New York State of Health Heads into Second Year

In August 2014, with New York heading into the second open enrollment period for its Exchange, MSSNY conducted a poll to better understand the experiences physicians have had in the first year of these Exchange products for the purposes of informing state policymakers. The poll also sought to understand physician’s experiences with Medicaid managed care, which was the majority of coverage obtained through the Exchange, as well as changes in the commercial market.

(Continued on page 6)

NY Exchange Comments  
Vol. 70  •  No. 9  •  October 2014  
www.mssny.org  
MSSNY Hosting E-Prescribing Fall Webinars for Members

The Medical Society of the State of New York will host an additional two webinars on “New York State’s Requirement for E-prescribing of All Substances” throughout the fall. The webinars are for MSSNY members only. Terence O’Leary, Esq., Bureau Narcotics Enforcement will be featured.

Objectives of the program are:
1) Describe the e-prescribing mandate, to whom it applies, when it becomes effective, and how physicians can comply with its requirements.
2) Describe the practitioner electronic prescribing of controlled substances registration process, to whom it pertains, and the information required to be provided by physicians in order to register eRX software with the Bureau of Narcotics Enforcement.
3) Describe the exceptions to the e-prescribing mandate and any additional requirements associated with those exceptions.
4) Describe the application process and criteria for a waiver from the e-prescribing mandate.
5) Describe what rules pertain to physicians who only prescribe non-controlled substances.

WEBINAR DATES AND TIMES:
Wednesday, October 29, 2014 7:30-8:30 a.m.
Wednesday, November 5, 2014 6-7 p.m.
Physicians must register for the webinars; seating at each webinar is limited to 94 seats. Physicians may view the webinar from their home or office. To register for one of these sessions, please visit https://mssny.webex.com and click on the “Upcoming” tab. Then click the “Register” link to the right of the date you wish to select.

MSSNY Welcomes Canton-Potsdam Hospital Physicians

MSSNY is pleased to announce that the physicians of Canton-Potsdam Hospital have entered into a hospital-supported MSSNY group membership. All 53 physicians at CPH – both hospital-employed and private practice physicians – have joined MSSNY under this medical staff membership arrangement.

“Our physicians want to be involved in shaping the healthcare in St. Lawrence County and throughout the state,” said Michael Maresca, MD, who has been a member of MSSNY for more than 23 years and was instrumental in this agreement. “And the Medical Society gives us the opportunity to do that. “Autonomy can be easily eroded as an employed physician. If we’re not involved, the terms are decided for us,” said Dr. Maresca, Chief of the Medical Staff at Canton-Potsdam Hospital. “It’s important for all physicians to stand together so that we are heard.”

All 53 members will also become members of the Medical Society of St. Lawrence County. “We are thrilled that every physician on the staff of Canton-Potsdam Hospital has joined the Medical Society of St. Lawrence County and MSSNY,” said Kathleen Dyman, Executive Vice President of the Medical Society of St. Lawrence County. “This partnership will serve to strengthen our physician community.”

The membership arrangement includes special pricing for legal services through the Physician Advocacy Program offered by Kern Augustine Conroy and Schoppmann, PC, MSSNY’s General Counsel and endorsed provider of legal services for members.
40 years ago this month, MSSNY established the Committee for Impaired Physicians, the predecessor to the current Committee for Physician Health, which provides a “safe harbor” of non-disciplinary and confidential assistance for physicians suffering from substance misuse and other psychiatric disorders.

“There was a tremendous need for this type of assistance,” said Sheila Blume, MD, one of the early organizers of the Committee on Impaired Physicians. “It was hard to get this kind of treatment for physicians in the 1960s. Many of us had colleagues struggling with mental health and addiction issues and we knew something had to be done.

“In the late 1960s, we set up a booth at MSSNY’s House of Delegates meeting with a sign that read, “The Sick Doctor,” said Dr. Blume, who was running a state hospital alcoholism program at the time. “We were trying to get the message across subtly—that we were here to help physicians with addiction and rehabilitation.

“Instead, we had physicians approach the table with questions about gallbladders and the like,” she recalled with a laugh. “But the message—which we eventually got across more effectively—was that we all knew fellow physicians who were struggling with mental health and addiction issues and we had to figure out a way to take care of our own.”

The idea for a MSSNY committee to help physicians in need was hatched. “The original concept to merge two MSSNY committees into the Committee for Impaired Physicians came from Stan Gitlow, MD, who was chair of MSSNY’s Committee on Alcohol in the early 70s,” said Herb Peyer, MD, chair of MSSNY’s Committee on Mental Health at the time. “We worked with the Commissioner of Health to get an agreement that highlighted the need for a program that addressed the mental health and substance abuse needs of physicians.” The Committee for Impaired Physicians was established on October 27, 1974.

But new challenges lay ahead. Three years after MSSNY established the Committee for Impaired Physicians, a mandatory misconduct reporting law was passed in New York State that required physicians and medical societies to report misconduct. Without the confidentiality component, the committee ceased to exist. An amendment law followed in 1979 that generally exempted MSSNY from reporting recovering physicians. MSSNY was required only to report physicians who endangered the public or failed to cooperate with the committee.

Reestablished as the Committee for Physician Health in 1980, CPH today remains an organization of “doctors helping doctors” with more than 1,000 volunteer physicians across the state. Additionally, CPH now maintains an office in Albany with a professional staff of 10, which is supported by the CPH Advisory Committee annually appointed by the MSSNY President.

“And it works extraordinarily well,” said Dr. Peyer, who continues to serve on the Committee for Physician Health 40 years after its inception. “The CPH staff members run a great program and maintain a strong mutual respect with the physician community throughout New York State.”

If you know a physician, physician assistant or medical student who may have a problem with a substance use or psychiatric disorder, please call the Committee for Physician Health of MSSNY at (800)338-1833. All calls are strictly confidential.

Disclosures

The Committee for Physician Health continues to serve on the Committee for Physician Health 40 years after its inception. This is the first time MSSNY has endorsed Assembly candidates; a discussion ensued about the number of Democrats on the list; Dr. Lee explained that the NYS Legislature tends to be overwhelmingly Democrat and that the list reflects champions for MSSNY’s key issues. Council approved the following list of MSSNPAC State endorsements:

NEW YORK STATE ASSEMBLY

Michael Cusick (D, 63rd, AD-Richmond)
Deborah Glick (D, 66th AD, NY County)
Richard Gottfried (D, 75th AD, NY County)
Charles Lavine (D, 13th AD, Nassau)
Bill Magee (D, 121st AD, Madison, Oneida and Otsego)
Daniel Quart (D, 73rd AD, NY County)
Michele Schimmel (D, 16th AD, Nassau Co)
Robin Schimminger (D, 140th AD, Erie and Niagara)
New York State Senate
Dean Skelos (R, 9th SD, Nassau)
Toby Ann Stavisky (D, 16th SD, Queens)

Moe Auster, on behalf of Vincent Calamia, MD, Chair of the Federal Candidate Evaluation Subcommittee, reported that the subcommittee met on August 12 to consider the endorsement of several candidates running for the US House of Representatives from New York State. Council approved the following candidates for endorsement:

US HOUSE OF REPRESENTATIVES:

Representative Joseph Crowley (D-parts of Bronx and Queens Counties)
Representative Chris Gibson (R-Broome, Columbia, Delaware, Dutchess, Greene, Montgomery, Otsego, Rensselaer, Schoharie, Sullivan and Ulster counties)
Representative Tom Reed (R-Allegany, Cattaraugus, Chautauqua, Chemung, Ontario, Schuyler, Seneca, Steuben, Tompkins, Tioga and Yates counties)
Nan Hayworth, MD (R)-candidate for New York’s 18th Congressional district (Putnam and Westchester Counties)

Council passed a motion allowing MSSNY to co-sponsor “Commissioner’s Grand Rounds” with Acting NYS Health Commissioner Zucker. Commissioner’s Grand Rounds is a new program that will be presented in hospitals on issues of importance to physicians and patients in New York.
BECAUSE A TRANSFORMING HEALTHCARE SYSTEM DEMANDS INNOVATIVE COLLABORATIONS IN COMMUNITY-BASED CARE:

VNSNY IS BRINGING MEDICINE HOME.

New challenges and new opportunities are spawning a burst of creative energy across the healthcare continuum. And nowhere is this more evident than at VNSNY. Throughout our enterprise we are collaborating with providers on innovative solutions that are patient-centered, evidence-based and outcomes-driven.

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Is Doctor Bashing Okay with You?

Are you tired of the negative portrayal of physicians in the media? I am. MSSNY has sent letters to media outlets all over our State to respond to inaccurate and unfair articles about the care we provide. We have proactively engaged the media to assure our perspectives are heard as reporters write about proposed legislation that would require physicians to disclose their prescribing practices.

As a result, we receive numerous contacts from reporters statewide, and, indeed, across the country, to provide comments on stories they are writing.

NEGATIVE ARTICLES

I am sure many of you read the articles in the New York Times and Poughkeepsie Journal this past month where the physician community was unfairly maligned. In one article, physicians were accused of charging patients exorbitantly.

In another article, we were unfairly criticized for recklessly prescribing pain medication. In both cases, it was asserted that the reporters had a physician-unfriendly predisposition in spite of the fact that Government Cuomo and the Legislature had already taken action to address each of the problems these reporters presented.

With regard to the New York Times article, our sharply-worded response was focused on the fact that the reporter chose to wait until the bitter end of her 5,000-word piece regarding out-of-network billing to note the most important point – that Governor Cuomo and the State Legislature had already passed a comprehensive law to address the out-of-network billing issues faced by the patients in the article.

And the reporter failed to note that this law was not only supported by the medical community, your MSSNY, but that MSSNY was extensively involved in helping to shape the final product of this law that was both measureably helpful to our patients and fair to physicians.

Additionally, the reporter failed to mention that this bill was being actively blocked by the insurance industry!

INSURANCE INDUSTRY IS THE PROBLEM

Our letter to the Times also noted that the article failed to report on the insurance industry’s culpability in this problem. As we know, insurers have in large part created this problem by slashing what they will pay their in-network physicians to levels that do not even cover practice overhead, by offering plans with minimal networks, and by not allowing their patients to buy coverage for out of network care.

With regard to the Poughkeepsie Journal article, our response was focused on the fact that New York State has already passed the LEAP law ensuring physicians’ prescription history prior to writing a controlled substance prescription. This law has been extremely successful in reducing patient “doctor-shopping.”

We also argued that the dearth of the mentality of the reporter in her conclusion that more doctors need to be prosecuted – could exacerbate already existing fears among physicians that prescribing medically appropriate pain medications could result in serious license sanctions, which in turn could cause patients to suffer with pain unnecessarily.

THAT’S DANGEROUS FOR PATIENT CARE!

These are but a few examples of our extensive efforts to interact with the media to assure that our perspective is heard loud and clear above the voices of so many conflicting interests. However, we need greater resources to execute a more sustained media relations strategy that will better assure that the public understands that our agenda is aligned with the needs of our patients.

WE NEED YOUR HELP TO EXPAND THESE EFFORTS

Again, we thank you many, many physicians who support MSSNY, but we also need the many others to join our efforts. Assuring that the media understands and fairly reports the physician perspective on issues is often a critical element of legislative success. Conversely, losing the PR war can often result in defeat on the legislative front.

I urge you to continue to advocate to your colleagues about the importance of supporting MSSNY. Among the many reasons, make sure they understand that a well-resourced MSSNY will result in more positive media portrayals of our dedication to our patients.

Is MSSNY PAC Doomed to Languish In Obscurity?

Since its formation, MSSNY PAC has been held in high regard by both sides of the political aisle in both houses of the NYS Legislature. Could its political standing be fading? Of course, the answer is a resounding “NO.”

That being said, we need you to put MSSNY PAC on the pathway toward restored health.

In September, the request of the MSSNY Council, MSSNY PAC launched a very extensive effort utilizing our MSSNY Officers, Commissioners and Trustees and PAC Executive Committee Members as ambassadors of inclusion. Each of our leaders was assigned to invite ten of their friends and colleagues to join MSSNY PAC; and if they were already members of MSSNY PAC, we wanted our leaders to invite them to become members of our exclusive Chairman’s Club. To be successful, we need to enroll 120 new Chairman’s Club members, or 685 new members. Given the stakes in this election just a few weeks away and the ever expanding perennial threats we face, the MSSNY Council believed that this goal was not only important to attain but was achievable.

You might think that this goal is “pie in the sky.” Respectfully, we disagree. The potential threat that legislation advanced by the Trial Lawyers such as the Date of Discovery or Wrongful Death bills is more tangible than ever before. We believe that you and your colleagues under stand this threat and will respond to our physician driven campaign to grow MSSNY PAC membership. Moreover, we believe that the threat of other governmentally imposed mandates such as a CME mandate on palliative and end-of-life care will motivate you and your colleagues to become involved with MSSNY PAC to defeat this proposal next year.

STRENGTH IN NUMBERS AND DOLLARS

Rather than labor in obscurity, MSSNY and MSSNY PAC must become more proactive and strong. Strength in any Political Action Committee is measured in the number of its members and the wealth of its resources. Without a growing membership and significant financial assets, a Political Action Committee is relegated to obscurity.

If the MSSNY and MSSNY PAC leaders reach out to you, just say yes. Join MSSNY PAC. If you are already a member, become a member of the 64 member Chairman’s Club. This is not only an opportunity for you to contribute your ideas on issues and on the level of MSSNY PAC contributions, but it is also an opportunity for you to become a real contributor to the political process and to policy development on the state and federal level.

We believe MSSNY PAC is doomed to languish in obscurity. Physicians are at the very heart of our health care system and we must play an important role in the shaping of health care policy. Rather, we believe that each of you appreciate the essential role MSSNY PAC has played and will continue to play by assuring that MSSNY and its members have a seat at the table is formative policy is developed.

In this instance, when a MSSNY or MSSNY PAC leader and colleague reaches out to invite you to join or enhance your membership in MSSNY PAC, JUST SAY “YES.”

The strength in numbers and dollars can only come if we take advantage of the collective power we can generate.

Come to www.mssny.org to join today.
A Message from the Nassau County Medical Society President

Michael Ziegelbaum, M.D.

Our office has recently hired medical scribes to assist in the electronic documentation that has become the bête noire of many medical practices today. I must admit that I really do love the scribe despite my pre-scribe reservations. I now see my patients without typing into a computer, I can speak and listen to my patients face to face and my (home)work load has been somewhat alleviated.

This luxury however comes at a price. I calculate that each physician will spend $25-40,000 more per year with little chance of recouping any of the cost. Admittedly, some of that cost can be offset by increasing patient volume but I still believe that to be a difficult goal to attain for many reasons.

Some of my concern is that this cost is one of many costs that physicians endure to maintain their practices. Precertification of procedures, radiology and medications have bumped up the cost of care enormously. No longer can I write (or e-scribe) a prescription with the knowledge that the patient will get what I feel is appropriate. And of course this comes at a price of upsetting the patient/physician relationship and trust. Another negative aspect of our current patient care climate is the establishment of a customer satisfaction survey which will dictate some of our future reimbursements. This is already in place for hospital services. Simply put a portion of funds for the federal programs have been placed in a pot to be disbursed based on these surveys. The lowest 25 percentile will see a reduction in fees and the highest will get a bonus-at least initially. This will go into effect for physicians in 2015

The problem with using Press Ganey scores for reimbursement is the subjectivity of the surveys. I do not believe that patients have the ability or the data to discern true quality of medical care. Waiting more than 15 minutes (one of the parameters) for an appointment does not equate with poor quality health care. It has however made patients far more demanding and sometimes abusive with regard to health care.

Moreover, a physician or facility that scores high but not perfectly may find themselves at the low end of the percentile grade but still providing a high level of care. Thus the system is a lose/lose. Those at the bottom will be squeezed out of the health care industry and society will simply lose care providers at a time when there is a need for more physicians.

Furthermore, while the concept was designed for federally based reimbursements, the insurance industry will latch on to this to justify trimming its provider panels and essentially rationing care. One large insurer has recently dropped large numbers of physicians from their plans and is currently assigning ‘premium’ designations to others based on cost and/or quality. Ultimately patients will be directed towards certain physicians by offering copay reductions.

It is one thing to define true quality based on outcomes data and best practices. It is quite another when cost becomes the sole rationale. Many insurers approve multiple treatment strategies, specialty consultants, radiology practices and medications. But choosing from the list may result in higher costs without the physician having a clue to the costs.

An example is a hospital based, article 28 facility that charges a rack rate of $6000 for a CT scan whereas the non-Article 28 based facility does the same for less than $500. Likewise enhanced fees for hospital based physicians may be significantly higher than that of the same consultant working in a non-hospital environment. Pair that with the very high deductibles that many people have since implementation of the federal programs have been placed in a pot to be disbursed based on these surveys. The lowest 25 percentile will see a reduction in fees and the highest will get a bonus-at least initially. This will go into effect for physicians in 2015

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(Continued on page 8)
DERMATOLOGISTS

Many patients have no idea what they really purchased. The burden falls to the physician’s office. Health Republic is terrible to deal with and pays very poorly. HIP Medicaid pays very poorly.

It is impossible to determine contract clauses in a reasonable period of time before seeing the patient. We are told to call the plan and check their website, but the information is sketchy and patients have no idea whether they have a deductible, copay or coinsurance, need a referral or for what months they paid their premiums. One just lied and the plan said she had not paid for 2 months and was no longer eligible. The amount of time spent calling these plans is terrible and when finally getting through (after 30 to 60 min on hold) I get operators in foreign countries who cannot answer any of the above data listed above or even if I participate in any of the plans. Instead, they give another number to call in doctor relations. However, those people are never in and if they do call back, it could be in a month and I may not remember why I called them.

These patients tell me they cannot find doctors who take the plan and have had just as much frustration trying to reach the plans as I described above. They cannot truthfully answer questions about their contract, saying they don’t know anything. The ones with $6000 deductibles invariably say they did not know they were responsible for this payment (and for a 50% co-insurance). One patient’s visit was denied for having no authorization for a minor office procedure that I do all the time and have never been asked for prior approval. I asked his plan’s rep, and the patient, and checked the website before seeing the patient and nowhere did it say that an auth was needed. It also did not say if a formal one issued by the company was needed and neither the website nor the operator said I needed a referral for any procedure I do in my office or how to verify that one was in place. The patient likewise said no referral was needed. THEY JUST DENIED THE CLAIM, I couldn’t reach them by phone and I emailed them a month ago but have not gotten an answer (it was very hard to find their email address – it should be readily available and easy for doctors to question refusals, etc but they obviously do not want to be transparent. I explained that I used every effort to obtain contract information but was still hit by a denial. They just look for technicalities to deny claims for which it was not possible to verify before seeing the patient. This patient needed follow up but did not show up for his next visit and 8 messages left for him have not been returned. I wanted to speak to him to see how he was doing since I was sure that the problem needed more treatment; maybe he found someone else to experience a denial.

I have heard horror stories from colleagues with huge amounts applied to deductibles and co-insurance and patients refusing to pay. This was always a problem with regular insurance contracts where patients had to pay more than their copay. Why should these plans be any different? The insurers should pay for these changes since they impose the fees. A doctor should receive his contracted fee for the service rendered, and not have to be the insurer’s bill collector for charges they wrote into contracts (without any input from doctors). This should apply to all insurance contracts both private and governmental.

So, the terrible hurdles needed to obtain insurance information about prospective patients are very big obstacles that almost make it impossible to comply with the rules that are not possible to ascertain in a reasonable amount of time. The websites often say that cannot give any information about the patient and to try later – but the information is still not there when accessing the site later. I have also heard from colleagues that say they participate in one but not all of the plans an exchange offers and they may care for a patient in the same exchange plan as they did before, only to find out that that level of contract was non-par for the doctor. Also, the data on these sites is often wrong, with some doctors participating and some not, even though they are listed. Doctors often have not been offered a chance to decide whether they want to participate or not. No plan has contacted me and told me that I am on their list (or not).

FAMILY MEDICINE/INTERNAL MEDICINE/GENERAL PRACTITIONERS

Help, it keeps getting worse.

The Affordable Care Act is fatally flawed in that it mandates individuals to buy health insurance that does nothing but shift the financial risk and burden to the patient and doctors. It is for this reason that the system will collapse under the real fraud, waste and abuse as perpetrated by the money laundering, Ponzi-scheming insurance industry.

Coverage for patients is poor.

Patients appear clueless about what a deductible is.

Too few good physicians with good reviews participate in the Medicaid managed plans.

The health exchange is too complicated; the people who need it most often don’t apply because of political pressure from their family or friends; poor people can’t afford ANY deductible; I wish we just had universal coverage like all other civilized countries.

The managed Medicaid companies routinely ignore the law. Specifically when it comes to providers prevailing in mental health meds. They think nothing of refusing to pay for medications that patients are stable on. I’ve even had one company state they should change to another managed Medicaid program if they don’t like it. Their appeals can take weeks while patients suffer.

More red tape bureaucracy and no improvement to real care.

This is not “access” to care, it is a segue to collapse.

I am retired from active practice, and only see nursing home residents and Free Clinic patients. I am a solo physician in the inner city, I received profit sharing, student loan repayment funds and other benefits from the federal government to remain and provide primary care services in my underserved community. I am willing to provide care to ACA patients who participate in the Medicaid managed plans. Instead, they don’t have an active role in billing, and no way of knowing how much I get from individual patients or how long it takes. So long as I get any money worth depositing, I will likely remain ignorant of the details.

The exchange is not working for patients because it’s too expensive and it’s not working for the doctors because there are too many “glibsters.”

I support the ACA, but these plans are far too intrusive regarding patient care. They all demand far too much and pay far too little.

I am not able to get Medicaid to pay me EVER... even with trillions of forms, demands, hassles etc. Some insurance carriers such as Empire BCBS NY have deliberately prevented many primary care physicians from participating in Obamacare. Primary care physicians who are willing to provide the care are not given the opportunity by BCBS. I am a solo physician in the inner city, I received student loan repayment funds and other benefits from the federal government to remain and provide primary care services in my underserved community. I am willing to provide care to ACA patients but BCBS reps have discouraged me from participating. I did not opt out of Obamacare. I feel very badly that my hands are tied by BCBS. I participate with all other carriers in my community. I participate with all other BCBS products except exchange “Obamacare.” Whenever BCBS comes up with a new commercial line of insurance the reps push for us to participate but in the case of Obamacare they discourage us. This has caused massive disruptions in care for many, many New Yorkers.

NEUROLOGISTS

Obamacare is state-sponsored terrorism! The 2-3 useful features are outweighed by the dozens of
dangerous and/or unfair provisions.
We get payments of $5 with $35 co-pays. Reimbursements are so horrible as to be a bankruptcy threat. Unbelievable amount of paperwork approvals and preapprovals, simply there are no resources to deal with all the bureaucracy. Patients who pay for these plans cannot see doctors of their choice. All medications are essentially denied. Doctors cannot be reimbursed for patients they see. Tremendous delays in payments. Insurance companies at the steering wheel bankrupting private practice, while malpractice insurance and overhead gets larger and larger.

I think that by getting rid of Healthy NY and Child Health Plus, patients are suffering. Copayments are higher, defaults higher, our reimbursements lower, and coverage for the patient is less comprehensive. More hassle factor with Prior Authorizations, which are denied in a capricious way. Patients are FORGIVING. They are forgotting needed surgery or treatment due to costs. Some guidelines are not consistent with professional organizations, NYS laws or competing plans. The exchanges are a DISASTER for physicians and patients.

Doctors should be reimbursed for phone time and plans should offer patients out of network options and reimburse patients appropriately for out of network services. Using 140% of Medicare rates, especially for Ob/Gyn, is ABSURD!
I have multiple patients that have informed me they can no longer afford to get their care with us because of the ACA. We have seen larger copays and patient responsibility and failure to keep scheduled appointments and pay for them. I am considering a concierge practice.

These things are best asked of our billing people considering a concierge practice. Many of us do care about our patients. I am having difficulty on two fronts. WE have a large Medicaid population. Parents are having trouble negotiating the system. This demographic may have education and language barriers that compound this issue. Also Fidelis tells me that they are waiting for NYS Medicaid to load the patients first so they can add them to the Fidelis roster and website. Patients arrive at my practice without a card and I cannot verify that they have insurance online with Fidelis. I called Fidelis to complain and they tell me that delay is at the state. This needs to be resolved.

ORTHOPEDIAGTISTS
I only participate in Excellus of Rochester on the exchange because reimbursements are comparable to commercial plans. I don't know how many patients' plans were exchange vs. commercial. All other exchange plans seemed fly-by-night and reimbursements were ridiculous so I don't participate. Although I saw my name listed as participating on some of these other plans, I didn't bother contacting them. We have had only a few calls this year from patients who chose not to schedule an appointment if we didn't participate. I see a lot of Blue Choice Option patients because reimbursements are reasonable relative to commercial. Don't do MVP Option, Fidelis, etc because of low rates.

The key to keeping costs down is an accurate assessment of the problem, i.e. an accurate diagnosis and cost effective treatment taking into consideration the patient's individual circumstances. Take well trained physicians to execute such basic principles and pay them garbage and you will get garbage, and no good physician will take these cases. Your health care costs will continue to rise because of poor medicine resulting from doctors spending too little time because they have to keep their numbers up to make a living due to the pathetic payments to physicians. The diagnostic mistakes due to this are disgraceful and when you see an article in the media that a high percentage of diagnoses are wrong you need to look at this and start to put a value on a physician and his training and ability. I see too many poor diagnoses and resultant mismanagement and the need for revision treatment that you need to take a look at this and not rely on patient surveys which express outcomes that hold a small credence on the fixing of patients problems.

The exchanges are a disaster. We are bailing out.

PEDICATRICIANS
I am going the way of the dodo bird and slowly becoming extinct. Not included on certain panels even though taking the rest of their plans (Emblem health) for years. We are having problems with the Exchange plans: errors, patient names, patients showing as not eligible for months when they actually do have coverage and we have no way of contacting any provider reps with the state plans to work out these issues. It's been very frustrating for the office staff. All insurers consistently make errors in payments to me, requiring time-consuming follow-up. Their errors are repeated over and over, especially for vaccinations and well care, which are rarely paid properly on the first submission. Insurers should be financially penalized for these purposely repeated errors. After all, I am penalized if I make a billing error (they don't pay me). Why should their repeated errors be free of cost to them? They are “incapable” of paying some codes without phone follow-up.

It is not the physicians who are increasing the cost of medical care. Most of us are hard-working honest people. Granted there may be some bad apples, but most of us do care about our patients. I am having difficulty on two fronts. WE have a large Medicaid population. Parents are having trouble negotiating the system. This demographic may have education and language barriers that compound this issue. Also Fidelis tells me that they are waiting for NYS Medicaid to load the patients first so they can add them to the Fidelis roster and website. Patients arrive at my practice without a card and I cannot verify that they have insurance online with Fidelis. I called Fidelis to complain and they tell me that delay is at the state. This needs to be resolved.

(Continued on page 8)
New York State of Health Heads into Second Year

Patients haven’t a clue about their coverage. The exchange insurances never offered me to participate in any of their plans. This was a sham—sign people up and then pay the doctors much less than normal. Medicine today is a sorry state of affairs. Also, I thought Obama and the other politicians said that we would have the same insurance that they have in the US government.

PSYCHIATRISTS

Just say no to socialized Medicine. I am obligated by a unilateral agreement to participate in ACA BC/BS plans. The rates are 20% lower than non-ACA rates. Referrals from PMDs are required. They are not for non-ACA plans. This causes delays in payment and undue burden on the patient compared to non-ACA patients. I don’t like this.

How can patients who barely are able to pay premiums manage the highest deductibles? It’s a preposterous set up to leave patients with unpaid bills and docs forced to write off or send to collection.

The deductibles in non-exchange plans have grown since 2010—both in and out of network coverage—as have copay and premiums. All because of the ACA.

I don’t take insurance and I expect when there are no patients looking for a psychiatrist and less psychiatrists to take them I will do quite well.

Amerigroup, an affiliate of Empire, misidentifies its clients as PPO when they are actually Medicaid, and then fails to pay according to our contracted rates. Much arguing later, we have decided not to accept their patients.

Given that I’m a solo practitioner, I actually have an exchange plan for myself (Empire BC/BS). Overall, the plan has worked well. I can educate without punishment. And I do believe that a potential patient is another physician.

(Continued from page 7)

Patients haven’t a clue about their coverage. The exchange insurances never offered me to participate in any of their plans. This was a sham—sign people up and then pay the doctors much less than normal. Medicine today is a sorry state of affairs. Also, I thought Obama and the other politicians said that we would have the same insurance that they have in the US government.

(Continued from page 4)

the Affordabe Care Act and the problem becomes huge for the patient who purchases insurance products based on cost alone.

Additionally the enhanced fee structure creates an unlevel playing field thus pushing many independent practitioners into hospital acquired practices. Quality may or may not suffer but cost certainly does. In New York State, office based surgery when appropriate is the least expensive alternative. However the insurers do not pay facility fees nor do they recognize the disposable equipment. An Article 28 facility not only receives a facility fee, but many disposables (hernia mesh, stents etc.) are reimbursed at 150% or more of the usual commercial rate and then either deny the claim or pay us almost nothing. And they don’t tell the patients that they have huge deductibles.

We don’t have adequate networks to refer patients to – this is horrendous – Fidelis and Embleem are just terrible with all plans. Emblem doesn’t allow physicians in

A Message from the Nassau County Medical Society President

Westchester to participate with the exchange products because they made a special deal with a couple of large groups and are exclusive to them. United never even tried to contact providers—just tried to send patients and then offered the Medicaid rate when we questioned them about the products.

We’ve lost a lot of patients due to small panels that don’t let most doctors in.

OTHER SPECIALTIES

The patients have a health savings account without the savings, which instead go to the insurance company who also save by paying doctors the Medicaid rate, who have no choice to enroll because of call products clauses.

Obamacare is a huge mess. Nobody knows what is going on; money is not flowing; delivery of health care is deteriorating; patients feel they are entitled to receive optimum health care for no money; the amount of illegal patients is mind boggling.

Worse than I expected.

The whole program has resulted in poor quality care.

We have been excluded from plans for no reason.

MVP does not indicate on any of their insurance cards that they are a high deductible plan or what the deductible is. Excellus deductible information on their website is inaccurate resulting in many unnecessary patient confrontations.

Often, the patients do not seem to understand the deductible plans (most of the Exchange plans seem to be deductible plans). For private practice physicians, the Exchange plans could be a disaster in the making. Overall, very few patients we see have purchased insurance on the exchange. The few that have are relatively indigent and cannot pay high deductible because they can’t afford it, or end up not paying premiums and get dropped. Exchange insurance is equated to charity care/Medicaid in our practice, and we would prefer to not see any of these patients.

is critical to the future of medicine. A recent article in the NY Times noted that the Congressional Budget Office’s predic-

tions through the end of this decade were overstated and that the real numbers will be much lower than the budgetary predictions.

Commenting on this in a Labor Day editorial, Paul Krugman congratulates the Affordable Care Act for the lower figures. I am not sure how he arrives at this conclusion as the numbers were sliding down well before 2008 when Obama was elected and 2010 when the ACA became law. More likely the drop in actual spending is multifactorial and is in part due to the increase in privatizing many Medicare beneficiaries. Insurance companies have been excellent at steering patients away from care by placing huge hurdles for practitioners to overcome to provide that care. Of course the fees spent on physicians account for a small fraction of medical care and those have been reduced to an amount that makes practice non-viable for many of us.

I continue to practice in an independent manner as best I can. I utilize best practices. I attend many CME programs to improve my skills as a urologist. I am only too happy to utilize less expensive alternatives where outcomes are not compromised. If a third party payer indicates a less costly approach where quality is not compromised I am only too willing to comply. But I cannot accept punitive actions when I have not been armed with the appropriate cost data. Insurers can educate without punishment. And I do believe that a given service should be reimbursed equally regardless of where that service is rendered.

Much of what I have written here may be news to the reader. It certainly is not well known to the recipients of health care or to the legislators who have allowed these disparities to occur. We have seen a severe increase in the number of administrators and business people in our industry. It is the only way that we can continue to surmount the obstacles to patient care but it comes at a high price.

My scribe helps my workload and assists in making sure that my documentation is done well with all of the ‘T’s crossed and the ‘I’s dotted’ but the cost is enormous. I realize that the practice of medicine is due for an upgrade in its delivery. Meaningful use parameters, outcomes analysis and quality measures are certainly welcome and needed as we go forward.

But the involvement of those of us ‘in the trenches’ is the only way that we can move forward in a positive manner.

We are the best advocates for our patients’ health and our ability to provide care in a non-obstructive manner is critical to that role. That implies unity amongst the physicians. We still remain the basic force in health care. It is of the utmost importance that we all are members in our state medical societies and national specialty societies whose mission is to advocate for high quality care via its physician members. Regardless of one’s practice situation, it is imperative to unite for the benefit of our profession.
**ICD-10-CM: What’s Up With That?**

By Jacqueline Thielan, CPC, CPC-I, CHCA / Medco Consultants, Inc.

With all the starts and stops of the ICD-10-CM implementation, it is understandable why many physicians put their ICD-10-CM implementation plans on hold.

On May 1, 2014 the Centers for Medicare and Medicaid Services (CMS) declared Oct. 1, 2015 as the new compliance date and issued the following statement, “All HIPAA covered entities MUST implement the new code sets with dates of service or date of discharge for inpatients that occur on or after October 1, 2015. Health and Human Services (HHS) has no plans to extend the compliance date for implementation of ICD-10-CM/PCS; therefore, covered entities should plan to complete the steps required to implement ICD-10-CM/PCS on October 1, 2015.”

While we heard that song before and I am sure many are thinking the deadline will be extended yet again, here are some important reasons why medical practices should continue the ICD-10-CM implementation process.

Firstly, the use of the word “must” is strong language which we haven’t seen before.

Secondly, the transition from ICD-9-CM to ICD-10-CM is a massive undertaking, which many fail to realize. The transition will have an impact on every aspect of your practice. Consider the following:

- Your software must be able to support the two code sets (ICD-9-CM & ICD-10-YOU’RE YOUR hardware needs to support any software upgrades, and all your reports and interfaces will need to be able to support seven characters.
- Your staff will require training on the new code set. Keep in mind everyone in your practice who uses a diagnosis code, from the clinical staff to the billers and coders, to authorizations, and medical necessity for ordering laboratory, radiology and diagnostic testing will need to be well versed in the new code set to keep the wheels moving. Additionally, you can expect to see a decrease in productivity as your staff starts to adjust to the new code set.
- All of the CMS Local Coverage Determinations (LCDs) and insurance carrier policies will change.
- While the format of ICD-10-CM is similar in many aspects to ICD-9-CM, the effects on clinical documentation are very different in a number of cases. For example, the terminology used to describe asthma has been updated to reflect the current classification system. Asthma is now classified as either, mild persistent, moderate persistent or severe persistent. Additional factors include the cause, e.g., induced, cough variant, related to smoking, etc.
- For hypertension, the concept of “benign” or “malignant” as it relates to hypertension no longer exists.
- Finally you may be ready but will your vendors and payers be ready? Staying updated is essential in following your vendors and payer’s timelines and guidelines.

So while we have been granted an extension of time, it is recommended to use this time to move forward with the steps required for a successful ICD-10-CM transition.

The chart below lists the CMS websites for additional information and assistance with the transition process.

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**Author! Doctor!**

Tompkins Society member, Jim Fogel, MD has written a techno-thriller novel about human population and the effect it is having on the environment.

Procreation is the story of a brilliant but risky genetic engineering discovery that produces male sterility. It is an e-book that may be purchased for $3.99 online from Kindle, iBooks, Nook, Smashwords, Kobo and other e-book retailers.

Congratulations, Dr. Fogel!

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**ALLIANCE**

**SAVE Day is October 8th!**

The SAVE initiative to “Stop America’s Violence Everywhere” was launched by the AMA Alliance in June 1995. Alliances across the country recognized the toll that violence was taking in their communities. The national organization responded with the largest health promotion project undertaken by our membership. Over 700 anti-violence programs covering a broad spectrum of activities have been implemented by county and state Alliances. Our October 8 SAVE Day coincides with the “National Health Cares about Domestic Violence Day.”

Many local Alliances work with schools using the children’s activity booklets developed by the AMAA. Other activities include providing support for domestic violence shelters, mentoring programs for the prevention of child abuse, physician education on domestic violence, distribution of teen and adult safety cards, and mental health screenings at health fairs and schools. Activity books include “Hands Are Not for Hitting,” “I Can Choose,” and “You Don’t Have To Be Bullied.”

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*You will qualify for a $100 in bonus cash rewards if you use your new account to make purchases totaling at least $500 (exclusive of credits, returns and adjustments) that post to your account within 90 days of the account open date. Limit (1) item per new account. This one-time promotion is limited to new customers opening an account in response to this offer. Allow 8-12 weeks from qualifying for the bonus cash rewards to post to your rewards balance. The value of this reward may constitute taxable income to you. Bank of America may issue an Internal Revenue Service Form 1099 (or other appropriate form) to you that reflects the value of such reward. Please consult your tax advisor, as neither Bank of America, its affiliates, nor their employees provide tax advice.

**The 2% cash back on grocery store purchases and 3% cash back on gas applies to the first $1,500 in combined purchases in these categories each quarter.**
BLOOMFIELD, Randall D.; Brooklyn NY. Died July 31, 2014, age 90. Medical Society County of Kings.


HOLLANDER, Joshua; Rochester NY. Died August 25, 2014, age 88. Erie County Medical Society.

KESKIN, Necati; Nesconset NY. Died July 22, 2014, age 77. Monroe County Medical Society.

MAUSER, Donald I.; Wantagh NY. Died August 05, 2014, age 93. Nassau County Medical Society Inc.

MAUSER, Donald I.; Wantagh NY. Died August 05, 2014, age 93. Nassau County Medical Society Inc.


RACANELLI, Luigi; New York NY. Died August 11, 2014, age 93. New York County Medical Society Inc.

SMITH, Cedric M.; Palm Harbor FL. Died June 13, 2014, age 87. Erie County Medical Society.

ZODIATIS, Demetrius C.; Stony Brook NY. Died August 29, 2014, age 71. Suffolk County Medical Society.

ZOELLNER, Irwin Joseph; Endicott NY. Died August 13, 2014, age 77. Monroe County Medical Society.

Rosenberg, Irwin Joseph; Endicott NY. Died August 13, 2014, age 77. Monroe County Medical Society.

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Medical Liability Mutual Insurance Company (MLMIC)
New York Facial Plastic Surgery Society
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Question: I recently received a letter from National Government Services stating that I am under an Administrative Simplification and Compliance Act ("ASCA") review. What does this mean?

Answer: You have received this notification because you still submit paper claims to the Centers for Medicare & Medicaid Services ("CMS"). CMS requires all providers to submit their claims for payment via electronic means unless the provider (i) meets an ASCA exception and (ii) has a waiver on file with their Medicare Administrative Contractor. It is important to understand that even if you were granted an ASCA waiver in the past, such waivers automatically expire after two years. Current providers who are being targeted for review include those (i) who are submitting a significant volume of paper claims and whose waiver is more than two years old, (ii) providers who have previously been issued certain particular categories of waiver, regardless of the volume of paper claims, that are more than two years old and (iii) providers who are submitting more than 30 claims per quarter and have never been subject to ASCA review. If you believe you are entitled to a waiver and you are not currently under review, a request should be made immediately as the typical review period for such requests is 30 days. If you have received notification that you are under review, it is critical that a comprehensive response be submitted prior to the 90 day deadline. Failure to do so will result in an immediate cessation of the permission to submit paper claims. For more information, please see http://www.cms.gov/AGZZs.

If you have any questions, please contact our Managing Partner, Michael J. Schoppmann, Esq at 1-800-445-0954 or via email at MSchoppmann@DrLaw.com.
From potential insurer insolvency to the drawbacks of shared limits, there are many factors to consider when evaluating medical malpractice coverage. MLMIC is New York’s #1 medical liability insurer for a reason. Our policyholders know they can count on us to be there for them. Today, and tomorrow.

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