WESTCHESTER PHYSICIAN

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Caps on Out-of-Network Benefits Bad for All Physicians

Joseph Tartaglia, MD, FACC, President
Westchester County Medical Society

Certain health plans administered or insured by affiliates of UnitedHealth Group have decided to cap "out-of-network" benefits at 140% of the Medicare rate, and by doing so are, in effect, saying they will ignore the "usual and customary charge" by deciding that the beneficiary will be responsible for the difference between the reasonable fee and 140% of the Medicare fee. Many customers will renew their insurance not realizing how much they may be responsible for. Until now, the company would reimburse 80% of the "usual and customary charge." But, starting in 2011, their new traditional plans will only offer out-of-network benefits at 140% of the Medicare rate. This decision comes in the wake of a settlement with the New York Attorney General's office after the way the company had been determining the "usual and customary" fees was deemed fraudulent by then Attorney General, Andrew Cuomo. The system was based on a computer database operated by Ingenix, a wholly-owned subsidiary of UnitedHealth Group. UnitedHealth underpaid millions of people in New Jersey, Florida, and California. The scheme involved tossing out high fees, and including in-network fees, to artificially lower the "usual and customary charges." Cuomo described it as a "black box" and a "closed system riddled with conflicts of interest." Under the settlement, UnitedHealth Group and Ingenix would pay $50 million to finance a new, non-profit entity that would develop a new health care pricing database. A new independent database has been established by FAIR Health, Inc., a non-profit organization chosen by the New York Attorney General. Although it admits no wrong doing, UnitedHealth Group agreed in January of 2009, to pay $350 million to settle claims by customers in a class action lawsuit. Aetna, which also used Ingenix, agreed to pay $20 million.

The new plan by UnitedHealth Group to seemingly circumvent the Attorney General's settlement will affect all physicians negatively. Many specialists, such as neurosurgeons, could be drastically affected. They will not be able to afford to stay in practice. Their exceptionally high malpractice premiums ($250 thousand dollars annually) overshadow the Medicare fee schedule that reimburses a fraction of "the usual and customary charges." The patients will be in for an unexpected shock when they receive a bill for a craniotomy, removal of a brain tumor, and subsequent care for many thousands of dollars and their insurance (Oxford, UnitedHealthcare) covers only 10% of the cost. Prior to this those insurance companies would have paid $24,000 of the $30,000 charges. **Owen J. O'Neill, MD,** a hyperbaric medicine and wound care specialist at Phelps Memorial Hospital and Director of their Department of Hyperbaric Medicine, as well as a member of the Membership Committee of the WCMS, says, "I have seen more

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A Look Inside . . .

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(914) 967-9100 / FAX (914) 967-9232

Mark Your Calendar

January 17, 2011
Martin Luther King Day—Office Closed

January 19, 2011
Section on Ophthalmology
4th Annual Westchester Ophthalmology Grand Rounds
Eclisse Restaurant, White Plains

February 3, 2011
WCMS Board Meeting—6:30 pm

February 7, 2011
CME Committee Meeting—5 pm

February 21, 2011
Presidents' Day—Office Closed

March 3, 2011
WCMS Board Meeting—6:30 pm

March 7, 2011
CME Committee Meeting—5 pm

March 8, 2011
MSSNY Legislative Day
Albany, NY

April 8-10, 2011
MSSNY House of Delegates
Westchester Marriott
Tarrytown, NY

Newsletter Submissions

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 February 2011 issue is January 31st.

Please email your submissions for review to Brian Foy, Executive Director at ***bfoy@wcms.org***.

From The Editor
Dutch Treat

By Peter Acker, MD

(I am in the midst of preparation for surgical mission to El Salvador (leaving in less than 48 hours). I am going with four other docs from Greenwich Hospital who will be doing the surgery and anesthesia, while I provide pre- and post-op care. So, alas, I haven't had time to write my column! So please find below an article from several years ago that I wrote about a trip to Holland and I promise an account of my El Salvadorian adventure in the next issue.)

As I write this I am, I think, in the company of many who are bemoaning the end of summer and the return of our normal grind. Luckily, there is a spare moment or two to recall the summer's highlights, the escape from the daily medical routine. The highlight of my summer was a trip to Holland and, from the moment we landed, I felt transported from my ordinary life into a different culture and life style. We, of course, did the usual sort of sight seeing – the Van Gogh Museum, the Red Light district, leisurely walks by canals, and a trip to Edam were just a few of the things we did. We were fortunate to stay with friends, a Dutch family consisting of a husband, wife, and three kids aged 13, 10, and 9. They live in a house that by Westchester standards is extremely small, yet our family of five was able to settle in comfortably. The staircase to the second and third floors curved upward in a narrow spiral. Each bedroom was closet sized, with efficient uses of space. Outside were parked five bicycles and one small car that would just about fit into the back of an average SUV. On a daily basis, one of the family would bike to the market to get some groceries. Each morning, all ten of us would crowd around a small table and feast on several kinds of bread and cheese. Daily grooming and toilet were carried on apace as we were cognizant of sharing just two bathrooms and one shower. I began to feel a bit abashed as I made some mental comparisons between my spacious New York abode and life-style and that of our Dutch friends.

My observations of Dutch life continued in a similar vein as I wandered outside my first morning. Bicycles were everywhere – being ridden by people of all ages. People pedaled with an ease and comfort that is seldom witnessed here, wearing ordinary clothes, such as suits for the work-bound business men. I could not but help contrast this with the accoutrements of the serious Westchester cyclist (aerodynamic helmet, sleek biking outfit, special shoes). Many times, I would see a young woman riding with another woman sitting comfortably side ways on the back. People's expressions carried none of the intensity or anxiety that is usually displayed on the New York biker's visage (especially when being narrowly passed by one of those behemoths we call cars, which typically give no quarter to the smaller road denizens). No wonder – bikers in Holland have their own designated space to ride in. Bike lanes are ubiquitous. In downtown Amsterdam, each intersection has special traffic signals specifically for bike riders.

Though I was on vacation and making strenuous efforts to "relax," I found that my medical mind was never far away and I began to make some fairly obvious public health observations. First off, despite what appeared from my own limited sample that the Dutch do not mind lingering at the dinner table, there was very little obesity or even slight middle age spread evident among the populace. It doesn't take a public health genius to immediately make a connection between this observation with the prodigious amount of biking people do. It is, of course, closely interwoven into their culture and thus would be difficult to incorporate here overnight, but wouldn't it be nice to have a few bike paths leading to our workplaces and markets? For the Dutch, physical activity is incorporated into all the routine daily activities, whereas here we rush to gyms and personal trainers to burn calories that could have been consumed during a daily commute.

On the flight home, seated next to us was a Dutch rheumatologist (enviably thin) who was en route to a conference in New York, and she confirmed my hunch that diabetes is not rampant in Holland as it is in the US. I also asked about bicycle helmets which simply do not exist in the Netherlands as far as I could tell. The Dutch doctor had no statistics at her fingertips comparing rates of head trauma among bikers. Made me wonder – how tragic to lead a life of enviable fitness only to have it end wrapped around a tree, head unprotected. I guess we can all learn from each other.♦

CAPS ON OUT-OF-NETWORK BENEFITS BAD FOR ALL PHYSICIANS

(continued from page 1)

patients (this year) with no out-of-network benefits. They were unaware that they signed on for no out-of-network benefits (contract fine print) or what the financial impact would be on them."

He asks why the insurance companies are not required to notify their insured of the change in benefits during the yearly policy renewal, and document that the insured are completely understanding of the same. Furthermore, he asks, "Why was UnitedHealthcare sanctioned to pay millions of dollars to a neutral university to establish a "fair and customary" fee schedule if the private insurance industry is allowed to set their fee schedules at 140% of Medicare rates? If patients don't have "out-of-network" benefits, what is the purpose of the usual and customary fee schedule anyway?"

Physicians who accept only in-network benefits should understand that if UnitedHealthcare is successful at capping out-of-network benefits, then it is only a question of time before in-network benefits are cut. If United doesn't have to pay much more than Medicare to out-of-network physicians, then there will be less incentive to keep in-network fees high to attract physicians into the network. "Every year there is a new plan that we are told will help the patients, but, in reality, just tries to rob us of more money," says **Gino Bottino, MD**, an oncologist at Northern Westchester, who is Co-Chair of the WCMS Ethics Committee. "There is only one way out, and that, I believe, is for the state medical society to become the voice for doctors and our bargaining agent," says Dr. Bottino.

Andrew Kleinman, MD, a plastic surgeon and Chair of the WCMS Socio-Economic Committee, agrees that if the insurance companies can cap out-of-network benefits to a figure so close to the Medicare fee then there will be no incentive to pay any physician much more than Medicare rates. Even large groups with more bargaining power stand to suffer considerable erosion in their earnings. It creates a system of Medicare for all, and, according to Dr. Kleinman, could begin "a major shift toward the end of private practice in America."

But even more important is the negative effect it will have on patient's choice of physicians and hospitals. "Patients are ultimately harmed by this," said Dr. Kleinman. He added, "Many middle class patients will no longer be able to go out-of-network because they will not be able to afford it and that will limit their choices of physicians."

Many wonder if a plan that caps out-of-network benefits really meets the definition of insurance, since it limits so drastically whom patients can afford to see. "It is another attempt at assaulting the choices of practicing medicine. In no other profession do insurance companies unilaterally dictate the terms of engagement. Such sham out-of-network benefits are obviously not worth the yearly rising premiums honest companies and individuals think they are paying for," says **Thomas Lee, MD**, a neurosurgeon at Phelps and Chair of the WCMS Legislative Committee.

Indeed, we all need to take a stand against this outrageous assault on our ability to establish our own reasonable and customary fees. If a physician chooses not to be in a network, he should expect indemnity insurance to cover a percentage of the usual and customary fee as determined by FAIR Health, not based on a government standard, which we have seen is more of a political football that beckons to the whims of Congress, rather than a fee based on practice expenses. The Westchester County Medical Society intends to fight this attempt to restrict the practice of our trade. We need to fully inform the public and enlist the aid of our elected officials in Albany. I, for one, intend to drop any plan from covering my family and my employees that caps out-of-network benefits. Please support us in our efforts by going to our website ***www.thewestchesterphysician.com*** and answering our poll questions: How will a cap on out-of -network fees at 140% of Medicare affect your practice? Would you use a health insurance product that caps out-of-network benefits at 140% of Medicare fees? Give us your opinion and, most importantly, continue membership in the Westchester County Medical Society and encourage other fellow physicians to join. Your support makes all the difference.♦

Physicians Needed to Judge Westchester Science & Engineering Fair

Physicians are needed to serve as judges for the Westchester Science & Engineering Fair 2011. The Westchester Academy of Medicine provides sponsorship for the "Fourth Place in Category" awards and the prestigious awards for the top projects in Medicine and Health.

Westchester Science & Engineering Fair (WESEF) provides a forum for high school students to showcase their scientific research studies and compete for scholarships and prizes, including a grand prize all-expenses paid trip to the INTEL® International Science & Engineering Fair. Students prepare a poster detailing their projects which, in most cases, have involved complex research conducted under the guidance of a professional researcher in their field of interest, and deliver formal presentations to scientists, business leaders, and the general public.

The top 8 individual projects and top 4 teams are awarded the honor of representing Westchester & Putnam counties in the INTEL® International Science & Engineering Fair, where they will compete with over 1500 top high school research students from over 50 different countries worldwide! Year after year, WESEF Finalists compete and win against the best High School research students.

Since its inception in 2000, the WESEF organization has grown tremendously; last year almost 200 students participated in the fair from over 23 different schools.

This year's fair will be held on Saturday, March 12, 2011, at Sleepy Hollow High School. If you would like to serve as a judge, please call or email Karen Foy at the Medical Society at 914-967-9100 or kfoy@wcms.org.

Be Proactive - Don't Delay Your Enrollment in PECOS!

Do you order laboratory tests, radiology services, other types of diagnostic tests, diabetes self management training, medical nutrition therapy or durable medical equipment or supplies?

If the answer is yes, your National Provider Identifier (NPI) is entered on claims sent to Medicare as an ordering/referring physician. The implementation of the ordering/referring edits has been delayed. However, it is coming and when it does, if your individual NPI is not in PECOS, then your payments for claims that require an ordering/referring physician will **stop**. Additionally, if your practice will be registering for the Electronic Health Record (EHR) Incentives in 2011, you must also have a PECOS record.

If you order or refer items or services for Medicare beneficiaries and you do not have an enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS), you need to submit an enrollment application to Medicare.

The fastest, easiest way to enroll is through the internet-based PECOS. To learn more about the implementation of the ordering/referring edits, please review the revised Centers for Medicare & Medicaid Services *Medicare Learning Network (MLN) Matters Special Edition* article SE1011 which can be accessed at the following link: ***http://www.cms.gov/MLNMattersArticles/downloads/SE1011.pdf***

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OPMC Consequences of Improper Delegation

Michael J. Schoppmann, Esq.
Kern Augustine Conroy & Schoppmann, P.C.

As the regulatory umbrella overshadowing physicians and their practices continues to expand, the corollary investigative intrusions by state agencies, the federal government and through civil litigation have brought about a dramatic increase of scrutiny into the permissive, and non-permissive, delegation of medical services throughout the rendition of care. As a result, physicians must be ever more vigilant to ensure that their practice acts only within the permissive (and ever changing) boundaries set by law.

One of the leading authorities in determining the propriety of delegation with a medical practice is the Office of Professional Medical Conduct of the State of New York ("OPMC"). One of the most prevalent areas of scrutiny by OPMC, and resulting professional discipline, is the controversial role of a medical assistant. Every physician must bear in mind that Medical Assistants, regardless of "certification" status are not licensed by the State of New York and, therefore, their role is by law (and must be in practice) severely limited.

According to the New York State Education Department, Medical Board Office:

> "Medical assisting is not a licensed profession in New York State, therefore, there is no associated scope of practice and no detailed list of procedures that medical assistants may perform. A medical assistant, even if nationally certified by the American Association of Medical Assistants, is afforded no legal privileges to perform medical acts that are within the scope of practice of licensed professions such as medicine, nursing, and respiratory therapy. In accordance with the laws of New York State, medical assistants may perform a wide range of administrative and several non-medical clinical duties. Administrative duties include scheduling and receiving patients, preparing and maintaining medical records, performing basic secretarial skills and medical transcription, handling telephone calls and writing correspondence, serving as a liaison between the physician and other individuals such as patients, and managing practice finances. Clinical duties may include taking patient histories and vital signs, performing first aid in emergency situations, preparing patients for procedures, assisting the physician in examinations and procedures, collecting specimens, performing phlebotomy, and asepsis and infection control of examination and treatment rooms. Even under the supervision of a physician, a medical assistant may not perform functions that are within the scope of practice of nursing, physician assisting, respiratory therapy, medicine, and other professions granted licensure under Title 8 of Education law."

A brief summary of the laws of the State of New York reveals:

Education Law section 6522: Only a person *licensed or otherwise authorized* under this article shall practice medicine or use the title "physician." In light of the limitations and restrictions placed upon licensed health professionals such as PA's and nurses (discussed below), and in light of the fact that medical assistants are unlicensed, the State of New York has consistently held that medical assistants are not permitted to insert IV's, much less administer substances, and that OPMC would charges such actions as constituting the unauthorized practice of medicine.

Education Law section 6542 (illustrating the limitations on Physician Assistants): A physician assistant may perform medical services, but only when under the supervision of a physician and only when such acts and duties as are assigned to him are within the scope of practice of such supervising physician. Supervision must be continuous; however, the physician is not required to be physically present when the assistant is rendering such services.

Education Law section 6902 (illustrating the limitations on Nursing): The practice of nursing is defined as performing tasks and responsibilities within the framework of case finding, health teaching, health counseling, and provision of supportive and restorative care under the direction of a physician.

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OPMC Consequences of Improper Delegation

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Registered nurses and nurse practitioners do not need direct supervision; a licensed practical nurse needs direct supervision from a physician or registered nurse. To those physicians or practices who remain ignorant of these limitations, or act in defiance of them, and face scrutiny by OPMC, Education Law, Section 6530, No. 25, defines Professional Misconduct as "delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified, by training, by experience, or by licensure, to perform them" and Section 6530, No. 33 further includes "failing to exercise appropriate supervision over persons who are authorized to practice only under the supervision of the licensee" as an additional potential charge of professional misconduct.

In reviewing actions undertaken by OPMC under these laws, the courts of the State of New York have been consistent in their endorsement that unprofessional conduct includes "delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified, by training, by experience or by licensure, to perform them".

Of note, in *Taylor v. Board of Regents*, 617 N.Y.S.2d 926 (1994), the physician argued that while he never delegated duties to any employees, if it was found that he did, those employees were qualified by training and experience to perform the duties so delegated even if they did not have the requisite license or permit. The physician further contended that these regulations enabled him and or any other licensed professional, which may include a physician, dentist, podiatrist or social worker, to determine without any objective review that an individual in their employ is qualified to perform certain functions based upon their training and experience that would normally be limited to individuals who are licensed. Therefore, since such conduct would be permitted, pursuant to this regulation, any charge alleging a violation of Education Law §6509(7), which defines professional misconduct as including "[p]ermitting, aiding or abetting an unlicensed person to perform activities requiring a license", would be in error. The physician's argument was summarily rejected by the Court, ruling that his "attempt to excuse his conduct strains the credulity of this court."

Additionally, in *Huh v. NYDOH*, 681 N.Y.S.2d 872 (1998), the Appellate Division reviewed an OPMC decision holding a physician guilty of fraudulent practice, permitting unlicensed persons to perform activities requiring a trained professional and delegating professional responsibilities to unqualified individuals. The Hearing Committee had found the appropriate penalty to be revocation of the physician's license and the higher court upheld the OPMC determination and the revocation of the physician's license.

The potential consequences to a physician and/or their medical practice for the inappropriate delegation of services do not end with charges by OPMC. In *People v. Santi*, 3 N.Y. 3d 234 (Court of Appeals, 2004) the court held that a licensed physician could be subject to criminal prosecution under Education Law section 6512 (1) (establishing the unauthorized practice as a crime) for aiding and abetting an unauthorized individual in the unlawful practice of medicine. In this case, a "medical assistant" (a physician with a suspended license) inserted IV's into patients (administering anesthesia) and was subsequently charged with a criminal act.

Moreover, Section 6512 (1) provides that:

Anyone not authorized to practice under this title who practices or offers to practice or holds himself out as being able to practice in any profession in which a license is a prerequisite to the practice of acts, or who practices any profession as an exempt person during the time when his professional license is suspended, revoked or annulled, or who aids or abets an unlicensed person to practice a profession... shall be guilty of a class E felony.

Section 6512 (2) further provides in part:

Anyone who knowingly aids or abets three or more unlicensed persons to practice a profession or employs or holds such unlicensed persons out as being able to practice in any profession in which a license is a prerequisite to the practice of the acts ... shall be guilty of a class E felony.

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WCMS & Academy Annual Holiday Party a Success!

Our Annual Holiday Party and Silent Auction took place on December 9th, at the Knollwood Country Club. About 100 WCMS members and their guests enjoyed wonderful food, friends, and the beautiful singing voice of Alexandra Tartaglia, daughter of WCMS President, Joseph Tartaglia, MD. The successful auction and raffle will benefit the Westchester Academy of Medicine Scholarship Fund and the Board of Directors and Staff would like to thank our donors for their generosity.

A special thank you to our Sleigh Bell Sponsors for their support.

Photos and a list of our sponsors can be found on pages 10 and 11 of this newsletter.

OPMC Consequences of Improper Delegation

(continued from page 8)

In the arena of civil litigation, the impermissible delegation of services to patients may well also jeopardize the protections customarily afforded a physician and/or the medical practice under their medical malpractice insurance policy. Attorneys representing patients are becoming increasingly more knowledgeable in this area of law and frequently seek either preemptive action through the State of New York, plead the non-permissive delegation within the action for medical malpractice – or both. An action which contains non-insured claims for improper delegation of services places great pressures upon the physician to settle the action, expend great expense for the costs of personal defense counsel and/or risk personal asset exposure through jury verdict.

In *Hoffson v. Orentreich*, 562 N.Y.S.2d 479 (1990), an action for medical malpractice and negligence for disfiguring, permanent scars allegedly sustained by patient as result of procedure performed by registered nurse in draining acne cysts and removing blackheads from patient's face, the jury was permitted to decide whether the nurse acted in accordance with proper nursing standards or engaged in the practice of medicine without license.

In conclusion, each and every physician and/or medical practice should immediately undertake a step-by step, detailed audit and/or review of the specific roles being imposed upon, or undertaken by, each and every employee – regardless of licensure status or the degree of involvement within the medical care being so rendered by the practice. Careful comparison of those roles against the limitations imposed by the laws of the State of New York may well reveal not only great exposures previously unknown to the practice but also great opportunities for truly productive risk management, threat reduction and prospective regulatory compliance.♦

Mr. Schoppmann, working closely with MLMIC to protect its physicians on issues and/or actions involving OPMC and/or other authorities, may be contacted at 1 - 800 - 445 - 0954 or via email - mschoppmann@drlaw.com.

WCMS & Academy Annual Holiday Party

L-R: Ed Hopkins, Esq.; Kevin Lynch, NY Services, Inc.; Drs. Kira & Robert Ciardullo, WCMS Treasurer

L-R: Joe Gorelick, Affinity Group; Andrew Kleinman, MD; Noella Kleinman

L-R: Brigitte Davison; Bruce Davison, Citibank; Sudeep Chaudhuri, DataMatrix Technologies

L-R: Antonella, Alexandra & Joseph Tartaglia, MD, WCMS President

Ednalin McNelis; Joseph McNelis, MD, WCMS Vice President

Iris Schwartz; Stephen Schwartz, MD

WCMS & Academy Annual Holiday Party

L-R: Elaine DeMarco; Joseph Tartaglia, MD; Tina Discepola, MD; Mark Williams; Marlene Galizi, MD; Luciano DeMarco, MD

L-R: Sarah Selby, DO; Luke Selby; Andrew Kleinman, MD; Noella Kleinman; Bonnie Litvack, MD

Brian Foy, WCMS Executive Director and Karen Foy

Caroline Bauman, MD; Anthony SanFilippo, MD; Catherine SanFilippo

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President Obama Signs the *Medicare and Medicaid Extenders Act of 2010*; New Law Includes SGR Fix through December 2011

On December 15, 2010, President Obama signed into law the *Medicare and Medicaid Extenders Act of 2010 (MMEA)*. This new law prevents a scheduled payment cut for physicians who treat Medicare patients from taking effect. The Centers for Medicare & Medicaid Services (CMS) reported that this law addresses key issues for beneficiaries and providers and are that they are actively engaged in implementing these changes.

CMS is also working to implement several important new provisions for Medicare beneficiaries made possible by the Affordable Care Act – the health reform law. In 2011:

- Beneficiaries who reach the prescription drug coverage gap, known as the donut hole, will receive a 50-percent discount when buying Part D-covered brand-name prescription drugs.
- Virtually all Medicare beneficiaries are eligible to receive many free preventive care services and a free annual wellness visit.

These provisions will improve care for Medicare beneficiaries and we encourage you to share this information with your patients. More information on these Affordable Care Act provisions can be found at ***www.Medicare.gov*** and at ***www.healthcare.gov***; healthcare.gov also contains a timeline and other key information about the new law and a highly praised insurance finder for coverage options in public and private insurance programs, which family members and friends of Medicare beneficiaries may find useful. Below please find technical summaries of key provisions of the MMEA along with some information about how these changes may affect providers and provider billing.

- **Physician Payment Update—**Section 101 of the MMEA prevents a payment cut for physicians that would have taken effect January1, 2011. While the physician fee schedule update will be zero percent, other changes to the relative value units (RVUs) used to calculate the fee schedule rates must be budget neutral. To make those changes budget neutral, the conversion factor must be adjusted for 2011. **CMS is currently developing the 2011 Medicare Physician Fee Schedule (MPFS) to implement the zero percent update, and we expect all 2011 claims to be processed timely, in compliance with the new legislation**.
- **Extension of Medicare Physician Work Geographic Adjustment Floor—**Current law requires payment rates under the MPFS to be adjusted geographically for three factors to reflect differences in the cost of provider resources needed to furnish MPFS services: physician work, practice expense, and malpractice expense. Section 103 of the MMEA extends the existing 1.0 floor on the "physician work" geographic practice cost index, through December 31, 2011. As with the physician payment update, this change will be accomplished through a revised 2011 MPFS.♦

Without proper legal counsel, your practice could be in jeopardy.

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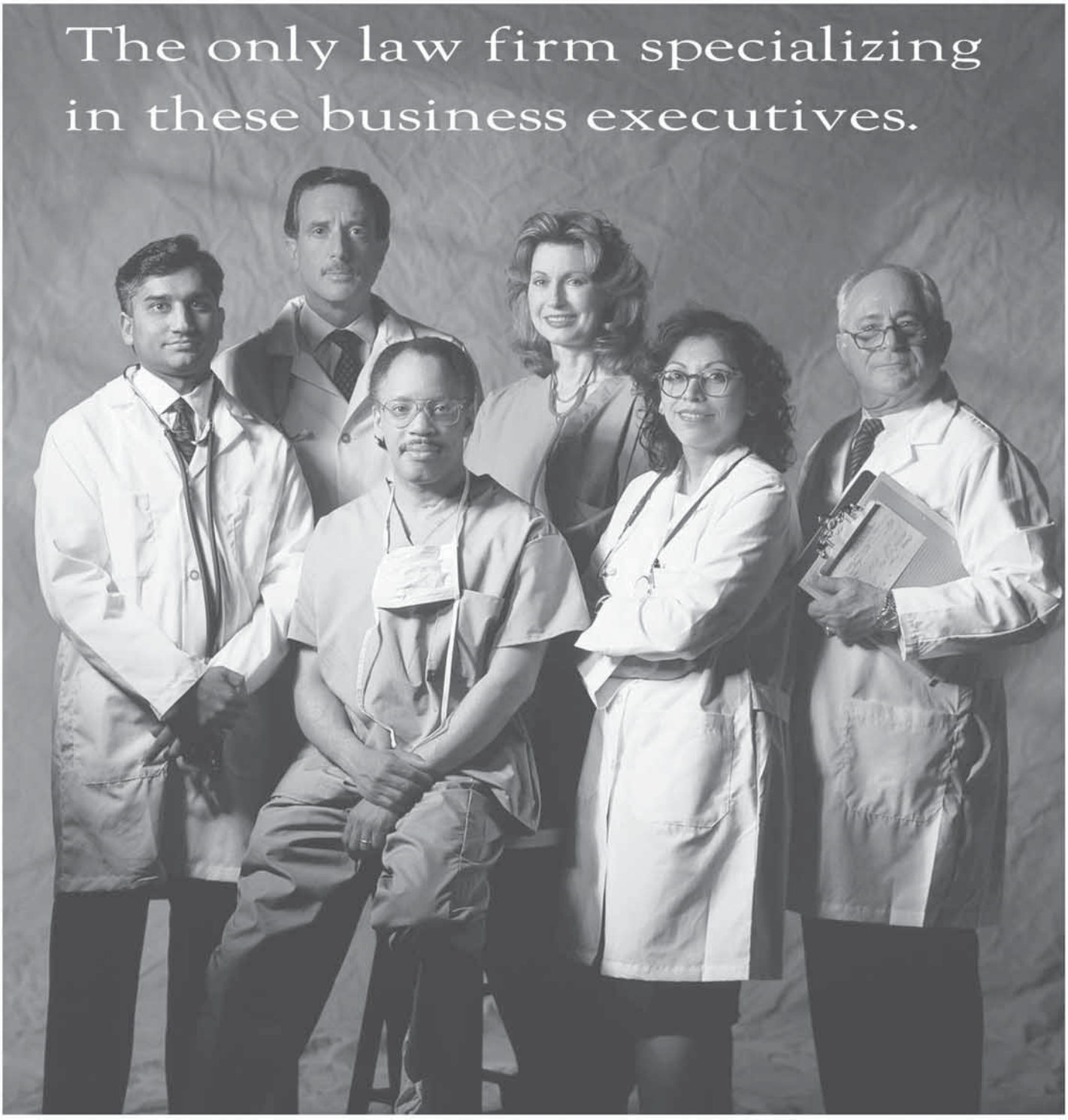

GUEST COLUMN

Now Do The Right Thing

By Joseph McNelis, MD, Vice President
Westchester County Medical Society

Metron ariston (Everything in moderation)
-Cleobulus (or some other DEWM)

Listen to me people, I've been pushed around/ I've been lost and found
I've been given until sundown/ To get out of town
I've been taken outside/ And I've been brutalized
And I've had to always be the one/ To smile and apologize
But I've never/ In my life before
Seen so many love affairs/ Go wrong as I do today
So I want you to stop/ Find out what's wrong
Get it right right right/ Or just leave love alone
Because the love you save today/ May very well be your own
-Joseph Arrington Jr.

The election of President Barack Obama in November, 2008, represented a 'mandate for change' to many of his acolytes. Allegedly radical initiatives such as the stimulus bill, the bank and automobile bailouts, actually could be rationalized as necessary interventions preventing a systemic catastrophe. Of all the initiatives enacted in his first two years, the Patient Protection and Affordable Care Act (PPACA) adheres closest to the 'mandate for change' agenda. It also remains the defining piece of legislation for the Presidency and the one dearest to the President's heart.

The recent elections markedly changed this landscape. As promised by incoming House Majority Leader Eric Cantor, the first item on the agenda on January, 2011, will be a repeal of PPACA. This repeal will be mainly symbolic, as the Senate will not uphold the repeal. As the House controls the purse strings, they can refuse to allocate the necessary funds as the schedule for PPACA proceeds, resulting in 'death by a thousand cuts.'

The actions taken by the President and Congress during the Lame Duck session lead some to believe that PPACA is salvageable. The President, displaying newfound horse-trading skills, exchanged Bush tax cuts for prolongation of unemployment benefits. Repeal of the 'don't ask, don't tell' military policy towards gays succeeded, while the DREAM Act, which in certain circumstances, proposed offering permanent residency to illegal immigrants attending college or serving in the military, was allowed to wither on the legislative vine. In an unprecedented maneuver, President Obama abdicated the platform to ex-President Clinton at a Presidential press conference explaining the Bush tax cut compromise. Dick Morris was the only piece missing in order to 'triangulate' things off properly.

Rep. Paul Ryan, Chairman of the House Budget Committee, will play a pivotal role in upcoming negotiations. During the debate immediately preceding ratification of PPACA, Ryan presented his 'Roadmap for America,' the only coherent Republican alternative to Obama's health bill. While considered a strong conservative, Ryan has demonstrated an ability to reach across the aisle when needed. Ryan was appointed to the President's Deficit Commission and worked closely with Clinton era Director of the Office of Management and Budget Alice Rivlin during the deliberations.

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GUEST COLUMN . . . Now Do The Right Thing

(continued from page 14)

The bipartisan Deficit Commission does not appear to have reached a firm consensus. The President can be expected, nonetheless, to use its data in confronting the Four Horsemen of the Deficit Apocalypse: Social Security, Defense, Medicare, and Medicaid. Much of the recommendations with regards to health care entailed rounding up the usual suspects, including quality measures, computerization of medical records, etc., etc. Much to the surprise of many was the inclusion of the 800 lb. gorilla in the room that dare not speak its name: malpractice reform.

The decision of Judge Hudson of the Federal District Court in Richmond, VA, rejecting the Administration's rationalization of the individual mandate changes the calculus as well, (see *New York Time* article of 12/29/2010, "Shifting terrain in the challenges to the health care law"). The ultimate decision in the individual mandate likely will be made by the United States Supreme Court sometime in 2012. Without the proper compromises, the PPACA will be but a Pyrrhic victory for the President by then. As demonstrated by the 'switch in time that saved nine' decisions during FDR's Presidency, the Supreme Court does not operate in a political vacuum. A PPACA providing coverage to 32 million currently uninsured and fortified with strong and necessary malpractice reform would be difficult even for a conservatively leaning Supreme Court to overturn. ♦

Welcome to our Newest WCMS/Academy Members

Join us in welcoming the following new members who were elected into membership of the Westchester County Medical Society and the Westchester Academy of Medicine at the January 2011 Board of Directors Meeting.

George DiRago, MD
(Emergency Medicine)
Hartsdale, NY

Michael Grasso, MD
(Urology)
Valhalla, NY

AnneBeth Litt, MD
(Internal Medicine)
White Plains, NY

Jill Marie Mattern, MD
(Obstetrics/Gynecology)
White Plains, NY

Gary Midelton, MD
(Internal Medicine)
White Plains, NY

Malathi Shanmugam, MD
(Family Medicine)
Yonkers, NY

Hanni George Youssef, MD
(Family Medicine)
Yonkers, NY

From MSSNY Enews

2011 Electronic Prescribing (eRx) Incentive Program Update

In November, the CMS announced that, beginning in 2012, eligible professionals who are not successful electronic prescribers may be subject to a payment adjustment on their Medicare Part B Physician Fee Schedule (PFS) covered professional services. Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorizes CMS to apply this payment adjustment whether or not the eligible professional is planning to participate in the eRx Incentive Program.

From 2012 through 2014, the payment adjustment will increase each calendar year. In 2012, the payment adjustment for not being a successful electronic prescriber will result in an eligible professional or group practice receiving 99% of their Medicare Part B PFS amount that would otherwise apply to such services. In 2013, an eligible professional or group practice will receive 98.5% of their Medicare Part B PFS covered professional services for not being a successful electronic prescriber in 2011 or as defined in a future regulation. In 2014, the payment adjustment for not being a successful electronic prescriber is 2%, resulting in an eligible professional or group practice receiving 98% of their Medicare Part B PFS covered professional services.

The payment adjustment does not apply if <10% of an eligible professional's (or group practice's) allowed charges for the January 1, 2011 through June 30, 2011 reporting period are comprised of codes in the denominator of the 2011 eRx measure.

Please note that earning an eRx incentive for 2011 will **NOT** necessarily exempt an eligible professional or group practice from the payment adjustment in 2011.

How to Avoid the 2012 eRx Payment Adjustment

Eligible professionals – An eligible professional can avoid the 2012 eRx Payment if (s)he:

- Is not a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of June 30, 2011 based on primary taxonomy code in NPPES;
- Does not have prescribing privileges. Note: (S)he must report (G8644) at least one time on an eligible claim prior to June 30, 2011;
- Does not have at least 100 cases containing an encounter code in the measure denominator;
- Becomes a successful e-prescriber; and
- Reports the eRx measure for at least 10 unique eRx events for patients in the denominator of the measure.

Group Practices - For group practices that are participating in eRx GPRO I or GPRO II during 2011, the group practice **MUST** become a successful e-prescriber.

- Depending on the group's size, the group practice must report the eRx measure for 75-2,500 unique eRx events for patients in the denominator of the measure.

For additional information, please visit the "Getting Started" webpage at ***http://www.cms.gov/erxincentive*** on the CMS website for more information; or download the *Medicare's Practical Guide to the Electronic Prescribing (eRx) Incentive Program* under Educational Resources.♦

WCMS Public Health Corner

Westchester County Led Nation in 2008 Immunizations

According to the December 10th ***Morbidity and Mortality Weekly Report*** **(MMWR) report, "Surveillance for Certain Health Behaviors among States and Selected Local Areas – United States, 2008",** health care providers in Westchester county administered flu shots to a much higher percentage of its 65-and-over population than did the rest of the nation or the rest of the state in 2008. To access this report, visit the CDC website at ***http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5910a1.htm?s_cid=ss5910a1_e.***

Results of the 2009 NAPH Hospital Characteristics Survey

Each year the National Association of Public Hospitals and Health systems analyzes NAPH its members' financial and utilization data. Below are some key findings from the 2009 survey demonstrates that during challenging times, public hospitals continue to serve a diverse patient population with varying health care needs through primary and specialty care delivered in both inpatient and outpatient settings.

- *In 2009, 16 percent of NAPH members' costs were uncompensated, compared to 6 percent of costs for hospitals nationally. NAPH members delivered 20 percent of the uncompensated hospital care provided by U.S. hospitals that year despite representing only 2 percent of the nation's acute care hospitals.*
- *NAPH members rely on a combination of federal, state, and local funding sources for financial viability. Two-thirds of these hospitals' patient care revenues came from government sources. Medicaid remained the most important source of financing for public hospitals, accounting for 35 percent of net revenues.*
- *NAPH members provided an extraordinary amount of ambulatory care, averaging more than 582,000 visits in 2009. Furthermore, 31 percent of ambulatory care services were provided to uninsured patients.*
- *Medicaid DSH was a vital funding source for public hospitals in 2009, representing 22 percent of financing for unreimbursed care.*
- *Public hospitals serve as key training sites for health care professionals. In 2009, NAPH members trained more than 19,000 full-time equivalent (FTE) medical and dental residents.*
- *Because of their leading role as providers of emergency, trauma, and burn care services, NAPH members serve as first-receivers for catastrophes such as chemical spills, fires, disease outbreaks, and natural disasters.*

CDC's Office of Public Health Preparedness and Response

The CDC's Office of Public Health Preparedness and Response (OPHPR) helps the nation prepare for and respond to urgent public health threats by providing strategic direction, support, and coordination for preparedness activities across CDC. Each year, CDC's preparedness office receives over $1 billion from Congress to build and strengthen national preparedness for public health emergencies including natural, biological, chemical, radiological, and nuclear incidents. This funding supports a range of activities at CDC and state and local public health departments. Visit their website at ***http://emergency.cdc.gov/cdcpreparedness/*** to access **the *Public Health Preparedness: Strengthening the Nation's Emergency Response State by State (2010)*** which features national and state-by-state data on public health preparedness activities across the nation.

Immunization Reminder

Physicians are reminded to continue to immunize their eligible patients 6 months and older against flu throughout the winter season & to also remind them to be vaccinated and to encourage vaccination among their medical staff to decrease the likelihood of their transmitting flu to their patients.

EHR INCENTIVE PROGRAMS
Take Steps Now to Prepare for Registration

All eligible professionals, hospitals, and critical access hospitals must register to participate in the EHR Incentive Programs. Registration for the Medicare program became available on January 3, 2011. The Medicaid EHR Incentive Programs can also begin in 2011, but actual start dates will vary by state. Registration has become available in eleven states --Alaska, Iowa, Kentucky, Louisiana, Oklahoma, Michigan, Mississippi, North Carolina, South Carolina, Tennessee, and Texas. In February, registration will open in California, Missouri and North Dakota. Other states will launch Medicaid EHR incentive programs during the spring and summer. **New York State is planning to begin during the fourth quarter of 2011.**

Ahead of the registration process, physicians and hospitals can take steps now to prepare. Make sure you have enrollment records in the appropriate systems, including:

National Provider Identifier (NPI)
All eligible professionals, eligible hospitals, and critical access hospitals must have an NPI in order to participate in the Medicare and Medicaid EHR Incentive Programs.

National Plan and Provider Enumeration System (NPPES)
Most providers will need an active user account in the National Plan and Provider Enumeration System (NPPES). Please visit the link under "Related Links Inside CMS" for more information on NPPES.

Provider Enrollment, Chain and Ownership System (PECOS)
All eligible hospitals and Medicare eligible professionals must have an enrollment record in PECOS to participate in the EHR Incentive Programs. *(Eligible professionals who are only participating in the Medicaid EHR Incentive Program are not required to be enrolled in PECOS.)* CMS has encouraged all physicians and hospitals to act now to verify that you have an enrollment record in PECOS.

CMS has established an EHR Information Center to assist members of the EHR Provider Community who have questions regarding the EHR Incentive program. The EHR Information Center will be open from 7:30 a.m. – 6:30 p.m. (Central Time) Monday through Friday, except federal holidays. The Center can be accessed by phone at 1-888-734-6433 (primary number) or 888-734-6563 (TTY number).

Also, the Centers for Medicare & Medicare Services (CMS) launched the official website for the Medicare & Medicaid EHR Incentive Programs. The link for the website is ***http://www.cms.gov/EHRIncentivePrograms/*** and provides the most up-to-date, detailed information about the EHR incentive programs including "tip sheets," flowcharts, and presentations on eligibility, certification, "meaningful use," and registration.♦

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

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