MEDICAL
SOCIETY NEWS
A Publication of the Medical Society of the County of Orange

Volume XI, Number III Fall 2012

In This Issue...

2011-2013 Executive Committee

The Medical Society of the County of Orange, Inc.
91 Thompson Street, Newburgh, NY 12550

David A. Lambert
Executive Director

Tel: (845) 561-0381 **FAX: (845) 561-0852**
e-mail: ocmsnys1@aol.com **www.ocmsnys.org**

Ahmad Masood, M.D.
President

President's Message

Ahmad Masood, M.D.

Dear Colleagues:

I wanted to call your attention to the critical importance of physician participation in this fall's elections. Health care is a defining campaign issue. We are presented with a tremendous opportunity to shape our delivery system in a meaningful way. But we can only accomplish our goal if we are respectful of each other's differences. While we may not agree on the means, we all agree on the end—patient access to high quality care. For the next few months, I am asking us to focus on what we all share, and respectfully avoid the divisions, so we can accomplish our goal.

27 House Seats, 213 Legislative Seats Open

In addition to a Presidential election, in New York we have an election for a US Senate seat, all 27 House seats in addition to all 213 State Legislative seats. What makes this election year so unique compared to past elections is the significant number of seats without an incumbent running, and the significant number of seats that are likely to be closely contested.

For the New York State Assembly, there are 18 seats where no existing incumbent is running for re-election. In addition, there are many new members of the Assembly running for their first re-election. For the New York State Senate, there are 5 seats where no existing incumbent is running for re-election and several other races where a new Senator is running for their first re-election. Moreover, for the New York State Senate, there are a handful of likely closely contested races, in the Buffalo area, Rochester area, Westchester area and on Long Island, and perhaps a few others, the outcome of which will go a long way to determining which party controls the New York State Senate come January.

MSSNYPAC Has Candidate Questionnaire for You

The large number of new candidates presents a tremendous opportunity for physicians and physician advocacy organizations to engage these candidates as they compete for office. To assist

(continued on page 3)

Health Commissioner's Update

by: Colleen Larsen, Nurse-Epidemiologist (on behalf of Dr. Jean Hudson)

Public Health Nursing - Yesterday and Today

More than one hundred years ago, Lillian Wald made history as the first public health nurse caring for the sick and poor at the Henry Street Settlement in New York City. Public Health Nurses in 1893 faced many challenges including poverty, an influx of new immigrants, unsanitary and poor housing conditions and communicable diseases.

Today, public health nurses face many of the same challenges as Lillian Wald did and continually adapt to the changing needs of the community. Public health nurses respond to emerging and re-emerging communicable diseases, chronic diseases, bioterrorism, environmental hazards, uninsured populations, immigrant health issues, and an aging population requiring more intensive home health services. Public health nursing continues to compassionately serve individuals, families and entire populations.

As the nation prepares to implement the Affordable Care Act, a strong public health infrastructure is essential with public health nursing playing a key role. Public health nurses working in partnership with hospitals, physicians, community health organizations and schools will help prevent hospital re-admissions, prevent early admission to nursing homes, help reduce communicable and chronic diseases in the community, and provide safe, affordable care in the home while maintaining the independence and dignity of patients.

Jean M. Hudson, M.D., M.P.H.

Public health nurses are uniquely qualified to care for patients at home. Their experience working with communicable diseases, maternal and child health, community organizations, emergency preparedness and environmental health allow them to provide a comprehensive assessment of the patient at home.

(continued on page 5)

Reimbursement For Smoking Cessation: Every Smoker, Every Visit

By: Edward Anselm, MD, Member, NYACP Tobacco Prevention Task Force

Most clinicians do not bill Medicare, Medicaid, or commercial carriers for the advice they offer to patients on quitting smoking. The resources below provide clinicians with an explanation of physician reimbursement for smoking cessation interventions, and a set of tools that optimize use of physician and staff time to deliver evidence-based smoking cessation interventions regardless of the patients' readiness to quit.

The documentation templates support reimbursement for smoking cessation at every visit. Although the reimbursement of $12-20 per visit with an annual limit of eight sessions for Medicare, and six sessions for Medicaid, is modest, a small effort to re-engineer your practice flow to support smoking cessation will substantially impact the health of your patients. Following are links that explain full coverage details and codes for reimbursement.

Resources

Outline for Practice Transformation:

Tools to assist clinicians in organizing effective delivery of smoking cessation services in the office setting: **Outline for Practice Transformation** summarizes the essential details of patient flow, documentation, and coding for reimbursement.

http://www.nysmokefree.com/subpage.aspx?p=70&p1=70230&curcat=7075

Guide to Build a Better Office System:

This guide, produced by the American Academy of Family Physicians, addresses the U.S. Public Health Service's (USPHS) Clinical Practice Guideline; Treating Tobacco Use and Dependence 2008 Update, recommendation for clinicians to change the clinical culture and practice patterns in their offices to ensure that every patient who uses tobacco is identified, advised to quit, and offered evidence-based treatments.

"Reproduced with permission from Treating Tobacco Dependence Practice Manual, 2010, issue of Scientific Activities Copyright ©

(continued on page 15)

President's Message

Continued from page 1

local physician engagement, MSSNYPAC has created and shared with the County Medical Society executives a candidate questionnaire that will better enable physicians as you engage candidates. We must question them on their positions on a variety of issues of importance to New York's physicians. Questions should address reforming abusive health insurer practices, achieving necessary liability reforms, and preventing inappropriate expansion in scope of practice. MSSNYPAC will also be sending the questionnaire to candidates running in open seats, and will share the responses with MSSNY member physicians prior to the November election.

MSSNY's Political Action Committee is a representation to legislators of physician unity. And, MSSNYPAC represents ALL Physicians. In order to better assist physicians regarding incumbent legislators' voting and legislation sponsorship record on bills of importance to New York's physicians, MSSNYPAC has created its 2011-12 legislator "scorecard." If you are member of MSSNYPAC, we encourage you to obtain a copy of the "scorecard" by sending an e-mail to mssnypac@mssny.org. If you are not a member of MSSNYPAC, I really need you to join today! The more physicians who join MSSNYPAC, the greater our ability to play a meaningful role in this fall's elections, and the greater our ability to have a seat at the table to help shape health care policy in New York State

We have been given a tremendous opportunity, as physicians, to help shape the future. We can only be successful if we engage and inform our legislators as they determine NYS policy. I recognize we all have differences. But we have much more in common. So let's focus on the issues we all agree upon. We all care about the future of New York State and the patients who live here. So, as we engage the election process, we must maintain integrity while we focus on shared goals. We can make a difference.

Our patients' health and our profession's future depend on us.

❑

Three Things Every Physician Must Stop Doing Right Now

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

From an admittedly pro-physician, overly "doctor-protective" and openly biased perspective, there has never been a greater need for all physicians throughout the United States to immediately increase their healthy paranoia, eliminate any residual trust they may have had in their state and federal governments, and become completely and relentlessly self-protective. Let me say it directly - No investigator from any office of the federal or state government visits a physician to "help" them, "educate" them or simply "chat" with them. No request for medical records is benign, academic or routine. What is even more disturbing than the use of these deceptions, however, is that physicians continue to fail to recognize them as deceptions and, to make matters worse, blindly cooperate in (and many times, enable) their own destruction.

So, while there are certainly more, here are the three things every physician can, should and must stop doing right now:

1. STOP TALKING TO INVESTIGATORS: Any investigator, from any entity and/or agency, is specifically and vigorously trained to deceive the person being investigated. Deceive them into lowering their guard, deceive them into thinking the investigator and/or investigation is harmless, and deceive them into believing that the target will be treated more harshly if they do not speak with the investigator. All of these deceptions are bald-faced lies, nothing more. No investigator is granted a raise, given a promotion or advances their career by announcing that he or she has exonerated the target. Physicians have a duty to cooperate in an investigation but doing so alone, without obtaining all of the information that can be obtained, without proper preparation, and without the protection and guidance of experienced health law counsel, is professional suicide and must stop today.
2. STOP IGNORING YOUR LEGAL OBLIGATIONS: Frankly stated, many physicians and medical practices are enabling their enemies (and those enemies are aware of the opportunity) to harm them. Like it or

(continued on page 6)

Health Commissioner's Update

Continued from page 2

The Orange County Department of Health has a Certified Home Health Agency to provide compassionate, individualized home care services to the residents of Orange County. The services provided include:

- Skilled Nursing (adult and pediatric)
- Rehabilitation Therapies PT/ST/OT
- Home Health Aides
- Medical Social Work
- Registered Dietician Education
- Respiratory Therapy
- Wound Care
- PRI Screening for Nursing Home Placement
- Medication Education, Administration and Management
- Asthma management
- Neonatal Care
- Management of Lead Poisoned Children
- Communicable Disease Investigations and Interventions
- 24 hour on-call services

Watch out for the bright orange signs on our county cars with the logo and "Home Nursing."

The Department of Health's Certified Home Health Agency accepts Medicare, Medicaid, all private insurance, and the uninsured. Please feel free to call with any questions, to discuss how we can work together, or refer your patients directly to:

Marilyn Ejercito RN, BSN, MS
Director of Patient Services
Orange County Department of Health
124 Main St.
Goshen, NY 10924

Phone: 845-291-2330
Fax: 845-291-2380

email: mejercito@orangecountygov.com++

❑

Three Things Every Physician Must Stop Doing Right Now

Continued from page 5

not. Agree with it or not. Find it to be counter to your ability to focus on patient care. You must acknowledge that there are very specific rules that gove**rn you and your practice.**

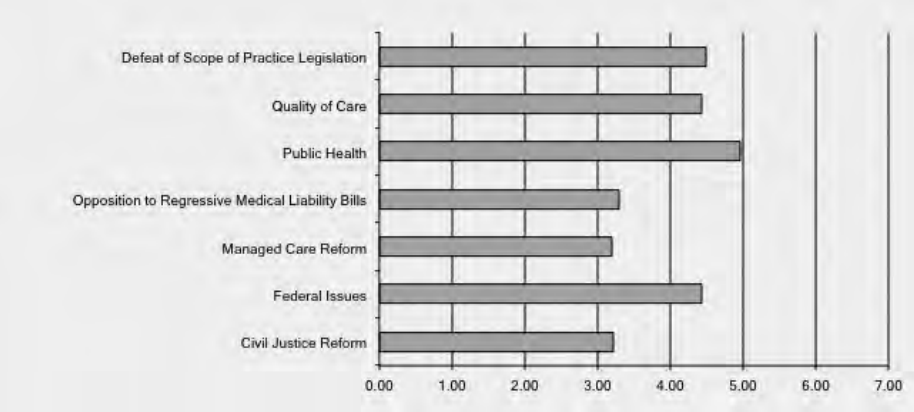
To remain "deliberately ignorant" (a term created to prosecute physicians) of these rules not only fails to protect you, it increases your liability, and the severity of the resulting damage/punishment. As but one example, every "payor" in the United States (Medicare, Medicaid, private health plans, union plans, etc.) publishes specific rules on what a physician must do and must provide in order to get paid. Yet most practices remain defiant in refusing to seek out these rules, incorporate them into their practice methods, and comply with their requirements. As a result (bearing in mind, the payors are well aware of this defiance and resulting deficiency), the payors audit the physicians, readily identify violations (whether intended violations or not), and easily demand and obtain monies back from the physician (even though the physician provided the service they billed for) Once again, this must stop today.

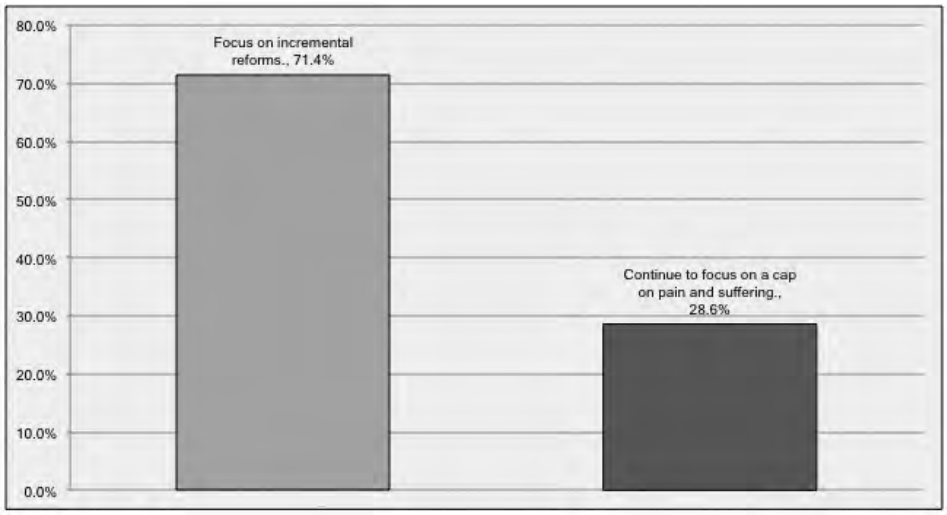
3. STOP TAKING LESS THAN WHAT YOU ARE ENTITLED TO: There is virtually no other profession or business in this country that provides a critical service to the public, does it at an incredibly high level of success and sophistication, and yet fails to get paid for the services they've provided. That is, however, exactly the current state of most medical practices. Throughout medicine, contracted rates are ignored (or unknown), unpaid bills go uncollected, reduced payments are accepted without challenge or explanation, and co-pays and deductibles are ignored or not acted upon. No physician should accept less than 100% of the monies due them for their services, regardless of the debtor or payor. However, the first step in doing so is for every physician to KNOW the amount to which they are entitled. Every physician

(continued on page 10)

MSSNY Legislative Priorities Survey Results

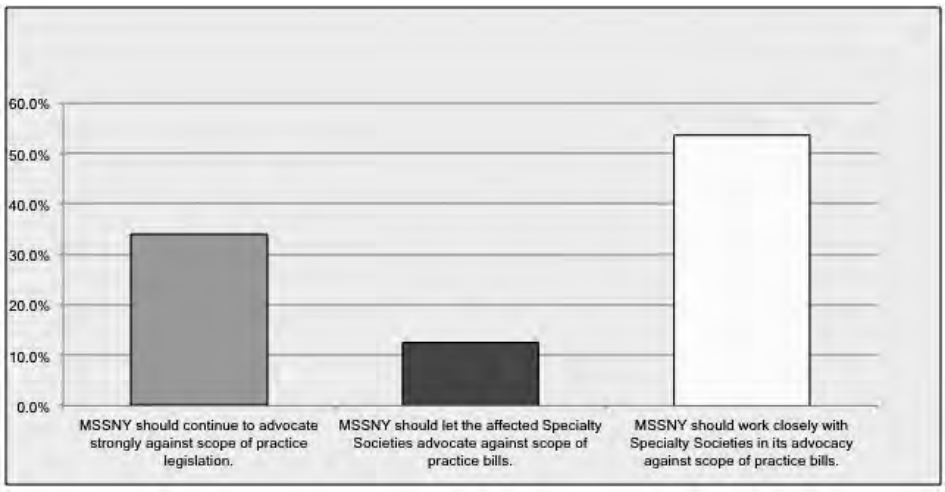
Each year MSSNY supports or opposes hundreds of bills that would affect the practice of physicians and/or the quality of health of your patients. Listed below are broad issue categories into which legislation MSSNY advocates fall. Please rank in priority order (from 1-7, #1 being your top priority) each category of legislative interest.





Despite MSSNY's efforts over the past three decades, a cap on pain and suffering damages in medical liability actions has remained elusive. In your opinion, should MSSNY focus on incremental reform such as alternative dispute forums, certificate of merit reform and expert witness reform or should MSSNY continue to focus on trying to obtain a cap on pain and suffering.

For decades, non-physician providers including nurse practitioners and certified nurse anesthetists have advocated to expand their scopes of practice. These groups argue that they can help address the dwindling supply of physicians, while reducing the overall cost of health care. MSSNY has expended substantial advocacy resources to defeat much of this legislation. Should MSSNY continue to expend its efforts fighting scope of practice legislation or should MSSNY defer to the advocacy of Special Societies affected by these bills?

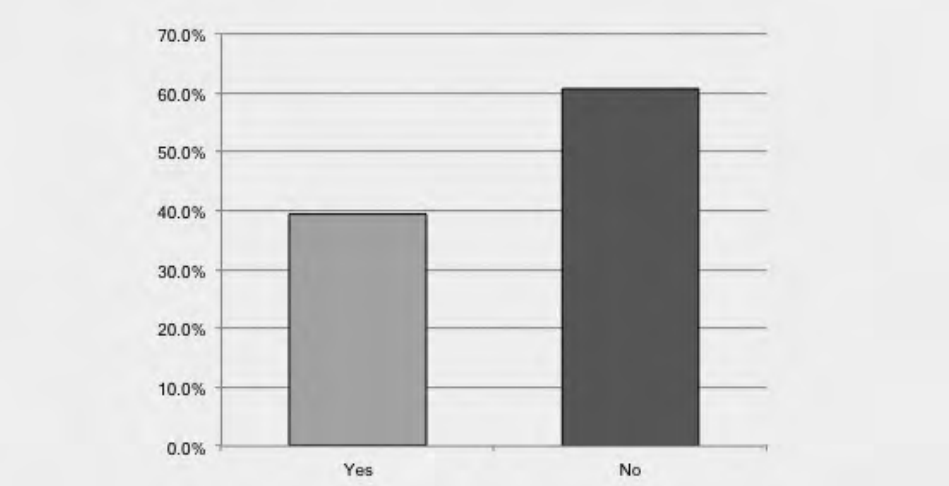


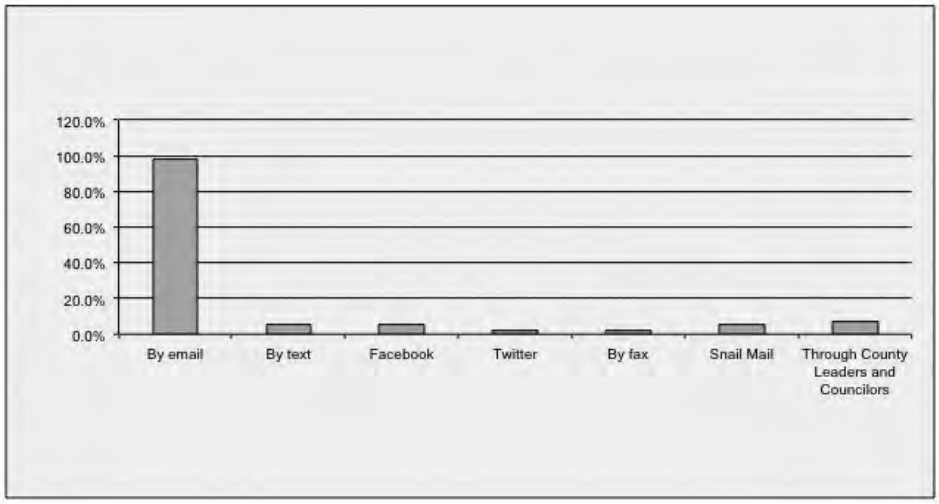
(continued on page 8)

MSSNY Legislative Priorities Survey Results

Continued from page 7

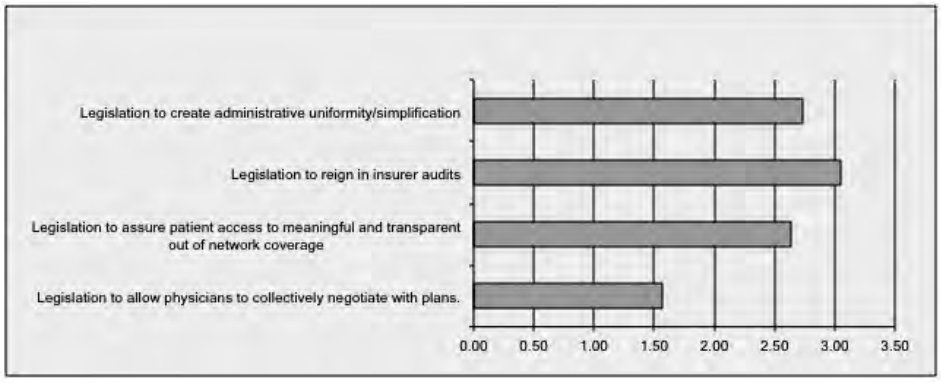
Each year, legislation is introduced that would allow physicians and non-physicians such as dentists, chiropractors, physical therapists to practice together in one corporate entity such as a PD, LLP or other business entity. MSSNY has opposed these bills, even though it has received letters from physicians who would like to partner with non-physicians. Should MSSNY continue to oppose these bills?





What is the best way for MSSNY to communicate about its advocacy efforts with you?

Managed Care is again being viewed by certain policy makers as a panacea for holding the line on health care costs, particularly no whtat the coverage mandate will soon go into effect. However, the managed care industry's long history of abusive practices, administrative hassles and interference with clinical decision making of physicians and their patients is well documented, as is the stranglehold insurers with substantial market power have over solo and small group physicians. This is why MSSNY has advocated for legislation to allow physicians to collectively negotiate with health plans and for legislation to assure access to meaningful out of network coverage, as well as a myriad of other bills to address health plan abuses. Please rank in priority order the following legislative objectives.

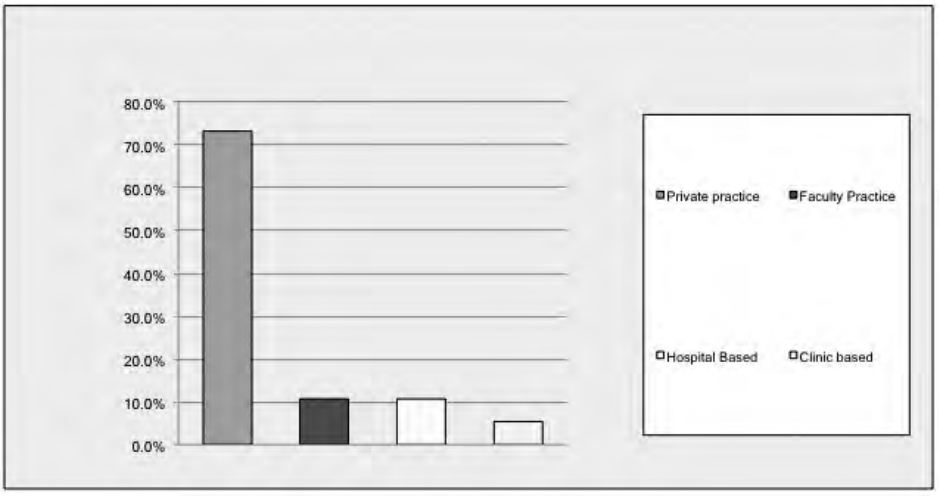


(continued on page 9)

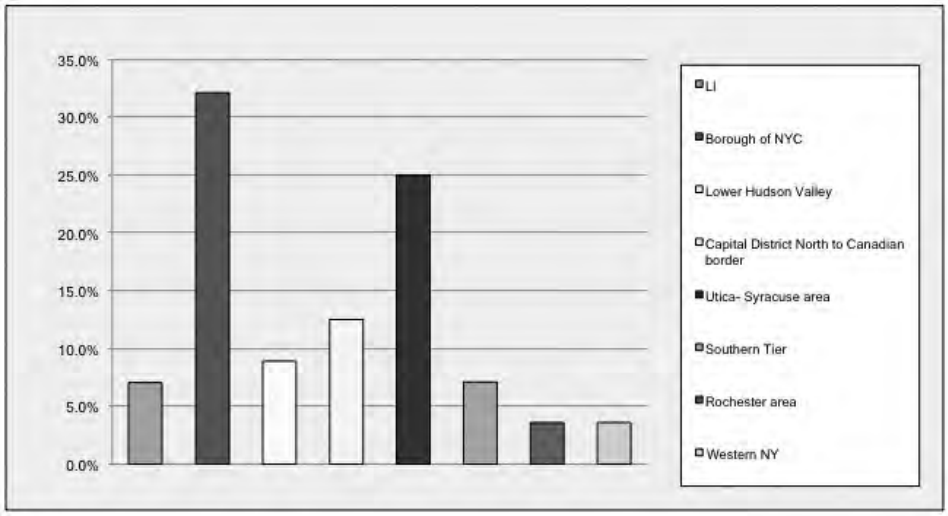
MSSNY Legislative Priorities Survey Results

Continued from page 8

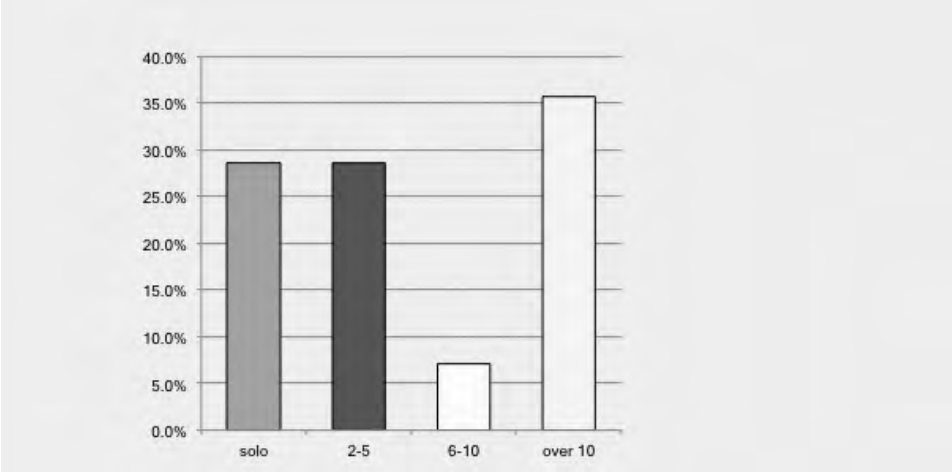
Please idendify your practice type.



In what region of NYS is your practice located?



How many physicians are in your practice?

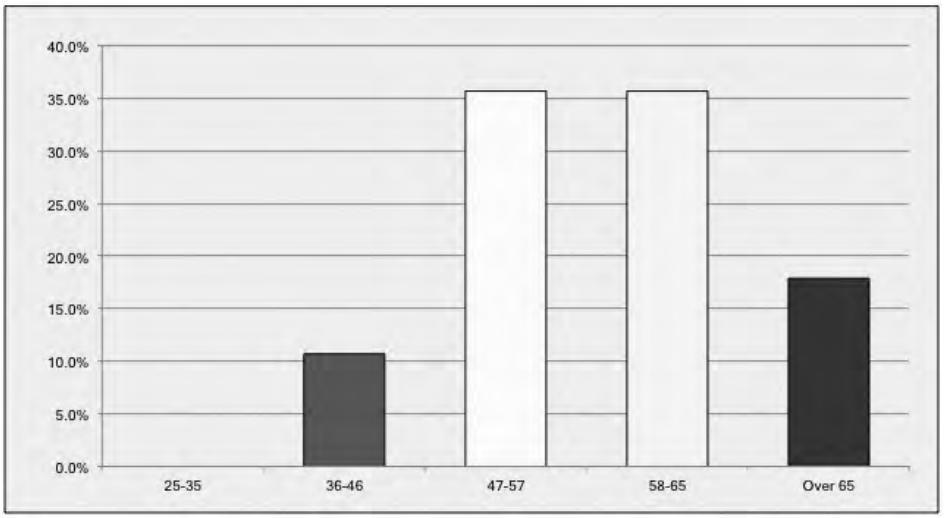


(continued on page 10)

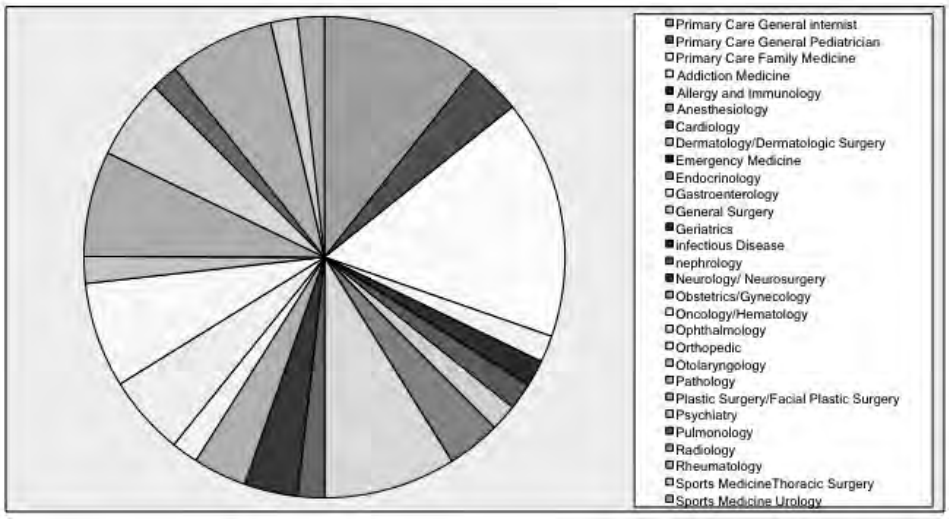
MSSNY Legislative Priorities Survey Results

Continued from page 9

What is your age?



What is your specialty?



❑

Three Things Every Physician Must Stop Doing Right Now

Continued from page 6

and/or medical practice should have the current fee schedule for each payor with which they deal readily available to their staff for cross-checking and payment audits. Accepting the hard reality that virtually everyone who obtains medical care tries very **hard not to pay for it is the first step for physicians in getting paid for the services they render. Accepting less than every penny physicians are entitled to must stop today.**

Unfortunately, there are many other pro-active, self-protective and positive measures that physicians and medical practices should undertake. However, these are the foundational first three. Taking these three steps will help insure that physicians will no longer enable their enemies, do no harm to themselves financially, and actually see an increase in reimbursement. Certainly such results (counter to every aspect of the current culture of medicine) are worth pursuing – today.

Kern Augustine Conroy & Schoppmann, P.C., Attorneys to Health Professionals, www.DrLaw.com, is solely devoted to the representation and defense of physicians and other health care professionals. Mr. Schoppmann may be contacted at 1-800-445-0954 or via email at mschoppmann@drlaw.com.

❑

The Affordable Care Act Survived, But Will Physicians?

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

The U.S. Supreme Court, in reviewing appeals as to the constitutionality of the Affordable Care Act (ACA), with a 5 to 4 Decision and Chief Justice Roberts breaking with dissenters, has left the ACA intact, for now. The foundational requirement that most citizens buy health insurance or pay a fine was held to be a tax permitted by the Constitution, and not decided under the Commerce Clause. As all provisions hinging upon the mandate remain intact, the focus should now shift to – what will the ACA mean to physicians?

Some key surviving insurance provisions:

- Insurers cannot deny coverage based on pre-existing condition,
- Annual or lifetime coverage limits are barred,
- Dependent coverage is now mandated to age 26,
- Preventive services must be provided without cost-sharing.

In addition, the ACA provides that insurers must also now meet medical loss ratio limits, maintain quality reporting requirements, coordinate with health insurance exchanges, meet employee enrollment/coverage requirements, include prescription drug benefit expansion, provide funds for recruitment/training/retaining of healthcare work force, and empower Accountable Care Organizations and the Medicare Shared Savings Plan.

However, the ACA's Medicaid expansion provision was limited by the Supreme Court. Originally, the ACA would have forced states to expand Medicaid or face the loss of all of their Medicaid federal dollars. The ACA is now limited to acting on the potential loss of funds only for the newly eligible poor.

So, what does the ruling mean for physicians? While expanded insurance coverage should equate to additional patients, the "reimbursement" system remains profoundly broken. The ACA did not fix the reimbursement formula and the "hidden" provisions affecting physicians will continue, unless and until Congress acts to repeal.

Some of the ACA's provisions that the public and the average practicing physician doesn't hear about:

- Failure to comply could result in severe sanctions,
- Increased funding for health care fraud and abuse enforcement,
- Expansion of civil monetary penalties,
- Claims for services from an Anti-Kickback Statute violation now equate to false claims,
- Lower triggers for application of federal False Claims Act,
- Modified "knowing and willful" requirement under Anti-Kickback Statute,
- No need to prove actual knowledge of Anti-Kickback Statue, nor specific intent,
- CMS can suspend provider pending investigation of "credible allegation of fraud",
- Increased scrutiny of Medicare enrollment applications,
- CMS can exclude for knowing false statement or omission on the application,
- Overpayments must be refunded within 60 days or face False Claims Act liability.

The hard reality of the ACA ruling is that the regulatory burden on physicians will continue to accelerate, building an exponential growth curve of unprecedented scrutiny. To survive, physicians must actively and aggressively embrace a new concept – Prospective Compliance. It is no longer advisable, acceptable or survivable to focus exclusively on patient care. Physicians and medical practices must become multi-dimensional – caring for patients while also remaining compliant with law, regulation and contract.

Post ACA, Prospective Compliance means that physicians and practices must permit (if not dedicate) staff time and focus on issues beginning with proper credentialing, progressing through periodic snapshot audits and risk self-assessments, building toward a compliant medical practice. However, what the ACA foretells is that every physician, every practice must become Prospectively Compliant now, not after an investigation or action commences. Under the ACA, the risks and requirements lie not only with issues of fraud or abuse. The ability of any physician and/or practice to be compensated, compensated on a timely basis and rewarded under a "pay for performance" system will be dictated by the level of compliance held by the physician and the medical practice. While mandatory compliance plans presently exist only in the arena of Medicaid, they are certain to become an integral part of health care "reform".

In conclusion, to survive the aftermath of the ACA ruling, physicians must view it as an awakening. While an awakening of the giant known also as government oversight, it must also be an awakening to every physician that the need for Prospective Compliance is no longer a political question, a legal dispute or an option.

❑

Legal Q & A

Jennifer Kirschenbaum, Esq., Kirschenbaum & Kirschenbaum, P.C.

Question:

Jennifer,

I am thinking about my 3-5 year plan and that includes no longer practicing. Is my practice sellable? I've been hearing a lot of talk that hospital and large practice models scoop up solos for guaranteed employment, only, and no sale price.

Thanks for your comment.

Dr. T

Answer:

Excellent question, and the answer will absolutely depend on who you ask. It's true that local hospital systems and mega-groups are offering many practitioners employment at a guaranteed salary (usually for 3 years) and absorbing their practices for little or no cost. Owners may be receiving a lump sum (de minimis) for tangible property. The problem with this model is that the guaranteed salary is only for 3 years, and you have to continue working! Practitioners are not being compensated for their good will. If after the 3 years are up, there is oftentimes nothing stopping the hospital system from terminating the practitioner. That practitioner may also have been coerced to sign a restrictive covenant. The patients are now in the hospital system and the practitioner is now prohibited from practicing in the same geographic location. Of course these terms I have discussed above are general and not necessarily terms you may be presented should you consider a hospital system or mega-group. I have worked on hospital deals where devices are built into the deal documents to theoretically allow for patient attrition back to the practitioner should the arrangement not work out. If are considering joining a hospital or mega-group, it is imperative that you work with counsel on deal terms, structuring and contracts associated with the deal. Any time you are taking an action that impacts your practice's structure, it is paramount that you discuss same with your competent healthcare attorney.

In general, the market for selling a practice has changed dramatically over the past few years, however, that does not mean there is not a market for your practice. The best opportunity for sale is often an internal one. Do you have partners or associates who may be interested in maintaining your patient population? If so, you may have an obvious purchaser interested in buying you out in a lump sum, payout, severance or other arrangement. As you have specified you are looking towards your 3-5 year plan, you may want to take steps now to ensure you have a buyer when the time comes. Approach your associate, see whether he/she is interested in being a practice owner. However, before doing so, or bringing in an associate and introducing him/her to your patients, be sure to enter into a contract with a restrictive covenant and non-solicitation provision so that if your intended arrangement does not work out, you do not end up losing patients to your intended heir. If you are a joint-owner in a practice, talk with your partners and see what their exit strategy is if you have not already done so and agree upon a course of action . (Buy-out upon retirement, expulsion, voluntary surrender, etc. should be addressed in your partnership, operating or shareholder agreement. If you do not have one in place, work with counsel while times are good to plan prior to times going bad.)

(continued on page 15)

Legal Q & A

Continued from page 13

Approaching a practice broker is another option. Brokers are still in business, despite the rumors, and there are still buyers looking to walk into a functioning practice, including larger practices using M&A as a growing tactic. Definitely worth exploring if you are considering retirement and do not have associates or partners. See what you can get. Test the waters. There is no reason to walk away from practice without some compensation for good will, if it can be helped. Your patients and relationships have value. I encourage you not to close your doors without considering sale. If you would like to discuss in greater detail or strategize, call (516 747 6700 x. 302) or email me at Jennifer@kirschenbaumesq.com.

This Q&A is provided for news and information purposes only and does not constitute legal advice.

About the author:

Jennifer Kirschenbaum manages Kirschenbaum & Kirschenbaum, P.C.'s healthcare department and regularly counsels healthcare practitioners in regulatory compliance, transactional, audit defense, licensure, litigation and general practice management matters. If you have a question for Jennifer or you would like to schedule her for a speaking engagement, contact Jennifer Kirschenbaum at(516) 747-6700 x. 302 or at Jennifer@Kirschenbaumesq.com.

❑

Smoking Cessation Reimbursement

Continued from page 3

2010 American Academy of Family Physicians. All Rights Reserved."

http://www.nysmokefree.com/subpage.aspx?p=70&p1=70230&curcat=7080

NYS Smokers' Quitline:

A complete source of patient resources for smoking cessation including tools for clinicians to facilitate patient referrals

http://www.nysmokefree.com/ ❑

We specialize in tiny

Our New Level II Neonatal Intensive Care Unit provides specialized care for your baby.

Orange Regional Medical Center's 10-bed NICU is located in the beautiful Rowley Family Birthing Center. Full-time neonatologists, affiliated with Maria Fareri Children's Hospital at Westchester Medical Center, together with a skilled team of neonatal nurses and support staff stand ready to care for your family's precious new addition. Now expectant moms can be confident knowing an experienced team of specialists is available to care for their little miracle.

For more information on the Rowley Family Birthing Center and the new Level II NICU, visit www.ormc.org/nicu or call 1-888-321-6762.

ORMC ORANGE REGIONAL MEDICAL CENTER

A member of the Greater Hudson Valley Health System