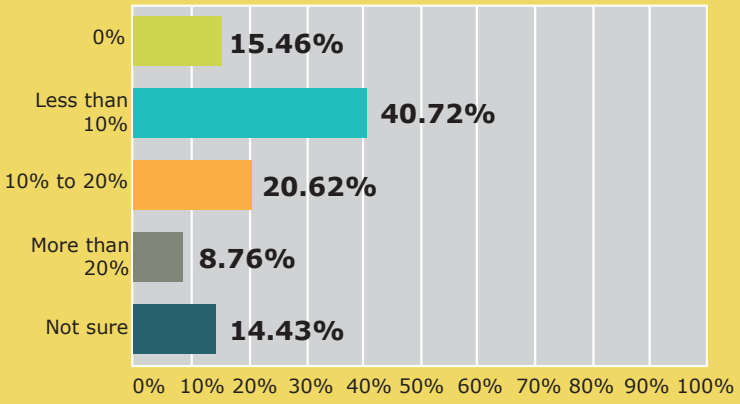
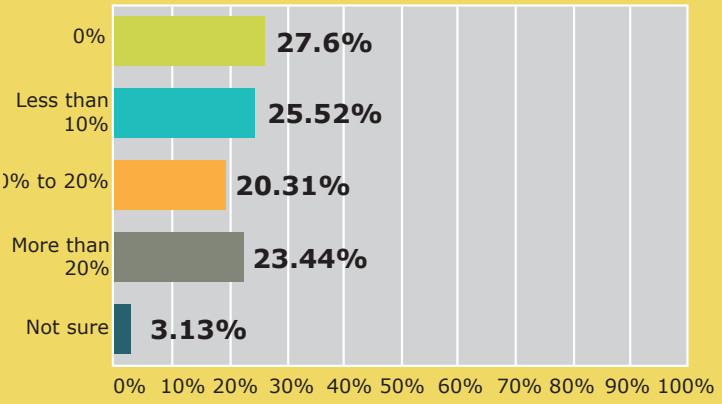
MEDICAL SOCIETY OF THE STATE OF NEW YORK
NEWS OF NEW YORK
Providing Information to Assist Physicians in the State of New York
Volume 71 • Number 8 www.mssny.org September 2015

Health Insurance Hassles Survey

Approximately what percent of your patients have coverage through the New York State Exchange?



Approximately what percent of your patients are insured by Medicaid or a Medicaid managed care plan?



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MSSNY Survey Details Physician Concerns with Inadequate Health Insurance Coverage Faced By Patients

Legislators in New York and Washington D.C. must take action to assure that health insurance coverage truly provides patients with coverage for needed care, instead of a limited catastrophic benefit, according to survey results gathered by the Medical Society of the State of New York.

"The increased availability of subsidized health insurance coverage through New York's Exchange has certainly been a positive development for our patients, but at the same time we find that more and more of our patients are underinsured due to the increasingly inadequate coverage and narrow networks offered by insurers," said Dr. Joseph Maldonado, President of the Medical Society of the State of New York.

LARGE DEDUCTIBLES SURPRISE MANY PATIENTS

Many patients are surprised that the health insurance policies for which they have paid thousands of dollars per year will not cover many costs of care until they spend thousands of dollars out of pocket first.

MSSNY's survey found that significant

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ACP: State Immunization Laws Should Eliminate Non-Medical Exemptions

Support for eliminating existing exemptions, except for medical reasons, from immunization laws was among the policy recommendations adopted recently at the summer meeting of the Board of Regents of the American College of Physicians (ACP).

"Allowing exemptions based on non-medical reasons poses a risk both to the unvaccinated person and to public health," said Wayne J. Riley, MD, MPH, MBA, MACP, president of ACP. "Intentionally unvaccinated individuals can pose a danger to the public, especially to individuals who cannot be vaccinated for medical reasons."

The ACP Board of Regents said it supports:

1. The immunization of all children, adolescents and adults, according to the recommendations and standards established by the U.S. Advisory Committee on Immunization Practices (ACIP), the National Vaccine Advisory Committee (NVAC) and the Centers for Disease Control and Prevention (CDC).

2. State laws designed to promote all recommended immunizations.

3. States passing legislation to eliminate any existing exemptions, except for medical reasons, from their immunization laws.

Members Only: Your Patients Can Save Up to 75% on Prescriptions

With the rising cost of both generic and name brand medications, your patients could all use some help these days! The New York RX Card, MSSNY's newest Member Benefit, is a 100% Free and 100% Confidential point of sale prescription discount card that can save your patients up to 75% on prescription medications! It is free to everyone with no minimum nor maximum uses, no age or income requirements, no enrollment or approval process and it is accepted at over 68,000 pharmacies, nationwide!

This card will provide you with Rx medication savings of up to 75% at more than 68,000 pharmacies across the country including CVS/pharmacy, Duane Reade, A&P, Hannaford, Kinney, Kmart, Pathmark, Stop and Shop, Target, Tops, Waldbaums, Walgreens, Walmart, Wegmans, and many more. You can create as many cards as you need. We encourage you to give cards to friends and family members. This card is pre-activated and can be used immediately!

The NYRX Card works on lowest price logic, to guarantee the best prices on medications. It won't lower co-pays or replace existing insurance, but in some cases the New York Rx price is even lower than your patients' co-pay! It can be used during the deductible periods in Health Savings Accounts and High Deductible Plans, lowering out-of pocket-expense on prescriptions. Medicare Part D recipients can use the card to discount their prescriptions not covered on their plan as well as receive discounts on medications not discounted when in the "donut hole."

The NYRX Card is pre-activated and ready to go with no personal information taken or given. NYRX will mail as many cards you desire, directly to your office, with display stands. The cards typically are placed at the patient check out area. Some doctors place them at the check in area as well. Contact rraia@mssny.org for your cards!

Update to Physicians Advocacy Program from KACS Law Firm

Kern Augustine Conroy & Schoppmann, P.C. is proud to announce that the Physician Advocacy Program® has expanded to include the new Premier Partner Program.

The Premier Partner Program, as a stand-alone program, or an addition to your current Physician Advocacy Program® membership, will provide members with immediate access to their own expert health law defense team, in case of a legal investigation, as well as trusted advisors to build proactive solutions regarding Asset Protection, Estate Planning, HIPAA Compliance as well as Billing and Coding Documentation for reimbursement.

Calling All Amateur Photographers for MSSNY's Social Media Feeds

We'd like to include more happenings from around the state in our Twitter, Facebook and Instagram feeds. If you're at an event that you think might be of interest to our followers, please snap a picture with your phone and send to jvecchione@mssny.org.

Be sure to include a caption or some identifying words. We're open to any and all ideas and hope to hear from you!

Take CME Courses at www.mssny.org

PRESIDENT'S COLUMN

Local Help Required for Project

Joseph R. Maldonado, Jr., MD, MSc., MBA, DipEBHC

CAN YOU HELP US?

Who are we as a society? Whom do we represent? On what basis do we claim to speak for physicians of the State of New York? These are questions we are often asked by physicians, industry leaders, the press and legislators. Often, we provide a generic response that the Medical Society of the State of New York speaks on behalf of the physicians of the state of New York. This is followed by more nuanced questions. Does that mean you speak on behalf of all physicians practicing in the state of New York? Do you speak on behalf of all physicians who hold a license to practice medicine by the State of New York? Do you speak for all physicians regardless of whether or not they are actively engaged in the clinical practice of medicine in New York? Do you speak only for members of the Society?

HARNESSING THE POWER OF OUR MEMBERSHIP

The answers to these questions pose a challenge for us. If we are to effectively harness the power of our membership, our brand and our professional standing, we need to know more accurately the numbers of physicians we represent. The Society needs your help to make it possible for us to more authoritatively and effectively use the power our membership represents to demand the healthcare reform initiatives advanced by those who know clinical medicine best: MEDICAL DOCTORS.

Obtaining exact numbers concerning physicians in the state of New York is not a precise endeavor. If we use as a baseline the roster of physicians on the Doctors' Profile website hosted by the NYS Department of Health, we discover a roster with names of residents that are transient in our state, individuals who were resident physicians several years ago but no longer work in New York, retired physicians and those licensed in the state of New York but practicing outside the state. If we use the NY State Department of Education's professional verification database, one can only obtain individual verifications rather than a complete roster. If we use the Centers for Medicare and Medicaid Services database, we ascertain only those physicians registered with CMS, leaving out many who do not treat Medicare or Medicaid patients. The Society's database needs updating so as to more accurately represent to the public and legislators the base for whom we speak.

WE NEED YOUR HELP

During my tenure as President of the Society, I am seeking to engage our leadership and members in updating the accuracy of our database. I am seeking volunteers in each county to help our county leadership, executives, Councilors and Commissioners update our membership roster. Are you a life member? Are you retired? If you are actively practicing and serving on your hospital medical staff, would you be able to review our rosters for physicians in your community to ascertain their accuracy? If so, we need to hear from you! This is a nine-month project aimed at ascertaining exactly WHO WE ARE and WHO WE REPRESENT. We need to reassess who is a member and who is not. We need to reassess where we are going as a society and how to best represent our membership.

Consider this the Society's Manhattan Project. Will you volunteer to help us accomplish this task in the next nine months? Please reach out to Eunice Skelly at eskelly@mssny.org and/or your county society so we can begin this project this month.

MSSNY-PAC

The Rush To So-Called Reform Necessitates Political Action on State Level

Much has been happening within the state over the summer months that will likely dramatically change the shape of our health care system in the next few years.

As you have read, the State received approval from CMS to invest $8B for comprehensive Medicaid delivery and payment reform through the Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program promotes community based collaborations/integration with the goal of reducing avoidable hospital readmissions by 25% over five years. 25 Performing Provider Systems (PPSs) have been established statewide to

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MEDICAL SOCIETY OF THE STATE OF NEW YORK
NEWS OF NEW YORK

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MSSNY Survey on EHR Usage and Functionality Shows Continued Frustration with EHR Technology. Physicians Who Haven't Yet Done So, Urged to Complete Survey

Preliminary response to MSSNY's survey on EHR usage and functionality are consistent with results of other surveys, which show a level of dissatisfaction with regard to EHR systems.

While 78% of respondents to MSSNY's survey are using or plan within two years to use EHRs in their practice or at their hospital, 53% stated that they are either disappointed or very disappointed with their EHR. Notably, 38% of the respondents stated that their EHRs cannot generate routine reports to help manage their patient population, like diabetics, hypertension or ad hoc reports like finding patients due for a flu shot, and 29% replied that their EHRs do not support meaningful use 2 or provide guidance on how to achieve MU-2. 56% responded that their EHR did not have prompts to notify them of gaps in patient care.

Of the 45% of physicians who stated that they were currently participating in pay for performance (P4P) programs that require reporting from their EHRs, 32% stated that their EHR did not give adequate support to collect data to support their P4P program. Many stated that they or their staff either manually aggregated the data or purchased additional software to do so.

75% of the respondents did indicate that they were e-prescribing either non-controlled substances only (46%) or both non-controlled and controlled substances (29%). Of those who were not e-scribing, a majority (66%) indicated that the delay in the implementation of the law was the primary reason why they were not yet e-scribing.

With regard to educational programming, 46% of respondents stated that they would like more information on three topics: the Delivery System Reform Incentive Program (DSRIP) and how it will affect my practice; the State Health Innovations Plan and how will it affect my practice; and how to get the most out of the data in your EHR.

Other educational programs thought to be of value to respondents included: Value Based Purchasing; What is it and how can physicians position themselves to maximize payment (40%)and Practice transformation; what does this accomplish for the typical physician practice (33%).

Physicians are encouraged, if they haven't yet done so, to complete the survey by clicking here.

Is Your Infection Control Certification Up-to-Date?

New York State law requires that all health care providers – including physicians, medical residents and medical students – receive training on infection control and barrier precautions every four years upon renewal of their license. The Medical Society of the State of New York is approved by the New York State Department of Health to provide Infection Control and Barrier Precautions to all healthcare professionals. Additionally, MSSNY is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Measures to prevent the transmission of disease in health care settings have evolved over the years and, as such, this state-mandated course, with six elements total, includes the most updated information from the New York Department of Health. The cost of the course is $50, payable online by credit card. Upon successful completion of the course work, you will be able to print out your Infection Control Certificate of Completion. Click here to take the course.

Clarifying Questions and Answers Related to the July 6, 2015 CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities

Question 1: *When will the ICD-10 Ombudsman be in place?*
Answer 1: The Ombudsman will be in place by October 1, 2015.

Q 2: *Does the Guidance mean there is a delay in ICD-10 implementation?*
A 2: No. The CMS/AMA Guidance does not mean there is a delay in the implementation of the ICD-10 code set requirement for Medicare or any other organization. Medicare claims with a date of service on or after October 1, 2015, will be rejected if they do not contain a valid ICD-10 code. The Medicare claims processing systems do not have the capability to accept ICD-9 codes for dates of service after September 30, 2015, or accept claims that contain both ICD-9 and ICD-10 codes for any dates of service. Submitters should follow existing procedures for correcting and resubmitting rejected claims.

Q 3: *What is a valid ICD-10 code? (Revised 7/31/15)*
A 3: All claims with dates of service of October 1, 2015 or later must be submitted with a valid ICD-10 code; ICD-9 codes will no longer be accepted for these dates of service. ICD-10-CM is composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide greater specificity. A three-character code is to be used only if it is not further subdivided. While diagnosis coding to the correct level of specificity is the goal for all claims, for 12 months after ICD-10 implementation, if a valid ICD-10 code from the right family (see question 5) is submitted, Medicare will process and not audit valid ICD-10 codes unless such codes fall into the circumstances described in more detail in Questions 6 & 7.

An example is C81 (Hodgkin's lymphoma) – which by itself is not a valid code. Examples of valid codes within category C81 contain 5 characters, such as:

- C81.00 Nodular lymphocyte predominant Hodgkin lymphoma, unspecified site
- C81.03 Nodular lymphocyte predominant Hodgkin lymphoma, intra-abdominal lymph nodes
- C81.10 Nodular sclerosis classical Hodgkin lymphoma, unspecified site
- C81.90 Hodgkin lymphoma, unspecified, unspecified site

During the 12 month after ICD-10 implementation, using any one of the valid codes for Hodgkin's lymphoma (C81.00, C81.03, C81.10 or C81.90) would not be cause for an audit under the recently announced flexibilities.

In another example, a patient has a diagnosis of G43.711 (Chronic migraine without aura, intractable, with status migrainosus). Use of the valid codes G43.701 (Chronic migraine without aura) or G43.719 (Chronic migraine without aura, intractable without status migrainosus) instead of the correct code, G43.711, would not be cause for an audit under the audit flexibilities occurring for 12 months after ICD-10 implementation, since they are all in the same family of codes.

Many people use the terms "billable codes" and "valid codes" interchangeably. A complete list of the 2016 ICD-10-CM valid codes and code titles is posted on the CMS website. The codes are listed in tabular order (the order found in the ICD-10-CM code book). This list should assist providers who are unsure as to whether an additional 4th, 5th, 6th or 7th character is needed. Using this free list of valid codes is straightforward. Providers can practice identifying and using valid codes as part of acknowledgement testing with Medicare, available through September 30, 2015. For more information about acknowledgement testing, contact your Medicare Administrative Contractor, and review the Medicare Learning Network articles on testing, such as SE1501.

Q 4: *What should I do if my claim is rejected? Will I know whether it was rejected because it is not a valid code versus denied due to a lack of specificity required for a NCD or LCD or other claim edit?*
A 4: Yes, submitters will know that it was rejected because it was not a valid code versus a denial for lack of specificity required for a NCD or LCD or other claim edit. Submitters should follow existing procedures for correcting and resubmitting rejected claims and issues related to denied claims.

Q 5: *What is meant by a family of codes? (Revised 7/31/15)*
A 5: "Family of codes" is the same as the ICD-10 three-character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition. For instance, category H25 (Age-related cataract) contains a number of specific codes that capture information on the type of cataract as well as information on the eye involved. Examples include: H25.031 (Anterior subcapsular polar age-related cataract, right eye), which has six characters; H25.22 (Age-related cataract, morgagnian type, left eye), which has five characters; and H25.9 (Unspecified age-related cataract), which has four characters. One must report a valid code and not a category number. In many instances, the code will require more than 3 characters in order to be valid.

Another example, K50 (Crohn's disease) has codes within the category that require varying numbers of characters to be valid. The ICD-10-CM code book clearly provides information on valid codes within this, and other categories. And if in doubt, providers can check the list of valid 2016 ICD-10-CM codes to determine if all characters have been selected and reported. Examples of valid codes within category K50 include:

- K50.00 Crohn's disease of small intestine without complications
- K50.012 Crohn's disease of small intestine with intestinal obstruction
- K50.90 Crohn's disease, unspecified, without complications

To include the Crohn's disease diagnosis on the claim, a valid code must be selected. If the paid claim were to be selected later for audit, the Guidance makes it clear that the claim would not be denied simply because the wrong code was included, so long as the code was in the same family. As long as the selected code was within the K50 family, then the audit flexibility applies.

Q 6: *Does the recent Guidance mean that no claims will be denied if they are submitted with an ICD-10 code that is not at the maximum level of specificity?*
A 6: In certain circumstances, a claim may be denied because the ICD-10 code is not consistent with an applicable policy, such as Local Coverage Determinations or National Coverage Determinations. *(See Question 7 for more information about this)*. This reflects the fact that current automated claims processing edits are not being modified as a result of the guidance.

In addition, the ICD-10 code on a claim must be a valid ICD-10 code. If the submitted code is not recognized as a valid code, the claim will be rejected. The physician can resubmit the claims with a valid code.

To read more, click here.

MEMBERS IN THE NEWS

MICHAEL T. GOLDSTEIN, MD, JD, ELECTED PRESIDENT OF NEW YORK COUNTY MEDICAL SOCIETY

Dr. Michael T. Goldstein

Michael T. Goldstein, MD, JD, a board–certified specialist in ophthalmology who practices in Manhattan, was elected the 177th president of the New York County Medical Society at the Society's Annual Meeting on June 2, 2015. In his inaugural remarks, Dr. Goldstein pledged that the Society would continue to work to ensure that patients could continue to have choice of physician, and physicians could continue to thrive in their communities in private practice.

A graduate of Harper College in Binghamton, New York, Dr. Goldstein received his medical degree from the State University of New York (SUNY) Downstate in 1974. He did his post–graduate training at the Brookdale Hospital in Brooklyn, and a corneal fellowship at Manhattan Eye Ear and Throat Hospital in Manhattan. Dr. Goldstein is Assistant Professor of Ophthalmology at SUNY Downstate. He is affiliated with Beth Israel Medical Center, New York Eye and Ear Infirmary, Manhattan Eye Ear and Throat Hospital and North Shore University Hospital.

In 2007, Dr. Goldstein graduated from the Pace University School of Law. He is admitted to the Bar in New York, Connecticut and California. In addition to his private medical practice, he is of counsel to the law firm of Kern Augustine Conroy and Schoppmann, PC.

Dr. Goldstein has had a long history of service to organized medicine. In addition to serving on the Board of Medical Ethics of the New York County Medical Society and the Board and Executive Committee of that organization, he is a delegate to the Medical Society of the State of New York. He is a member of the American Academy of Ophthalmology, the New York State Ophthalmologic Society and the Board of Managers of the SUNY Downstate College of Medicine Alumni Association.

Dr. Goldstein and his wife Belle live in Manhattan and Connecticut.

MICHAEL BRISMAN, MD, F.A.C.S., NAMED PRESIDENT OF THE NEW YORK STATE NEUROSURGICAL SOCIETY

Dr. Michael Brisman

Dr. Michael Brisman was recently named President of the New York State Neurosurgical Society, which represents the interests of all board-certified neurosurgeons in New York State. The Society's fundamental goal is to make sure that New York residents have access to the highest level of neurosurgical care.

After receiving his undergraduate degree with high honors in Biology from Harvard University, Dr. Brisman earned his medical degree from Columbia College of Physicians and Surgeons. He then completed a General Surgery internship and Neurological Surgery Residency at The Mount Sinai Medical Center in New York City, where he was appointed Chief Resident in his final year of residency.

A board certified neurosurgeon at Neurological Surgery P.C. in Rockville Centre, Dr. Brisman specializes in the treatment of facial pain, trigeminal neuralgia, hemifacial spasm and brain tumors including pituitary tumors, acoustic neuromas, meningiomas, metastatic brain tumors and gliomas. He is board certified by the American Board of Neurological Surgeons and a Fellow of the American College of Surgeons.

In 2005, Dr. Brisman was named Chief of Neurosurgery and Co-Director of the Neuroscience Institute at Winthrop University Hospital. He also serves as the Co-Medical Director of the Long Island Gamma Knife® at South Nassau Communities Hospital.

Dr. Brisman has been an active member of MSSNY since 1998 and is a Past President of the Nassau County Medical Society.

DR. LISA ENG RECEIVES APPROVAL FOR FREESTANDING BIRTHING CENTER

The Birthing Center of NY, a new corporation owned and operated by MSSNY member Dr. Lisa Eng, will create a state-of-the-art center with four home-like birthing rooms. The Public Health and Health Planning Council recently approved the freestanding birthing center, located in a 3,500 square foot space near NYU Lutheran in Southwest Brooklyn.

"One percent of New York State's births occur in the home and it is our hope to offer women more choices in childbirth," said Dr. Eng. "The center will be open to all midwives, obstetricians, and family practitioners who wish to credential and are willing to abide by the selection criteria for delivering at the Center."

A graduate of Queens College, Dr. Eng received her Doctor of Osteopathic Medicine from New York College of Osteopathic Medicine in Old Westbury. She completed her residency training in Obstetrics and Gynecology at Lutheran Medical Center in Brooklyn and has been in private practice since 1995, as owner of New Life Medical Esthetics & Wellness in Manhattan and Brooklyn.

Dr. Eng, an obstetrician and gynecologist, has been a member of MSSNY since 1994 and is a member of the Committee to Eliminate Healthcare Disparties. She has also been the Chair of Section 2, District II of ACOG, and was part of Listening to Mothers II workgroup. She is Past President of the Medical Society of Kings.

Queens Physician Sentenced for Conspiring to Illegally Distribute Oxycodone

The Acting United States Attorney for the Eastern District of New York announced that a Queens physician was sentenced to 54 months in prison and $20,000 forfeiture after pleading guilty to conspiring to illegally distribute oxycodone. The physician admitted that he provided prescriptions to a co-conspirator for patients he had not examined in exchange for cash, and continued to write prescriptions after surrendering his DEA registration to prescribe controlled substances. The Office of the United States Attorney for the Eastern District stated that the Prescription Drug Initiative, which is being undertaken in conjunction with the Drug Enforcement Agency (DEA), the five District Attorneys in the jurisdiction (Brooklyn, Queens, Richmond, Nassau and Suffolk Counties), the New York City Police Department and the New York State Police Department, along with several other federal, state and local agencies, has brought over 160 federal and local criminal prosecutions, including prosecution of 15 health care professionals. For more information *click here.*

For more information on the above items, contact Kern Augustine Conroy & Schoppmann, P.C. at 1-800-445-0954 or via email at info@DrLaw.com.

Your New Video – Countdown to ICD-10: 10 Facts About ICD-10

The Centers for Medicare & Medicaid Services (CMS) has released an exciting new video to help ease your transition as we count down to ICD-10 implementation. This animated video highlights ten facts of what to expect during the ICD-10 transition.

The following videos are currently available for viewing on CMS's YouTube channel:

- Road to 10
- Introduction to ICD-10 Coding
- ICD-10 Coding and Diabetes
- Medicare's Testing Plan for ICD-10 Success
- Converting the Home Health Prospective Payment System Grouper to ICD-10-CM
- ICD-10 Coding Basics 01/14/14
- Coding for ICD-10-CM: More of the Basics 12/02/14
- ICD-10 and Clinical Documentation
- Navigating ICD-10, the Provider Perspective
- ICD-10 Roadmap for Small Clinical Practices
- ICD-10 Rural or Urban; It Impacts All Providers

The 10/1/2015 implementation date is fast approaching and these videos will provide an overview of ICD-10 as well as explain the benefits of the new code set. It will also provide implementation guidance and coding examples. We hope you find these videos to be a valuable asset as we count down to ICD-10.

Transitioning to ICD-10-CM

This webinar will provide Part B providers with an overview of ICD-10-CM and will assist you with planning for the mandated ICD-10-CM transition. This session will include testing opportunities and transition stages that will help you prepare your office for the upcoming implementation. Please note: As per the CMS IOM Publication 100-09, Chapter 6, Section 30.1.1, National Government Services cannot make determinations about the proper use of codes for the provider. Questions related to ICD-9-CM and ICD-10-CM are handled by the American Hospital Association's Coding Clinic. Details are available here.

Sessions are available on:

- **Thursday, 9/10/15,** 10 - 11:30 a.m. ET Register for session
- **Tuesday, 9/22/15,** 10 - 11:30 a.m ET Register for session

Bring Back Prostate Screening

By Deepak A. Kapoor, MD

MELVILLE, N.Y. — For years, research on prostate cancer has sought an approach to screening that is more individualized than a one-size-fits-all measurement of the level of prostate-specific antigen in a man's blood. These efforts are now paying off.

That's why it's time to re-evaluate the nation's current approach to prostate cancer. Even though we anticipate 221,000 new diagnoses this year, and 28,000 deaths, recommendations drafted in 2010 and finalized in 2012 strongly discourage PSA screening men without symptoms for this disease.

Those decisions didn't take into account adaptations that urologists have made to help better identify patients likely to develop deadly prostate cancers. Some tools, called PSA derivatives, were being developed as early as the mid-1990s, and all have been refined since.

The result: Rather than use the historical arbitrary cutoff of a 4.0 PSA reading to define abnormal, we now have tools to adjust our interpretation of readings for age (PSA levels normally rise with age); for race (this, too, affects what is considered normal); and for the size of a man's prostate, which affects how much PSA he produces. We can test for how fast PSA levels rise over time. And we can analyze how PSA circulates in the bloodstream (free or bound to serum proteins), which can predict prostate cancer risk.

When we use these markers together, these varied interpretations of PSA levels give us a clearer picture of who does, or doesn't, need further testing.

And we keep refining our approach. Already, a urine test can find and measure the presence of genes associated with prostate cancer. M.R.I. images can help identify high-risk prostate lesions. And tests for the presence or activity, or both, of genes present in prostate tissue can help distinguish which patients can safely defer therapy from those who cannot.

When prostate cancer is found, we also have better actuarial data to help identify those men likely to live long enough for that cancer to become a fatal risk.

Nevertheless, in 2012 the United States Preventive Services Task Force made official its recommendation that no asymptomatic man undergo screening with a PSA test. And that decision grew in importance when the Affordable Care Act elevated the task force's recommendations from advisory to a basis for Medicare payment policies.

To be fair, measuring PSA as a stand-alone test is far from perfect. Cancer is just one of several conditions that can elevate PSA Using the test alone often led to painful biopsies that found no cancer. And we faced a more difficult problem: Even when a biopsy found cancer, uncertainty remained. If aggressive cancer was present, a decision to treat it was straightforward. But prostate cancer can grow slowly or remain dormant — indolent, in medical parlance. And until recently, we didn't have the tools to determine whether cancers were likely to spread quickly enough to shorten the patient's life.

In that circumstance, some patients whose cancers might have grown very slowly chose surgery or other rigorous treatment just to be safe, not sorry. But the price could be high; surgery always involves some risk of complications,

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DO YOU KNOW AN OUTSTANDING PHYSICIAN?

Medical Society of the State of New York

2014 ALBION O. BERNSTEIN AWARD

The Medical Society of the State of New York is accepting nominations for the 2014 Albion O. Bernstein, MD Award. This prestigious award is given to:

"…the physician, surgeon or scientist who shall have made the most widely beneficial discovery or developed the most useful method in medicine, surgery or in the prevention of disease in the twelve months prior to December, 2014."

This award was endowed by the late Morris J. Bernstein in memory of his son, a physician who died in an accident while answering a hospital call in November, 1940.

The $2,000 award will be presented to the recipient during a MSSNY Council Meeting.

Nominations must be submitted on an official application form and must include the nominator's narrative description of the significance of the candidate's achievements as well as the candidate's curriculum vitae including a list of publications or other contributions.

To request an application, please see the MSSNY website at: http://www.mssny.org. Click on "CME", then on "Bernstein Award" or contact:

Committee on Education
Joanne Wise, Manager, Continuing Medical Education
Medical Society of the State of New York
99 Washington Avenue, Suite 408
Albany, NY 12210
518-465-8085 or email: jwise@mssny.org

DEADLINE FOR NOMINATIONS: September 30, 2015

55 Million Enrolled in Medicare; 3.3 Million in New York

55 million Americans are now covered by Medicare, according to a recent press release issued by CMS recognizing the 50th anniversary of Medicare and Medicaid. There are over 3.3 million New Yorkers enrolled in Medicare, with over 2 million enrolled in traditional Medicare, and 1.25 million enrolled in Medicare Advantage plan. Moreover, more than 2.5 million New Yorkers have prescription drug coverage through Medicare, broken down between nearly 1.4 million enrolled in a Part D plan, and over 1.1 million enrolled in a Medicare Advantage plan with drug coverage.

CMS Proposes End-Of-Life Counseling Payment

On July 8, CMS stated that Medicare plans to reimburse physicians for having discussions with patients about advance care planning. The proposal, which was included in the agency's 2016 physician payment rule, was praised by advocates and medical groups.

Dr. Patrick Conway, chief medical officer for CMS, said, "We think that today's proposal supports individuals and families who wish to have the opportunity to discuss advance care planning with their physician and care team." According to the article, the plan would allow "qualified professionals like nurse practitioners and physician assistants," as well as physicians, to be reimbursed for face-to-face consultations with a patient and any relatives or caregivers the patient chooses to include. Dr. Conway said a final decision on the proposal will be made by Nov. 1.

CMS is seeking public comment **on the proposal until Sept. 8.** In particular, CMS is asking for feedback on whether the payment for end-of-life conversations should be part of annual wellness exams. You may submit electronic comments on this regulation to www.regulations.gov. Follow the instructions for "submitting a comment."

Bring Back Prostate Screening

(Continued from page 9)

including death, and cancer treatment can reduce quality of life.

Adding to the confusion was conflicting data on the effectiveness of prostate cancer screening. Despite strong evidence that the prostate-cancer-specific death rate has decreased since PSA testing started in the 1980s, the two largest studies of the screening produced contradictory results — one saw a decrease in prostate-cancer-related deaths among men screened, the other no advantage. Equally problematic, both were flawed methodologically. Yet instead of acknowledging uncertainty, the task force said PSA testing offered no benefit to anyone.

At the time, I and many other urologists warned of public health repercussions. Our fears have materialized. Since 2010, fewer biopsies have been performed and fewer prostate cancers found. But studies show an increase in the risk that a cancer, when found, will be more aggressive.

No increase in cancer mortality has been observed, but that may be a matter of time; aggressive cancers are less treatable. One study concluded that annual prostate cancer deaths may increase as much as 5 percent, for the first time in more than 20 years.

That is what frustrates urologists most: Rather than using refined screening techniques to identify those who will benefit most from treatment, we're just evaluating fewer men. So the task force needs to re-evaluate its recommendation based on the current state of medical knowledge.

But men should not wait for a government agency to tell them what's best. My own strongest recommendation is that men insist on a baseline PSA test while in their 40s. From this baseline, a personalized screening regimen that considers risk factors and other indicators can be developed.

Men must understand that screening does not commit them to further testing or treatment, even if abnormalities are found. Screening, followed up with today's sophisticated tools, simply provides information that helps them and their doctors make sound decisions — which could prolong their lives, or leave them reassured that they have little to fear from an indolent tumor.

Deepak A. Kapoor, a urologist, is a professor at the Icahn School of Medicine at Mount Sinai and chairman of health policy for the Large Urology Group Practice Association.

Editor's note: MSSNY member Dr. Kapoor is Chairman and CEO of Integrated Medical Professionals, a multi-specialty group of 100 physicians in the greater New York Metropolitan area. IMP is one of a growing number of physician groups that have adopted a policy of 100% membership in MSSNY and their county medical societies.

Reprinted from *The New York Times,* July 6, 2015

Fall Events: Leadership Conference and Domestic Violence Awareness Month

Save the date for our Fall Leadership Conference, to be held Sunday, October 18th - Monday October 19th at the historic Glen Sanders Mansion in Scotia, New York. The Mansion's location, gracious hospitality, delightful setting and stunning autumn colors always make it a favorite choice! All Alliance members and potential members – physician spouses or domestic partners – are welcome to attend.

CONFERENCE SCHEDULE

Our physician spouses are encouraged to join us for Sunday night dinner. There will be raffles to benefit Physicians Home, Alliance Educational Health Initiative, and the Belle Tanenhaus Leadership Fund. Our speaker for the evening is Mellany Bagtas of Merrill Lynch, who will address "Investment and Retirement Options." On Monday morning we will begin the conference at 8:15 am with Continental breakfast and workshops. Wendi Bekkering from the Schenectady YWCA Battered Women's Shelter will lead us in an interactive experience based on domestic violence issues in observance of the 20th anniversary of SAVE—an initiative of the AMA and the AMAA. Additional topics will include the importance of social media and membership, as well as our Initiative for Helmets for Girls Lacrosse.

The overnight stay at the Mansion is $119 plus tax, but a Monday morning registration is also an option. There is a $35 registration fee for the conference. Dinner will be offered on Sunday evening at a cost of $35 per person and the luncheon on Monday is $30 per person. Following our luncheon and closing remarks, the raffle winners will be selected. The Nominating Committee will meet prior to the start of the Conference on Sunday afternoon at 3:00 PM. Members will receive an email invitation. If you are not yet a member please contact our Executive Director Kathleen Rohrer at Krohrer@mssny.org or 1-800-523-4405 ext. 396 for more information.

OCTOBER IS DOMESTIC VIOLENCE MONTH

On October 14th, Alliance members across the state will be involved in activities to raise awareness about bullying, including our program "Hands are NOT for Hitting." Additionally, Onondaga County Medical Society Alliance invites Alliance members across the state to help celebrate the 20th Anniversary of the AMA Alliance SAVE DAY- STOP AMERICA'S VIOLENCE EVERYWHERE – by participating in a "shower" for Vera House residents on October 14. An online registry is being set up for donations for the women sheltered at Vera House in Syracuse, NY. A celebration will be held at an Alliance member's home in Fayetteville, NY at 6:30 on October 14th (more details to follow). This is an opportunity for members and future members to participate in an important cause which has been on the forefront of the AMAA agenda for twenty years!

We welcome you to join our mission of "supporting our physicians and promoting health in our communities."

United Healthcare and In-Network Labs

Effective September 1, 2015, UHC will require its network physicians and other qualified healthcare professionals in NYS to refer to or use network laboratories and pathologists for UHC Oxford NY members. Any questions? Call United Healthcare Oxford network Laboratory Services Manager, Catherine Schaal at 631-584-0152.

NOW YOU KNOW

MLB Pitchers Most Effective in Second Inning

Whiteside D, Martini DN, Zernicke RF, Goulet GC

ABSTRACT

PURPOSE:

With a view to informing in-game decision making as it relates to strategy and pitcher health, this study examined changes in pitching performance characteristics across nine innings of professional (MLB) baseball games.

METHODS:

129 starting MLB pitchers met the inclusion criteria for this study. Pitch type, speed, ball movement, release location, and strike zone data-collected using the MLB's ball tracking system, PITCHf/x-were obtained for 1,514,304 pitches thrown between 2008 and 2014.

RESULTS:

Compared with the first inning, the proportion of hard pitches thrown decreased significantly until the seventh inning, while the proportions of breaking and off-speed pitches increased. Significant decreases in pitch speed, increases in vertical movement, and decreases in release height emerged no later than inning five and the largest differences in all variables were generally recorded between the first inning and the late innings (seven to nine). Pitchers were most effective during the second inning and significantly worse in innings four and six.

CONCLUSION:

These data revealed that several aspects of a starting pitcher's pitching characteristics exhibited changes as early as the second or third inning of an MLB game, but this pattern did not reflect the changes in his effectiveness. Therefore, these alterations do not appear to provide reasonable justification for relieving a starting pitcher, although future work must address their relevance to injury. From an offensive standpoint, batters in the MLB should anticipate significantly more hard pitches during the early innings, but more breaking and off-speed pitches, with decreasing speed, as the game progresses.

Int J Sports Physiol Perform. 2015 July

NYSIF Announces Launch of Online Medical Provider Portal

The New York State Insurance Fund recently announced the launch of its new online Medical Provider Portal at www.nysif.com. The new portal will allow registered providers and third party billers to retrieve claims payment information regarding their workers' compensation patients.

Once a provider registers at nysif.com, he or she will be able to self-serve and obtain access to an explanation of benefits (EOB), bill payment status (with amount paid), claims covered on an issued check and claim-by-claim pricing and payment accounting.

To register for a medical provider user account, go to www.nysif.com and follow the instructions for registration. Providers will need a copy of their latest check from NYSIF to complete registration. To safeguard the privileged information of both the medical provider and the claimant, obtaining EOB and bill payment information will now require a log-on before accessing that data.

If a provider uses a third-party billing company, the biller must also register for an account to obtain access to the provider's information. Once the vendor completes the registration, NYSIF will send the vendor a unique identifier code that they must share with the provider. Once a medical provider has designated the vendor as an approved third party biller, the biller will have online access to that provider's medical bill payment information and explanation of benefits. Please note only the medical provider can approve access to the portal for the third party billing company.

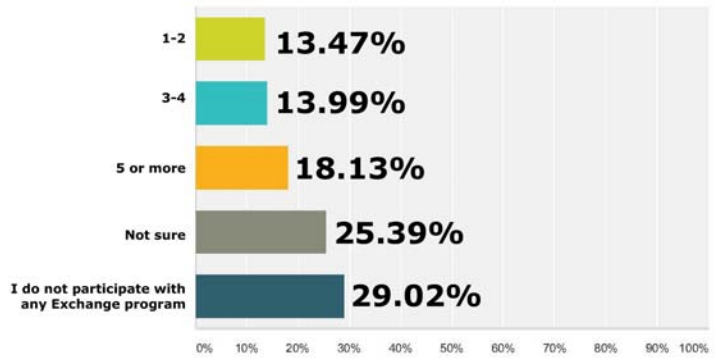
Please take a moment to visit nysif.com today and register!

BUSINESS SHOWCASE

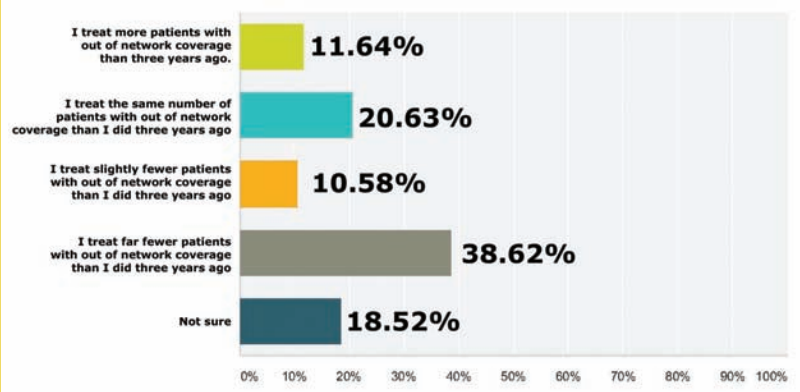
Health Insurance Hassles Survey

(Continued from page 1)

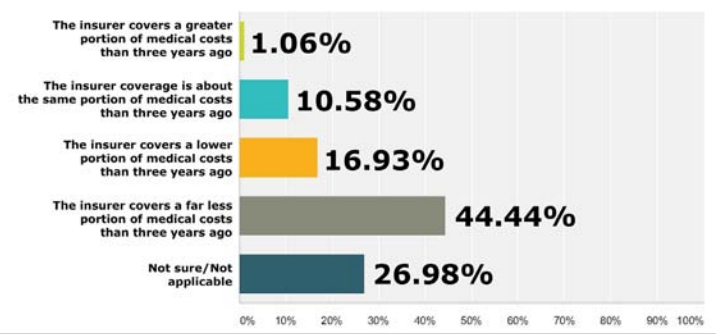
How many Health Insurance Exchange plans do you participate with?



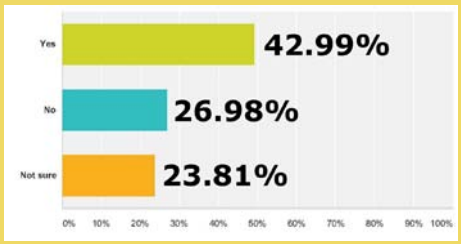
Compared to three years ago, how would you characterize the number of patients you treat with out of network coverage?



Compared to three years ago, how would you characterize the level of coverage for your patients with out of network coverage?



In the last year, have you been inappropriately listed as a participant in a health plan in which you were not participating?



Physician Concerns with Inadequate Health Insurance Coverage

(Continued from page 1)

numbers of patients are facing deductibles imposing huge out of pocket costs before health insurers begin to pay for care. The survey showed that nearly 21% of responding physicians indicated that one ¼ - ½ of their patients faced deductibles of $2,500-$5,000, and that 32% of responding physicians indicated that up to 10-25% of their patients faced deductibles of $2,500-$5,000. Moreover, nearly 25% of responding physicians indicated that 25 to 50 % of their patients faced deductibles of $1,000-$2,500, and 36% of responding physicians indicated that up to 25% of their patients had deductibles of $1,000-$2,500.

INADEQUATE PHYSICIAN NETWORKS

And many physicians report that the networks that insurers offer to patients are increasingly inadequate. Nearly 14% of responding physicians indicated that their participation contract with an insurer was not renewed in the last three years, while another 22% indicated that in the last three years they were not invited to participate in a product offering with an insurer despite participating in other products offered by that insurer. At the same, over 45% of responding physicians indicated that they were inappropriately listed as a participating physician on a health insurer's website in the last year, which could mask an inadequate physician network.

SHRINKING OUT OF NETWORK COVERAGE

Even as networks shrink, so do our patients' ability to be treated by physicians outside the network. Over 33% of responding physicians indicated that the number of patients they treat with out of network coverage has gone down significantly in the last 3 years, while 42% noted that, for those patients who do have out of network coverage, the insurer covers a far less portion of medical portion of medical costs than they did 3 years ago. The recent enrollment report by the New York State of Health showed that out of network coverage benefits were only available in 11 counties in New York State, and none below the Bear Mountain Bridge, since insurers have refused to offer this coverage in most areas of the State.

MSSNY is urging policymakers to review these findings closely and to make necessary changes to federal and state laws and regulations to assure health insurers offer comprehensive health care coverage as well as comprehensive physician networks. A significant part of the problem is a provision of the ACA that enables insures to sell health insurance policies that foist up to 40% of the costs of care on patients. MSSNY also continues to strongly urge the Legislature to enact legislation (S.1846, Hannon/A.3734, Rosenthal) to assure that our patients have the ability to purchase coverage in New York's Health Insurance Exchange that enables them to be treated by physicians outside the plan's network.

"What many physicians find particularly difficult to understand is that, while health insurers continue to constrain the scope of their coverage as noted by the survey results, they also continue to request significant increases in the premiums they charge to consumers and businesses," said Dr. Maldonado. "We urge that policymakers look closely at the policies being offered by these insurers and assure that these policies will actually provide coverage for the care needed by our patients."

MSSNY Survey Details Physician Concerns with Inadequate Health Insurance Coverage Faced By Patients

ANESTHESIOLOGY

Denial on claims for procedures (seems at random) has increased, requiring more staff time (for both physician and insurer) to review the appeal.

CARDIOTHORACIC SURGERY

Has worked out well for some patients, however, some still fall through the cracks as they are not able to pay the premiums but make too much for the Medicaid plans.

DERMATOLOGY

Insurance companies are ruining medicine. They do not pay enough to keep practices running without doctors having to rush through and not give patients enough time.

Because of higher cost sharing, patients are putting off necessary care.

I have lost a great deal of my practice due to the fact that the people no longer have out of network coverage. My practice has become almost all cosmetic or Medicare patients. My cosmetic patients use other, in network dermatologists for their non-cosmetic concerns because of lack of coverage for out of network physicians.

FAMILY PRACTICE

Insurance companies are constantly auditing charts and asking back for visits from 6 months ago as covered by other insurance or not covered. Outside vendor General Dynamics has been very aggressive and unethical in attempting to recoup extrapolated funds on patients seen for routine office visits.

Patients are getting significantly less coverage for significantly higher prices - many refuse appointments that they feel their insurer should be covering (with the high premiums they pay) and they feel that they have less access to their doctor with higher insurance costs. This is unacceptable to all.

INTERNAL MEDICINE

I am being underpaid on my contracted rates by three major plans. I have had to reach out many times to correct this.

After 23 years, I have more patients paying me out of their pocket than ever.

The insurance rate has gotten far worse in the last few years. Obamacare also allows patients to manipulate and cheat the system, where patients get free service when they do not pay the premiums and the insurance gets retro-inactivate. But we do not know at the time of the service since this information is not up-to-date with the insurance. By the time the insurance company withdraws its payment to us due to the patient's ineligibility, it is months later and it is very difficult to get the money back from the patient. It is a fundamentally unfair system and puts the entire burden on the providers.

Current trend is to benefit insurance companies and providers are getting less and less payments; also patients refuse to pay their deductibles.

NEUROLOGY

Was told I was not participating in BCBS exchange. When I asked for the fee schedule and to consider participation they passive aggressively tried to bully me in.

We can no longer advocate for medically necessary prescriptions for our patients. That means patients are taking less than optimum medication for very serious problems. The patients themselves say "the insurance company wants me to die so they don't have to pay for me anymore." This is a direct quote from a former nurse. With all the new rules and regs we are contemplating getting out of insurance altogether. They simply do not want to pay at all. Increasing salaries, increasing malpractice and decreasing reimbursement equals Obamacare.

OB-GYN

There are outrageously low reimbursements for some, outrageously high reimbursements for others and certain procedures. Clinicians who are performing out of scope of care services has increased. It is a big mess.

The biggest hassle now is getting authorization for surgery; there are many, many delays.

A majority of our patients have large deductibles. These patients have had to cancel surgery, cancel appointments or ask to be seen gratis. It appears that the hard working people have huge deductibles on top of the monthly premiums. We have patients who are getting assistance, who should not be receiving assistance. They are college educated people who say they are better off not working, being defeated from their school loans, getting their insurance for free. This insurance program does not work.

The deductibles are a big problem, the patients do not know what they have and get very nasty about it when we try to explain it to them. Health Republic, one of the new companies, is terrible to deal with and they take months to pay bills and constantly request records. By the time we get payment or no payment the bills are very old so we find it very difficult to collect money. We are not happy with the insurance deductibles.

ONCOLOGY

Even for an out of network doctor there is an excessive amount of time to obtain prior authorization for very routine care. It is a waste of everyone's time and adds unnecessary costs and burdens. We were asked to pre-certify a doxycycline Rx last week. Ridiculous!

OPHTHALMOLOGY

Patients refuse to pay deductible and copayment, saying they have no money or they will pay when they have their check.

We are very concerned about the high deductibles for patients without means to pay. Some will not seek out care. Others will simply ignore the patient responsibility, leaving the physicians to personally shoulder the burden of the previously uninsured. The high deductible policies simply defer the problems to the next level. I receive promotional materials from collection agencies every week now. I am also aware that some physicians will employ outside credit companies for their patients (i.e. CareCredit). This is no solution to our healthcare troubles.

ORTHOPEDIC SURGERY

Patients are shocked with their increased out-of-pocket costs that often we as doctors are announcing to them through EOBs. Patients are NOT routinely receiving EOBs, so they think MDs are paid in full, when fees go to deductibles instead. Getting paid for medical care is an increasing hassle.

Patients still have little or no understanding of their benefits and the impact it has on paying for their care. Things like "co-insurance", "out of network" and Medicare fee-based plans are not understood at all. We often have to explain this to the patient. Their broker or HR has never taken the time to explain this important information.

OTOLARYNGOLOGY

Out of network payments are not being allowed or paid by insurers even if patient contracts say that they have that benefit. High deductibles are causing people to avoid required medical care and testing...a very dangerous trend!

Blue Cross has offered plans, which normally we are forced to participate in. I find it interesting that they will not allow us to participate in exchange plans although we have asked numerous times.

PAIN MANAGEMENT

The question should be asked, how many people pay after being seen if they have a deductible? As we are not allowed to charge people up front but only after submitting to insurance, the refusal to pay afterwards has skyrocketed. Also the percentage of people gaming the system by never paying their premiums and then the denials to doctors has also exploded.

NY State Insurance Fund started down-coding my claims. Commercial insurers don't want to pay at all.

PATHOLOGY

Medicine is being criminalized in the grandiose plan to ultimately go to a single payer system.

PEDIATRIC CARE

Whatever you want to call this mess... what it created is the legalization of already criminal behavior by despicable companies that use family's contributions to enrich their entities. Nothing, NOTHING is done for the benefit of health care.

PSYCHIATRY

My insurance premiums keep going up with lower reimbursements.

The meteoric rise of deductibles is driving patients into networks with assembly-line care;doctors make up in quick turnover what they lose in reimbursement.

Prior Authorizations are a crime which waste time without reimbursement, damage patient care, and allow ignorant people to make medical decisions.

THORACIC SURGERY

The system will fail, as current rates are below the real costs of doing business. Many of the providers used by hospital clinic systems have no experience in "outpatient" care.

Q&A Regarding Out of Network Telephone Audits

Question: I am an out of network physician, but a health plan wants to audit me. What are my obligations?

Answer: Being out of network, physicians would be non-participating and therefore have NO contract with a health plan. To par or not to par with a health plan must be an individual business decision by any physician/practice.

A physician without a contract with a health plan who is asked to go through an audit process, should tell the health plan that a patient authorization is required before an audit can be conducted. Without a contract, physicians have no obligation to a health plan but do have a privacy obligation to their patient. If the patient is covered by a health plan, the link is between the health plan and the patient. If the health plan wants the patient's medical record, the health plan needs to obtain the patient's authorization for disclosure of his/her medical information by the physician.

Physicians without contract with a health plan have no obligation to the plan. The physician's only obligation is to the patient. Physicians should not leave themselves open to violations of their patients' privacy. Without the patient's authorization to disclose their medical record, the physician has no authority to disclose the information.

Question: What if I have a contract with the plan?

Answer: If the health plan takes a negative position and wants the call to proceed without the benefit of recording and the physician has a contract, then the physician would need to make a business decision about the possibility of putting his/her contract at risk of termination.

Question: I am out of network. What if I receive a check from the plan?

Answer: When a physician has no contract with a health plan and the health plan inadvertently sends the physician a check, if the physician cashes the check, there could be an implied assignment of benefit whereby the physician is expected to *"stand in the shoes of the patient."* If the physician does not want an implied assignment of benefits, the word "VOID" should be written across the face of the check and the check should be returned to the health plan with the instruction to reissue the check to the health plan's insured/patient.

Question: Can I record a telephone audit?

Answer: It would be a good idea and a professional courtesy to inform the auditor that the telephone call will be recorded. If the health plan representative chooses not to be recorded, then the audit would not need to proceed for a physician who has no contract.

In reference to recording a telephone audit, the law on this is as follows:

NYS Penal § 250.00 Eavesdropping; definitions of terms.

The following definitions are applicable to this article:

1. "Wiretapping" means the intentional overhearing or recording of a telephonic or telegraphic communication by a person other than a sender or receiver thereof, without the consent of either the sender or receiver, by means of any instrument, device or equipment. The normal operation of a telephone or telegraph corporation and the normal use of the services and facilities furnished by such corporation pursuant to its tariffs or necessary to protect the rights or property of said corporation shall not be deemed "wiretapping."

2. "Mechanical overhearing of a conversation" means the intentional overhearing or recording of a conversation or discussion, without the consent of at least one party thereto, by a person not present there at, by means of any instrument, device or equipment.

3. "Telephonic communication" means any aural transfer made in whole or in part through the use of facilities for the transmission of communications by the aid of wire, cable or other like connection between the point of origin and the point of reception (including the use of such connection in a switching station) furnished or operated by any person engaged in providing or operating such facilities for the transmission of communications and such term includes any electronic storage of such communications.

4. "Aural transfer" means a transfer containing the human voice at any point between and including the point of origin and the point of reception.

5. "Electronic communication" means any transfer of signs, signals, writing, images, sounds, data, or intelligence of any nature transmitted in whole or in part by a wire, radio, electromagnetic, photoelectronic or photo-optical system, but does not include:

(a) any telephonic or telegraphic communication; or

(b) any communication made through a tone only paging device; or

(c) any communication made through a tracking device consisting of an electronic or mechanical device which permits the tracking of the movement of a person or object; or

(d) any communication that is disseminated by the sender through a method of transmission that is configured so that such communication is readily accessible to the general public.

6. "Intercepting or accessing of an electronic communication" and "intentionally intercepted or accessed" mean the intentional acquiring, receiving, collecting, overhearing, or recording of an electronic communication, without the consent of the sender or intended receiver thereof, by means of any instrument, device or equipment, except when used by a telephone company in the ordinary course of its business or when necessary to protect the rights or property of such company.

7. "Electronic communication service" means any service which provides to users thereof the ability to send or receive wire or electronic communications.

8. "Unlawfully" means not specifically authorized pursuant to article seven hundred or seven hundred five of the criminal procedure law for the purposes of this section and sections 250.05, 250.10, 250.15, 250.20, 250.25, 250.30 and 250.35 of this article.

It would be a good idea and a professional courtesy to inform the auditor that the telephone call will be recorded. If the health plan representative chooses not to be recorded, then the audit would not need to proceed for a physician with no contract.

If the health plan takes a negative position and wants the call to proceed without the benefit of recording and the physician has a contract, then the physician would need to make a business decision about the possibility of putting his/her contract at risk of termination.

When a physician has no contract with a health plan and the health plan inadvertently sends the physician a check, if the physician cashes the check, there could be an implied assignment of benefit whereby the physician is expected to *"stand in the shoes of the patient."* If the physician does not want an implied assignment of benefits, the word "VOID" should be written across the face of the check and the check should be returned to the health plan with the instruction to reissue the check to the health plan's insured/patient.

–From Regina McNally, VP, MSSNY, Socio-Medical Economics Division
Questions? Contact:
rmcnally@mssny.org

MSSNY General Counsel Develops Template Forms for Physicians To Comply With Out of Network Law Required Disclosures

As a reminder, MSSNY's General Counsel Donald Moy, Esq. has developed model template disclosure forms that physicians can use in their practices to comply with the new "surprise medical bill" law which took effect on April 1, available from the MSSNY website (Members Only) here. These new requirements include:

NETWORK AND HOSPITAL AFFILIATIONS

All physicians must provide to patients or prospective patients in writing or on the physicians' website prior to the provision of non-emergency services:

- The health care plans with which the provider participates; and
- The hospitals with which the health care professional is affiliated

For the model form physicians can use in their practice, click here.

In addition, this participation/affiliation information must be provided verbally at the time an appointment is scheduled.

FEE DISCLOSURE

Physicians **who do not participate in the network** of a patient's or prospective patient's health care plan must:

- Prior to the provision of non-emergency services, inform the patient or prospective patient that the amount or estimated amount the patient will be billed for health care services is available upon request;
- Upon receipt of a patient or prospective patient's request, the amount or the estimated amount (in writing) the patient will be billed for health care services, absent unforeseen medical circumstances that may arise when the health care services are provided

For the model forms physicians can use in their practice, click here, Model Forms #2-A, 2-B and 3

OTHER HEALTH CARE PROVIDERS INVOLVED IN PROVIDING PATIENT CARE

All physicians who refer or coordinate services for patients with another provider must provide to their patients the name, practice name, mailing address and telephone number of any health care provider scheduled to perform anesthesiology, laboratory, pathology; radiology; or assistant surgeon services, in connection with care to be provided:

- in the physician's office;
- as coordinated by the physician; or
- as referred by the physician.

For the model forms physicians can use in their practice, click here, Model Form, #4

OTHER PHYSICIANS INVOLVED IN HOSPITAL CARE

At the time of a patient's pre-admission testing, registration or admission for scheduled hospital admission or outpatient hospital services, all physicians must provide their patients with the name, practice name, mailing address and telephone number of any other physician whose services will be arranged by the physician and are scheduled at the time non-emergency services are scheduled.

For the model forms physicians can use in their practice, click here, Model Form #5.

There are also numerous other provisions incorporated into this new law which took effect this past April 1. For a summary, click here.

CCNY Medical School to Welcome First Class in 2016

The City College of New York announced the establishment of the CUNY School of Medicine at City College in partnership with Bronx-based St. Barnabas Hospital, which is part of the SBH Health System. The new Harlem-based medical school, whose first class is scheduled to begin fall 2016, will be an expansion of City College's Sophie Davis School of Biomedical Education. Established in 1973 on the City College campus, the Sophie Davis School currently offers a unique seven-year BS/MD program that integrates an undergraduate education with the first two years of medical school.

The new medical school on the City College campus builds on the record of achievement of the Sophie Davis School of Biomedical Education, whose mission is recruiting underrepresented minorities into medicine, increasing medical care in historically underserved communities and boosting the number of primary care physicians.

MSSNY-PAC

(Continued from page 4)

achieve improved clinical health outcomes and population health goals. It is believed that a thorough transformation of the delivery system can only be achieved and sustained when payment reform is implemented. The state's goal is to transition traditional Medicaid managed care payment over five years to a system wherein 80-90% of MCO-physician payment contracts are based on value based payment (VBP) methodologies of which at least 35% must involve health care providers sharing some so-called "downside" risk.

CMS has approved the State's blueprint entitled A Path Toward Value Based Payment; New York State Roadmap For Medicaid Payment Reform which details its premises, timeline, considerations and objectives for accomplishing Medicaid payment reform.

The design of the value based payment methodologies will likely not just define a payment structure for the Medicaid program. It may also be replicated in contract with commercial payers.

The State has also received a SIM (State Innovation Model) grant to assure that 80% of the state's population receives primary care within an Advanced primary care setting and that 80% of such care will be paid for under value based financial arrangements.

Work groups have been established to iron out the parameters of value based payment arrangements based not on dollar amounts or volume but on the achievement of quality metrics and the level of risk sharing. MSSNY's President has assured that MSSNY physician leaders are involved in every facet of the value based payment discussion—including on clinical advisory groups focused on how to construct payment bundles for primary care, acute and chronic care and subpopulations. As of today, much of the detail has not yet been delineated, but work will continue through the end of the year.

Why is this policy discussion being presented as part of our MSSNYPAC article? First, it underscores the importance of being at the table(s) as important issues are being discussed. Most importantly, there are many facets of these discussions which must be brought to the attention of our elected representatives such as the fact that only State data show that only 39.4% of physicians in New York State have adopted EHRs and that little if any of the money being targeted for DSRIP and the SIM will go to support or incentivize physician adoption of this technology. Without it, physicians will not be able to demonstrate adherence to quality metrics and will thus lose money under the VBP arrangements over time potentially severely impacting access to care. Moreover, there is little to no discussion regarding how to empower solo and small practice physicians who are not associated with ACOs, IPAs or other integrated systems.

OBITUARIES

ACKERMAN, Marvin; Bronxville NY. Died June 16, 2015, age 87. Medical Society County of Westchester.

AMMAZZALORSO, Michael David; Glen Cove NY. Died May 25, 2015, age 53. Nassau County Medical Society.

ANDERSON, Ernest T.; Rochester NY. Died May 12, 2015, age 94. Monroe County Medical Society.

ATKINS, Harold L.; South Setauket NY. Died May 01, 2015, age 88. Suffolk County Medical Society.

BONOM, Hugo; Jackson Heights NY. Died July 29, 2015, age 106. Medical Society County of Queens.

BROSS, Robert B.; New York NY. Died July 31, 2015, age 89. New York County Medical Society.

COPELY, Andrew Richard; Fort Myers Beach FL. Died July 29, 2015, age 106. Medical Society County of Queens.

EPSTEIN, Robert D.; Yorktown Heights NY. Died June 16, 2015, age 98. Medical Society County of Westchester.

FAGAN, James Michael; Saint Johnsville NY. Died June 23, 2015, age 74. Medical Society County of Herkimer.

FELDMAN, Bluma T.; San Diego CA. Died July 29, 2015, age 114. New York County Medical Society.

FRIEDMAN, Shep Joe; Cooperstown NY. Died May 24, 2015, age 56. Otsego County Medical Society.

FLANAGAN, Thomas Vincent; Glens Falls NY. Died June 11, 2015, age 83. Warren County Medical Society.

GEARY, Francis Joseph; Staten Island NY. Died March 27, 2015, age 76. Medical Society County of Kings.

GLYNN, James M.; North Palm Beach FL. Died June 28, 2015, age 89. Nassau County Medical Society.

HANSON, Susan Elizabeth; Wittenberg WI. Died May 02, 2015, age 77. Monroe County Medical Society.

HARRIS, H. William; Mineola NY. Died January 01, 2015, age 95. Medical Society County of Queens.

ILAGAN, Emiliano; Amsterdam NY. Died January 01, 2015, age 84. Medical Society County of Montgomery.

KONCZYNIN, William T.; Setauket NY. Died June 03, 2015, age 63. Suffolk County Medical Society.

KOUYOUMGIAN, Joseph S.; Punta Gorda FL. Died June 11, 2015, age 88. Medical Society County of Albany.

LIPSON, Jacques Maurice; Rochester NY. Died May 04, 2015, age 84. Monroe County Medical Society.

MARANO, Anthony J.; White Plains NY. Died January 22, 2015, age 80. Medical Society County of Westchester.

MASTRIANNI, Benedict F.; Mechanicville NY. Died June 11, 2015, age 91. Saratoga County Medical Society.

MELTON, Ernest I.; Brooklyn NY. Died July 29, 2015, age 100. Medical Society County of Kings.

NOYA, Joseph T.; Farmingdale NY. Died July 23, 2015, age 90. Nassau County Medical Society.

OKTAY, Aslan; New York NY. Died July 09, 2015, age 88. New York County Medical Society.

PASTERNACK, Jonathan B.; Tucson AZ. Died June 11, 2015, age 77. Medical Society County of Albany.

PEARCE, David Barry; New York NY. Died June 01, 2015, age 76. New York County Medical Society.

PETERSON, Alfred E.; Binghamton NY. Died July 20, 2015, age 93. Broome County Medical Society.

PYRROS, Dimitri; Port Jefferson NY. Died June 30, 2015, age 56. Suffolk County Medical Society.

RAVELO, Raul Al; Staten Island NY. Died July 09, 2015, age 84. Richmond County Medical Society.

RIGGIO, Charles J.; Clarence NY. Died July 05, 2015, age 87. Erie County Medical Society.

ROSENBERG, Harold William; Miami FL. Died June 27, 2015, age 103. Bronx County Medical Society.

SHAHEEN, Albert H.; Naples FL. Died July 07, 2015, age 85. Medical Society County of Oneida.

SHORE, Jeanne E.; New York NY. Died July 29, 2015, age 111. Medical Society County of Kings.

SOLEY, Robert Lawrence; Scarsdale NY. Died June 01, 2015, age 80. Medical Society County of Westchester.

STAVROLAKES, Paul A.; Miller Place NY. Died March 20, 2015, age 86. Suffolk County Medical Society.

TURKELL, G. Silverman; New Hyde Park NY. Died July 29, 2015, age 111. Medical Society County of Queens.

WHYLAND, William A.; Castleton on Hudson NY. Died May 31, 2015, age 91. Medical Society County of Rensselaer.

WILSON, Edwin Robert; Rochester NY. Died January 13, 2015, age 85. Monroe County Medical Society.

ZAKIN, David; New York NY. Died July 29, 2015, age 107. New York County Medical Society.

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