WESTCHESTER PHYSICIAN

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POINT AND COUNTERPOINT

Two Opposing Opinions of the New Health Care Legislation

John J. Stangel, MD, WCMS President

The recently passed health care legislation has stimulated intense discussion. We see it in the public as well as among our colleagues. In a recent Town Hall Meeting, hosted by WCMS, we invited Westchester physicians, members and non-members, to voice their concerns. For more than two hours, doctor after doctor stood up to voice his or her frustration with the omissions in the proposed laws and the blatant disregard of the constitutional process used to pass these laws. Others argued that, while the process was deplorable, the need to provide health care for the needy was so strong that it was worth the price. People of goodwill on both sides voiced intense, passionate opinions.

WCMS is committed to representing the views and needs of all physicians within the county of Westchester. When there are divergent opinions, they must be respected and heard. It is in keeping with this philosophy that I have invited two of our members to present their thoughts. Regardless of your position on health care, it is critical that you read both articles. ***After you have finished you are invited to share your opinion with us and your colleagues by writing or emailing the Society office.***

Louis F. McIntyre, MD, the author of our first article, is an Orthopedist and has been in practice at Westchester Orthopedic Associates since 1994. He has lectured and published widely. He is Chairman of the Health Policy and Practice Committee of the Arthroscopy Association of North America and a member of the Coding, Coverage and Reimbursement Committee of the American Academy of Orthopedic Surgeons. These committees deal with economic and political issues in medicine and work hard to ensure maximum patient access to quality, affordable orthopedic care.

Robert G. Lerner, MD is the author of the second article. He is a Professor of Medicine at New York Medical College. Dr. Lerner is the Program Director of Hematology/Oncology at New York Medical College and the Chief of Hematology/Hemostasis at Westchester Medical Center. In addition, he is a member of the WCMS Board of Directors and the Chair of the Public Health Committee of WCMS.

Once again, each has a strong opinion. I strongly suggest that you read both and then share your thoughts with all of us. ✦

A Look Inside . . .

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May 3, 2010
CME Committee Meeting - 5:00 pm

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**All meetings held at WCMS offices unless otherwise specified.*

SAVE THE DATE

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Details will be provided to members shortly.

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FROM THE EDITOR . . .
End of Life

By Peter Acker, MD

A recent front page article of the New York Times featured a story about Dr. Desiree Pardi who lost a long heartfelt battle against breast cancer when she died last September at the age of 41. What separates her story from those of thousands of others who have died tragically before their time, is that Dr. Pardi was a palliative care specialist. She had first been diagnosed with cancer when she was on leave from her medical studies and decided with that background she could be especially effective in counseling patients at the end of life.

The circumstances of her initial diagnosis were also unusual. She had left midway though her studies at Mt. Sinai to be with her husband, who had a work assignment in Dubai. She had a physical exam there to fulfill a visa requirement and the cancer was discovered. Because of the prevailing local cultural mores of gender roles, all communication was directed to her husband alone and then he would relay it to her. Interestingly, this high achieving female New Yorker found she liked having her husband serve as intermediary and upon returning to the United States, she elected to have all communication from her American caregivers via her husband.

Palliative Care is a growing field in this country and in many ways has been shaped in reaction to the high tech aggressive treatment options that have often turned the last months of life into an extremely painful (and expensive!) nightmare. Instead, the therapeutic model employed is decidedly non technological, emphasizing human connection, counseling with direct communication as to options, with the goal of allowing patients to choose a more gentle treatment course which would keep pain at bay and dignity intact.

Dr. Pardi's illness reached a crisis point and she was admitted emergently to a hospital in Boston where her doctors, noting the widespread and terminal nature of her cancer advised a palliative care consultation. She was shocked at the suggestion and while appreciating the irony of her choice, refused the consultation and chose the most aggressive therapy available. It was a high stakes gamble which ultimately she lost.

She was, by all accounts, an extremely talented physician who had an especially humane way with her patients. She was also, like many doctors, driven and so it is perhaps not surprising that she would elect the treatment course that she did and she demonstrated self awareness when she would refer to herself as the "Queen of Denial".

It's a sad story that exemplifies the limits of our profession; that the most empathetic of physicians can not always know a priori what it is like to be at the other end of the stethoscope. ✦

YOUR NEWSLETTER SUBMISSIONS ARE WELCOME

We encourage our members to submit articles, letters to the editor, announcements, classified ads, members in the news, etc. for publication in the ***Westchester Physician.***

The deadline for the May issue is **April 30th**.

Please email these to Peter Acker, MD, *Editor* at **Peterrba@aol.com** and Lori Van Slyke, *Newsletter Coordinator* at **lvanslyke@gmail.com.**

MEMBER OPINION . . .
The Health Care Reform Debacle

By Louis F. McIntyre, MD

On Christmas Eve, the Senate approved health care legislation, HR 3590, by a strict party-line vote of 60-39; with just enough votes to prevent further debate or filibuster. The bill was in the process of closed reconciliation amongst the Democratic leadership of the House, Senate and White House when the election of Scott Brown of Massachusetts seemed to have derailed the entire reform effort. Brown had campaigned against the health care reform bill promising that he would end the Democratic Party supermajority in the senate and thwart passage of the bill. The President and House Speaker Pelosi continued their effort to pass the bill and had the House pass the Senate bill with a reconciliation measure meant to improve the legislation. The legislation passed only after a group of pro-life Democrats , led by Bart Stupak of Michigan, were pressured to vote for the bill with an executive order by President Obama outlawing the expenditure of federal funds for abortions. The bill was signed into law by President Obama and now the task of writing the rules to enact the measure is in the hands of CMS and the Health and Human Services Secretary, Kathleen Sebelius.

The Westchester County Medical Society opposed this bill because of its many deficiencies. WCMS was joined by many state, county and specialty societies in this opposition. Enumerated below are provisions of the Senate bill that should cause all physicians to consider the serious ramifications of the bill in limiting access to care, harming quality and increasing costs. Outlined below are provisions of the Senate bill of concern:

- The creation of an Independent Payment Advisory Board that will have the power to determine coverage decisions. The Board will be made of unelected appointees that must submit coverage policy to the President and Congress. This will politicize treatment decisions best left to physician and patients. It may be hard fighting with insurance companies; imagine having to go to unelected, unaccountable bureaucrats or Congress to affect treatment decisions!
- New comparative effectiveness research programs (CER) similar to the NICE (National Institute for Health and Clinical Excellence) board in the UK that rations care and leads to as many as 15,000 premature cancer deaths in that country per year according to the National Cancer Intelligence Network. How will this board determine treatment decisions for cancer patients whom are on new protocols or surgical patients for who double-blind prospective studies are unethical?
- The bill depends on the recommendations of the US Preventive Service Task Force in setting coverage and treatment policy. This is the same organization that recently caused such an uproar over advising women under age 50 not to undergo annual mammograms.
- The bill nationalizes insurance regulations including mandatory community rating and the prohibition of denial of coverage based on previous medical conditions. This will drive up the cost of insurance in the majority of states which currently do not have such rules. New York has had such regulations since 1994 and our insurance costs are two to three times costs in other states. WellPoint ran an actuarial analysis of its insurance programs and found that this will cause a significant (up to 168% in some instances) increase in premiums.

(continued on page 5)

The Health Care Reform Debacle *(continued from page 4)*

- 6.7 Billion in new fees (taxes) on insurance companies to help fund the bill. Where do the Senators, Congressman and President think the money for this new tax will come from? The bill also dictates insurance executive salaries and limits their profitability. I am no fan of the insurance companies but making them federally controlled utilities will not reform the perverse incentives created by the current third-party payer system. In fact, this reform give them a steady stream of new customers and insulates them from competition because it sets coverage, payment and premium rates!
- Increased Medicare payroll taxes for those earning over $200,000. New taxes on "passive" income of 3.8%.
- Failure to address reform of the SGR (Sustainable Growth Rate) of Medicare. As of April 1, 2010, a 21% reduction in physician fees for Part B Medicare will take place, despite passage of health care reform. CMS will hold claims for 10 days to allow Congress to try to fix this on its return from Easter Recess. This is the third time this year doctors have been held hostage to CMS with Congress' refusal to fix the SGR. How much longer will we face such uncertainty? When will this start to bankrupt physician practices? Does the government really want to continue to test these waters?
- 400 million dollars in Medicare cuts over the next 10 years. Medicare will be insolvent in seven years if unreformed. The bill's answer to that fact is this cut. It was also necessary to keep the overall cost of the bill under the arbitrary 1 trillion dollar cost set by the President. If history is any guide, these cuts will never materialize because Congress knows that the program is already underfunded and that making these cuts will limit seniors' access to health care as doctors flee the system. This is why they have voted every year to override the hated SGR and not cut provider fees. The plan includes completely changing the way doctors are paid to take care of Medicare patients; it proposes paying for "quality not quantity". Who will define the parameters of "quality"? Will those parameters be more concerned with costs than care? Will specialty care continue to suffer under this arrangement limiting access to surgery and medications? Will there be a global cap on medical expenditures as in Canada or as contemplated in Massachusetts? These and countless other questions await the promulgation of the final rules from the legislation.
- An expansion of Medicaid to those well above the poverty level. Medicaid is the largest line item in many state budgets. Increasing eligibility will place enormous stress on state budgets already crippled by the current economic climate. It will necessitate huge state tax increases, unless you live in Nebraska where Senator Ben Nelson was able to negotiate no increases for new Nebraskans in Medicaid in exchange for his yes vote. So all the rest of us get to pay for the Nebraskans and also those from Louisiana, since Senator Mary Landrieu also switched her vote to yes in exchange for 300 million in Medicaid subsidies to her state. In addition, all these newly insured will find that 40% of doctors do not accept their new insurance so by definition they will be underinsured.
- The creation of government-run exchanges that will subsidize insurance for those making up to 400% of the poverty level, or $96,000 per year. Under the Senate bill, someone who earned $42,000 would get $5,749 from the current tax exclusion for employer-sponsored coverage, but $12,750 in the exchange. An employee making $60,000 would get $3,758 in the current system and $8,310 in the exchanges. This will significantly distort the labor market making much more attractive for small business to offload insurance costs to the exchanges or to make employees "contractors". It also may significantly underestimate the government's costs as more employers flee the private insurance market for the exchanges.

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The Health Care Reform Debacle *(continued from page 5)*

- The creation of a health care insurance mandate. All individuals will be forced to purchase some type of health insurance or face a fine that will be levied by the IRS. The bill authorizes the IRS to police and enforce this policy but how they will do it is unclear and awaits the final rules on the bill. Some may choose to pay the fine and not get insurance. This would be especially attractive for young, healthy males since they will be able to purchase insurance anytime they have a medical problem under the guarantee issue part of the bill. Some legal experts believe that such a mandate is unconstitutional and it is likely to face protracted battles in the courts.
- New taxes of 2 billion (increasing to 3 billion in 2018) on medical device makers. Physicians' collaboration with the device industry has been a resounding success with the benefits accruing to our patients in terms of less pain, scarring and improved outcomes. It has also greatly facilitated medical education. This tax represents a real threat to innovation, patient care and education.
- Limitations and new taxes on Health Savings Accounts. These accounts are popular because they give patients more control over how they spend their health care dollars. In an era of rising co-pays and deductibles they are a great hedge against increased expenses and offer a way for patients to control their own costs. I know, I've had one for five years. They will be severely limited in this bill.
- Restrictions on Medicare Advantage. This popular program, which enrolls about 20% of Medicare recipients, will be slowly abolished, unless you live in Florida, where Senator Bill Nelson negotiated a 3 billion dollar deal to exempt Florida seniors who currently have Medicare Advantage from losing their benefits.
- Severe limitation on physician owned hospitals.
- No serious effort at tort reform as a potential health cost saver.

This legislation will affect all of us as practicing physicians, as employers and as patients. We will face threats that will severely curtail our ability to care for our patients. We will be limited by central decision makers in Washington determining coverage and treatment options. We will be limited in our ability to order diagnostic tests and use new instruments and devices. Our patients will face increasing insurance costs and limitations of coverage; especially seniors who face rationing of their care. As employers we will see our insurance cost increase and will face the possible elimination of health care insurance from the benefits we offer our employees.

This bill is reckless, irresponsible and poorly constructed. In many provisions it may violate the Constitution. The unintended consequences will be manifold. It does not lower or control costs, it increases them. It does not improve quality, quality will suffer. It does increase access for some, but not all, of those who currently lack insurance. Some, like those on Medicaid, will remain underinsured.

To look at the future, visit Massachusetts where health care reform much like the current federal reform was enacted in 2006. Currently that state has the highest insurance costs and per capita spending on health care in the nation. Its Medicaid program is bankrupt and is currently seeking a bailout from the federal government. The Massachusetts State Senate is currently considering a bill that would cap physician and hospital fees because of the cost overruns of the subsidized system. Six hospitals are suing the state because they are approaching bankruptcy. Is this what we want for the entire nation?

Before enacted, the current reform is in need of complete revision to decrease costs, ensure access and provide for a sustainable health care system that serves all Americans. We deserve so much better than this.✦

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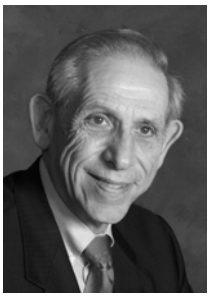
MEMBER OPINION . . .
The New Health Care Reform Law



By Robert G. Lerner, M.D., FACP

I have been asked to write a response to another article is this issue of the Westchester Physician by Dr. Louis F. McIntyre, entitled "The Health Care Reform Debacle". I will start out by saying that I am very disappointed in the law but I am still glad that it passed. I will not respond to the criticism of how the law was passed except to note that all of the legislative processes have been used many times before with or without partisan sham outrage depending on the politics of the moment.

I am disappointed in the law because it does not provide health insurance to everyone by spreading the risk over the entire population as a single payer system would. A single payer system would have provided enough administrative savings to pay for health care for everyone instead of leaving 23 million people uninsured.

I am disappointed in the law because in order to get it passed the rights of women were further eroded, making it even more difficult to obtain abortion services.

I am disappointed in the law because it leaves insurance companies in a strong position to devise new ways to exploit loopholes and avoid paying for the care of sick people.

I am disappointed in the law because I don't think enough money will be found rooting out "waste, fraud and abuse" to hold down premiums.

I am disappointed in the law because I think everyone (patients, insurance companies, pharmaceutical industry companies, other providers and even physicians) will game the system because it is so complex that there are many opportunities to do so.

Despite my many disappointments I am glad that the law was enacted because it does provide insurance coverage to 32 million individuals who were otherwise uninsured. It does eliminate some of the most odious insurance company practices. It does provide for new experiments in innovation to control costs. It does provide security to many now in fear of bankruptcy because of health care costs. It goes a long way to correcting a system that has been a national disgrace. It is a forward step that has been blocked by partisan bickering for 100 years.

I would now like to respond one by one to the points made elsewhere in this issue.

- An independent Payment Advisory Board will have the power to determine coverage decisions. That to me is infinitely better than leaving such decisions in the hands of "for profit" insurance companies. The insurance companies are required by law to work for the fiduciary interest of their stockholders, thus creating a conflict of interest. The new law is clearly an improvement on the long-standing practice of "just say no" until the insured party gives up or dies or occasionally wins his case after much delay and anguish.
- The claim that comparative effectiveness research (CER) will lead to 15,000 premature cancer deaths per year is patently absurd. CER is very much needed and is a way to provide more effective and safer treatment. I am a practicing hematologist/oncologist and I don't want charlatans selling the latest bunk to patients based on phony claims.

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Member Opinion … The New Health Care Reform Law

(continued from page 8)

- The claim that the US Preventive Service Task Force was wrong because it suggested that women of 40 to 50 years of age should discuss the risks and benefits of a mammogram rather than routinely get a mammogram is incorrect. This was a sound recommendation grossly distorted by the media to such a degree that it caused hysteria.
- Mandatory community rating and prohibition of denial of coverage based on preexisting medical conditions is derided because it results in higher premiums. The alternative is to tell the chronically ill patient "tough luck, it's your problem". The function of insurance is to spread the risk. I favor the new law with its fair and humane approach. Using an actuarial analysis from the insurance industry known for fraudulent data can not be relied upon to predict the future cost.
- The taxes on insurance companies are criticized because it is thought that the money will come from the insured people. It is then stated that making the insurance companies into federally controlled utilities will not help. Actually such a system has worked very well in Germany, although I agree that perverse incentives do have to be addressed.
- Increased taxes on the wealthy and passive income is listed without comment. I think that is a good idea since in the last 30 years America has become the industrialized country with the greatest polarization of income in the world.
- Failing to address the flawed SGR (Sustainable Growth Rate) is an ongoing problem and I agree with that.
- The cuts in Medicare are criticized. The cut to Medicare Advantage which is a giveaway to insurance companies is a good thing. The future cuts are not defined and I share some concern as to how "quality not quantity" will be implemented.
- Expanding Medicaid is one of the ways insurance coverage was extended to the uninsured. If it pays so little that physicians do not participate, it will have to change. The increase for primary care seems unlikely to solve the problem. That situation will have to evolve.
- The "government run" exchanges will actually be run by the states. The federal government will only run the exchanges if the states refuse to do so. There is a lot of incentive for small business to continue insurance coverage for their employees. It is a far better deal for those in the labor market than the current situation where people are afraid or unable to change jobs because of health insurance.
- The mandate is criticized as unconstitutional. In my opinion, it is not unconstitutional and the Attorneys General are wasting time and money with this.
- It is claimed that physicians' collaboration with the device industry has been a resounding success. That certainly is open to debate although it clearly has been a resounding expense.
- Health Savings Accounts are preserved and they certainly are a good deal for rich people.
- The law is criticized for slowly abolishing Medicare Advantage. See above. This is a giveaway to insurance companies and should be abolished.
- Should there be limitations on physician owned hospitals? I think so.
- The law makes no serious effort at tort reform. I agree that this is a serious flaw.

This is now the law of the land. It will affect all of us and we have to be vigilant to keep it on the right track. It is not reckless or irresponsible. It will not be repealed. We must see to it that the practice of medicine is protected, but we must protect the public health as a first priority. ✦

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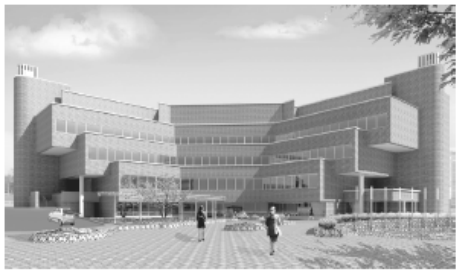

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COMMISSIONER'S CORNER . . .

Energy Drinks and Associated Health Risks

Janet Forcina, MS, RD, Health Care Administrator
Cheryl Archbald, MD, MPH, Acting Commissioner of Health

Energy drinks are being used more and more as recreational stimulants, especially by young people. A review article published by the Johns Hopkins University School of Medicine indicates that the United States is a worldwide leader in sales of energy drinks, with an annual retail market that exceeds $5 billion. Energy drinks are promoted as alternatives to caffeinated soda and to individuals who favor herbal and vitamin-containing products. Energy drinks are also actively promoted to youth, especially on college campuses, through involvement of college students in direct marketing and promotional activities.

The primary active ingredient in energy drinks is caffeine. The amount and concentration of caffeine found in energy drinks depends on the specific brand and portion size. As a result, the amount of caffeine in six ounces of an energy drink could range from 20mg to 1000mg depending on the brand, as compared to 75mg to150mg of caffeine found in a six-ounce cup of coffee. Although the U. S. Food and Drug Administration regulates the caffeine content found in over-the-counter caffeine-containing stimulants and in caffeinated soda, similar federal regulations do not exist for caffeinated energy drinks.

Due to the excessive caffeine in energy drinks, energy drink consumption can cause health risks associated with caffeine intoxication and can also lead to caffeine dependence. Such health risks include:

- restlessness, irritability, tremors
- headaches
- insomnia
- increased blood pressure and heart rate
- chest pain, arrhythmias, myocardial infarctions, sudden cardiac death
- nausea, dehydration, decreased appetite

Health risks from energy drinks can also result from the varying content of additional ingredients found in these beverages. Energy drinks may also contain a wide range of additional active ingredients such as: plant-based stimulants (e.g., guarana), herbs (e.g., ginkgo, ginseng), and amino acids (e.g., taurine), as well as various vitamins and excessive sugar. The health effect of excessive sugar is well documented, with sugar being linked to weight gain, obesity and type-2 diabetes. However, research is lacking with regard to the upper limit of intake for the additional substances found in energy drinks, the potential interactions among ingredients, and the long-term health effects from energy drink consumption.

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Commissioner's Corner - *Energy Drinks and Associated Health Risks*

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In addition to excessive energy drink consumption, another problem has arisen with youth mixing energy drinks with alcohol. A study published by the Society for Academic Emergency Medicine investigated the prevalence of this behavior among college students. Of the approximately 4,300 students surveyed, 16 percent reported drinking alcohol mixed with energy drinks at some time during the past 30 days. Researchers found that the practice was associated with excessive alcohol intake among students in addition to increased likelihood of risky behaviors, sexual assault, injuries, driving while intoxicated, or being in a car with an intoxicated driver. As energy drinks can lessen perceptions of intoxication, the study found that energy drinks mixed with alcohol was a riskier practice than alcohol ingestion alone. The health and behavioral consequences that resulted from mixing alcohol and energy drinks did not depend solely on the amount of alcohol consumed.

Physicians may encounter patients experiencing side effects associated with the consumption of energy drinks. Physicians are encouraged to inquire about energy drink usage, to counsel patients on the health impact of excessive energy drink consumption, and to caution patients against mixing alcohol or other drugs with energy drinks. Due to the caffeine content and other active ingredients in energy drinks, energy drinks may not be advisable in any amount for patients who have pre-existing health conditions that could be exacerbated through consumption of these beverages. For other patients, energy drinks, if consumed, should be consumed only in moderation.

As some patients may be replacing meals with energy drinks, or taking them to suppress appetite or reduce stress, patient counseling may focus on the advice below:

- Eat three small meals and three small snacks throughout the day. Choose healthy options to prevent extreme fluctuations in blood sugar and the desire for a caffeine boost from energy drinks.
- Meals and snacks should include protein, which takes longer to digest, provides longer satiety and therefore prevents excessive carbohydrate intake.
- Reduce your sugar intake to avoid fluctuations in energy levels that can trigger the desire to eat more sugar.
- Drink sufficient amounts of water during the day, to ensure adequate hydration based on diet, climate and level of activity.
- Get enough sleep, because a lack of sleep has been associated with abnormal eating patterns and reduced energy levels.
- Engage in 30 minutes of moderate-intensity exercise at least five days a week, a general recommendation for most adults.

Identify stress reduction techniques to replace the need to respond to stress through excessive food and drink consumption.

For more information about energy drinks, please contact the Westchester County Department of Health at (914) 813-5000 or visit ***www.westchestergov.com/health*** ✦

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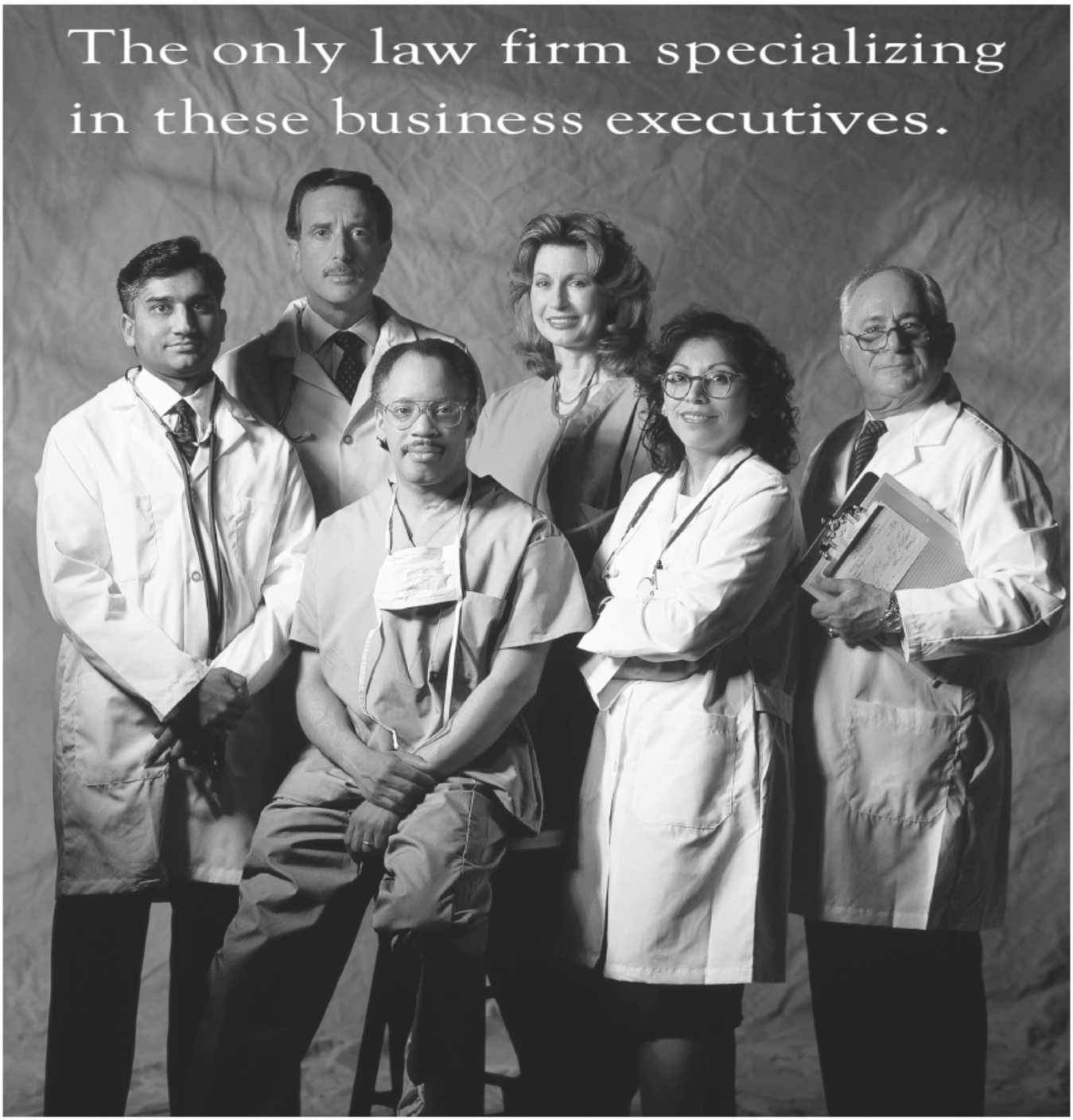

MEDICARE CONTRACTOR PROVIDER SATISFACTION SURVEY

CMS Needs to Hear From You!

Attention all Physicians, Hospitals, Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) (and their designated Proxy Billing Agents) Selected to Participate in the 2010 Medicare Contractor Provider Satisfaction Survey (MCPSS)

Approximately 30,000 Medicare FFS health care providers were randomly selected to participate in the 2010 survey; only those selected may participate. A new random sample is selected each year. **To date, the response rate for is lower than expected.**

If you or your office received a letter inviting you to participate in this survey, or you have been designated by a provider as a proxy respondent, now is the time to give CMS your feedback on your satisfaction with the performance of the Medicare contractor that processes and pays your fee-for-service (FFS) Medicare claims.

Your feedback is very important to the success of this survey, as you represent many other organizations similar in size, practice type, and geographical location. Completion of the survey is quick and easy – it only takes a few minutes of your time. To complete the survey or to designate a proxy respondent to complete the survey on your behalf, please call the MCPSS Provider Helpline at 1-800-835-7012 or send an email to ***mcpss@scimetrika.com***.

For more information, visit the CMS MCPSS website at ***http://www.cms.hhs.gov/mcpss***, or read the CMS MLN Matters Special Edition article, SE1005, at ***http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1005.pdf*** featuring the survey.

CMS urges you to take a few minutes today to complete and submit this important survey. ***Your feedback is needed now. Don't delay. Please respond today!***

120-Day Claim Submission Time Frame Begins April 1

Beginning April 1, commercial health insurers may not require physicians to submit claims earlier than 120 days from the date medical care was provided. The 120-day time frame is part of the comprehensive managed care reform law that was enacted by the State Legislature and Governor in 2009 that included a number of other incremental positive reforms. Many provider contracts currently limit such claim submission time period to 60 or 90 days. This provision would also require health plans to, at a minimum, pay a provider 75% of the claim when it is submitted more than 120 days after the date of service if the health provider can demonstrate that the claim could not be submitted within 120 days as a result an "unusual occurrence".

Importantly, the 2009 law also clarified that these provisions are only a statutory "floor" and that a longer time period or other more favorable terms to the provider for late consideration can be agreed upon. Moreover, this 120-day time frame is also subject to more generous provisions that are articulated in the recently enacted Coordination of Benefits (COB) regulation promulgated by the State Insurance Department.

That regulation assures that, for claims involving patients covered by more than one health insurance product, a provider will have at least 60 days to submit a claim to a financially responsible health insurer, following receipt of a benefit determination from another health insurer, no matter how long after the date of service such benefit determination is received from the other health insurer.

WCMS is on Facebook and Twitter

Check out our Facebook page by going to ***www.facebook.com*** and search for Westchester County Medical Society.

You can access our Twitter via our Facebook page or go to ***http://twitter.com/wcmsdocs***

Surviving Healthcare Reform
A Disaster Plan for your Office
"How to Survive an Investigation or Audit"

Kern Augustine Conroy & Schoppmann, PC, has created a publication for WCMS members to use as a guide for surviving an investigation or audit of their practice.

These are available at WCMS headquarters in White Plains. If you would like a copy, please stop by anytime to pick one up. These are also available in PDF format which can be emailed to you.

Contact Denise or Caitlin at (914) 967-9100.

"PTSD and TBI: How to Recognize Them and What to Do Next"

CME Program—Friday, April 23, 2010—Fordham University

A Veterans' Mental Health Training Initiative sponsored by the New York State Chapter of the National Association of Social Workers, the Medical Society of the State of New York, and the New York State Psychiatric Association will held on **Friday, April 23, 2010**. The program will be held at Fordham University, Lincoln Center Campus in the Lowenstein Academic Building at 60th St & Columbus Ave, New York, NY.

Physicians are welcome to attend the all day Symposium on Enhancing Community Capacity to Meet the Needs of Returning Service members & Their Families or the individual morning session (10:45AM – 12:15PM) entitled PTSD and TBI: How to Recognize Them and What to Do Next. Physicians who attend this session will be eligible to receive 1.5 AMA PRA Category 1 Credits™. Frank Dowling, MD, Associate Professor of Clinical Psychiatry at SUNY at Stony Brook, will be the presenter. Dr. Dowling has a private practice in Hauppauge, NY, specializing in the treatment of emergency responders and healthcare professionals.

PTSD (Post Traumatic Stress Disorder) and TBI (Traumatic Brain Injury) often look similar and have similar impacts on those affected by them. This workshop will provide a review of signs and symptoms, presentation of screening and assessment tools and methodologies, as well as information on evidenced–based treatment. **The event is free of charge**.

For more information contact Eileen Clinton at ***eclinton@mssny.org*** or register online at ***www.naswnys.org/tiglance.htm***

WCMS April Board Highlights

At its meeting on April 6, 2010 at WCMS Headquarters, the Board…

- Welcomed William Mooney, Jr., President, and Amy Allen, Director of Advocacy, Westchester County Association (WCA), who made a presentation regarding the WCA's ***"Call to Action" Campaign,*** an effort to improve the business climate in Westchester and around the state by reforming state government. This Campaign will likely involve working to elect business-friendly legislators in November who favor repeal of burdensome tax laws and regulations which deter business growth, as well as who support the passage of laws that reward and incentivize businesses that wish to grow and create jobs. A press conference to launch the Campaign will be held on April 15th and a Rally for Action will be held on May 20th at the Rye Town Hilton. Following the presentation, and acknowledging that the WCA has been a friend of medicine and a strong supporter of issues important to physicians, ***the Board voted to join the Call to Action Campaign as a partner and raise the awareness of the Campaign among its members, including the Rally.***
- Discussed the aftermath of the WCMS-sponsored Town Hall Meeting on Health Care Reform, which was held on March 18, 2010 at the WCMS Offices. Approximately 45 physicians and guests, along with several media outlets, attended the meeting and spoke out on the pro's and cons of the then-pending federal health care legislation, which actually was passed by Congress three days later and signed into law on March 23rd. The relatively impromptu event generated a passionate audience and allowed physicians to address their concerns with media present and listening. While the eventual coverage was somewhat minimal (CNN, RNN and The Journal News reported on the meeting), the town hall format will be considered by the Board for future activities to give members the opportunity to express their views on issues important to the practice of medicine and patient care.
- Heard from John Stangel, MD, President, whom the Board elected to serve on the Nominating Committee for 2010-11. Dr. Stangel will represent the Board and appoint members in addition to those required by the Bylaws. The Committee will meet in the near future and recommend a slate of officers for member review. Election of officers will take place at the Annual meeting in June.
- Heard fromDr. Stangel that he is appointing a special Task Force on membership and communications, to meet as soon as feasible, to explore the membership needs of physicians and determine how best the WCMS should communicate with physicians now and in the future, with a report back to the Board by September.
- Heard from the President of the Westchester Academy of Medicine (WAM), Joseph McNelis, MD, who reported that a total of 12 essays had been received from local high school juniors in competition for the annual WAM Scholarship Awards. A financial award will be given to the top three essays as determined by a panel of judges, and the winners will be invited to and recognized at the WCMS Annual meeting in June.
- Discussed the 2010 WCMS Annual Meeting and asked that it be combined with a Membership Meeting/Event in early June and include educational offerings. As soon as a date and location have been determined, a save-the-date will be sent to all members.
- ***Approved the Report of the Committee on Membership/Member Credentials***, which included seven new members: Ellisa Bookner, MD, internal medicine, Scarsdale; Gregg Caporaso, MD, neurology, Mount Kisco; Gail DeLasho, MD, obstetrics and gynecology, White Plains; Michael Lasser, MD, pediatrics, Yorktown Heights; Liang Liu, MD, pathology, Rye Brook; Jonathan Smith, MD, otolaryngology, Bronx; and Kristin Woodard, MD, pediatrics, Rye Brook. The Board also approved a dues remission in the case of Carter Pottash, MD, and two new life members: Allen Friedland, MD (WCMS member for 33 years); and Bernard Bernhardt, MD (WCMS member for 40 years). Lastly, the Board approved and welcomed nineteen (19) new resident members via the MLMIC-sponsored project.
- Heard from the Chair of the Legislative Committee, Thomas Lee, MD, that nearly 40 WCMS members and invited guests attended the annual MSSNY Physician Advocacy Day in Albany on March 9, 2010. All legislators representing Westchester were visited and subsequently sent follow-up communications from WCMS regarding MSSNY Talking Points on issues important to medicine (including medical liability and managed care reform) and the results of the MSSNY Economic Study of the impact of privately practicing physicians on the Westchester economy. ✦

WESTCHESTER COUNTY MEDICAL SOCIETY
333 Westchester Avenue
Suite LN01
White Plains, NY 10604