WESTCHESTER PHYSICIAN

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Thoughts of the Outgoing WCMS President

2009-2010

John J. Stangel, MD, WCMS President

I have had the privilege of being President of this Society during a time that I have heard described as the most tumultuous period in recent memory.

Within days of my taking office we lost our Society Executive Director. We began a search that later gave us the good fortune of bringing back Brian Foy, as our new Director. The stock market fell, Washington began dismantling our health care system and many of us found that the AMA, though it had a place at the table, did not represent our views. In December 2009 I, as President of our Society, with the support of the Board of Directors, made a public statement against the then proposed health care legislation. We opposed "…any legislation, which negatively impacts patient care, unfairly and adversely affects our profession, or compromises the physician-patient relationship…The practice of medicine, must always remain a sacred "contract" between patient and physician, and the only meaningful role for our government is to facilitate this relationship…" *(See the December, 2009 Westchester Physician for the full statement)*. Our position is still passionate and unchanged.

We instituted blast email so that we could present our position, the one the AMA could not present. When we publically announced our position, suddenly we had friends and supporters in neighboring states extending as far as Hawaii, and even on to the floor of the United States Senate. With the enactment of the new health care laws we found the further need to directly communicate the needs of physicians, our patients, as well as our hospitals to our local politicians.

Though the initial flurry of activity about the recent health care legislation has ebbed a bit, it is particularly important not to lapse into a state of distance or disinterest. Regardless of your position on the legislation, it still has onerous consequences. Now is the time that it is critical to maintain our voices, to make our legislators understand that THE VOICE AND THE POSITION OF THE AMA WAS NOT THE VOICE ITS MEMBERS. To do this we have to become and stay politically active. As we make our position known we must not break into rival camps, fighting among ourselves. It is critical that we stay focused and relentless in our efforts. It is not good enough for us to send emails to each other to point out the dire consequences of the legislation. We have to use the laws themselves as a motivation to do something. We must never think back to this time and realize, but for our efforts the finest medical system in the world was

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A Look Inside . . .

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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 July/August issue is ***Friday, July 16th.***

Please email these to:

Peter Acker, MD, *Editor*
peterrba@aol.com
and
Lori Van Slyke, *Newsletter Coordinator*
lvanslyke@gmail.com

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FROM THE EDITOR . . .
Dickens Delivers

By Peter Acker, MD

It has been my habit for a number of years to listen to books on tape while riding in my car. This has been facilitated by a move I made some twelve years ago to Northern Westchester, the hamlet of Goldens Bridge specifically, which has served to lengthen my commute from about five minutes to twenty five. I suppose it is possible to listen to a novel in five minute bursts, but I can't imagine it to be an enjoyable experience. Twenty- five minutes, on the other hand, is an ideal length of time to get engaged in a narrative, the way a wood screw after a few twists gains purchase and pulls itself into the board. I have been consuming miles and books thusly now for years at a rate of about two per month. It has proven to be an ideal way to shake off the rigors of a day at the office or tension laden breakfasts at home as teenagers rush around looking for things while their mother chases with proffered items of food. Contrast that with my previous commute: I'd leave the office of screaming children and almost instantly find myself catapulted into a house of screaming children (my kids were young then).

An additional advantage of living further from my office is that I am afforded fewer out of office encounters with the parents of my patients. I don't mean to suggest that I have anything against any of my wonderful patients and their families, but there is no question that a pediatrician bending over a vegetable bin in the market is considered by most to be fair game for an earnest mother's inquiry about her toddler's toilet training. One of the wonderful things about pediatrics is, because of our days spent smiling at young children, that people consider us quite approachable; but it can wear one down if it continues into the off hours. Some years ago a mother called me late at night, waking me from a sound sleep, with a question about her son who had had an ENT procedure that day. It was purely a post-op type question. I suggested that the ENT might be the best person to consult. Her rejoinder? "I wouldn't dream of disturbing him at this hour."

There are also the awkward situations created by the notion that we should be paradigms of virtue and set an example. I'm not suggesting that I want to be free and careen around the village sated to the gills with gin, but more like the simple walking into that den of equity, the local MacDonalds - the raised eyebrows followed by the slightly embarrassed cough as they glance at their kids in a feeding frenzy over some big macs and fries and then a quick return to the offensive - "Doctor, what are you doing here?" Then there was the time in the supermarket with my then three-year-old to whom I had just delivered the word 'no' when she asked for some ice cream. This word, so unfamiliar to her virgin ears, set off a major tantrum - of the drop to the floor, kicking and screaming variety. The market was crowded that day and several shopping carts had to literally screech to a stop to avoid running over her. As I took steps towards her to deal with the crisis, I couldn't help but notice a number of familiar faces in the crowd that had assembled around us and while my view was focused on my daughter, I could still detect a collective smugness on the countenances around me which seemed to say "Well, let's see how Mr. Big Shot deals with this." I wanted to retort – "excuse me that's Dr. Big Shot".

So I confess that I enjoy my privacy. The changed circumstances that have afforded me the chance to live further from my office are emblematic of the way the practice of medicine is changing. When I started in practice 23 years ago, I had lived close to the hospital because at that time pediatricians covered the delivery room and performed various neonatal services. Also, the pediatric training of ER physicians was less than it is today, so we were quick to come in to see our patients. Today, neonatologists, and hospitalists have obviated the need for the pediatrician to rush in at a moment's notice and the experience of call is far different today than it was back then. There is no question that I enjoy

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Thoughts of the Outgoing WCMS President

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lost, and it was lost on our watch. There are outside opportunistic forces circling the medical profession, like buzzards, slowly picking us apart. They are doing it now, even as you read these words. Having good intentions or planning to help in the future is not enough. **The time is now! Take your energy, now, at this moment and get involved in the WCMS and MSSNY.** By merely joining, you increase our numbers and thus our power. Write letters to the Westchester Physician newsletter. We want and need to hear from you whether or not you agree with us. **We represent all physicians, of all views, from within Westchester.** By writing you do not even have to leave your home to make yourself heard by hundreds of others. Our new health care system is far from perfect and there is a profound need for improvement. The direction of the force for improvement, that leadership, must come from our physicians!

The activity of the past year took tremendous work. All of you, our members, pulled together. Many of you freely gave of your weekends and evenings. When the need was there so were you. I will remember all of you who worked so passionately, for the rest of my life. The presidency, for me, was truly an exciting and life-changing experience.

I want to thank my wife, Lois, for her understanding and patience during the many, many times I was busy and away. This past year would have been impossible without her. I want to thank my sons, Justin and Eric, for helping me laugh when I really needed it. It will be good to spend more time with my family again. And I want to sincerely thank the Society for giving me an opportunity to serve our organization and our profession.

I am turning over the leadership of this Society to our next President, Dr. Joseph Tartaglia. He is an exceptionally talented and able physician well equipped to carry us into the next year. WCMS's vital signs are stable, but there is still a lot to be done. I know he will not allow what I consider the finest health care system in the world to fall during his watch.✦

FROM THE EDITOR—Dickens Delivers

(continued from page 3)

the considerable reduced tension and angst, but I must say, in some ways, it is a Faustian bargain. Living in the same community as one's patients provides a sense of intimacy and connectiveness. I occasionally run into a mother whose delivery I attended years ago and inevitably the face lights up and there is no question that my presence there is indubitably etched into her memory.

Currently I am listening to Charles Dickens' Oliver Twist. There is a wonderful passage near the beginning which recounts Oliver's birth which reminds me of those days of old in the delivery room. His birth was not an easy one and afterwards "there was considerable difficulty in inducing Oliver to take upon itself the office of respiration." This transported me back to experiences, often in the middle of the night, when a baby would lay apneic seconds after birth and I'd watch anxiously for that first breath and the collective sigh of relief with the first cry. Then with typical Dickensonian humor: "for some time he lay gasping on the little flock mattress, rather unequally poised between this world and the next: the balance being decidedly in favor of the latter. Now if, during this brief period, Oliver had been surrounded by careful grandmothers, anxious aunts, experienced nurses and doctors of profound wisdom, he would have most inevitably and indubitably been killed in no time." ✦

FROM THE INCOMING PRESIDENT. . .
Doctors Need Organized Medicine

Joseph Tartaglia, MD
2010-2011 WCMS Incoming President

As I look back over my career in medicine and my father's career before me, a time span that dates back to the 1950's, I see that the practice of medicine for the past 60 years has been shaped by politics, first in the name of public health and lately to regulate the increasing economic burden of the public entitlement programs for the poor and elderly that started in 1965.

In my father's era, no one told him he needed to fill out insurance claims for payment, or that he would need to ask permission from an insurance clerk to obtain pre-authorization for certain tests. He wasn't told how to write his notes, or how long to keep his patients in the hospital. He didn't have to take his boards every ten years or take an exam on child abuse or infection control to renew his license. He wasn't afraid to give a patient a shot of penicillin during a house call and his malpractice insurance cost less than $1000 a year in today's dollars. I can go on, but the point is that we physicians have to face a myriad of socio-economic and political challenges that the last generation hadn't envisioned.

When I started my practice, I asked my father if I should belong to the medical society and his answer was short and with a hint of annoyance, as if I was wrong for even questioning it; "Of course, son, you must belong, otherwise who will represent us?" I joined without further discussion, and over the subsequent years I became more involved. I first was asked to be on a committee, public health, then I was chair, then chair of communications and finally on the Board of Directors. I learned how wise my father was because I saw how skillfully and eloquently my fellow physicians of the medical society have fought for and protected physicians and their patients on all the issues that have unfolded over the past 20 years. I was happy to know that through the medical society I have such a knowledgeable and influential resource to fall back on if I need help with any payment problems, insurance audits, OSHA problems, OPMC, etc. I saw how the physicians in the society spent their free time, what little they had, without compensation or special recognition to defend all the physicians in the community and their right to practice medicine unencumbered by zealous bureaucrats, greedy insurance executives, or ill-informed politicians. I learned that the medical society is a democratic organization. AMA policy and MSSNY starts with resolutions at the county level, that then get voted on by elected representatives at the State level and eventually policies from the states get incorporated into AMA policy by elected delegates to the national meeting. Over the years, however, I am dismayed to see fewer physicians getting involved in organized medicine or even understand how it works. The specialty societies are primarily concerned with education and science and the universities and hospitals seek more to control the physician than to protect him. Only organized medicine can represent physicians and advocate for them at the local, state and national level. If current trends continue, we will not have an effective medical society to represent and defend us.

As incoming President of the Westchester County Medical Society I vow to reverse this trend of diminishing membership. As I talk to physicians in and outside of the medical society, I hear multiple reasons for members not joining. Some just don't know what we have done for them, others think their specialty society will defend them, or their group or hospital; some don't agree with some particular AMA stance, still others selfishly just don't pay the dues thinking the medical society will benefit them anyway. In my view, none of these arguments are valid. In a world that is anxious to divide us, we need to stand together. What's bad for one physician is bad for all.

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FROM THE INCOMING PRESIDENT. . . *Doctors Need Organized Medicine*

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In order to improve communications so that the membership can stay informed on what the Westchester County Medical Society is doing for you, the Society is engaged in an effort to improve its website. The web will not only be a source of up-to-the-minute information, but also a way for members to contact each other, give biographical and demographic information about themselves and their practice and even advertise themselves and promote their practice to other members.

Blast emails will keep you up-to-date and be linked to our website for more details. We also want to hear opinions from the membership. I announce with this publication a website, ***www.thewestchesterphysician.com,*** where you can send us your comments, take a survey question and post an opinion on our blog. I ask you to take a moment to give us your comments on the web. Tell me how we can make the medical society better and vote for which issues are most important to you. This website will be updated for feedback after each publication of the Westchester physician and will be viewed regularly by the president.

Furthermore, I intend to have more membership drives and social gatherings as a way for members to interact and network. I am looking for members who would be willing to help us move forward and serve on committees. We need physicians to help us lobby and support politicians that understand our cause, who can help develop our networks and communication with the press, or who are interested in serving on ethics, public health or membership. The medical society is about local physicians fighting the good fight to make the lives of all physicians better. I want to save the practice of the noble profession for future generations. I want to be happy if my daughters chose to become doctors, just as happy as my father was when I became a physician.✦

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2010 MSSNY House of Delegates

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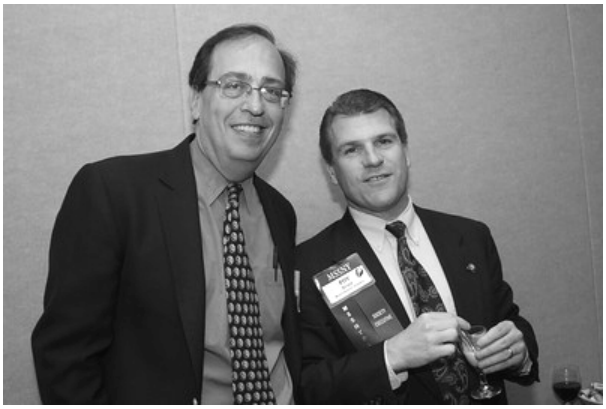
(Left to right) Luke Selby and Marissa Friedman *(NYMC Medical Students);* ; Robert Lerner, MD; Andrew Kleinman, MD, *Co-Chair*; Joseph McNelis, MD; Bonnie Litvack, MD, *Chair*: Robert Soley, MD; John Stangel, MD, *President*; Mark Fox, MD; Kira Geraci-Ciardullo, MD; Peter Liebert, MD; Michael Rosenberg, MD; Stephen Schwartz, MD; Robert Ciardullo, MD; Joseph Tartaglia, MD; William Walsh, MD; and Brian Foy, *Executive Director*.

WCMS Sponsored Resolutions

Below is a list of the final actions taken by the MSSNY House of Delegates on April 16-18, 2010 on resolutions that were authored or co-authorized by WCMS. WCMS would also like to recognize and thank the its members that were part of the delegation representing the Westchester County Medical Society as listed on page 9:

Resolution 53 - Insurance Industry Antitrust Protection
SUBSTITUTE RESOLUTION ADOPTED

***RESOLVED**, That the Medical Society of the State of New York reaffirm MSSNY Policy 165.901; and be it further*
***RESOLVED**, That the Medical Society of the State of New York support repeal of antitrust exemptions afforded to health insurance companies under federal law that may permit health insurance companies excessive domination and anti-competitive control over physicians in any given market.*



L-R; Michael Rosenberg, MD, WCMS and MSSNY Past President and Brian Foy, WCMS Executive Director

Resolution 54 - Truth in Out-of-Network Healthcare Benefits Act
ADOPTED

***RESOLVED**, That the Medical Society of the State of New York (MSSNY) seek legislation and/or regulation to require insurance companies to provide to potential purchasers the true expected out-of-pocket costs if patients go out of network for medical care; and be it further*
***RESOLVED**, That MSSNY endorse the American Medical Association (AMA) draft legislation entitled, the "Truth in Out of Network Healthcare Benefits Act", as proposed by the AMA Advocacy Resource Center, and seek adoption of similar legislation in the State of New York.*

Resolution 64 - Major Reform of Medical Liability Trials
SUBSTITUTE RESOLUTION ADOPTED

RESOLVED, That the Medical Society of the State of New York re-affirm MSSNY Policy 80.998

Resolution 67 - Military Medicine
REFERRED TO COUNCIL

***RESOLVED**, That the Medical Society of the State of New York instruct its delegates to the American Medical Association to introduce a resolution requesting the Secretary of Health and Human Services to evaluate the cost and quality of medical care in a setting relatively free from malpractice litigation, by conducting a study with the cooperation of the military, to determine if the quality of care in the military is equivalent to the quality in civilian practice.*

***L-R;* David Hannan, MD, Outgoing MSSNY President; Mark Fox, MD, a WCMS Past President and Outgoing Speaker of the House.**

Resolution 68 - NO Taxes on Physician Services
SUBSTITUTE RESOLUTION ADOPTED

***RESOLVED**, That the Medical Society of the State of New York re-affirm MSSNY Policy 265.921*
***RESOLVED**, That the MSSNY delegation to the American Medical Association introduce a resolution requesting that the AMA reaffirm its position in opposition to taxes on physician services.*

Resolution 90 - Health Care Costs Task Force
ADOPTED AS AMENDED

***RESOLVED**, That the Medical Society of the State of New York use an existing committee to explore methods to reduce health care costs in New York State and report back to the House of Delegates in 2011.*

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WCMS Sponsored Resolutions

(continued from page 10)

Resolution 91 Child Health Plus Program
SUBSTITUTE RESOLUTION ADOPTED IN LIEU OF RESOLUTIONS 91 AND 92

***RESOLVED**, That the Medical Society of the State of New York continue to work with New York's Congressional Delegation to assure that federal funding for care provided to beneficiaries of the Child Health Plus and Medicaid programs in New York is not diminished in the future; and be it further*

***RESOLVED**, That the Medical Society of the State of New York convey the urgency of this message to the American Medical Association and encourage the AMA to work proactively with MSSNY to assure that federal funding for Child Health Plus and Medicaid programs in New York is not diminished in the future.*

Resolution 92 Medicaid Funding
SEE RESOLUTION 91

Resolution 99 Orthopedic Implant Extraction
ADOPTED

***RESOLVED**, That the New York State Delegation to the American Medical Association (AMA) introduce a resolution asking the AMA to petition the Food and Drug Administration, or other appropriate agency, to require all implant manufacturers to develop implant insertion and extraction devices which can be used interchangeably in any surgical implant procedure.*

***L-R;* Robert Lerner, MD and Joseph Tartaglia, MD**

Resolution 150 Rumble Strips
SUBSTITUTE RESOLUTION ADOPTED

***RESOLVED**, That the Medical Society of the State of New York petition the New York Department of Transportation to use rumble strips only on major highways and on those roadways for which an engineering study or crash analysis suggests that the number of run-off-the-road crashes would likely be reduced by the presence of rumble strips.*

Resolution 151 Non-Wooden Baseball Bats
ADOPTED

***RESOLVED**, That the Medical Society of the State of New York oppose the use of non-wooden, specifically aluminum, bats by children playing baseball or softball through the age of 18.*

Resolution 154 Use of Waiting Rooms Educational DVDs
ADOPTED

***RESOLVED**, That the Medical Society of the State of New York (MSSNY) assist in the distribution of available educational videos to members, as needed, on appropriate topics (i.e., medical liability reform) for use in physicians' waiting rooms; and be it further*

***RESOLVED**, That MSSNY collaborate with the Medical Liability Mutual Insurance Company (MLMIC) and other entities as appropriate, to produce and make available, at no cost to MSSNY, educational videos to be shown to patients on topics determined by MSSNY.*

Resolution 208 - Medical Errors Reduction Program
NOT ADOPTED

Resolution 212 - Public Attacks on the Medical Profession **SEE RESOLUTION 209**

Resolution 209 - Physician Respect

Introduced by The Medical Society of the County of Kings, Inc.

SUBSTITUTE RESOLUTION ADOPTED IN LIEU OF RESOLUTIONS 209 AND 212

***RESOLVED**, That the Medical Society of the State of New York (MSSNY) continue to promote and publicize the positive aspects of the medical profession in any and all media possible within the parameters of its budget; and be it further*

***RESOLVED**, That MSSNY be responsive and have a process for handling negative statements that are made about the Profession; and be it further*

***RESOLVED**, That MSSNY have a dedicated mode of communication similar to its Hassle Factor Form to allow members to report abusive, negative and/or false attacks on the medical profession.*

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WCMS Sponsored Resolutions

(continued from page 11)

Resolution 260 Transparency in Insurance Contracts
ADOPTED IN LIEU OF RESOLUTIONS 260 AND 261

***RESOLVED**, That the Medical Society of the State of New York seek legislation and/or regulation that would enforce health insurance plans to clearly and transparently declare what exactly is covered and not covered in each of their plans in a plain, simple and concise summary, with carefully documented exclusions to coverage, in a standardized format to be approved by the New York State Superintendent of Insurance; and be it further*

***RESOLVED**, That such legislation and/or regulation should state that once these limitations of coverage are outlined they cannot be changed without first notifying the insured of these changes in a timely manner, sufficient enough to allow an insured the ability to change policies without disruption to healthcare coverage.*

Resolution 261 - Standardized Form for Health Plan Comparison **SEE RESOLUTION 260**

Red Flags Rule
The FTC Cries Wolf Again

On the last business day before they were to begin enforcing the Red Flags Rule, the Federal Trade Commission again extended the deadline - this time until December 31, 2010. The Red Flags Rule was promulgated by the FTC to address the risk of identity theft. In announcing the latest delay, FTC Chairman Jon Leibowitz blamed Congress for the uncertainty concerning the Rule. According to Leibowitz: "*Congress needs to fix the unintended consequences of the legislation establishing the Red Flags Rule - and to fix this problem quickly. . . . "As an agency we're charged with enforcing the law, and endless extensions delay enforcement.*"

In blaming Congress, the FTC says it developed the Rule because Congress directed it to develop regulations requiring "creditors" as well as "financial institutions" to address the risk of identity theft when it passed the Fair and Accurate Credit Transactions Act. Because the Act applied to "creditors" the FTC claims it was obligated to include in its Red Flags Rule all entities that have "covered accounts", including medical practices. Numerous efforts to get the FTC to alter its opinion have proven unsuccessful.

When it last delayed enforcement, in October of 2009, the FTC announced that it was doing so to allow Congress time to finalize legislation that would limit the scope of businesses covered by the Rule. Since then, Congress has failed to act. However, according to the FTC, it has received another request from "certain Members of Congress" for another delay in enforcement of the Rule beyond June 1, 2010.

In announcing the latest delay, the FTC urged Congress to act quickly to pass legislation that will resolve any questions as to which entities are covered by the Rule and obviate the need for further enforcement delays. If Congress passes legislation limiting the scope of the Red Flags Rule with an effective date earlier than December 31, 2010, the FTC will begin enforcement as of that effective date to those entities still within the scope of the new legislation.

Just one week before the latest announcement the AMA and the American Osteopathic Association filed a lawsuit asking the courts to declare that the legislation which resulted in the Red Flags Rule was not intended to apply to physician offices. However, neither organization asked the courts to immediately enjoin enforcement.

Unfortunately, the delay in enforcement by the FTC does not delay numerous state laws which also address identity theft. Some of these state laws are even more burdensome than the federal regulations.

It is inexcusable that Congress cannot quickly clarify its intent and, hopefully, remove physician offices from the scope of a law that most observers believe was initially intended only to apply to banks and other financial institutions. While most believe that the FTC has drastically overstepped its bounds in applying the law to physician offices, only Congress or the Courts can eliminate this uncertainty, which has already cost physicians many millions of dollars, and untold lost time.

(Article reprinted from the "StatLaw Weekly Update" provided by Kern Augustine Conroy Schoppmann PC)

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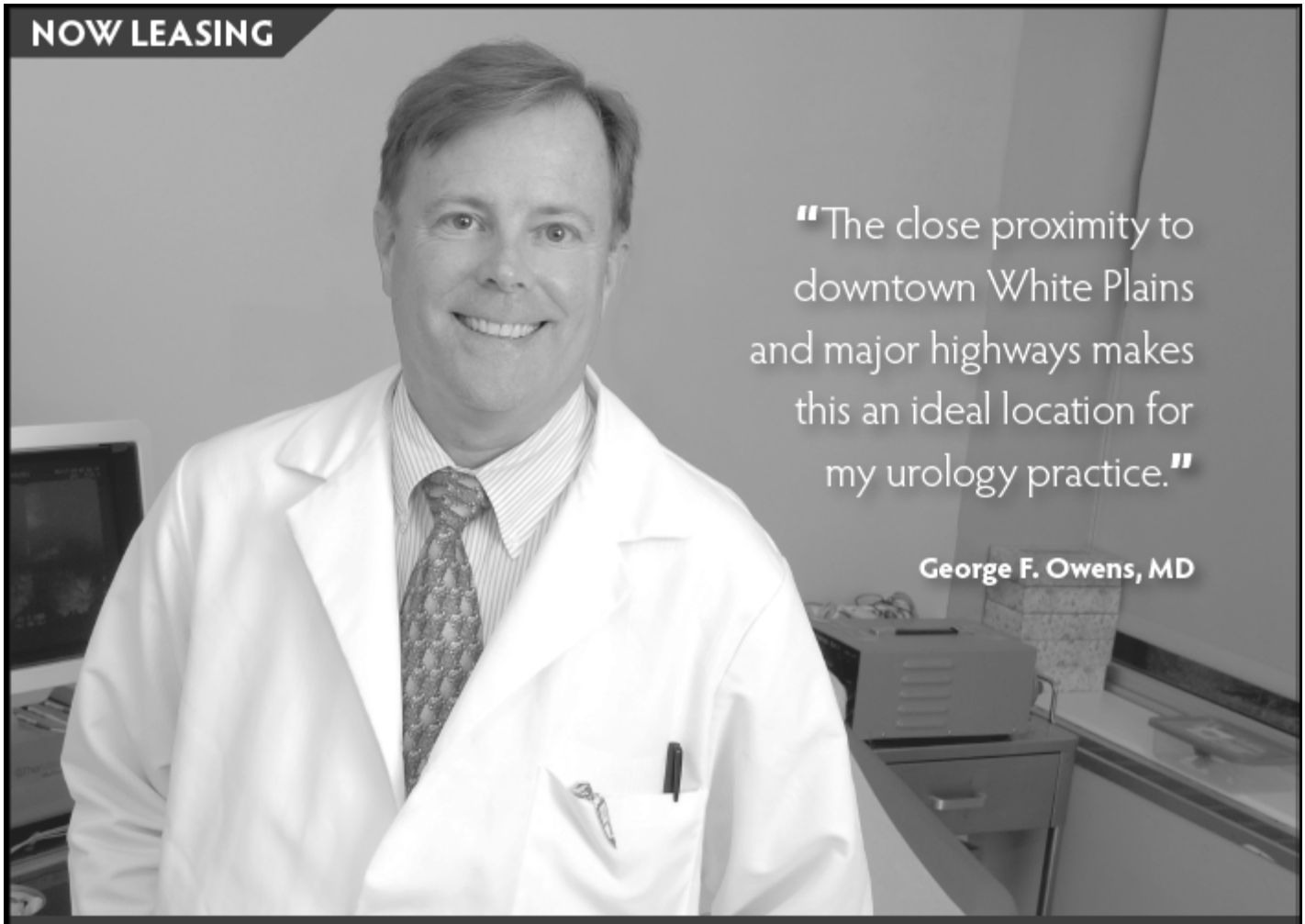

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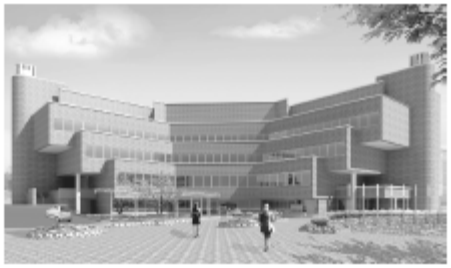

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New Coding Rules, New Potential Pitfalls

Joseph Tartaglia, MD
2010-2011 WCMS Incoming President

The current administration's plans to cut fraud and waste in the Medicare and Medicaid programs reveals some of the truth behind the disinformation spewed forth by politicians over the past few years in the healthcare debate. The government plans to invest $561 million dollars of discretionary spending to expand the Health Care Fraud Prevention and Enforcement Action Team (HEAT), a team composed of officials at the Department of Health and Human Services and the Department of Justice. This would be double the budget of 2010. While no physician is against routing out "true" fraud and abuse, targeting inappropriate payments can often snare innocent physicians who commit coding errors with no intent to commit fraud. Every physician who codes and bills Medicare and Medicaid will need to scrutinize what constitutes criminality and what is a billing error. For those physicians in groups who rely on an army of billers to assist in coding, the physician is ultimately responsible and needs to oversee his operations as ignorance does not abrogate responsibility. Physicians beware of being caught in the zeal to uproot fraud! Kathleen Sebelius, Secretary of the Department of Health and Human Services is quoted as saying in response to the announcement *"This budget sends a clear message to those who commit fraud: Stop stealing from seniors and tax payers or we'll put you behind bars."*

For those who think they understand the coding rules, think again. The complexity of the E and M coding has long been the lament of many physicians who think they understand them but then realize they over-billed only after an audit draws scrutiny of their practice. Recently, CMS eliminated payment for consultation codes which has sent many specialists scurrying to use the E and M codes in a way they're not accustomed to. Unfortunately, the word is that CMS has plans to take advantage of the confusion and strictly enforce the "proper" use of the E and M coding. Therefore, it is imperative that physicians familiarize themselves with the E and M codes, especially if they were used to billing consults which now no longer exists since January of 2010.

What is the physician to do? First, remember that some private insurance are still using the old consult codes and they should still be used whenever possible. For Medicare, the practice of one physician asking another for opinions will still go on so we must understand how to bill. First, let's examine how to bill a new consult in the outpatient or office setting. The physician must remember that if he or his partner has seen the patient within the last three years, he can only bill an office follow-up visit (99212-15) and not a new patient encounter. For the inpatient consult the situation is more complex. The first step is to determine the status and location of the patient, *i.e. inpatient, ER, or observational*. If the patient is "inpatient," then use the initial visit codes (99221-3) or the old "H&P" codes. Remember, the consultant would not use the AI modifier (I not 1) which should only be used by the primary physician responsible for controlling the patient's care on his service.

Be careful to document all the elements needed for a comprehensive visit. Make sure the medical necessity justifies the level of care. For example, seeing a patient after three months with established controlled hypertension does not justify a comprehensive history and physical. Conversely, if you have a complex assessment and plan be careful to include the proper elements from the history and physical exam. For example, the higher-level office consult codes (99244 and 99245) require a comprehensive history and exam. So if one element is not documented in the history of present illness, the review of systems, and the past family, social history, the encounter becomes a level 3, even though the doctor could have done a very thorough exam and a very complicated assessment and plan.

If the patient is physically in the hospital, but admitted in observational status then Medicare is telling us that this encounter is technically an outpatient even though it physically occurs in the hospital.

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Ophthalmology Section Westchester Academy of Medicine

By Morris Glassman, MD

The last meeting of the Ophthalmology Section of the Westchester County Medical Society of this fiscal year was held on May 20th at the Pleasantville Country Club with a gathering of over 35 ophthalmologists. As with the previous meetings, this was a chance for the county's ophthalmologists to meet and reconnect with each other. We have learned, through these meetings, a lot about different modalities of practice as well has having the ability to discuss interesting and difficult patient problems.

After an initial "meet and greet" hour, an educational meeting was held. The opportunity to gather with colleagues and discuss matters that affect us is almost as valuable as the educational portion of the meeting. This meeting's topics were Advances in Cataract Surgery, Anti-Inflammatory Therapy and Treatment of Iris Anomalies. The first speaker was Eric Donnenfeld, MD, a highly respected ophthalmologist and surgeon from Long Island Ophthalmology Associates. He discussed multiple surgical topics related to cataract extraction. These included multifocal intraocular lenses, astigmatic (toric) lenses, use of latest generation anti-inflammatories and advanced antibiotics to improving vision and reduce corneal inflammation. Ken Rosenthal, MD also from Nassau County, discussed iris implants to be used with people who have had severe ocular trauma or diseases that otherwise destroy normal iris tissue. Both speakers were well-received.

Next year's meetings and topics will include advances in oculo-plastics, on October 5th, a Grand Rounds discussing patient care and difficult patient presentations on January 19. The last meeting will be held on May 12th with pediatric ophthalmology as its main subject. All members of Westchester County Medical Society are invited to these informative collegial events.✦

New Coding Rules,New Potential Pitfalls

(continued from page 14)

If you have not seen the patient in the last three years you should perform and document the encounter as a "new office patient." If the patient has been seen by you or a partner in the last three years, then document the encounter as an "established office patient."

In the ER, the consulting physician needs to ascertain if the patient is to be discharged from the ER. If so, perform and document the encounter as an ER visit (99281-85). Thus, multiple doctors can bill the ER visit codes on the same day. However, if the patient is to be admitted then it gets more confusing. If you are the admitting physician you use the initial visit with the AI modifier. If you are a consultant who will be following the patient then use the initial visit if the patient is an inpatient. However, if the patient is admitted to observational status then the outpatient initial or follow up codes are used (99221 or 99212 etc.). You can see how confusing this can be so please review carefully the new rules. A thorough review of coding basics is beyond the scope of this article, however for those of you who want a good review for free; I found ***http://emuniversity.com/free-area-login.html*** a good start.

Some doctors feel that if they are covering another physician in the hospital they are justified in using the initial visit code and not a follow up code. However, if the physician was truly fulfilling the role of the covered physician it would be a mere follow up visit. The physician may be accused of abusing the intention of the "initial visit" which is only for the initial evaluation (something which has already been fulfilled by the original consultant). Performing multiple initial visits by the same specialist runs the risk of triggering an audit. Being honest is the best policy. The medical necessity of the level of care needs to be taken into account. Don't let anger at the system color your judgment and lead to scrutiny by Medicare. The reality is that we all have to live with the new rules if we want to participate in Medicare. ✦

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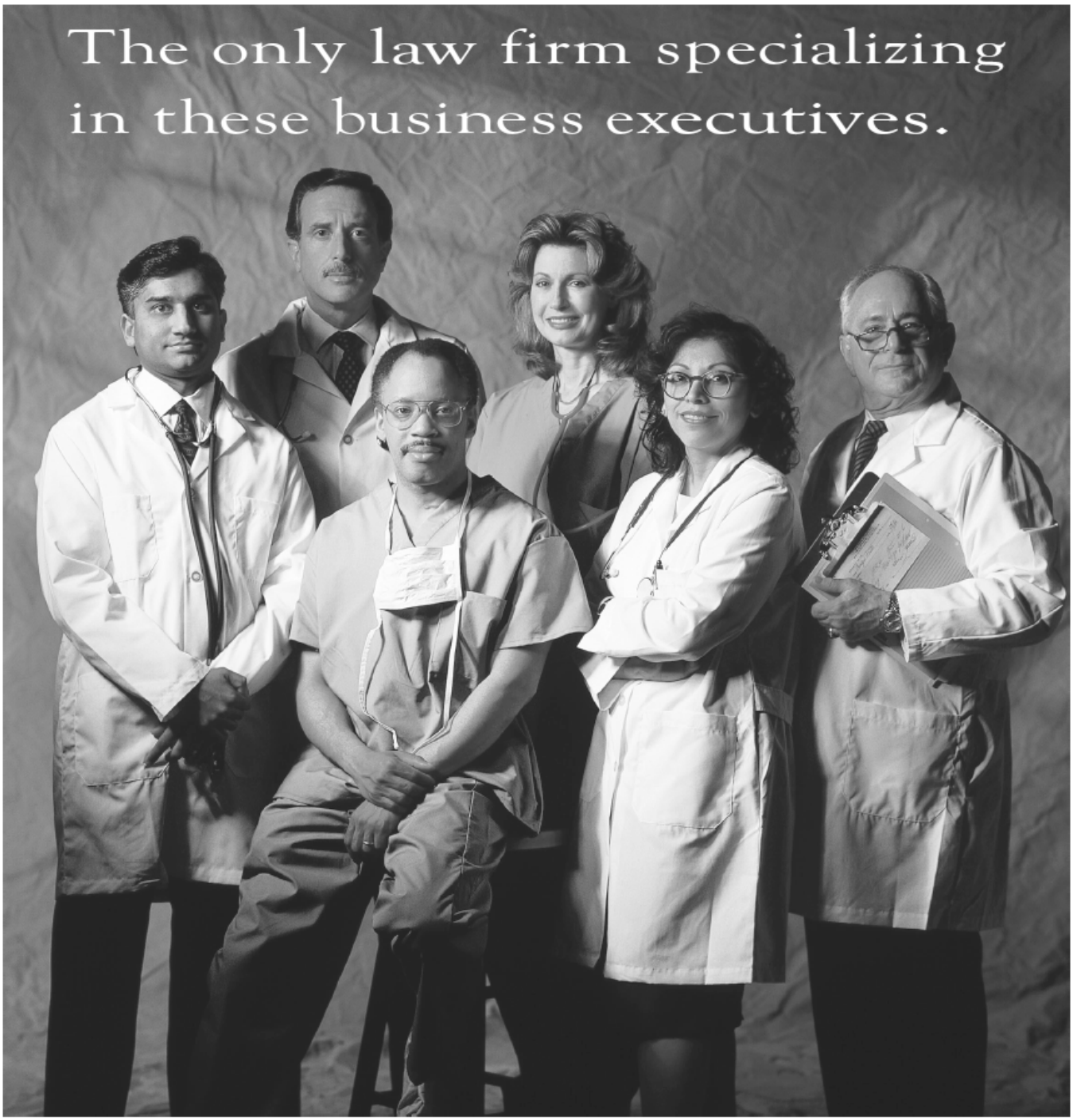

WCMS Member Recognitions

Mark L. Fox, MD, an Otolaryngologist from Tuckahoe and Past President of the Westchester County Medical Society, was presented an award from MSSNY Outgoing President, David Hannan, MD, recognizing his years of service as Speaker of the MSSNY House of Delegates during the 2010 MSSNY House of Delegates (HOD) meeting in Tarrytown.

Kira A. Geraci, MD, MPH, is an Allergist/Immunologist from Mamaroneck and Past President of the Westchester County Medical Society, became the second woman to serve as Vice Speaker of the Medical Society of the State of New York (MSSNY) when she was elected at its 2010 MSSNY HOD meeting.

Andrew Y. Kleinman, MD, a Plastic and Reconstructive Surgeon from Rye Brook and Past President of the Westchester County Medical Society, was elected Assistant Treasurer of the Medical Society of the State of New York (MSSNY) at the 2010 MSSNY House of Delegates meeting in April.

Dr. Kleinman was also elected as Alternate Delegate from MSSNY to the AMA for a two-year term ending in 2012

Bonnie L. Litvack, MD, FACR, a Diagnostic Radiologist from Mount Kisco and Past President of the Westchester County Medical Society was inducted as a Fellow in the American College of Radiology (ACR) during its May 2010 Annual Meeting & Chapter Leadership Conference in Washington, DC.

Dr. Litvack was also elected as MSSNY Councilor of the 9th District Branch and an Alternate Delegate from MSSNY to the AMA for a two-year term ending in 2012

Michael Rosenberg, MD, a Plastic and Reconstructive Surgeon from Mount Kisco, Past President of the Westchester County Medical Society and Immediate Past President of the Medical Society of the State of New York was appointed a MSSNY Trustee for term ending in 2015.

WCMS Blast E-mail Service

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If you have not done so yet, please send your email to Denise Oneill at *doneill@wcms.org*

(NOTE: Your email address will be used for WCMS communications ONLY and will not be shared with any 3rd parties.)

2010 Physician Quality Reporting Initiative (PQRI) Program Update

It is not too late to start participating in the 2010 Physician Quality Reporting Initiative (PQRI) and potentially qualify to receive incentive payments. A new six month reporting period begins on July 1, 2010.

The 2010 Physician Quality Reporting Initiative (PQRI) has two reporting periods: 12-months (January 1-December 31, 2010) and 6-months (July 1-December 31, 2010). For 2010, eligible professionals (EPs) who satisfactorily report PQRI measures for the 6-month reporting period will become eligible to receive a PQRI incentive equal to 2.0% of their total Medicare Part B allowed charges for services performed during the reporting period.

If you have not participated in the PQRI program, you can begin by reporting PQRI data for July 1-December 31, 2010 using any of the following four options:

- Claims-based reporting of individual measures for 80% or more of applicable patients on at least 3 individual measures or on each measure if less than 3 measures apply
- Claims-based reporting of one measures group for 80% or more of applicable Medicare Part B FFS patients of each EP (with a minimum of 8 patients)
- Registry-based reporting of at least 3 individual PQRI measures for 80% or more of applicable Medicare Part B FFS patients of each EP
- Registry-based reporting of one measures group for 80% or more of applicable Medicare Part B FFS patients of each EP (with a minimum of 8 patients)

PQRI claims-based reporting involves the addition of quality-data codes (QDC) to claims submitted for services when billing Medicare Part B. EPs also have the option of using a qualified registry to assist in collecting PQRI measure data. The registry will submit this quality data directly to Medicare, eliminating the need for adding QDCs to the Medicare Part B claim.

Eligible professionals do not need to sign up or pre-register to participate in the 2010 PQRI. Submission of QDCs for individual PQRI measures to CMS through a qualified registry or for a measures group through claims or a qualified registry will indicate intent to participate.

Although there is no requirement to register prior to submitting the data, there are some preparatory steps that EPs should take prior to undertaking PQRI reporting. CMS has created many educational products that provide information about how to get started with PQRI reporting.

To access all available educational resources on PQRI please visit ***http://www.cms.hhs.gov/PQRI/*** on the CMS website. Eligible professionals are encouraged to visit the PQRI webpage often for the latest information and downloads on PQRI.

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