WESTCHESTER PHYSICIAN

April 2011 Vol. 21 No. 8

We May Have Lost the Battle, but Not the War!

Joseph Tartaglia, MD, FACC, President and Thomas Lee, MD, Secretary
Westchester County Medical Society

Despite our best efforts including over 15,000 emails in two weeks to our legislators, numerous visits to our representatives in Albany, the united support of the unions and the hospitals; **and the initial support of the Governor and the Senate,** the physicians of New York could not overcome the special interests in the Assembly and win a $250,000 medical liability cap on non-economic damages. The Medicaid Redesign Teams recommended liability reforms were carved out of the deal probably as a bargaining chip for some other concession by the Assembly. The state medical society immediately withdrew its support for the Governor's budget and now opposes the concessions physicians are being required to make, including taxing our practices, restricting our ability to prescribe expensive medications and asking us to accept low-fee managed Medicaid. Our sentiments were expressed to the Governor in a letter from the state medical society and to the New York State Health Commissioner, Nirav R. Shah, MD, MPH. last Friday after he addressed the House of Delegates in Tarrytown on the prospects of the transformation of health care in the state to a new model of care.

During the past month, WCMS met with many members of the Westchester delegation of the NY State legislature not just to push for medical liability reform but also collective negotiations, scope of practice issues, and preservation of out of network insurance benefits. ***While the significant setback in medical liability reform frustrated many of us, we are determined to continue to advocate for our members and to achieve positive outcome on many other issues important to the medical profession.***

Since we cannot meaningfully lower the expenses associated with professional liability premiums at this time, we should work harder to pass other legislation and regulations to maintain and improve physician revenue/reimbursement. Our New York legislators on both sides of the aisle may be more anxious to come to our aide in other matters knowing how they have just dealt a devastating blow to all the physicians of the state. This is not the time to hide and be frustrated. We have gathered significant good will from our recent strong advocacy efforts, and can hopefully achieve tangible progress on collective negotiation and out of network benefit legislation. Even Senate and Assembly legislators who were not willing to support medical liability reform have voiced strong support for our other important agenda. ***This is the time for us to unite and refocus our effort on these other important issues. Continued advocacy and engaging our elected officials by WCMS and its members are of paramount importance.***

The WCMS Board looks forward to hearing from our members and non-members on issues important to our profession and practice. It is only with one voice and in great number that we can achieve our goals. As always please share with us your comments or tell us your opinion on *www.thewestchsterphysician.com*. ♦

A Look Inside . . .

The Westchester Physician
Published by the
Westchester County Medical Society

333 Westchester Avenue
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White Plains, NY 10604
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Mark Your Calendar

April 28, 2011
Affinity Goup Seminar - 6:00pm

May 2, 2011
CME Committee Meeting—5:00 pm
Budget & Finance Committee Meeting—6:30 pm

May 5, 2011
WCMS Board Meeting—6:30 pm

June 9, 2011
WCMS Annual Meeting—5:30 pm
Knollwood Country Club, Elmsford

WCMS Blast FAX & Email Service

If you have not been receiving WCMS blast FAXs and emails, we may not have your correct fax number or email on file. This is how we communicate with our members on important and timely issues, including legislative alerts and upcoming events.

Please update this information by sending it to Karen Foy at *kfoy@wcms.org*. Your information will be used for WCMS communications only and will not be shared with 3rd parties.

The Westchester County Medical Society would like to wish its members and their families a Happy Easter and Passover.

FROM THE EDITOR
Le Cinema

By Peter Acker, MD

I have since college loved French cinema. My wife gave me as a gift a weekend pass for the Focus on French Cinema, an annual event at SUNY Purchase, sponsored by the Alliance Française of Greenwich, which just ran from March 18-20. We had the opportunity to view seven films in 48 hours and participate in discussions afterward which often included the director and/or screenwriter of the film. Why would I bring this up in a column that will be read mainly by physicians? Well, for one thing, being a doctor does not preclude enjoying superbly crafted films by masters from across the Atlantic! More importantly, two of the films had direct medical relevance and I hope many of you will seek them out (I'm sure they will available on Netflix in the future).

The first film was entitled *La Dernière Fugue* (The Last Escape) which is about an extended family in Quebec which has gathered together for the Christmas holiday. Dominating the atmosphere is the patriarch's rapidly advancing Alzheimer's. In his prime, he had been dominating and even dictatorial. The movie centers on Christmas Eve dinner with the whole family. The father, at the head of table, in the typical state of disinhibition that often characterizes Alzheimer's, continually blurts out comments that range from buffoonish non sequiturs to pointedly cruel barbs. The various family members are in turn sympathetically solicitous, embarrassed, and hurt by the spectacle before them. The film cuts frequently to flashbacks to slowly reconstruct the narrative of how the family in more halcyon days interacted, particularly on summer trips camping at a lake. Andre, the eldest son, in particular reflects back on the origins of his conflict with his father which stemmed from an incident that occurred on a father-son fishing trip. The details are only slowly revealed throughout the movie, but once fully realized set up the film for an amazing and sad denouement. The lead part is brilliantly portrayed by Andrée Lachapelle, in a stunning tour de force that manages to convey pain in a realistic and nuanced way. The rest of the cast is effective in expressing the myriad feelings evoked by the father, especially the actress who plays his wife whose subtle facial expression reveals the deep love she still has for her husband.

The second film couldn't have been more different (*Le Bruit Des Glaçons* –The Clink of Ice). The opening scene shows a man of early middle age sitting poolside at a large country estate. Though it appears to be not late in the day, he is considerably inebriated and has a bottle of wine at the ready. He hears the front gate chime and he goes down to greet an unexpected visitor: a younger somewhat dapper man who announces "Hello, I am your cancer. I thought it might not be such a bad idea to get to know each other." I must say, I was taken aback by the premise, but quickly found myself enthralled with this dark, desperate film, shot through with wit and humor. The dialogue between the man (who was once a successful writer, but now dissipated and divorced) and his "cancer" is sharp and original and in a strange way portrays the chronic course of illness with its desperation and hope and like the guest from hell that just won't leave. The discussion afterwards was lead by Dr. Barry Boyd, an oncologist from Greenwich Hospital.♦

Westchester Delegates Debate/Shape MSSNY Policy

By Brian O. Foy
WCMS Executive Director

The Medical Society of the State of New York (MSSNY) recently concluded its annual policy meeting, April 8-10, 2011, at the Westchester Marriott Hotel in Tarrytown, NY. Physicians from all parts of the state travelled to Tarrytown, representing their county or specialty medical societies to debate, amend and ultimately approve MSSNY policy on a wide range of medical issues. ***See MSSNY 2011 Annual Meeting Highlights on page 7 for a summary of actions taken by the House of Delegates.***

The Westchester Delegation to MSSNY met several times prior to the meeting and submitted a total of eight resolutions. The Delegation caucused multiple times during the meeting on the issues before the House. The Delegation members were as follows:

Bonnie Litvack, MD, *Mount Kisco*, ***Chair***
Andrew Kleinman, MD, *Rye Brook*, ***Vice Chair***
Robert Ciardullo, MD, *White Plains*
Peter Liebert, MD, *White Plains*
Robert Lerner, MD, *Valhalla*
Louis McIntyre, MD, White Plains
Stephen Schwartz, MD, Pleasantville
Joseph McNelis, MD, *New Rochelle*
Joseph Tartaglia, MD, *White Plains*, ***WCMS President***
Mark Fox, MD, *Tuckahoe*
Abe Levy, MD, *Mount Kisco*, ***WCMS President-elect***
Thomas Lee, MD, *Tarrytown*

Others caucusing with the Westchester Delegation included: Kira Geraci-Ciardullo, MD, *Mamaroneck*, MSSNY Vice Speaker; Michael Rosenberg, MD, *Mount Kisco*, MSSNY Trustee; David Bank, MD, *Mount Kisco*, representing Dermatology; James Pollowitz, MD, representing Allergy; Biagio Mignone, MD, representing Ophthalmology; William Walsh, MD, representing New York Medical College (NYMC); and Marissa Friedman, medical student, NYMC and newly elected Secretary of the MSSNY Medical Student Section.

As listed previously in the March issue of the ***Westchester Physician***, here are the resolutions brought forward by WCMS by title and ***final House action:***

Out of Network Reimbursement

RESOLVED, That the Medical Society of the State of New York (MSSNY) support and advocate for legislation and/or regulation that requires managed care organizations to use the FAIR Health benchmarks as the basis for reimbursement for out-of-network charges for any policy that provides out of network benefits; and be it further

RESOLVED, That MSSNY support and advocate for regulation and legislation that will prevent health insurance companies from selling policies that purport to but, in fact, fail to adequately cover out-of-network health care benefits; and be it further

RESOLVED, That MSSNY support and advocate for regulation and/or legislation to require health insurance companies to "crosswalk" their out-of-network reimbursement methodology to true UCR (such as that being developed under FAIR Health).

Deductible Transparency

RESOLVED, That the Medical Society of the State of New York seek legislation, regulation or other appropriate means to require health insurance companies to provide a patient's in-network and out-of-network deductible information both on the patient's insurance card, as well as available on the health insurance company's website; and be it further

WESTCHESTER DELEGATES DEBATE/SHAPE MSSNY POLICY

(continued from page 4)

RESOLVED, That the Medical Society of the State of New York seek to assure that the deductible information provided on the company's website be updated on a reasonably frequent basis.

Compensation for Emergency Department Coverage

RESOLVED, That the Medical Society of the State of New York recommend that hospitals that utilize voluntary physicians to provide coverage for emergency departments provide appropriate compensation for these services in a manner consistent with Advisory Opinions issued by the Office of the Inspector General; and be it further

RESOLVED, That voluntary physicians should not be required by hospitals to provide emergency department coverage without compensation.

Specialty Exams

RESOLVED, That the Medical Society of the State of New York request of the American Medical Association delegation to recommend to the American Board of Medical Specialties that a physician in private practice be required to take only one proctored board exam within that physician's specialty every ten years, and that within the maintenance of certification at the same exam other optional sections should be devoted to the added qualifications; and be it further

RESOLVED, That the MSSNY AMA Delegation ask the AMA to request that its component specialty societies restrain from dividing every aspect of their specialist physician practice into numerous added qualification exams and that whenever possible, alternate methods be sought to ensure adequate qualifications and make the process less onerous for physicians in private practice.

Dedicated Medical Liability Reform Website

RESOLVED, That the Medical Society of the State of New York examine the medical liability reform component of the Advocacy section of its website to ensure that it currently and in the future will contain at least these components: position statements; talking points; research and data highlighting the need for reform; media clips; legislator votes and comments; and all other pertinent material that will educate and equip our members to advocate effectively on this critically important issue.

Additionally, the WCMS submitted three memorial resolutions in honor of three recently deceased past presidents: Richard L. Fenton, MD; Thomas D. Rizzo, MD; and Bertram J. Oppenheimer, MD, all of whom passed away since the 2010 MSSNY Annual Meeting. The resolutions were made part of the official proceedings of the House and a letter along with a copy of the resolution will be sent by MSSNY to their surviving spouses.

WCMS was pleased to be involved in securing a visit by Congresswoman Nan Hayworth, MD, a WCMS and MSSNY member representing New York's 19th Congressional District. Dr. Hayworth addressed the House of Delegates on April 9, having just returned from the budget deliberations in Washington, DC that afternoon.

WCMS is proud of its past presidents: Kira Geraci-Ciardullo, MD (2002); and Andrew Y. Kleinman, MD (2003), who were re-elected Vice Speaker and elected Treasurer, respectively. See page 6. Also, Dr. Gercai-Ciardullo and Dr. Michael Rosenberg, WCMS past president (2004), were elected alternate delegates to the AMA for two-years terms ending in 2013.

More information regarding the MSSNY Annual Meeting, including the inaugural address of newly-elected president Paul A. Hamlin, MD, an internist practicing in Lake Success, NY, will be published in the May issue of the newsletter. ♦

WCMS Members Elected to MSSNY Leadership Positions

Kira A. Geraci-Ciardullo, MD, Re-Elected Vice Speaker

Kira A. Geraci-Ciardullo, MD, MPH, was re-elected Vice Speaker of the Medical Society of the State of New York (MSSNY), at MSSNY's 205th annual House of Delegates (HOD) meeting in Tarrytown, NY, on April 9. Only one other woman has achieved this honor.

Dr. Geraci-Ciardullo, an allergist in Mamaroneck, has been a dedicated member of MSSNY for over twenty-five years and has held many leadership positions, including chair of MSSNY's emergency preparedness committee and vice-chair of MSSNY's rural subcommittee. She currently serves on MSSNY committees for quality improvement, health system reform, and preventive medicine and family health. She is also a member of MSSNY's Medical, Educational and Scientific Foundation.

Dr. Geraci-Ciardullo has served as president of the Westchester County Medical Society, the Westchester Academy of Medicine and the Westchester Allergy Society. She has been part of MSSNY's AMA delegation for six years and represents MSSNY at the AMA-sponsored Physician Consortium for Performance Improvement. In her community she volunteers for asthma education programs and serves on the Hudson Valley Asthma Coalition Steering Committee.

Dr. Geraci is married to plastic surgeon Robert Ciardullo, MD, WCMS Treasurer and also an active MSSNY member and delegate to MSSNY's HOD.

Andrew Y. Kleinman, MD, Elected Treasurer

Andrew Y. Kleinman, MD, was elected Treasurer of the Medical Society of the State of New York (MSSNY) at its 205th annual House of Delegates (HOD) meeting in Tarrytown, NY, on April 9. He will be overseeing the finances of the state's primary professional organization for physicians. Dr. Kleinman has a private practice in Rye Brook and is on the plastic surgical staff of the Sound Shore Medical Center of Westchester.

Dr. Kleinman has held all leadership positions for the WCMS, including president, and is currently vice president of the Ninth District, which represents physicians in several counties. He is also a member of the American Society of Plastic Surgeons and president of the New York State Society of Plastic Surgeons.

Dr. Kleinman has served MSSNY in many capacities, including as commissioner of its Socio-Economics Division. He was a councilor for six years and has been part of MSSNY's AMA Delegation for the past three years. He currently vice-chairs MSSNY's Professional Medical Conduct Committee and serves on committees for membership and physician advocacy.

HIGHLIGHTS OF THE 205TH MSSNY HOUSE OF DELEGATES

The Medical Society of the State of New York has adopted the following policies and been directed to take the following actions as the result of resolutions passed by the physician delegates from around the state who attended MSSNY's 205th House of Delegates meeting, held in Tarrytown, NY, this past weekend.

MSSNY will support legislation that gives US medical students from LCME/ COCA-accredited medical schools preference over students from international and dual-campus medical schools for clerkship rotations in hospitals or affiliated clinics.

MSSNY will seek legislation that requires 1) young athletes suspected of having an acute traumatic brain injury, including concussion, be removed from play/practice; and that 2) injured players get written approval from a physician before returning to play/practice.

MSSNY will advocate for legislation requiring all high school students to attend a training course in CPR and the use of an automated external defibrillator (AED), using the course guidelines recommended by the American Heart Association and endorsed by the American Academy of Pediatrics.

In an effort to reduce overdose deaths, MSSNY will work with the NYS-DOH and specialty societies to expand Naloxone (which can reverse overdoses) programs as part of its overdose prevention programs.

MSSNY should seek legislation that 1) permits physicians to report to the DMV patients whom the physician believes should not operate a motor vehicle and that 2) provides civil and criminal immunity for good-faith reporting.

MSSNY adopted as policy the statement that "restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented; or if they fail to make reasonable accommodation of patients' choice of physician."

MSSNY will urge the AMA to seek an immediate delay of the penalty for non-compliance with e-prescribing (eRx), scheduled to go into effect in 2012, to allow physicians more time to explore available eRx options, weigh their alternatives and make conscious, educated decisions.

MSSNY will 1) advocate for proactive enforcement of NYS regulation that gives patients necessary information to make informed decisions in choosing who to provide their healthcare; and 2) seek legislation to require all healthcare professionals in all healthcare settings to wear identification tags that state their professional designation in large block letters (e.g. PHYSICIAN, NURSE, PA, etc.).

MSSNY adopted policy recommending that hospitals that utilize voluntary physicians provide appropriate compensation for these services consistent with the advisory opinion issued by the Office of the Inspector General (OIG).

MSSNY should seek NYS Insurance Department regulations that require: 1) patients' health insurance cards to include [provide clearer information by including]: the payer's claim address, product line (Medicare, Medicaid, PPO, HMO, etc.), primary care physician, co-payments, deductible and/or co-insurance amounts, etc., and health plan's website; and regulations that require 2) the health plan's website to include a direct link to a webpage verifying this patient eligibility and financial responsibility information.. MSSNY should also seek swipe-card technology with verification.

HIGHLIGHTS OF THE 205TH MSSNY HOUSE OF DELEGATES

(continued from page 7)

MSSNY should: 1) inform CMS that technical errors by NYS's Multi-Carrier System (MCS) are responsible for many Medicare claims errors; and 2) petition CMS to set up a dedicated unit or contact at the MCS to respond to – and resolve – erroneous claims denials reported by county, state and specialty medical societies.

MSSNY will seek legislation that 1) only permits the title "physician" to be used by MDs and DOs and that 2) imposes penalties on those who mislead the public with the unauthorized use of the title.

MSSNY will work with NYS pharmacists and their professional organizations to help patients maintain the option of having their prescriptions dispensed at a local pharmacy and counseled face-to-face by their pharmacist. ♦

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 April, 2011, Board of Directors Meeting.

Jonathan Feingold, MD
(Gastroenterology)
Bronxville

Steven Francescone, MD
(Internal Medicine)
Larchmont

Nicholas Germanakos, MD
(Pediatrics)
Mount Kisco

Madeleine Kitaj, MD
(Neurology)
Croton-on-Hudson

Kayvan Keyhani, MD
(Ophthalmology)
Yorktown Heights

David Markowitz, MD
(Gastroenterology)
Mount Kisco

Samina Nur, MD
(Pathology)
Rye Brook

Larry Roberts, MD
(Urology)
New Rochelle

Michael Werner, MD
(Urology)
White Plains

Save the Date

Westchester Academy of Medicine

GOLF OUTING

September 21, 2011

Westchester Hills Golf Club
White Plains

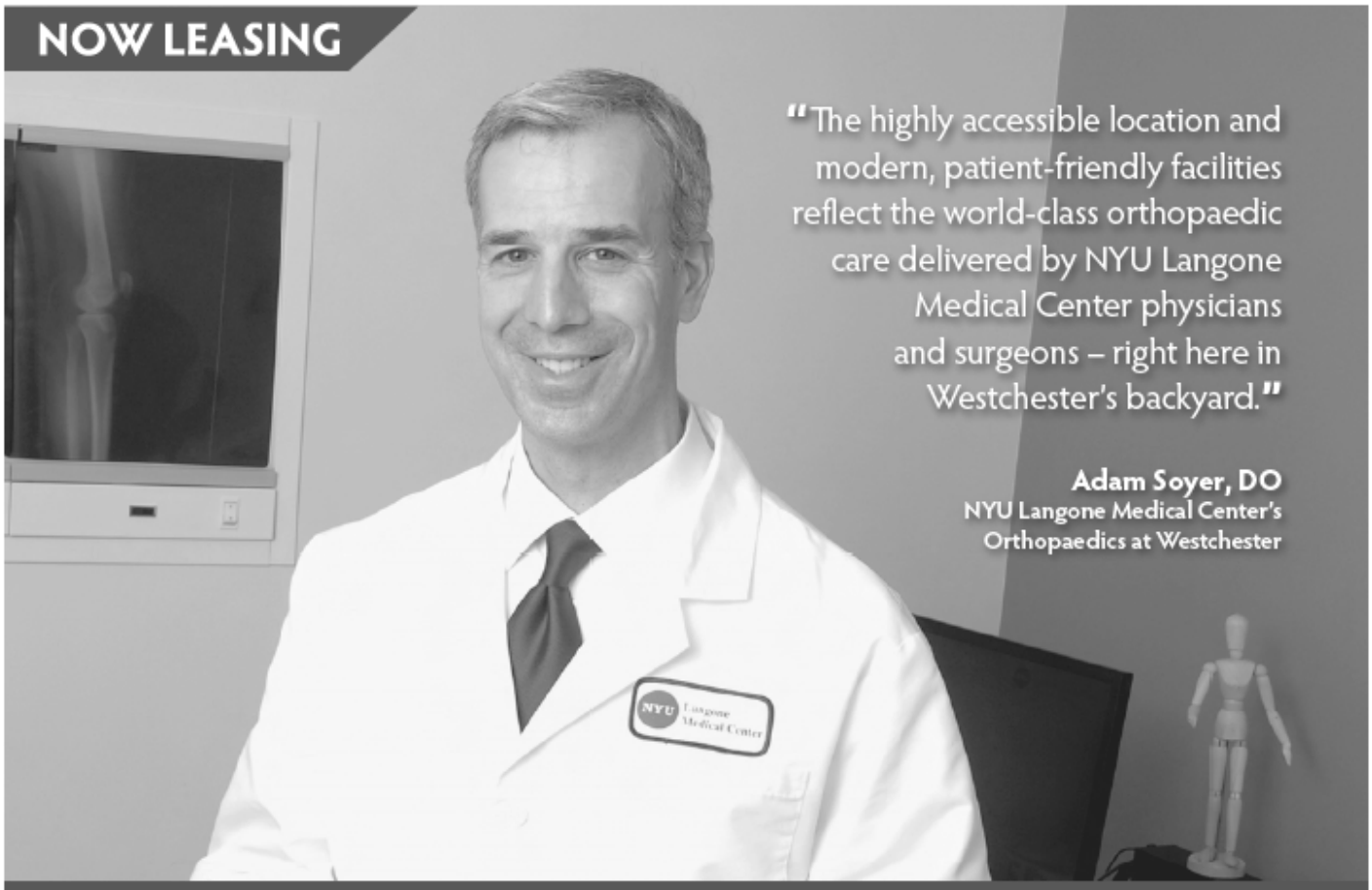
Watch for Details!

2011 MSSNY House of Delegates

Congresswoman & WCMS member Nan Hayworth, MD addresses the MSSNY HOD

WCMS members and guests enjoy the 9th district branch dinner

WCMS Delegation members at work



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Liability Obstacles Promote Nursing Homes' Fall

By Joseph McNelis, MD
Vice President, WCMS

From 1965 to 2007, the number of elderly rose from 20 million or 10% of the population to 37 million or 12.6% of the population. Those over 85 years now comprise five million people and this number is expected to increase to 7.3 million by 2020. The need for long term care is often dictated by the level of assistance required to perform 'activities of daily living' (ADL) such as bathing, dressing, toileting, or eating. More than 70% of the elderly needing assistance with these ADLs resides at home, cared for by a spouse or adult children.

As the level of assistance increases to five or six ADLs, the likelihood of nursing home entry becomes greater. About one million elderly live in nursing homes nationwide, while a similar number receiving assistance reside in the community (69% of the nursing home population and 25% of the community population with long care needs, respectively,) New York State had approximately 110,000 nursing home residents in 2008.

Long term care services nationwide entailed $206.6 billion in 2005, with 63% spent in nursing home care. In terms of the long term care dollar, 47% was paid by Medicaid, 17.8% by Medicare, 20% was out of pocket, and 8.7% was paid by private insurance. Medicare coverage stretches from home health care services and nursing home services as well as acute care needs. After hospitalization, though, Medicare pays for only 100 days of nursing home care. At that point, those requiring a long term nursing home stay rely on Medicaid for coverage, 58% nationally. A typical nursing home semi-private room costs $62,000 per year and a single occupancy room $75,000 per year.

The federal government and the states divide Medicaid payment through the use of the federal matching assistance percentage (FMAP) formulas. New York benefits from this formula compared to most of the other states, receiving $1.86 for every dollar it spends on Medicaid. Medicaid spending for New York nursing home care exceeds the national per capita average by 78%. Seventeen percent of national Medicaid nursing home spending occurs in New York.

By the FMAP formula, there is no limit to the amount of state dollars which the federal government will match, allowing New York to scale the astronomical heights of $6.95 billion. Several reasons account for this. New York Medicaid has a larger percentage of blind, aged, and disabled beneficiaries than the national average, 32% vs. 24%. New York nursing homes were 46% more expensive than the national average, and with cost of living adjustments, 29% more expensive than the national average. Compared to the other major cities, nursing homes in New York City are twice as expensive.

Determining nursing homes payments has been a difficult task. Inpatient admissions usually follow a relatively short course and payment can be tabulated with the diagnosis related group (DRG). As one authority stated, it is more challenging for nursing homes as "you often stay until you die." For many years, nursing homes were reimbursed on an equivalent per-patient basis. The less the nursing home spent on the patient, the better would be their profit margin. Needless to say, nursing homes sought out a relatively healthy clientele requiring lesser resources.

Resource utilization groups (RUGs) were developed to reflect the relative intensity of services provided to patients and to translate them into reimbursements. The Health Care Financing Administration, since renamed Centers for Medicare and Medicaid Services or CMS, put them into effect with the Balanced Budget Act of 1997. While anticipated to be a cost-cutter in the Medicare and Medicaid programs, RUGs have, for the most part, been thought to reflect increasing costs.

(continued on page 12)

Liability Obstacles Promote Nursing Homes' Fall *(continued from page 11)*

The goal of the RUG for each patient is to tabulate a case mix index (CMI) factor which will be multiplied against the typical per day costs. There are actually two CMIs assigned to a patient, one relative to the patient's clinical nursing care and the other relative to the patient's physical rehabilitation needs.

A somewhat dizzying algorithmic array is used to tabulate each resident's CMI. According to the latest RUG-IV guidelines, the resident is first categorized in one of eight broad listings: rehabilitation with extensive medical services, rehabilitation without extensive medical services, extensive medical services, special care high intensity, special care low intensity, clinically complex, behavior or cognitive performance, and reduced physical function. The category "extensive medical services" describes patients who require tracheostomy care, are on a respirator or are in infectious isolation. The category "special care high intensity" describes a range of conditions including sepsis, comatose state, quadriplegia, diabetes, emphysema, and the use of parenteral nutrition. The category "special care low intensity describes chronic neurologic conditions such as multiple sclerosis and Parkinsonism, feeding tube use, oxygen therapy, decubitus ulcers, foot infections or renal dialysis patients. The category "clinically complex" describes patients with pneumonia, hemiplegic patients, burn patients, and those receiving chemotherapy, transfusions or any intravenous medication while in the nursing home. The categories "behavior or cognitive" and "reduced physical function" refer to residents without any of the aforementioned conditions, albeit with some level of mental or physical limitation.

The two categories of patients receiving physical therapy can be further subdivided into five levels of care determined by the total number of minutes the resident receives therapy from a physical therapist in a given week. The various categories involving less extensive medical services are divided further into those with or without depression. Finally, all of the subcategories reach a CMI rating dependent on the degree of assistance needed with ADLs. Those requiring greater assistance with ADLs will receive a higher CMI.

The daily baseline reimbursements for nursing services and rehabilitation services differ in New York. For nursing services, the baseline is $155 per day. For rehabilitation services, the baseline pay is $117 per day. For those receiving nursing care with physical therapy, the sum of the products of the respective CMIs and the respective baselines determine the daily reimbursement for the resident.

The highest nursing CMI, belonging to a patient requiring major assistance with ADLs with extensive medical services, is 3.55. Daily reimbursement for nursing services is 3.55x$155 or $551.07. The highest therapy CMI for such a patient is 1.87. Daily reimbursement in this instance for physical therapy services is 1.87x$117 or $218.66. Combining the two products, along with a non-case mix component of $79.22, results in a total daily reimbursement of $848.95. The RUG-IV algorithm proceeds down the line of severity with seventy-six different permutations. The lowest paying category is for residents requiring minimal assistance with ADLs and receiving no form of physical therapy by the nurse. That resident's CMI is 0.54, producing a total reimbursement of $178.44 per day.

Within the first fourteen days of admission, the nursing home staff electronically submits a 38 page questionnaire about the resident called the minimum data set (MDS). With this data, a computer-generated CMI number is produced. Should the patient's clinical status change, the MDS should be updated and the CMI thereby either increased or decreased. Should there be no obvious change in the resident's clinical condition, the MDS must be completed every three months.

Each nursing facility employs a staff of MDS coordinators, often registered nurses, to submit these documents as performing an evaluation typically lasts about an hour, and therefore could not be done by the floor nurses. Coordination of information is crucial and precise data about the level of services must be obtained from both the floor nurse and the physical therapists by the MDS coordinators. Without a clear understanding of all services provided, the MDS coordinator will lose a good deal of potential reimbursement for the home. No reimbursement is provided for the psychologically important group activities for the resident, but otherwise it appears that most everything else is listed.

(continued on page 13)

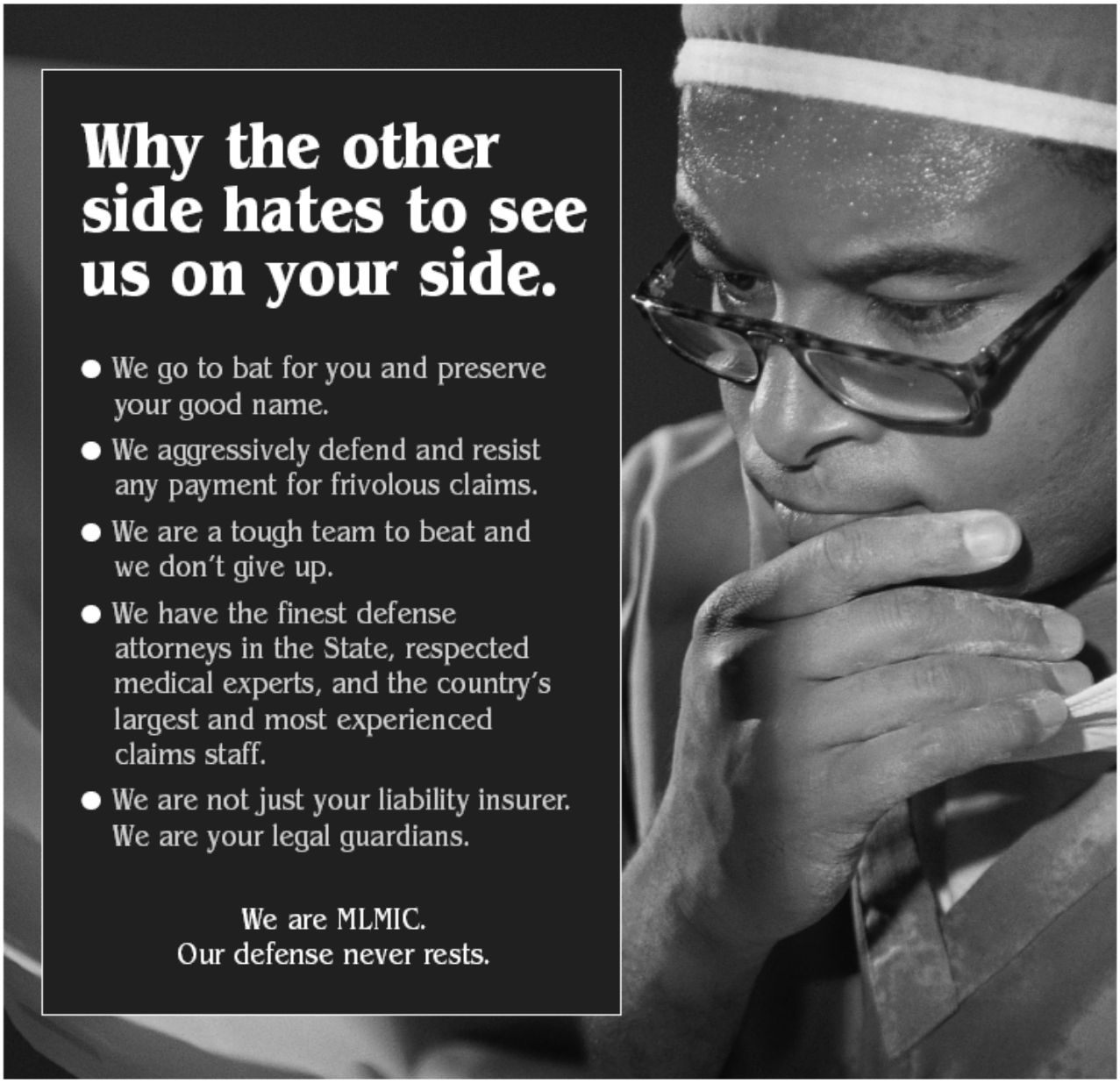
Liability Obstacles Promote Nursing Homes' Fall *(continued from page 12)*

The reimbursement system may seem complex and Byzantine in theory, but not so in practice. Medical documentation and reimbursement will never be a subtle and nuanced art, but the MDS provides incentives for the nursing home to accept difficult and challenging patients. The MDS document, while intimidating in its length, produces a quick CMI figure electronically. It would seem difficult to realistically formulate an algorithm as accurate in delineating clinical services. The problems lie less with the current reimbursement system than in the political and legal environment surrounding the provision of medical care.

Much has been made of the 'middle class entitlement' aspect of Medicaid coverage for nursing homes. Studies have shown asset transfers prior to nursing home residence to be less prevalent than commonly assumed. A large percentage of the elderly have little or no assets when entering the nursing home and what assets they had were spent on necessities. With the five year 'look back' in place, penalties will be assessed equivalent to the number of days of nursing home care, which any transferred monies would purchase. Aggressively pursuing such an avenue of enforcement may ensnare the occasional "Medicaid millionaire," but unlikely to produce significant revenues to defray the mounting costs associated with the Medicaid program.

In 2008, the Health Research Institute of the PricewaterhouseCoopers accounting firm estimated wasteful health care spending as $1.2 trillion annually, or over one-half of the $2.2 trillion health care bill. "Defensive medicine" performed strictly from fear of medical malpractice was tabulated as $210 billion annually. In 2008, $3.5 billion was paid nationally for malpractice claims, with an average claim payment of $323,000. In New York State, $618,178,300 was paid with $479,000 per claim, dwarfing payments in other states. While Texas and Florida nursing homes have been traditional targets, New York has been targeted increasingly over the last few years, increasing liability insurance costs.

The legal environment makes nursing home care very challenging both for the nursing home owners and the taxpayers. Quality measures combined with the medical malpractice industry's targeting of nursing homes will prevent any movement in decelerating the rising costs. With many patients over 85 years of age and possessing little physiologic reserve, many feared "sentinel events," such as worsening decubitus ulcers, fractures, and fecal impaction, may be hard to prevent. One nurse's aide assigned to each patient would struggle enough to prevent skin breakdown in such patients, much less one for every ten patients, as is the New York requirement. The latter is more consistent with what the health care system can afford. Given the extreme frailty of a large percentage of the patients, many bad outcomes are difficult to prevent, and to pretend otherwise, thereby setting aside increasing monies for liability costs, will close nursing homes and further bankrupt the state. Even with a team of superlative MDS coordinators, liability reform is an essential component to any effort at cost control, medical quality initiative, and, ultimately, the survival of any nursing home in New York. ♦



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Journal News—Letters to the Editor

Below is an April 3rd Journal News "Letter to the Editor" submitted by Joseph Tartaglia, MD, WCMS President as well as an April 10th response to his letter from J.W. Pettit of Yorktown Heights.

To the Editor:

Doctors are bitterly disappointed in the Governor's exclusion of meaningful medical liability reform from the negotiated budget agreement. The agreement comes after winning our cooperation to cut Medicaid costs by restricting our ability to prescribe expensive medications, taxing our practices, and asking us to accept very low paying managed care contracts to treat the neediest New Yorkers. Once again, we are protecting a legal system that encourages a trial bar lottery mentality to hunt for that one multimillion dollar case that is a bonanza for attorney law firms, rather than the vast majority of medical errors affecting most patients. In the landmark Harvard Medical Practice Study published in the New England Journal of Medicine, the doctor negligent error rate was 1.3% of hospital admissions, whereas the law firm error rate was 98.5% (8 claims out of 280 patients identified as having been exposed to medical errors.) State hospitals currently pay $1.6 billion in annual malpractice insurance with the trial lawyers collecting $352 million, $105 million from non-economic damages. In contrast, out of the $34 billion spent on Medicaid in all of New York State in 2007, only $268 million went to pay for physicians services. Only in a state where we allow trial attorneys to double as members of the Legislature can the malpractice premiums be the highest in the land. Thank God the law firms have such a high legal negligence rate that 80% of all claims are settled in favor of the physician. Right now a young neurosurgeon starting practice in New York State will have to find $250,000 to pay his malpractice premium before he treats his first patient. Yet in California, where they enacted the same reforms 25 years ago, the same premium is only $87,000. "Go west young man!"

Joseph J. Tartaglia, MD, President
Westchester County Medical Society

Speaker Silver is the problem

Re: "N.Y. still needs malpractice Rx,"

The letter writer bemoaned the fact that no medical malpractice legislation had been passed in the recent budget agreement. The answer to the captioned question is simple: Assemblyman Sheldon Silver, D-Manhattan, is a partner in the law firm of Weitz and Luxenberg, that entity being one of the largest law firms whose specialty is trying medical malpractice cases in this state. He has refused to discuss his association with the firm and also the salary he receives from Weitz and Luxenberg.

Silver was elected to the Assembly in 1976, and became the Assembly speaker on February 11, 1994. Silver has enough Democrats who will vote to pass anything he proposes, in a joint session without any votes at all. During the administration of then-Gov. George Pataki, Silver was criticized for his participation in a "Three Men in a Room" system of government, in which Silver, the governor and then Senate Majority Leader Joe Bruno exercised nearly all control over government business in this state.

If Gov. Andrew Cuomo is serious about "cleaning up Albany," a good place to start would be with Silver.

J.W. Pettit, Yorktown Heights

(This letter was originally published in the Journal News on April 10, and is reprinted with permission.)

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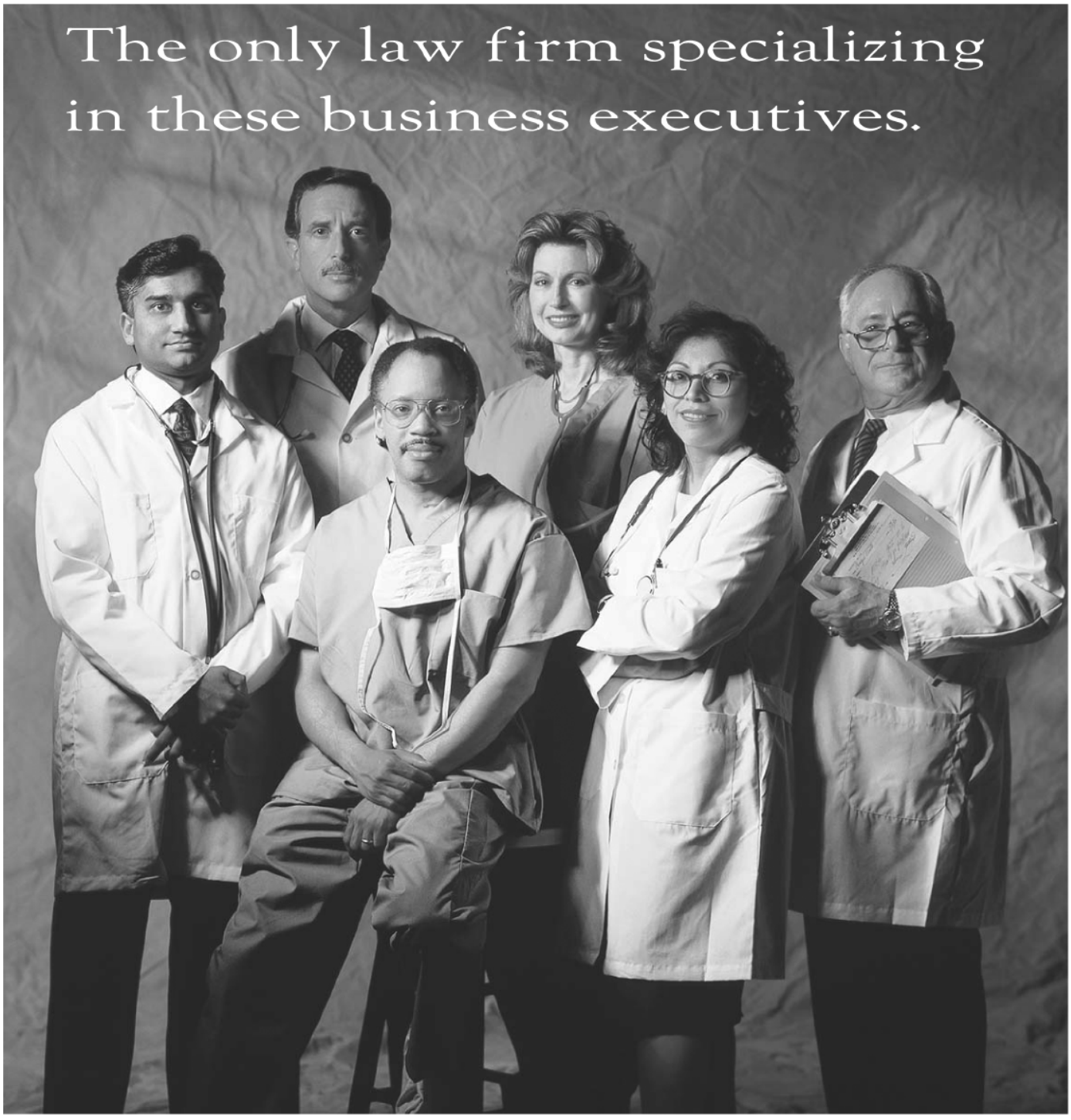

The Wage Theft Prevention Act
New Wage Notice Requirements for Employers

By Donald R. Moy, Esq.
Kern Augustine Conroy & Schoppmann, P.C.

The Wage Theft Prevention Act (WTPA), which goes into effect April 9, 2011, amends the notice of wage rate requirements under Section 195 of the Labor Law. The law covers all private sector employers in New York State. For more information go to the New York State Department of Labor website ***http://www.labor.ny.gov***

Section 195 of the Labor Law requires employers to provide a written notice to employees regarding their rate(s) of pay, designated pay day, the employer's intent to claim certain allowances as part of the minimum wage (e.g. tips or meal allowances) and the basis of the wage payment (e.g. hour, shift, day, week, piece, etc.). As amended by the WTPA, the wage notice must meet the following requirements:

1. The written notice must be provided at the time of hiring and on or before February 1st of each subsequent year of employment. The written notice must be in both English and in the primary language indentified by each employee at the time of hiring. The written notice must include the following information.

    - *The rate or rates of pay, whether paid by the hour, shift, day, week, salary, piece, commission, or other;*
    - *Allowances, if any, claimed as part of the minimum wage, including tip, meal, or lodging allowances:*
    - *The regular pay day designated by the employer;*
    - *The name of the employer;*
    - *Any "doing business as" names used by the employer;*
    - *The physical address of the employer's main office, or principal place of business, and a mailing address if different;*
    - *The telephone number of the employer;*
    - *Any other information that the Commissioner of Labor deems material and necessary.*
    - *Each time the employer provides such notice to the employee, the employer must obtain from the employee a signed and dated written acknowledgment, in English and in the primary language of the employee, of receipt of the notice. The employer must retain the written acknowledgement for six years. The written acknowledgment must include an affirmation by the employee that the employee accurately identified his or her primary language to the employer and that the notice provided by the employer to the employee was in the language so identified or otherwise complied with the requirements.*
    - *As an additional requirement, for all employees who are not exempt from overtime compensation as established by law and regulations, the notice must state the regular hourly rate and overtime rate of pay.*

2. The employer must notify employees in writing of any changes to the information set forth above, at least seven calendar days prior to the time of such change, unless such changes are reflected on the wage statement.

3. The employer must furnish each employee with a statement with every payment of wages, listing the following: the dates of work covered by that payment of wages; name of employee; name of employer; address and phone number of employer; rate or rates of pay, whether paid by the hour, shift, day, week, salary, piece, commission or other; gross wages; deductions;

(continued on page 18)

THE WAGE THEFT PREVENTION ACT *(continued from page 15)*

allowances, if any, claimed as part of minimum wage; and net wages. For all employees who are not exempt from overtime compensation, the statement must include the regular hourly rate or rates of pay; the overtime rate or rates of pay; the number of regular hours worked, and the number of overtime hours worked.

4. The employer must retain accurate payroll records (to include information listed above) for at least six years.

TEMPLATES – The WTPA requires the Commissioner of Labor to prepare templates that comply with the requirements of the law. Each template must be dual-language, including English and one additional language. The Commissioner has discretion to determine which languages to provide in addition to English.

When an employee identifies a primary language for which a template is not available from the Commissioner, the employee will comply with the law by providing that employee an English language notice and acknowledgment.

The templates are now available at the New York State Department of Labor website.

Employers must review the information available at the Department of Labor website regarding the WTPA now. The Department of Labor may assess penalties of $100 per worker per week if proper wage statements are not given. In addition, workers can sue the employer for not receiving the proper wage statement, but damages are capped at $2,500 per worker. ♦

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Members are encouraged to submit articles, letters to the editor, classified ads, members in the news, etc. for publication in the *Westchester Physician.*

The deadline for the May 2011 issue is April 30th.

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

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