Diabetes Prevention Program.

The AMA and CDC have collaborated to create a comprehensive toolkit that can be utilized by both physicians and patients. The Prevent Diabetes STAT Toolkit incorporates resources to assist with engaging and educating healthcare teams and patients, as well as resources to help healthcare providers seamlessly incorporate screening, testing, and referral systems within their practice. The toolkit enables patients to leave the office with concrete information for later reference. For physicians, the toolkit provides references such as letter/email templates for practices to conduct efficient follow-ups and patient referrals, among other valuable information. To view or download the complete Prevent Diabetes STAT Toolkit, click [here](#).

“MSSNY’s partnership with the AMA is a key step towards making an immediate impact on the health of New Yorkers,” said Dr. Geoffrey Moore, Chair of MSSNY’s Preventative Medicine and Family Health Committee and a lifestyle medicine physician based in Ithaca, NY. “The Centers for Disease Control and the American Medical Association have developed a great educational toolkit and, through our partnership, we seek to extend the benefits of these tools to all physicians and patients throughout New York State.”

Meanwhile, Medicare has launched the Medicare Diabetes Prevention Program Expanded Model (MDPP) that will provide coverage and reimbursements for beneficiaries participating in DPP services beginning in 2018. In like manner, the New York State’s Department of Health’s Evidence Based Benefit Review Advisory Committee conducted a hearing on December 8th, 2017 to consider a proposal for DPP to be covered under Medicaid. The DOH has not yet released an official decision.

MSSNY is dedicated to educating the physician population on prediabetes and will be providing educational webinars and podcasts in the coming months. Further information about diabetes and the Prevent Diabetes STAT toolkit will be highlighted in the MSSNY Daily and E-News. Physicians are encouraged to visit our [Diabetes webpage](#) to learn more about MSSNY’s collaboration with the AMA and the Prevent Diabetes STAT toolkit.

Please contact Carrie Harring at [charring@mssny.org](mailto:charring@mssny.org) for more information and to express your interest in developing a partnership.

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From MLMIC: Texting Medical Orders Presents Serious Risks

The texting of medical orders remains a significant concern for patient safety. The Institute for Safe Medication Practices (ISMP) conducted a survey of readers from June through August 2017, to assess opinions about texting medical orders in healthcare. The ISMP authors’ findings noted, “Respondents reported that the five most concerning risks associated with texted orders were associated with safety issues impacting order clarity, completeness and correctness, rather than information security, authentication or documentation issues.”

These five risks are:
• unintended phone/device autocorrection;
• use of potentially confusing abbreviated text terminology;
• potential for patient misidentification;
• misspellings; and
• incomplete orders.

Although the technology of texting has become commonplace, the risk that it poses in healthcare precludes its use until such time as the associated safety and technological issues have been resolved. Additionally, The Joint Commission continues to ban the texting of medical orders in its accredited organizations, asserting that computerized provider order entry is the preferred method for submitting orders, as it allows providers to directly enter orders into the electronic health record.

To read an article from FierceHealthcare discussing the study findings, click here.
To read the ISMP Medication Safety Alert, click here.

From MLMIC: Phishing Email Disguised as HIPAA Audit Notification

On November 28, 2016, the U.S. Department of Health and Human Services issued an alert that a phishing scam email is being circulated on mock HHS departmental letterhead under the signature of Jocelyn Samuels, director of the Office of Civil Rights.

This email, which appears to be an official government communication to HIPAA covered entities, prompts recipients to click a link regarding possible inclusion in the HIPAA audit program. The link connects to a non-governmental website marketing a firm’s cybersecurity services.

HHS warns covered entities that this is a serious misuse of government authority. In the event that your organization has a question as to whether it has received an official communication regarding a HIPAA audit, HHS asks you to contact it directly via email at OSOCRaudit@hhs.gov.

MSSNYPAC Is for Everyone!

We urge you to support our efforts. You can do it right now by clicking here and making a donation to MSSNYPAC.

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Dr. David M. Mastrianni

Lessons Learned: Stories from the Oncology Unit tells the fictional stories of the patients seen during a day in an oncology unit interwoven with nonfictional essays about the history of medicine and the remarkable advances in oncology treatments. The author, Dr. David M. Mastrianni, is an oncologist in Saratoga Springs and Clinical Associate Professor at Albany Medical College.

Cancer medicine is in the midst of tremendous change as traditional chemotherapy is being replaced with new “targeted” molecular treatments based on dramatic scientific advances. This era offers our patients new hope mixed with the realities of cancer and the human condition. The book tells the fictional stories of the patients seen on one day in our office. The descriptions of their lives and cancers are intermixed with non-fictional explanations of the diseases, medical history and new science. The format is loosely based on the “case-history” style of teaching we use for medical students and is written at the level of a well-educated layperson. I hope this work will appeal to others in the medical field, including non-oncology physicians, nurses and those in research. Some patients and their families might find it interesting. I will inflict it upon our students.

The book is available on Amazon in paperback and will soon be on Kindle.

Council Notes - January 18, 2018

(Continued from page 1)

• Kate Kirley, MD, MS, Director of Chronic Disease Prevention at the AMA, presented Diabetes Prevention: Clinical and Payment Considerations. As part of ongoing work to reduce the incidence of type 2 diabetes nationwide, the AMA has launched a multi-state effort to reach more of the estimated 84 million Americans who unknowingly live with prediabetes. MSSNY has partnered with the AMA to launch this proactive initiative to educate New York State physicians on how to initiate clinical practice change and prevent diabetes in patient population. If your practice is interested in implementing the program, please contact Pat Clancy: pclancy@mssny.org or Carrie Harring: charring@mssny.org.

• Speaker Kira Geraci-Ciardullo, MD, announced details regarding MSSNY’s 2018 House of Delegates in Buffalo, which include the following:
  • NYS Health Commissioner Howard Zucker, MD, JD will open the House at 8 am on Friday morning, March 23.
  • Dr. Andrew Gurman, AMA Immediate Past President, will address the House at 8am on Saturday, March 24.
  • Elections for AMA Delegates will be held at 7 am on Sunday, March 25.
Resolutions due to MSSNY at 5 pm on February 9.

For Advertising Opportunities with MSSNY Contact: Christina Southard
csouthard@mssny.org or 516-488-6100 x 355

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The specialists represented have included cardiologists, general surgeons, gynecologists, interventional cardiologists, neurologists, ophthalmologists, orthopaedic surgeons, psychiatrists, and urologists.

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MSSNY IN THE NEWS

• Long Island Business News – 12/05/17
  Doctors raise concerns over CVS buy of Aetna (MSSNY President Dr. Charles Rothberg, MD quoted)

• Crain’s Health Pulse – 12/05/17
  NY medical society pans $69B CVS-Aetna deal (MSSNY President Dr. Charles Rothberg, MD quoted)

• News 10 Albany (ABC Affiliate) – 12/06/17
  Local surgeons discover deficiencies in NY hospital (MSSNY mentioned)

• Bloomberg Law – 12/07/17
  CVS-Aetna Merger Could Face N.Y. Obstacles (MSSNY President Dr. Charles Rothberg, MD quoted)

• NB Herald – 12/07/17
  Antonio Alfonso, MD, quoted)

• Albany Times Union – 12/11/17
  UB Med School facility has shining potential (MSSNY President-elect Dr. Tom Madejski quoted)

• Who's Who (MSSNY member Antonio Alfonso, MD, presented with the Albert Nelson Marquis Lifetime Achievement Award by Marquis)

• WGRZ Buffalo – 12/11/17
  SightMD Announces New Ophthalmology Office In Huntington (MSSNY member Dr. Craig Richter, MD quoted)

MSSNY-PAC

(Continued from page 4)

action to resolve these concerns.

MSSNYPAC allows us to pool our resources together to help elect candidates for office that can help make a difference in protecting our ability to deliver quality health care.

Every member of MSSNY has an opportunity to get involved in one form or another. Whether you’re in independent practice or you work for a large group or institution, your future depends on a strong MSSNY and MSSNYPAC.

When the medical community takes the time to participate in the policy making process, we really can make a difference.

So when you can do?

First, please plan to join us ub Albany on Wednesday March 7, 2018, for MSSNY’s Annual Physician Advocacy Day. It is essential for legislators to see hundreds (thousands?) of white coats walking the State Capitol to know what they do in Albany will have impact on our patients, and their constituents, back home. To register, click here.

Second please make it a point to join our Physician Advocacy Liaison Network, to commit to maintaining ongoing contact with your local legislators. When tough votes happen, a key grassroots contact can often make a difference in the outcome! To join us, please contact jbelmont@mssny.org

Last but certainly not least, please join MSSNYPAC. Many physicians are members, but nowhere near what we need. What is challenging is that physician PACs are routinely outspent by the PACs from those whose agendas are often opposite of ours. We need to change that dynamic!

If you are already a member, we thank you and urge you to increase your contribution and to push your colleagues to join. Click here to join today.

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- Support calls
New York Physicians Boost the State’s Economy

In New York was 688,760; the average physician supported 11.40 jobs in the economy, including his or her own.

Wages and Benefits

Compensation (i.e., the wages and benefits that are paid to local residents) is also an important measure of an industry’s value to the local economy. The value of direct wages and benefits in New York includes compensation paid to physicians and non-physician staff who are on payroll. This direct amount of wages and benefits totaled to $51,990.1M in the state in 2015. The total amount of wages and benefits supported by patient care physicians in New York was $78,176.0M (including the indirect wages and benefits supported by the industry), or an average of $1,293,362 per physician.

Taxes

The total tax contribution is computed by summing taxation on employee income, proprietor income, indirect business interactions, households, and corporations. Tax revenues are included from the patient care physician industry (direct) and from other affected industries (indirect). These are the “total” tax revenues supported by the industry.

The state and local taxes incorporated in this study include:

- Social Insurance taxes: the state portions of social insurance taxes, including both the employee and employer-paid portions (e.g., retirement plans, workers’ compensation, and temporary disability insurance);
- Personal taxes: state and local income taxes, gift and estate taxes, motor vehicle taxes/fees, fishing/hunting and other license fees, property taxes, personal property taxes, and other fines/fees or donations;
- Business taxes: corporate profits and dividends taxes; and
- Indirect business taxes: property taxes, sales taxes, motor vehicle licensing, severance taxes, non-tax payments (e.g., rents and royalties, special assessments, fines, settlements and donations), and other taxes (including business licenses, documentary and stamp taxes).

The aggregate local and state taxes generated by patient

(Continued from page 1)

Table 1: Total Output, Jobs, Wages & Benefits, and State and Local Taxes Supported by Physicians in New York, 2015

<table>
<thead>
<tr>
<th>Economic Measure</th>
<th>Total</th>
<th>Per Physician</th>
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<tbody>
<tr>
<td>Number of Physicians</td>
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<tr>
<td>Output</td>
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<td>Jobs</td>
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<td>11.40</td>
</tr>
<tr>
<td>Wages &amp; Benefits</td>
<td>$78,176.0 million</td>
<td>$1,293,362</td>
</tr>
<tr>
<td>State and Local Taxes</td>
<td>$7,346.1 million</td>
<td>$121,536</td>
</tr>
</tbody>
</table>

(Continued on page 13)
NY Physicians Boost State’s Economy

(Continued from page 12)
care physicians in 2015 totaled $7,346.1M, or an average of $121,536 per physician.

Broad Specialty

Due to likely variation between specialties, we examined economic impacts across three broad specialty groups (primary care, non-surgical and surgical) (Table 2).

Table 2: Total Economic Impact of Physicians in New York, by Broad Specialty

<table>
<thead>
<tr>
<th>Broad Specialty</th>
<th>Number of Physicians</th>
<th>Output ($ in millions)</th>
<th>Jobs $52,017.9</th>
<th>Wages &amp; Benefits $29,354.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>22,342</td>
<td>$52,017.9</td>
<td>264,000</td>
<td>$29,354.7</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>29,604</td>
<td>$67,327.4</td>
<td>322,394</td>
<td>$36,576.2</td>
</tr>
<tr>
<td>Surgical</td>
<td>8,498</td>
<td>$21,900.7</td>
<td>101,596</td>
<td>$12,245.1</td>
</tr>
<tr>
<td>Total</td>
<td>60,444</td>
<td>$141,246.0</td>
<td>688,760</td>
<td>$78,176.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific Specialty</th>
<th>Number of Physicians</th>
<th>Output ($ in millions)</th>
<th>Jobs</th>
<th>Wages &amp; Benefits ($ in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology</td>
<td>3,401</td>
<td>$5,748.5</td>
<td>24,338</td>
<td>$3,972.1</td>
</tr>
<tr>
<td>Cardiology</td>
<td>2,498</td>
<td>$5,454.4</td>
<td>29,071</td>
<td>$3,414.3</td>
</tr>
<tr>
<td>Family medicine</td>
<td>3,817</td>
<td>$8,752.6</td>
<td>47,092</td>
<td>$4,905.5</td>
</tr>
<tr>
<td>General surgery</td>
<td>2,860</td>
<td>$4,186.7</td>
<td>21,836</td>
<td>$2,889.5</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>10,647</td>
<td>$18,333.3</td>
<td>100,054</td>
<td>$10,286.9</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>3,230</td>
<td>$7,124.3</td>
<td>36,348</td>
<td>$4,160.7</td>
</tr>
<tr>
<td>Orthopaedic surgery</td>
<td>1,569</td>
<td>$5,235.1</td>
<td>25,438</td>
<td>$2,782.2</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>6,390</td>
<td>$11,211.2</td>
<td>63,032</td>
<td>$6,094.2</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>5,059</td>
<td>$8,093.4</td>
<td>35,995</td>
<td>$4,401.5</td>
</tr>
<tr>
<td>Urology</td>
<td>773</td>
<td>$2,274.5</td>
<td>10,288</td>
<td>$1,239.6</td>
</tr>
</tbody>
</table>

There were 22,342 physicians classified under the broad specialty of primary care (representing 37.0% of all patient care physicians), 29,604 physicians classified under non-surgical (representing 49.0%), and 8,498 physicians classified under surgical (representing 14.1%).

In each state, either primary care physicians or non-surgical specialties generated the highest output, jobs, and wages and benefits. This was partly due to physicians most often belonging to one of those two broad specialties and, for the most part, output, jobs, and wages and benefits were highest among the broad specialty with the most physicians in a state. In each state, surgical specialties generated the lowest output, jobs, and wages and benefits related to a smaller number of surgical specialists. In New York, total output across broad specialties ranged from $21,900.7M for surgical to $67,327.4M for non-surgical. Total jobs ranged from 101,596 for surgical to 100,054 for internal medicine. Total wages and benefits ranged from $21,900.7M for surgical to $67,327.4M for non-surgical.

10 Specialties

Lastly, we examined the economic impacts for 10 specialties (Table 3). In New York, the number of patient care physicians ranged from a low of 773 for urology to a high of 10,647 for internal medicine.

For the most part, state-level economic impacts were lowest among urologists and, in general, highest among family medicine and internal medicine specialists. One driver of this observation is specialty size. Those specialties often had the fewest and greatest numbers of physicians, respectively. In New York, total output across the 10 specialties ranged from $2,274.5M for urology to $18,333.3M for internal medicine. Total jobs ranged from 10,288 for urology to 100,054 for internal medicine. Total wages and benefits ranged from $1,239.6M for urology to $10,286.9M for internal medicine.

To view the full report and an interactive map, please visit www.PhysiciansEconomicImpact.org.

5 For ease of reading, “wages and benefits” is used to mean salaries and wages plus other forms of compensation paid to employees. Values include wages and benefits to all support staff, non-physician practitioners and physicians.

CMS Signature Requirements

By Lorna Simons, CPC, Medco Consultants, Inc

How do you know if the signature on your health records is valid? Before working in medical coding, I had assumed that all signatures, even those ill-defined, were valid. We all know too well the jokes about doctor’s handwriting. However, the Center’s for Medicare and Medicaid Services (CMS) has certain requirements for physician signatures to be valid.

Signatures can be either handwritten or electronic. Signature stamps are only permissible if the provider suffers from a physical disability and can prove that they are incapable of signing a patient note due to disability.

Handwritten signatures must be legible. If the signature is not legible, it should be accompanied by the provider’s name either printed, typed or on the letterhead. Providers may have a signature log on file with their name typed and signed to show that the signature is their own or attest their signature if required for purposes of review.

Electronic signatures must protect against modification and have certain administrative safeguards. Once the note is signed with the electronic signature, the note should be locked and any changes and updates would have to be made with addendums. If the system does not protect the notes against modification, then the signature is invalid. Electronic signatures can be digitized (the provider’s signature in an electronic image) or statements indicating the note was signed electronically. The signature usually has a date and time stamp. It is important to note that as per the guidance provided by Palmetto GBA, “Indication that a document has been ‘signed but not read’ is not acceptable...”

It is important to remember that signatures are required to authenticate treatment/surgical notes, procedures and orders for diagnostic testing and labs. The signature must be by the treating or ordering healthcare provider.

SOURCES

Medicare Program Integrity Manual, Chapter 3.3.2.4- Signature Requirements, http://ow.ly/Tqjl30FsL0A

Complying with Medicare Signature Requirements, http://ow.ly/lOqD30fsKPh

Physician Employment by Hospitals Increased Medicare Costs

Beneficiary Financial Responsibility Was $411M Higher for Services Studied due to Hospital Employment of Physicians

Total Medicare Beneficiary Responsibility 2012-2015

<table>
<thead>
<tr>
<th>Service</th>
<th>2012-2015</th>
<th>Additional Cost due to Physician Employment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diag Card Cath (Cardiology)</td>
<td>$40,700,000</td>
<td></td>
</tr>
<tr>
<td>Echocardiogram (Cardiology)</td>
<td>$150,500,000</td>
<td></td>
</tr>
<tr>
<td>Arthrocentesis (Orthopedic Surgery)</td>
<td>$9,400,000</td>
<td></td>
</tr>
<tr>
<td>Colonoscopy (Gastroenterology)</td>
<td>$51,000,000</td>
<td></td>
</tr>
</tbody>
</table>

Additional Cost due to Physician Employment:
- Increased Cost to Medicare Beneficiaries
- Percent Increase to Medicare Beneficiaries

Note: Study adjusts for geographic practice pattern differences when comparing employed vs. independent physicians.

(Continued from page 5)

"This study underscores the fact that independent physicians continue to provide patients with affordable, quality care every day," noted Kelly Kenney, executive vice president and CEO of PAI.

PAI is examining these trends as part of an ongoing effort to better understand how physician employment affects the practice of medicine and impacts patients.

Click [here](http://www.libertymutual.com/mssny) to read the entire study.

<table>
<thead>
<tr>
<th>OBITUARIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGBAN, Galaa M.; Fairport NY. Died December 01, 2017, age 83. Monroe County Medical Society</td>
</tr>
<tr>
<td>Auerbach, Robert; Sag Harbor NY. Died November 08, 2017, age 85. New York County Medical Society</td>
</tr>
<tr>
<td>de FEO, Charles P.; New York NY. Died December 12, 2017, age 92. New York County Medical Society</td>
</tr>
<tr>
<td>delahanty, Donald W.; Rochester NY. Died November 04, 2017, age 92. Cayuga County Medical Society</td>
</tr>
<tr>
<td>Harrison, Raymond; Winchester MA. Died November 19, 2017, age 92. New York County Medical Society</td>
</tr>
<tr>
<td>hauser, a. daniel; new york NY. Died November 09, 2017, age 89. New York County Medical Society</td>
</tr>
<tr>
<td>israel, Jacob S.; New York NY. Died November 06, 2017, age 91. New York County Medical Society</td>
</tr>
<tr>
<td>licalzi, Luke K.; Garden City NY. Died December 10, 2017, age 68. Nassau County Medical Society</td>
</tr>
<tr>
<td>potter, Paul H.; Buffalo NY. Died March 13, 2017, age 84. Erie County Medical Society</td>
</tr>
<tr>
<td>Quash, Eugene Telfer; new york NY. Died December 03, 2017, age 96. New York County Medical Society</td>
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<tr>
<td>reichman, Stanley; new york NY. Died December 21, 2017, age 91. New York County Medical Society</td>
</tr>
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<td>stubenbord, John Charles; East Aurora NY. Died October 23, 2017, age 70. Erie County Medical Society</td>
</tr>
<tr>
<td>Zuckerman, Marvin B.; Boynton Beach, FL. Died December 17, 2017, age 89. New York County Medical Society</td>
</tr>
</tbody>
</table>

[1] Discounts and savings are available where state laws and regulations allow, and may vary by state. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify. Coverage provided and underwritten by Liberty Mutual Insurance and its affiliates, 175 Berkeley Street, Boston, MA 02116. ©2015 Liberty Mutual Insurance. Valid through February 24, 2016.
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MSSNY House of Delegate attendees are decision makers. They represent the full spectrum of New York State medical professionals, including all specialties and sub-specialties. These attendees represent the specific interests of group medical staffs, small practices, IPAs and single practitioners. County medical societies and specialty societies also participate in the deliberations, and send members of their executive staffs to seek out and recommend new and improved benefits for their members.

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Physician learners will be able to:

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- Describe a major benefit of Peer Support programs;
- Recite two key organizational interventions to reduce burnout;
- Describe actions on a national level that can be done to help the practice of medicine locally.

Presented by:

MSSNY Physician Burnout Taskforce

Presenters:
- Michael R. Privitera, MD, Chair of the MSSNY Task Force on Physician Stress and Burnout
- Arthur Hengerer, MD, Member of National Academy of Medicine Action Collaborative on Physician Burnout

Panelists:
- Frank Dowling, MD, Psychiatry, Member of MSSNY Burnout Task Force
- Caroline Gomez-DiCesare, MD, Internal Medicine/Pediatrics, Member of MSSNY Burnout Task Force
- Fouad Ataliah, MD, OB/GYN, Member of MSSNY Burnout Task Force

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