Effective Immediately: Marijuana Can Be Prescribed for Chronic Pain

On July 12, the New York State Department of Health announced the filing of emergency regulations adding any condition for which an opioid could be prescribed as a qualifying condition for medical marijuana. Effective immediately, registered practitioners may certify patients to use medical marijuana as a replacement for opioids, provided that the precise underlying condition for which an opioid would otherwise be prescribed is stated on the patient's certification. This allows patients (Continued on page 11)

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Are Insurance Companies Following the New STEP Therapy Law?

MSSNY supported the enactment of this law, which is applicable to all NY-regulated health plans as of January 1, 2018. It requires ALL NY-regulated health insurers to grant an override of its step therapy protocol upon receipt of information from the physician “that includes supporting rationale and documentation” that the drug(s) being required by the health insurer:

- Is contraindicated or will likely cause an adverse reaction by physical or mental harm to the patient;

(Continued on page 6)

Are Potential Earnings Influential in Specialty Choice?

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<th>Category</th>
<th>Total</th>
<th>Women</th>
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<td>Extremely/Very influential</td>
<td>41%</td>
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Slightly over two-fifths (41%) of residents indicated that future earnings are extremely or very influential in their specialty choice, compared with 98% in 2017. More men (36% vs 33% of women) said that future earnings are extremely or very influential. Still, not everyone is influenced by income. "Potential earnings do not play a part in my specialty choice," says Gregory Pelc, a third-year resident at Indiana University School of Medicine’s internal medicine residency program. He has chosen to subspecialize in hospice and palliative medicine.

Medscape Residents Salary & Debt Report 2018

More charts on page 10.

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Medscape Residents Salary & Debt Report 2018

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(Continued on page 6)
Stakeholder Beliefs About the Future of Continuing Certification: Survey Findings

To inform decisions about the future of the American Board of Medical Specialties (ABMS) Member Boards’ Maintenance of Certification (MOC) programs, the Continuing Board Certification: Vision for the Future (Vision Initiative) Commission conducted an online survey to elicit feedback from three key stakeholder groups: physicians, non-physician providers and other stakeholders involved in the delivery of health care, and the general public. The survey provided an open forum for input.

SURVEY DESIGN - CONVENIENCE SAMPLE

The survey questions were developed by the Vision Initiative Planning Committee, which included representatives from ABMS, the Accreditation Council for Continuing Medical Education, Accreditation Council for Graduate Medical Education, Coalition for Physician Accountability, Council of Medical Specialty Societies, and Council on Medical Education of the American Medical Association, as well as public members. The survey included a combination of closed- and open-ended questions.

The survey was implemented using Survey Monkey, a popular online platform. Participants were invited to take the survey through a variety of means, which resulted in a convenience sample. The survey invitation was widely distributed to individuals and organizations who shared it with their staff and members. The organizations that helped promote the survey included the Council on Medical Specialty Societies, Specialty Society Chief Executive Officer Coalition and the American Association of Medical Society Executives, individual associations and state medical societies. The Vision Initiative Commission appreciates the support of all the organizations who distributed the survey invitation.

In total, 36,392 people participated in the survey, including 34,616 physicians, 1,373 non-physician providers and stakeholders involved in the delivery of health care, and 403 members of the general public. The physician survey included responses from all 24 ABMS Member Boards and all 50 states.

Important Note: While the survey includes more than 36,000 responses from across the three audiences, it used a convenience sample and is likely to reflect selection bias. However, the results are important for the Commission to consider and are consistent with previous feedback received by ABMS and its Member Boards.

SURVEY FINDINGS

Physician Findings

When asked if they value MOC, one in 10 physicians (12%) said they value the program, nearly half (46%) said they have mixed feelings about it, while 41 percent said they do not value the program.

The survey asked physicians about their concerns regarding the MOC program. Participants were allowed to choose up to four options from a set list. The most frequently cited response was “costs” (58%). “Burdensome” was next highest (52%), followed by “does not accurately measure my ability as a clinician” (48%). “Does not help me improve my practice in a meaningful way” (43%) was the fourth most popular response.

Physicians were also asked to select which activities from a set list should be considered by the Vision Initiative Commission for continuing certification. The most popular responses were “continuing medical education” (84%) and “self-assessment questions delivered at regular intervals” (52%). Less popular choices were “open-book exam” (34%) and “assessment of the quality and safety of care provided” (24%), among the other choices.

Of the physician respondents, 96% are Board Certified. Additionally, 69% of respondents noted they are currently enrolled in a primary specialty MOC program, and 33% are currently enrolled in a subspecialty MOC program. Sixteen percent are lifetime certification holders. These categories are not mutually exclusive. Finally, six percent are not enrolled in an MOC program or are a lifetime certificate holder.

In summary, approximately half of physician respondents see MOC as too costly, burdensome, and not a true reflection of their abilities as clinicians. Some physicians want continuing certification to focus on practice-relevant continuing medical education (CME) opportunities, self-assessment, open-book exams and quality of care assessments.

OTHER HEALTHCARE STAKEHOLDERS FINDINGS

When asked how familiar they are with the requirements that physicians must fulfill to maintain their Board Certification, 39% of stakeholders said they were “very familiar,” 46% said they were “somewhat familiar,” nine percent said “somewhat unfamiliar,” and five percent said they were “not at all familiar” with the requirements.

When asked if they consider Board Certification when selecting a physician, more than half of the stakeholder respondents (57%) said they always consider it, more than a quarter (27%) said they sometimes consider it, and 15% said they never consider it. Next, when asked if Board Certified physicians provide higher-quality care than non-Board Certified physicians, nearly six in 10 respondents (59%) believe they do; one in five (22%) didn’t know. One in five (19%) said Board Certified physicians don’t provide higher-quality care.

CONSUMER FINDINGS

When asked if they consider Board Certification when selecting a physician, more than half of the general public respondents (56%) said they always consider it, more than a quarter (28%) said they sometimes consider it, and 16 percent said they never consider it. Next, (Continued on page 16)
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Colleagues:

I recently attended a meeting at the Medical Society of the County of Erie in order to better understand the DEA’s role in audits and investigations of buprenorphine providers.

Representing the medical community at this meeting were: Gale Burstein, MD, Chair, Public Health Committee (MSCE) and Commissioner-Erie County Department of Health; Nancy Nielsen, MD, PhD, Senior Associate Dean for Health Policy, Medicine, SUNY at Buffalo; and Christine Nadolny, Executive Director-MSCE. Representing the DEA were: Edward Orgon, Resident Agent in Charge-US DEA, Joseph Cowell, Group Supervisor – US DEA Diversion Squad and Michael Cerezo, Group Supervisor, US DEA Tactical Diversion Squad.

There are two types of visits that a prescriber might receive from the DEA:
- Compliance Inspections and Audits: Compliance Inspection is a minimally-invasive visit to an office wherein the DEA representative interviews the provider and may check buprenorphine stock on hand. This is done unannounced, but we received assurances that the DEA does not “shut down the office” while this is taking place, is done in a very respectful manner and in a way that does not alert patients that the DEA is on the premises.
- Audits, which are normally only done after a compliance inspection and only if the DEA feels that a more thorough audit of the practice may be necessary.

According to Mr. Cowell (US DEA Diversion Squad), the only reason the audits are conducted is to ensure that buprenorphine is not being diverted onto the streets and prescribing physicians are employing all the prescribing protocols put forth by SAMHSA and state and federal regulations, which include:
- Verifying the prescriber’s credentials
- Checking on the number of patients under the prescriber’s care
- Ensuring that patients are monitored regularly during their treatment
- Verifying the ages of patients being treated
- Verifying the number of prescriptions being written v. number of patients

(Continued on page 17)

MSSNY-PAC

Transitioning to the Fall Elections

As those lazy, hazy crazy days of summer transition to falling leaves that drift past windows (calling out all you Nat King Cole fans), the fall elections will be upon us before we know it.

Legislators have long since scattered out of Albany to focus their attention on attempting to win re-election. As you may have seen, there is an intense battle underway for political control of the State Senate, which is currently narrowly divided with the GOP in control. The Governor is also running for re-election, and several candidates are vying to take the place of Eric Schneiderman as the next New York Attorney General.

Not to mention the likely several close races for seats in the US Congress across New York State.

CANDIDATES SEEKING FINANCIAL SUPPORT

As these candidates get ready to blanket the public with TV, radio, social media and print ads, many groups, including MSSNYPAC, have been

(Continued on page 12)
Is expected to be ineffective based on the known clinical history and conditions of the patient and his/her drug regimen; Has been tried by the patient or another prescription drug(s) in the same pharmacologic class or with the same mechanism for action and such drug(s) was discontinued due to a lack of efficacy or effectiveness, diminished effect or an adverse event; Should not be required because the patient is stable on a drug other than the drug being required by the insurer; or Is not in the best interest of the patient because it will likely cause a significant barrier to a patient’s adherence with his/her plan of care, will likely worsen a comorbid condition of the patient, or will likely decrease the patient’s ability to achieve or maintain reasonable functional ability in performing daily activities.

Health insurers must respond to a step therapy override request within 72-hours of the request. A health insurer is required to respond within 24-hours if the request is for a patient with a medical condition that places the health of the patient in serious jeopardy without the prescription drug or drugs prescribed by the patient’s physician. If the health insurer fails to act within these 72 or 24-hour time periods, the request will be granted in favor of the patient.

The new law also requires that health insurers’ step therapy protocols be based on evidence-based and peer-reviewed clinical criteria that also take into account the needs of atypical patients. These criteria must be made available to physicians upon request.

**RESOURCE LINKS:**
- Webinar: How to override a health insurer’s step therapy protocol
- Template for physicians/staff to use in requesting a step therapy protocol override
- File a complaint with the Office of the NY Attorney General

**New STEP Therapy Law**

**WC Board Announces Technical Specifications for CMS-1500 Initiative**

As announced on April 17, 2018, in Subject Number 046-1058 Proposals to Improve Medical Care for Injured Workers, the New York State Workers’ Compensation Board (Board) will replace the current Board treatment forms: Doctor’s Initial Report (Form C-4), Doctor’s Progress Report (Form C-4.2), Occupational/Physical Therapist’s Report (Form OT/PT-4), Psychologist’s Report (Form PS-4), and Ancillary Medical Report (Form C-AMR) with the CMS-1500 to help reduce paperwork and lower provider administrative burdens. This initiative will leverage providers’ current medical billing software and medical records while promoting a more efficient workers’ compensation system. It is expected that the initiative will roll out in three phases, as follows:

**PHASE 1: COMMENCING JANUARY 1, 2019:**
- Providers may voluntarily transmit CMS-1500 medical bills (and required medical narratives, and/or attachments as applicable) through an approved XML Submission Partner (“clearinghouse”) to workers’ compensation insurers/payers. Guidance on required medical narratives and attachments is available on the Board’s website. As previously conveyed in Subject (Continued on page 12)

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JOIN US for an exciting full-day clinical conference focusing on HIV prevention and care for women of all experiences. This conference will feature interactive presentations and panel discussions highlighting the vital role of medical providers in women’s health.

Registration is free of charge and required as seating is limited. This program is for New York State medical providers including physicians, physician assistants, nurse practitioners, nurses, certified nurse midwives, dentists, and pharmacists. Check back for CE updates!

Questions? Contact Jessica Steinke at 212-731-3789 or jessica.steinke@mountsinai.org
SIX MONTHS LATER

Six months later, the patient returned to the hospital’s ED complaining of a worsening cough with clear white sputum and tightening of the chest. The patient was admitted to the hospital by the co-defendant primary care physician. A CT scan was ordered and read by the same MLMIC-insured radiologist. There was a large mass in the right upper lobe to the right of the hilum with at least one hilar node and possible mediastinal node. The mass had no benign criteria. The radiologist noted that the possibility of an underlying neoplasm was greater than demonstrated on the prior film. This information was relayed to the attending. A MLMIC-insured pulmonologist was called in for consultation. He ordered blood work and a bronchoscopy to rule out lung cancer. A bronchoscopy, multiple biopsies and brushings were performed. They were negative for malignancy, although there were reactive bronchial cells present. The patient was worked up for a possible myocardial infarction, but her enzymes were negative. An EKG showed a borderline increase in the thickness of the left ventricular wall.

A PET scan was recommended, but was not available at the insured hospital. The patient was discharged from the hospital and advised to follow up with both the pulmonologist and her primary care physician. The final diagnosis at discharge was a right lung mass of unknown etiology, a tricuspid valve disorder, unspecified chest pain and a non-specific abnormal EKG. She was status post bronchoscopy and stress test.

The plaintiff initially demanded $1.5 million to resolve the lawsuit. However, the lawsuit was eventually settled for $675,000. Of that sum, the radiologist paid $540,000 and the pulmonologist paid $135,000.

PATIENT DID NOT RETURN

Five days after her discharge, the pulmonologist saw the patient. She now was having hemoptysis. Her pulmonary function tests showed mild COPD. He planned to perform a PET scan and obtain a thoracic surgery evaluation. However, the patient did not return to see him. Two months later, her primary care physician contacted the patient to determine why she failed to both undergo the PET scan and to keep two appointments with the pulmonologist. The pulmonologist also sent the patient a letter advising her of the medical necessity of undergoing the PET scan.

DIED FOUR YEARS LATER

Subsequently, the patient advised the pulmonologist that she was being treated by a thoracic surgeon. One week later, the PET scan was performed at another hospital. The findings of the scan were extensive hypermetabolic activity which occupied most of the right upper lobe of her lung. Although she was evaluated to see if a surgical resection of her lung would be beneficial, it was determined that the cancer was not resectable. The patient then underwent chemotherapy and radiation. However, the cancer metastasized and she expired four years later.

A lawsuit was initially commenced by the patient. After her death, her daughter, the administratrix of her estate, was substituted as plaintiff. A cause of action for wrongful death was added to the lawsuit in addition to medical malpractice.

The patient’s medical records were reviewed by MLMIC experts. The in-house emergency medicine expert opined that a discrepancy report should have been completed by the radiologist, since his reading differed from the x-ray reading by the ED physician. Hospital policy and procedure required this. Further, the ED staff never alerted the emergency physician who initially read the film of the abnormal reading.

The expert found that at the initial visit, there was no suspicion that the right upper lobe consolidation was cancer. The ED physician appropriately identified this area as a possible pneumonia, requiring antibiotics. However, the expert was very concerned that the radiologist failed to communicate with this ED physician to notify him that he had identified a potentially neoplastic lesion in the right upper lobe, which differed from the original reading by that emergency physician.

ED PHYSICIAN’S NAME NOT ON REPORT

Unfortunately, the name of the ED physician was not placed on the radiologist’s report. Rather, the report was addressed only to the “Emergency Room doctor.” As a result, no specific person received the report and it was filed in the patient’s record without being reviewed. Because the ED physician did not make the diagnosis of carcinoma based on this x-ray, the failure of the radiology department to communicate with this physician about this significant and potentially abnormal finding was extremely detrimental to the patient.

The MLMIC radiology expert who reviewed the original ED films found they showed a mass-like density with lobulated, rather sharply defined borders posteriorly in the right upper lobe of the lung. He agreed that, although this could represent pneumonia, this was more suggestive of a mass or com-

(Continued on page 18)
Enjoy member-only discounts and corporate rates on everything from pizza and the zoo, to movie tickets, car rentals, and hotels. With over 302,000 offers across 10,000 cities and easy mobile access, you’ll always have a reason to Celebrate Your Savings!

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Almost half of primary care residents said they plan to sub-specialize, 40% said they will work in primary care, and 14% indicated that they will specialize but are undecided about the specialty. These results are similar to last year’s.

Residents’ schedules are quite rigorous. Over one third of residents (37%) are logging more than 60 hours per week seeing patients, while almost one fifth (18%) are spending 51-60 hours per week. Only 12% are seeing patients 30 hours or less per week. In Medscape’s Physician Compensation Report 2018, over half of physicians (56%) reported that they spent 30-45 hours a week seeing patients.

Almost half (46%) of residents are performing 1-10 hours of scut work (defined as unskilled tasks) on a weekly basis. Over one quarter (28%) have 11 to 20 hours, while 12% are spending 21 to 30 hours a week on scut work.

Almost a quarter of male and female residents have no medical school debt. Almost one quarter of both male and female residents have over $300,000 in medical school debt.

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MSSNY Speakers Available to Address Groups Regarding Physician Burnout

The MSSNY Committee on Physician Wellness and Resilience offers resources to help address the increasingly serious challenge posed by stress and burnout in the medical profession. The Committee’s Speakers Bureau is pleased to offer presentations on the causes, effects and treatment of physician burnout. These were developed for three different audiences to provide insight and effective approaches that can be taken to address the problem.

If interested in scheduling a presentation for your medical staff, group practice, county medical society, residency program or other meeting, please contact sbennett@mssny.org to make arrangements.

Please specify which kind of presentation you are seeking:
- One geared for individual physicians, on ways to reduce stress
- One for health system administrators, on actions that can be taken to reduce institutional stressors
- One for other stakeholders, such as health insurers, malpractice carriers, etc.

The committee plans to enlist other MSSNY members to add to the ranks of possible presenters on this topic. We are grateful to have already heard from a number of volunteers. Plans are now being prepared to familiarize volunteers with our presentations, and committee representatives will be following up with all volunteers soon.

If you are interested in having one or more of our prepared presentations to your group or institution, and haven’t volunteered already, please email sbennett@mssny.org and we’ll include you as part of our Speaker’s Bureau on Physician Wellness and Resilience.
Marijuana Can Be Prescribed
(Continued from page 2)

with severe pain that doesn’t meet the definition of chronic pain to use medical marijuana as a replacement for opioids.

In addition, the regulation adds opioid use disorder as an associated condition. This allows patients with opioid use disorder who are enrolled in a certified treatment program to use medical marijuana as an opioid replacement.

Plans to add opioid replacement as a qualifying condition for medical marijuana were first announced in June. As of June 18, 2018, there are 59,327 certified patients and 1,697 registered practitioners participating in the program.

Opioid replacement joins the following 12 qualifying conditions under the state’s Medical Marijuana Program: cancer; HIV infection or AIDS; amyotrophic lateral sclerosis (ALS); Parkinson’s disease; multiple sclerosis; spinal cord injury with spasticity; epilepsy; inflammatory bowel disease; neuropathy; Huntington’s disease; post-traumatic stress disorder; and chronic pain.

The permanent regulations were published in the New York State Register on August 1, 2018, and will be subject to a 60-day public comment period. In addition, certified patients and designated caregivers will be able to print temporary registry ID cards. This will allow them to purchase medical marijuana products more quickly after registering for the program. Patients may use the temporary registry ID card in conjunction with a government issued photo identification to purchase medical marijuana products from a registered organization’s dispensing facility. Prior to this enhancement to the Medical Marijuana Data Management System, it could take 7 to 10 days for patients and their caregivers to receive their registry identification cards after their registration was approved.

Other recent enhancements to New York’s Medical Marijuana Program include adopting new regulations to improve the program for patients, practitioners and registered organizations; authorizing five additional registered organizations to manufacture and dispense medical marijuana; adding chronic pain and PTSD as qualifying conditions; permitting home delivery; and empowering nurse practitioners and physician assistants to certify patients.

As of July 10, 2018, there are 62,256 certified patients and 1,735 registered practitioners participating in the program.

For more information on New York’s Medical Marijuana Program, go here.

The following is the public list for physicians registered with the medical marijuana program: https://www.health.ny.gov/regulations/medical_marijuana/practitioner/public_list.htm

The report was issued by the DOH under the direction of Governor Andrew Cuomo, who directed NYS agencies to evaluate the health, public safety and economic impact of legalizing marijuana. The report, to MSSNY’s knowledge, did not involve any outside medical groups or organizations in making this assessment. A copy of the report can be found here.
Number 046-785, if a CMS-1500 is submitted without the detailed narrative report or office note, it is not a valid bill submission. A listing of approved clearinghouses for the CMS-1500 will be posted on the XML Forms Submission section of the Board’s website after each entity successfully completes testing and executes an XML Submission Partner agreement with the Board.

- Workers’ compensation insurers/payers will accept CMS-1500 medical billing files from clearinghouses and electronically return acknowledgments of receipt of CMS-1500 files. Such acknowledgements (including receipt date) will be forwarded from the clearinghouses back to providers and the Board.
- The Board will receive CMS-1500 files, narrative attachments and acknowledgements of receipt from clearinghouses in a designated XML format. The CMS-1500 forms and narrative attachments will be combined and displayed in the applicable claimants WCB case folders

**PHASE 2: ON OR ABOUT JULY 1, 2019:**

- Workers’ compensation insurers/payers will electronically transmit Explanations of Benefits (EOB) to their clearinghouses upon adjudication of the associated electronic CMS-1500 medical bills. Such EOB data will be forwarded from the clearinghouses back to providers and the Board.
- The Board will receive EOB data from clearinghouses in a designated XML format.
- The Board plans to eliminate the requirement for the insurer/payer to file Form C-8.1B or C-8.4 form (to object to full or partial payment of a medical bill) when an EOB for the medical bill was transmitted through the clearinghouse and the Provider may file Health Provider’s Request for Decision on Unpaid Medical Billing (Form HP-1) (based on receipt of EOB).

**PHASE 3: ON OR ABOUT JANUARY 1, 2020:**

- Providers will be required to submit electronic CMS-1500 medical bills (and required medical narratives, as applicable) through their clearinghouses to workers’ compensation insurers/payers and to receive EOBs back through their clearinghouse.
- Providers will be required to electronically transmit any disputes for unpaid medical bills to their clearinghouse using the Board-prescribed form. The clearinghouses will electronically transmit medical disputes to the Board in a designated XML format. The Board will eliminate Forms C-4, EC-4, C-4.2, EC-4.2, C-4.1, PS-4, C-4AMR, EC-4AMR, OT/PT-4, EOT/PT4 and EC-4NARR forms. Web submission and XML submission of these forms will no longer be available.
- The Board will establish a hardship exception process for providers who are unable to meet the mandatory electronic reporting requirements.
- Visit the CMS-1500 Initiative section of the website to access technical specifications for the CMS-1500 medical billing and associated acknowledgement data and to find periodic updates.

Please direct questions to CMS1500@wcb.ny.gov.
Workers’ Compensation Changes

In July, we informed you about significant changes being proposed by CMS for the physician fee schedule. The NYS Workers’ Compensation Board has listened to us and is intent on reducing physician burden and enticing more participation in its program.

The New York State Workers’ Compensation Board (Board) will replace the current Board treatment forms: Doctor’s Initial Report (Form C-4), Doctor’s Progress Report (Form C-4.2), Occupational/Physical Therapist’s Report (Form OT/PT-4), Psychologist’s Report (Form PS-4), and Ancillary Medical Report (Form C-AMR) with the CMS-1500 to help reduce paperwork and lower provider administrative burdens. This initiative will leverage providers’ current medical billing software and medical records while promoting a more efficient workers’ compensation system.

Beginning January 1, 2019, physicians may voluntarily transmit CMS-1500 medical bills (and required medical narratives, and/or attachments as applicable) through an approved XML Submission Partner (“clearinghouse”) to workers’ compensation insurers/payers. Guidance on required medical narratives and attachments is available on the Board’s website. If a CMS-1500 is submitted without the detailed narrative report or office note, it is not a valid bill submission. A listing of approved clearinghouses for the CMS-1500 will be posted on the CMS Forms Submission section of the Board’s website after each entity successfully completes testing and executes an XML Submission Partner agreement with the Board.

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The Board will receive CMS-1500 files, narrative attachments and acknowledgements of receipt from clearinghouses in a designated XML format. The CMS-1500 forms and narrative attachments will be combined and displayed in the applicable claimants WCB case folders.

MSSNY’s Committee on Worker’s Compensation and No-Fault Insurance has been asking the Board to make these accommodations for several years. Using the CMS 1500 is anticipated to be less cumbersome than the former C4 Forms and filing electronically should help to alleviate many of the filing difficulties resulting from the limitations and hassles of paper claims. For more information on this matter, please click here.

The Deadline for Submitting MIPS Targeted Review Request is Now October 1

If you participated in the Merit-based Incentive Payment System (MIPS) in 2017, your MIPS final score and performance feedback is now available for review on the Quality Payment Program website. The payment adjustment you will receive in 2019 is based on this final score. A positive, negative, or neutral payment adjustment will be applied to the Medicare paid amount for covered professional services furnished under the Medicare Physician Fee Schedule in 2019.

MIPS eligible clinicians or groups (along with their designated support staff or authorized third-party intermediary), including those who are subject to the APM scoring standard may request for CMS to review their performance feedback and final score through a process called targeted review.

WHEN TO REQUEST A TARGETED REVIEW

If you believe an error has been made in your 2019 MIPS payment adjustment calculation, you can request a targeted review until October 1, 2018 at 8:00pm (EDT). The following are examples of circumstances in which you may wish to request a targeted review:

- Errors or data quality issues on the measures and activities you submitted
- Eligibility issues (e.g., you fall below the low-volume threshold and should not have received a payment adjustment)
- Being erroneously excluded from the APM participation list and not being scored under APM scoring standard
- Not being automatically reweighted even though you qualify for automatic reweighting due to the 2017 extreme and uncontrollable circumstances policy

Note: This is not a comprehensive list of circumstances. CMS encourages you to submit a request form if you believe a targeted review of your MIPS payment adjustment (or additional MIPS payment adjustment) is warranted.

HOW TO REQUEST A TARGETED REVIEW

You can access your MIPS final score and performance feedback and request a targeted review by:

- Going to the Quality Payment Program website
- Logging in using your Enterprise Identity Management (EIDM) credentials; these are the same EIDM credentials that allowed you to submit your MIPS data. Please refer to the EIDM User Guide for additional details.

When evaluating a targeted review request, we will generally require additional documentation to support the request. If your targeted review request is approved, CMS will update your final score and associated payment adjustment (if applicable), as soon as technically feasible. CMS will determine the amount of the upward payment adjustments after the conclusion of the targeted review submission period.

Please note that targeted review decisions are final and not eligible for further review.

For more information about how to request a targeted review, please refer to the Targeted Review of the 2019 Merit-based Incentive Payment System Payment Adjustment Fact Sheet and the Targeted Review of 2019 MIPS Payment Adjustment User Guide.

NYS County Contacts in Your County for Workers Compensation Applications

In June 2017, the NYS WCB asked MSSNY for clarity about where physicians should be referred when seeking to be authorized for treating WC injured workers and/or being authorized to provide Independent Medical Examinations (IMEs) for WC. The information for the NYS County Medical Society contacts for these WC applications is available here.

If you have any additional questions, please call Regina McNally at 516-488-6100, ext. 332 or email rmcnally@mssny.org or contact your county executive from the above link.
New York State Drug Take-Back Bill Becomes Law

Governor Andrew Cuomo signed the Drug Take-Back Act, which requires pharmaceutical manufacturers to finance and manage the safe collection and disposal of unused medications. The law requires pharmacies with ten or more locations to participate as drug collection sites to help ensure convenient access for residents. Program implementation will begin in mid-2019.

Unused medications accumulate in the home, where they are accessible to potential abusers and a danger to seniors, children and pets. When improperly disposed down the drain or in the trash, unused drugs contaminate New York waterways and harm aquatic organisms. New York is the fourth state to require manufacturers to fund and safely manage drug take-back, preceded by Massachusetts, Vermont and Washington, along with 22 local governments throughout the U.S.

The new law designates the New York State Department of Health (DOH) to oversee the program. Notably, the legislation gives pharmacies and other collectors the option to use kiosks, mail-back, or “other” approved systems.

MSSNY-PAC

(Continued from page 4)

besieged by requests by candidates to support these efforts with financial support.

Public data shows that many interest groups, including those that regularly oppose our agenda, are supporting these candidates’ efforts in record numbers. The physician community risks having its voice being crowded out by these competing voices.

We very much need your help to help assure that MSSNYPAC can provide assistance to those candidates and party committees who have a demonstrated history of supporting initiatives that help protect patient access to needed physician care.

THE FEW SUPPORT THE MANY

We appreciate that many of you have answered the call. But not enough do. We cannot let the few continue to support the many. Our numerous policy victories benefit all physicians, but are supported by only a relative few. This cannot keep up if too few physicians support these efforts.

To quote the great Stevie Wonder – “Sleepers, just stop sleeping.” We are trying to reach the “Higher Ground.”

In addition to providing MSSNYPAC ongoing support (please contribute here), it is imperative for physicians to be actively involved in engaging with local candidates for office. Assuring that their constituents have access to timely quality care is almost always a priority for candidates, but they need to hear from you about the challenges we face in assuring the availability of this care.

MSSNYPAC has developed a number of tools to assist physicians as they consider which candidates for office they should support for the 2018 elections:

• A “scorecard” for PAC members to provide information regarding the incumbent candidate’s voting records and co-sponsorship regarding key legislative items MSSNY supports and MSSNY opposes.
• A candidate questionnaire that has been distributed to county medical society leaders so they can use as a tool to engage their local candidates for State Senate and State Assembly.

The MSSNY State Candidate Evaluation Committee and Federal Candidate Evaluation Committees met during August to recommend to the MSSNY Council which candidates for office MSSNYPAC should endorse. Please avail yourselves of these tools. Engage your candidates. Go to Town Hall meetings. Check out their campaign websites. Find out where they are on the key health care challenges facing us.

And support your profession’s efforts to be sure legislators hear our voices on these issues.

Again, join MSSNYPAC today, or increase your contribution here. The future you save may be your own.
NYC Health Department
Re-Opening Electronic
Death Registry October 1

The NYC Health Department will again attempt to roll out an electronic death registration program that was plagued with glitches in October – and critics say the timing is problematic.

The $5.8 million “eVital” system launched in October of 2017 using facial recognition software so funeral directors and doctors could log in using cellphone selfies. But some morticians and doctors could not access the system, forcing the agency to pull it within days of launching.

Because burials and cremations require a signed death certificate, funeral home directors had to scramble to pick up certificates in person at hospitals and doctors’ offices. Then they had to deliver them to the Health Department’s Burial Desk to obtain the burial permit.

Some families waited days to bury loved ones – a disaster for the Jewish and Muslim communities whose customs require burials “as soon as possible,” according to Noor Rabah, president of the Muslim Funeral Services.

When eVital is re-launched on Oct. 1, there will be a 48-hour window between the time the existing “Electronic Vital Events Registration System” is taken down and the eVital system goes up – meaning morticians and doctors will be forced to use the same manual process that delayed burials in the fall.

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Support MSSNYPAC
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For more information about The Tuttle Center at The Amsterdam at Harborside, call 516-858-4866 or visit us online at www.TheAmsterdamAtHarborside.com.
AMA Urges DOJ to Challenge CVS-Aetna Merger

The American Medical Association (AMA) has urged the U.S. Department of Justice (DOJ) to block the proposed acquisition of Aetna, Inc. by CVS Health Corporation, and shared with federal regulators an exhaustive AMA analysis indicating the proposed merger would likely substantially diminish competition in many health care markets to the detriment of patients.

“The CVS-Aetna deal is popularly described as a vertical merger involving two companies that don’t operate in the same markets,” said AMA President Barbara L McAneny, M.D. “But in fact, CVS and Aetna do operate as rivals in some of the same markets, raising substantial concerns that are specific to horizontal mergers. A merger of these two rivals would risk a substantial reduction of competition in the stand-alone Medicare Part D prescription drug plan market and the pharmacy benefit management (PBM) services market.”

The 29-page analysis compiled by the AMA noted that the merger is expected to increase premiums due to an increase in market concentration in 30 of 34 Medicare Part D regional markets. In 10 of 34 Medicare Part D regional markets, the deal would exceed a threshold set by federal antitrust guidelines for a merger that should be presumed likely to enhance market power. According to the DOJ, “a merger enhances market power if it is likely to encourage one or more firms to raise price, reduce output, diminish innovation or otherwise harm customers as a result of diminished competitive constraints or incentives.”

The AMA analysis also notes that Aetna and CVS each have their own share of the highly concentrated market for PBM services. In addition to the extensive anticompetitive concerns generated by horizontal aspects of the merger, the AMA urged the DOJ to challenge the deal because the vertical ramifications of the merger violate federal law. Since CVS and Aetna already operate in concentrated or highly concentrated markets, the AMA expects the proposed merger would increase barriers to market entry and foreclose competitors.

The AMA also urged the DOJ to beware of vague and speculative efficiency claims that would not outweigh the anticompetitive effects of the proposed merger. As an example, the AMA analysis notes the alleged consumer benefits from combining CVS’ pharmacy data with Aetna’s medical data. However, Aetna already performs its own core PBM functions and already integrates pharmacy and medical data to lower health care costs. According to the AMA analysis, “the alleged principal efficiency justification for the merger is nonexistent.”

To ensure patients are better served by dynamic and competitive health care markets, the AMA will urge state regulators to review the analysis presented to the DOJ and continue to persuade state and federal officials to oppose the CVS-Aetna merger.

Stakeholder Beliefs

when asked if Board Certified physicians provide higher-quality care than non-Board Certified physicians, more than eight in 10 respondents (84%) believe they do; the remaining 16 percent said Board Certified physicians don’t provide higher-quality care.

General public respondents were also asked about the activities physicians should be required to do to stay up to date and maintain clinical skills and expertise. The participants were given a set list and asked to select all the options that may apply. More than half of general public respondents selected the following options: “participate in a minimum number of CME hours each year” (85%), “periodic exercises to measure, and if necessary, improve quality of care” (74%), “periodically assess performance to compare with other doctors in the specialty” (64%), “have communication and clinical skills rated via patient surveys” (59%), “have performance rated via colleague surveys” (56%), and “take exam at regular intervals assessing clinical knowledge” (56%). The only activity not selected by more than half of the respondents was “self-assessment activities to determine how well he or she is doing” (48%). Two percent said, “none of the above.”

CONCLUSIONS

While these data must be interpreted with caution, the results provide important insights for the Vision Initiative Commission. The Commission will consider these results as part of their overall continuing certification testimony.

Physicians

While a small percentage of physicians value MOC, a larger portion has either mixed views or do not value MOC. They currently see MOC as too costly and burdensome, not an accurate depiction of their abilities or relevant to their practice, and duplicative. However, physicians see some value in MOC for its CME opportunities and tracking, focus on lifelong learning, keeping physicians up to date and self-assessment programs. Respondents want continuing certification to include a focus on relevant CME opportunities, self-assessment delivered at regular intervals, openbook testing and an assessment of the quality and safety of the care provided.

Other Health Care Providers and Consumers

Board Certification is a recognized credential and plays an important role in selecting a physician. In fact, both groups strongly indicated that Board Certification is important when selecting a physician and they believe Board Certified physicians provide a higher quality of care.

ABOUT THE VISION INITIATIVE COMMISSION

As a collaborative process, the Commission brings together multiple partners to vision a system of continuing Board Certification that is meaningful, relevant and of value, while remaining responsive to the patients, hospitals and others who expect that physicians are maintaining their knowledge and skills to provide quality specialty care.

The Commission framework began with a comprehensive assessment of the current continuing Board Certification system. The Commission holds hearings, provides information publicly and tests and seeks feedback on concepts and ideas during the process. The Commission’s final recommendations will be submitted to ABMS and its Member Boards for consideration and implementation in February 2019.

American Association of Medical Society Executives. All rights reserved.
Mr. Cowell provided some stats that prove that these types of aforementioned actions by the DEA are rare: Of the 16,000 prescribers in the jurisdiction of the Division of the DEA that Mr. Orgon oversees, there have been only 20 cases of physicians being prosecuted criminally in the last 5 years. There is always a thorough investigation and evidence in hand before the DEA will “shut the office down” and bring an indictment against a provider.

The number of visits to provider’s offices (within the 17 counties overseen by this particular DEA office’s jurisdiction) have steadily decreased from 40 visits in 2013 to 9 visits in 2017, indicating that providers are prescribing within the confines of the law. The DEA has not conducted one inspection or audit of a buprenorphine provider in the 17 counties to date in 2018.

It was clear during our discussion that all parties involved have the same goal in mind—the safe prescribing of buprenorphine to stop diversion of buprenorphine on the streets and to keep the health and safety of the public as the main priority.

Physicians and other clinicians are called upon to help passengers during in-flight medical emergencies, but airlines often prefer the guidance of on-the-ground consultants in order to avoid diversions, according to Bloomberg.

A medical emergency occurs once every 604 flights, with 7.3 percent leading to diversions that ground the plane, according to a study in The New England Journal of Medicine. While it is standard protocol to first find out if a medical professional is on board before calling a consultant, a diversion can cost as much as $200,000, and airlines look to avoid these diversions whenever possible.

Passenger clinicians are more likely to recommend diversions, so airlines rely on contracted consultants on the ground, who are less likely to recommend such action, to guide pilots. Though the final decision rests with pilots and dispatchers, they rely heavily on the advice of consultants.

Becker Hospital Review, May 2018
Lack of Communication Between Treating Physicians is a Serious Detriment to Patient Care

(Continued from page 8)

bination of masses with surrounding infiltration. Therefore, in his opinion, it was the obligation of the radiologist to communicate this high level of suspicion of a possible malignancy promptly to the patient’s physician by telephone to make certain that the patient was closely followed.

The radiologist’s suspicion of a neoplasm was sufficiently high that the expert felt the radiologist failed to follow the recommendations of the American College of Radiology for direct communication between the radiologist and referring physician. He concluded that this was clearly negligent. He concurred with the MLMIC emergency medicine expert that the radiologist should have completed a discrepancy report because of the difference between his interpretation and that of the ED physician. Receipt of such a report should have triggered prompt notification of the patient of both the abnormal result and recommendations for follow-up.

The plaintiff initially demanded $1.5 million to resolve the lawsuit. However, the lawsuit was eventually settled for $675,000. Of that sum, the radiologist paid $540,000 and the pulmonologist paid $135,000.

A Legal & Risk Management Perspective

Donnaline Richman, Esq.
Fager Amsler Keller & Schopmann, LLP, Counsel to MLMIC

This case confirms the importance of physician-to-physician communication. It also illustrates the need to carefully follow hospital or office policy and procedure when communicating either abnormal results of a test or a discrepancy between a formal reading by a radiologist and a reading by an emergency department (ED) physician.

One of the major legal deficits in this case was that the radiologist failed to follow hospital policy and complete a discrepancy report when his reading of an image differed from that of a non-radiologist. Further, the report did not specifically name the ordering physician, which required some effort by the ED to identify that individual. Thus, the original ED physician was never alerted that he had missed a possibly abnormal result. The fact that neither the patient nor the primary medical physician were notified about the abnormality precluded the patient from receiving necessary follow-up testing and care, to the patient’s detriment.

The failure of physicians to communicate frequently leads to disastrous results such as serious delays in diagnosis and treatment or even a patient’s death. This case is particularly concerning because of the recent enactment of Lavenn’s Law, which extends the statute of limitations for the misdiagnosis or failure to diagnose cancer or tumors to a cap of seven years in most cases. Those cancers or tumors that might have been discovered earlier but were not identified within the prior two and a half years and for which there was no continuous treatment can now be pursued beyond the previous two-and-a-half-year statute of limitations, until the patient has actually or reasonably should have discovered the presence of undiagnosed cancer or tumors for up to seven years.

The American College of Radiology (ACR) has developed an educational practice parameter for the communication of diagnostic imaging findings. This parameter provides that “effective communication is a critical component of diagnostic imaging” and indicates that “quality patient care can only be achieved when study results are conveyed in a timely fashion to those responsible for treatment decisions.” It also provides that a final report is to be transmitted to the ordering physician. This parameter states that “a significant variation in findings and/or conclusions between the preliminary and final interpretations should be reported in a manner that reliably ensures receipt (of the new information) by the ordering or treating physician/healthcare provider, particularly when such changes may impact patient care.” The ACR further recommends that all non-routine communication be documented by the radiologist in a log in the radiology department and that the final report incorporate documentation of the communication of discrepancies. It additionally provides that, “when the ordering physician cannot be contacted expeditiously, it may be appropriate to convey the results to the patient, depending upon the nature of the imaging findings.” Unfortunately, in this case, none of the ACR parameters were met.

However, the radiologist was not alone in failing this patient. The ED was also subject to serious criticism by the physician reviewers. All reports coming back to the ED, and particularly discrepancies, should be reviewed by a licensed individual. Although the ED physician was not specifically identified in the report, the ED had sufficient information to identify that physician by the patient’s name and the time of the order. The patient should be informed of the results, before the report is filed in the patient’s medical record. Further, if the ED physician who initially read the image was not on duty when the final report was transmitted, the on-duty ED physician should have been advised of the discrepancy in the reading and recommended contacting both the patient and primary care physician. Thus, there was poor compliance with the policies and procedures of the facility and department.

In summary, when there is a serious lack of communication between physicians about a critical discrepancy in a test result in addition to noncompliance with practice parameters and a facility’s policies and procedures, patients can suffer serious, even deadly, injuries.

In summary, when there is a serious lack of communication between physicians about a critical discrepancy in a test result in addition to noncompliance with practice parameters and a facility’s policies and procedures of the facility and department.

OBITUARIES

DE COSTA, Carol V. R.; Brooklyn NY. Died April 15, 2018, age 61. Medical Society County of Kings

DEAN, David Campbell; Amherst NY. Died May 21, 2018, age 87. Erie County Medical Society

DURGIN, Francis John; Camillus NY. Died July 24, 2018, age 88. Onondaga County Medical Society

FAEGENBURG, David Herbert; Roslyn Heights NY. Died May 10, 2018, age 87. Nassau County Medical Society

FOLSON, Alan Laurence; Plattsburgh NY. Died March 27, 2018, age 86. Clinton County Medical Society

FREEMAN, Edwin Ned; South Hadley MA. Died June 29, 2018, age 88. Monroe County Medical Society

FAEGENBURG, David Herbert; Roslyn Heights NY. Died June 29, 2018, age 88. Monroe County Medical Society

HUMPHREY, Eleanor Nicholson; Spencerport NY. Died June 13, 2018, age 102. Monroe County Medical Society

HUMPHREY, Eleanour Nicholson; Spencerport NY. Died June 13, 2018, age 102. Monroe County Medical Society

JAKUBIAK, Jerome V.; Buffalo NY. Died May 13, 2018, age 82. Erie County Medical Society

KIRK, Kurken V.; Kingston NY. Died March 31, 2018, age 96. Medical Society County of Ulster

LAWRENCE, William D.; Buffalo NY. Died May 18, 2018, age 69. Erie County Medical Society

LEKA, Agim; New York NY. Died March 08, 2018, age 94. Nassau County Medical Society

LEVENTHAL, Harvey R.; Staten Island NY. Died March 14, 2018, age 90. Richmond County Medical Society

O’SULLIVAN, John Alfred; Rochester NY. Died May 20, 2018, age 80. Monroe County Medical Society

PAINTON, J. Frederick; Williamsville NY. Died May 18, 2018, age 79. Erie County Medical Society

REMPEL, Jacob; Lewiston NY. Died June 13, 2018, age 78. Medical Society of the County of Niagara

SCHEN, Charles R.; Hamburg NY. Died April 16, 2018, age 91. Erie County Medical Society

YUDIN, Howard Stephen; Purchase NY. Died June 23, 2018, age 72. Medical Society County of Westchester

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