MEDICAL SOCIETY STATE OF NY - YOUR DUES DOLLARS AT WORK

MSSNY advocacy resulted in the following tangible results:

- Secured the continuation of the Excess program funded at $127.4M for all physicians previously eligible and participating in the program and up to 1,000 new participants to fill slots which become open as a result of attrition caused by retirement, death or other change in physician’s employment status.
- Successfully fought to eliminate the burdensome and unnecessary imposition of accreditation and other costly regulatory requirements on urgent care practices.
- Succeeded in eliminating from the context of the budget language related to Office Based Surgical Practices. Of particular concern was language which would have empowered the Commissioner of Health through state recognized OBS accrediting agencies to conduct investigations for unspecified purposes.
- Succeeded in preventing the proliferation of retail clinics owned by publicly traded corporations.
- Successfully secured the removal of the requirement for separate, written consent when offering an HIV test. The budget language specifies that what is required is informed consent which at a minimum shall advise the individual that an HIV related test is being performed.
- Succeeded in eliminating from the budget language which would have enabled the Superintendent to investigate a no-fault provider’s office when the “Superintendent deems it expedient for the protection of the interests of this state”.
- Assured that nurse practitioners in practice for more than 3,600 hours would continue to have a collaborative relationship. The collaborative relationship however may be with a physician in private practice or a physician privileged at a hospital. Instead of a written practice agreement, the NP would need to include on an attested to form the name of the collaborating physician, the manner by which the NP and collaborating physician will communicate and which will acknowledge that a physician’s judgment shall prevail in the event that disputes regarding patient care are not resolved.
- Secured a $990,000 for MSSNY’s Committee for Physician’s Health. Secured a reappropriation of $165,000 and an appropriation of $150,000 was secured for MSSNY’s educational on Veteran’s Mental Health Initiative. MSSNY is working closely with the NYS Psychiatric Association and the NYS Association of Social Workers on this initiative. Each organization received the same appropriation.

MSSNY DGA would like to thank the many physicians who on their own or in tandem with their County and Specialty Medical Societies in our advocacy efforts. Our combined efforts have produced the above results...Job well done...
**After Passage by Congress, President Signs SGR "Doc Fix" & ICD-10 Delay**

On Tuesday, April 1, President Barack Obama signed the "Protecting Access to Medicare Act of 2014," **HR 4302**, which creates a **one-year patch for the Sustainable Growth Rate (SGR)** Medicare physician payment formula, to April 2015.

Among many other provisions in the **45-page bill** is a **delay in the conversion to ICD-10 by one year, to October 2015**. Section 212 reads, "The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD–10 code sets as the standard for code sets under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)) and section 162.1002 of title 45, Code of Federal Regulations." On March 31, in a **64-35 vote**, the U.S. Senate passed the legislation just hours before the previous SGR patch expired. The House passed the bill in a voice vote on March 27th.

Although ICD-10 is being delayed until no sooner than October 1, 2015, **NGS Medicare’s April 1, 2014 date for the use of the new paper claim form is quite firm**. For those who still file paper claim forms, here is the latest from NGS Medicare on this point – At NGS Medicare, the optical scanner was designed to handle both ICD-9 and ICD-10 diagnosis codes. The process is in place and we will not replace the new equipment at this point. Most important, we have started the process of returning out of date claim forms. It is a must and we are currently returning old forms to be resubmitted. The implementation date was April 1, 2014. No turning back at this point. If a form is returned, physicians will need to complete the new version (02/12) and resubmit the claim as soon as possible. As far as MSSNY knows, other payers have not said anything about what forms are needed/mandated; so, the older forms should still be viable for non-NGS Medicare plans. You might want to call the plans you contract with to be sure, though.

**eMedNY**

**Effective April 7, 2014** (Cycle 1911) **eMedNY** will no longer be permitted to make the X12 835 and the X12 820 electronic remittances available two weeks prior to release of payment. Electronic remittances will be available **two days** prior to the release of funds. The change is necessitated by requirements of Section 1104 of the Affordable Care Act (ACA) and the CAQH Committee on Operating Rules for Information Exchange (CORE), the authoring entity for operating rules for Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA) transactions. CORE Rule 370 requires that transmission of the 835 cannot occur more than three days prior to the availability of the EFT.

All providers receiving the 835/820 electronic remittance are affected and it is important that they assess what impact, if any, the change in the 835/820 delivery date may have on their business. The change will be implemented on April 7, 2014. Therefore, electronic remittances for cycle 1911 that would have been available on 04/07/14 will not be delivered to eXchange or FTP accounts until 4/21/14, 2 days before the Check/EFT release date. No electronic remittances will be delivered on 4/07/14 and 4/14/2014. For these two cycles electronic remittances will be released as follows:

<table>
<thead>
<tr>
<th>Cycle</th>
<th>Payment Issue Date</th>
<th>Electronic Remittance Issue Date</th>
<th>Payment Release Date 1911</th>
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<tbody>
<tr>
<td>1911</td>
<td>4/07/14</td>
<td>4/21/14</td>
<td>4/23/14</td>
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<tr>
<td>1912</td>
<td>4/14/14</td>
<td>4/28/14</td>
<td>4/30/14</td>
</tr>
</tbody>
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**The current payment schedule will not be impacted by this change. Payments will continue to be lagged for two weeks and two days from the issue date.**

Information on the CORE Operating Rules can be found at: [http://www.caqh.org/ORMmandate_index.php](http://www.caqh.org/ORMmandate_index.php)

Questions? Contact the eMedNY Call Center at 800-343-9000 or email emednyhipasupport@csc.com
Physician Profile Requirement

Pursuant to Subdivision 4 of Section 2995-a of the Public Health Law, physicians must report information for inclusion in the Department of Health Physician Profile and as a condition of registration renewal under Article 131 of the State Education Law update his/her profile within six (6) months prior to the expiration date of the physician’s registration period.

You can update your profile:

- Online, if you have a Health Commerce System (HCS) account, by logging on to https://commerce.health.state.ny.us and click on the Physician Profile Survey icon to review and update the profile information;
- If you do not currently have an HCS account and would like to request an application on-line, go to https://hcsteamwork1.health.state.ny.us/pub/top.html to apply.
- If you are not able to login to the HCS site, please contact their support line at 1-866-529-1890 for assistance.
- Print your profile by accessing the New York State Physician Profile web site, make changes on the printout and either fax it to 917-228-8700 or mail it to NY State Department of Health, PO Box 5007, New York, NY 10274-5007

Any questions you may have regarding the physician profile or this requirement can be answered by the New York State Physician Profile Help Desk at 1-888-338-6998.

Doctors Recognition Day

Wednesday, March 26, 2014 – 3:00 PM - at Albert Einstein College of Medicine of Yeshiva University

We marked our 11th Annual Doctors’ Recognition Day Symposium, Expo and Poster Presentations. A record number of abstracts were submitted in February. A total of 78 posters were presented. This is by far the largest presentation ever here in the Bronx. 253 registered for this event. –View the Program Abstract Book & photos Online at www.bronxdocs.org

Round Table Healthcare Symposium followed the expo The Impact of Health Care Reform on DIABETES

Faculty

Louis C. Rose, MD, President Bronx County Medical Society

Joel Zonszein, MD, FACE, FACP

New Data Show Diabetes Prevalence Continues To Rise in NYC – “Where do we Stand with Diabetes Outcomes & Where are we Going”

Keynote Speaker  Henry Chung, MD

“Developing New Partnerships & Approaches in the Accountable Care Organization to Improve Diabetes Care”

ROUND TABLE DISCUSSION - PANALISTS

Jane Bedell, MD
Assistant Commissioner & Medical Director Bronx District Public Health Office NYC Dept of Health & Mental Hygiene

Joel Zonszein, MD, FACE, FACP, Director Clinical Diabetes Center at the University Hospital of the Albert Einstein College of Medicine, a Division of Montefiore Medical Center

Henry Chung, MD, Chief Medical Officer
Montefiore Care Management Company and Medical Director for the Montefiore Accountable Care Organization

Paloma Izquierdo-Hernandez, President & CEO Urban Health Plan, Inc

A network of community health centers located in the South Bronx & Queens

This program was very well received by all that attended...Thank you to all who came out to support this event.
Doctors Train To Spot Signs Of A.D.H.D. In Children

During a training session in New York last month, Dr. Edward M. Hallowell portrayed a 6-year-old child with a behavior disorder. Ozier Muhammad/The New York Times

Jerry, 9 years old, dissolved into his Game Boy while his father described his attentional difficulties to the family pediatrician. The child began flitting around the room distractedly, ignoring the doctor’s questions and squirming in his chair — but then he leapt up and yelled: “Freeze! What do you think is the problem here?”

Nine-year-old Jerry was in fact being played by Dr. Peter Jensen, one of the nation’s most prominent child psychiatrists. On this Sunday in January in New York, Dr. Jensen was on a cross-country tour, teaching pediatricians and other medical providers how to properly evaluate children’s mental health issues — especially attention deficit hyperactivity disorder, which some doctors diagnose despite having little professional training.

One in seven children in the United States — and almost 20 percent of all boys — receives a diagnosis of A.D.H.D. by the time they turn 18, according to the Centers for Disease Control and Prevention. It narrowly trails asthma as the most common long-term medical condition in children. Increasing concern about the handling of the disorder has raised questions about the training doctors receive before diagnosing the condition and prescribing stimulants like Adderall or Concerta, sometimes with little understanding of the risks. The medications can cause sleep problems, loss of appetite and, in rare cases, delusions. Because the disorder became a widespread national health concern only in the past few decades, many current pediatricians received little formal instruction on it, sometimes only several hours, during their seven years of medical school and residency. But the national scarcity of child psychiatrists has placed much of the burden for evaluating children's behavioral problems on general pediatricians and family doctors, a reality that Dr. Jensen and others are trying to address through classes that emphasize role-playing exercises and spirited debate.

“Most continuing medical education is somebody standing up at a podium transmitting facts,” said Dr. Jensen, the former associate director of child and adolescent research at the National Institute of Mental Health. “But with A.D.H.D. that’s like showing a slide show of how to swim the butterfly. It takes real hands-on training.

“If all we change is residency, we won’t see benefits for 20-30 years,” he added. “We have the problem now, and it needs to be addressed now.” Pediatricians and family doctors handle the majority of office visits for children being medicated for A.D.H.D., according to a 2012 study in the journal Academic Pediatrics. Most experts blame the relative rarity of child psychiatrists: There are only 8,300 in the United States, compared with 54,000 board-certified general pediatricians, according to their professional organizations’ statistics. The result is that some rural families must drive 100 miles or more for an appointment with a child psychiatrist or neurologist, who often have long waiting lists and accept insurance less often than a family pediatrician.

Yet many practicing pediatricians, family doctors and certified nurse practitioners say they have received little training to prepare for today’s rising number of families asking that their children receive mental-health evaluations. Pediatric residency programs since 1997 have been required to include a month on developmental-behavioral pediatrics, a category into which A.D.H.D. can fall. But many doctors say the actual programs can vary widely and cover too many conditions too briefly. “When I trained, most of pediatrics was treating infectious disease,” said Dr. William Wittert, 57, a pediatrician in Libertyville, Ill.

“But we don’t treat bacterial meningitis anymore. We are being asked to evaluate and handle mental-health issues in kids like A.D.H.D. We have to get up to speed.” Dr. Wittert acknowledged that for years his handling of the disorder was inadequate. He said he often would run down a list of vague symptoms — like distractibility and forgetfulness. “If you had enough yesses, then you pretty much got the diagnosis of A.D.H.D.,” he said. Harriet Hellman, a certified pediatric nurse practitioner in Southampton, N.Y., who is licensed to make mental-health diagnoses, said that there were times she would identify the disorder through mere instinct, a “hair-on-the-back-of-your-neck feeling.” Many postgraduate and web-based continuing medical education classes are staffed and shaped by pharmaceutical companies, raising concern about bias toward encouraging diagnoses and subsequent prescriptions. Wary of this, Dr. Wittert and Ms. Hellman said they were immediately drawn to Dr. Jensen’s seminars, held by the Resource for Advancing Children’s Health Institute, a nonprofit he founded in 2006. About 2,000 health providers have paid about $2,000 for intensive three-day sessions, which Dr. Jensen holds about 10 times a year across the United States. The recent event in New York was immediately followed by another one in Chicago.

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York focused on A.D.H.D. But the day’s key acronym was D.J.D.S.: “Don’t just do something.” It was a reminder to the audience to resist the urge to simply prescribe medication and that a proper diagnosis requires far longer than the 15 minutes some health providers spend.

The institute’s team staged doctor’s-office visits in which a child comes in for an A.D.H.D. evaluation. A pushy father, played by Dr. Ned Hallowell, demands an Adderall prescription for his daughter to improve her grades. A distracted and fidgety boy might not have A.D.H.D. but rather might be the victim of bullying at school. A teenage girl might have been sexually assaulted. When Dr. Hallowell, a prominent A.D.H.D. psychiatrist, climbed under chairs and rolled aimlessly on the carpet, the audience appeared both amused and somewhat disturbed.

As the role-playing continued, Dr. Jensen called from afar, “Dr. Jones, you have six patients waiting!” Trainees consulted symptom evaluation forms submitted by teachers and parents. They evaluated family histories. They debated whether the child’s behavior was likely to be a result of depression, A.D.H.D., sleep problems or family tension. They rarely reached a consensus. With Jerry, the 9-year-old boy, some suspected he had A.D.H.D., while others wanted to learn more about whether his parents were providing enough structure at home or if Jerry had a different learning disability. “Doctors aren’t trained to say, ‘I don’t know what to do,’ ” Dr. Jensen said. The institute’s program does not stop with the three-day seminar. Attendees are allowed 12 hourlong conference calls with institute trainers and other trainees over the next six months to discuss real-life cases. A 9-to-5 hotline allows for further consultation with an expert on call.

Although the training does not discourage diagnosing the disorder or using medication — left untreated, the disorder carries significant risks for academic and social struggles — most graduates interviewed said they do so less often after taking the course.

Dr. Nina I. Huberman, a pediatrician in an underprivileged section of the Bronx, was among the doctors who said the class allowed them to begin providing care to those who otherwise would not get it. Once averse to handling A.D.H.D. and its medications because of her lack of training, Dr. Huberman said she no longer sent families to specialists they might never see because of cost, geography or perceived stigma. She used a third-grade girl as an example of someone whose life was turned around by what Dr. Huberman called a straightforward diagnosis. “She didn’t have any learning issues, she just had that textbook A.D.H.D. issue where she could not sit still or focus,” Dr. Huberman said. “Now she’s reaching her potential. Her whole way about her has changed. I don’t think that the parents would have ever brought her to a psychiatrist.”

The impact of the institute’s program is limited. Each training session is capped at about 40 health care providers, whose attendance is voluntary. So there is some question as to whether the sessions can improve the handling of the 400,000 children in the United States who receive an A.D.H.D. diagnosis each year. But its ethos may be spreading. Dr. Robert A. Jacobs, the chief of general pediatrics at Children’s Hospital Los Angeles, a premier teaching hospital, said he has sent 24 instructors to the institute so they can learn its methods, particularly role-playing. He plans to double the number of hours residents spend on depression, anxiety and A.D.H.D. “The scope of pediatrics has changed,” Dr. Jacobs said. “For many in the elementary-school population, A.D.H.D. is the primary concern.”

A version of this article appears in print on February 19, 2014, on page A10 of the New York Times edition with the headline: Doctors Train To Spot Signs Of A.D.H.D. In Children

Heroin Abuse and Overdose Deaths are on the Rise: Addiction Is a Societal Problem and Requires a Multi-Faceted Societal Solution

There has been much discussion on Long Island, NY and around the country about a surge in heroin usage and overdose deaths. Although the perception is that a drop in doc shopping caused the increase in heroin usage, the picture is more complex than that and the history goes back further than some may realize. Heroin started to make a comeback in the US in the early 1990’s. Around that time, drug dealers started to sell heroin in a more pure form, which gave a strong high even if snorted instead of used intravenously, as much less pure heroin had been used for years. Around this time, abuse of multiple substances started to become the cultural norm in drug using circles. The days of the “pure alcoholic” who did not abuse other drugs in addition were fading fast. By the mid-1990s, I recall detoxing many teen males and females who were using over a bundle (10 bags) per day of heroin—they might need 30-40 mg/day methadone and a 7-10 day detox, would feel uncomfortable but could manage to get through the detox process. Ultimately, if they did not achieve sobriety from snorting heroin, the disease process would progress and they would end...
believe, ISTOP is not to blame for the rise in heroin. As the market conditions changed, the dealers and users simply adjusted. Although MSSNY opposed the ISTOP 100% mandatory lookup, a 75% drop in doc shopping is a tremendous change for the better. However there is more work to be done. Substance Use Disorders are a societal problem and a full societal solution is needed. First, we must accept and acknowledge that drug abuse is a medical problem and not a character flaw. While this does not take away responsibility for choices around drug usage, we need to stop judging and start treating. Second, we need to increase access to screening and treatment, including more screening and treatment in primary care offices and clinics and in psychiatrist offices and mental health clinics. Too many psychiatrists place themselves into camps..."I treat mental illness...or I treat addictions." Well, folks, if psychiatrists address disorders of mood, thought, behavior and perception, then we must all treat addictions, at least to the degree that they can be treated in the outpatient setting. Since addictions are often challenging to treat, often chronic and with varied courses (same as other chronic medical illnesses), we need more specialized addiction training, in medical school and ongoing training after residency. We need more specialized addiction treatment services for patients whose needs cannot be met in the office or clinic setting, including detoxification programs, intensive outpatient rehabilitation programs, short and intermediate term rehabilitation programs. We need expanded access to Suboxone, a unique medication used to treat opiate addictions by allowing someone with an opioid use disorder to stabilize on this combination medication that includes a relatively low side effect opiate (Buprenorphine) with an opioid antagonist (Naloxone), which prevents one from abusing other opioids because it blocks the opiate receptors. More psychiatrists and primary care physicians need to step up to learn and become certified to prescribe Suboxone. The state and federal governments need to increase funding for such programs and initiatives. And all payers, public and private, need to provide fair payments to cover such services, including in primary care offices.

Expanded Use of Opioid Antagonist Naloxone for Overdoses Is One Critical Part of the Solution

Opiate overdose deaths (more often accidental) have been increasing for several years, due to both opiate pain medications and heroin overdoses. As doc shopping decreases and heroin usage increases, heroin overdoses appear to be increasing substantially, perhaps in part because heroin may be more dangerous in overdose than opiate pain medications. In Suffolk County, there were 163 opioid related fatalities in 2010, but a surge to 238 opioid related fatalities in 2011 and 234 fatalities in 2012. It will take a long-term, multifaceted approach to turn the tide on heroin abuse and decrease the risk of accidental overdoses. In the meantime, expanding the use of Naloxone, an opiate antagonist, should be seen as part of the solution to address the increase in opiate overdose deaths. Naloxone has been used in an injectable form for many years, in hospitals, ERs and by highly trained emergency responders. Although off-label, research and experience over several years demonstrates that intranasal Naloxone is about as effective in reversing opiate overdoses and overall very safe. On a trial basis, a patient in an opioid prevention and treatment program can appoint a partner to be trained to give Naloxone, which has been effective to reverse opiate overdoses in opiate abusers who have a relapse. In a pilot project over a couple of years, basic EMTS and police officers have been trained to identify and administer intranasal Naloxone to reverse opiate overdoses. The results have been extremely successful, with 211 overdoses reversed over 1 1/2 years and no reported adverse reactions to the Naloxone. A “same-as” bill in the NY State Senate and Assembly would allow the expanded availability and use of intranasal Naloxone, outside an opioid prevention and treatment program to be prescribed and dispensed with a patient specific or a non-specific prescription that could be given to a family member or other person concerned about someone with an opiate addiction problem. Such recipients would be trained to recognize an overdose situation and to administer the emergency intranasal Naloxone. Since the results of several projects around the country have demonstrated that Naloxone cannot be abused, has very low risk of adverse events, and is effective in reversing opiate overdoses, the MSSNY Council recently reviewed and voted unanimously to support the expanded availability and usage of emergency usage of Naloxone. While it is hoped that the bill passes both the Senate and Assembly this year, it’s important to remember that expanded use of Naloxone is only part of the solution, even if a very worthwhile part. The best solution is to work for a full societal solution-in doctor’ offices, hospitals, schools, youth sports and other programs, to educate youth and families about substance abuse and in particular the serious dangers of opiate/heroin abuse. Such a societal solution must include increased prevention strategies and screening, treatment and referrals for addiction treatment. It must include several options for treatment, from office based through inpatient or residential treatments. Perhaps most importantly, it’s time that we acknowledge substance use disorders as medical illnesses and not weaknesses or character flaws.
Coming together on bipartisan medical liability reform legislation are Congressmen Andy Barr (R-KY) and Ami Bera (D-CA), who earlier this month introduced H.R. 4106, the Saving Lives, Saving Costs Act. The Congressmen claim the bill will lower health care costs and improve patient care by reducing medical lawsuit abuse and using evidence-based guidelines developed by doctors. The unlikely allies are not only on different sides of the aisle, but come from what has traditionally been separate sides of the issue – as Bera is a physician and Barr is an attorney. The Saving Lives, Saving Costs Act will offer physicians who document adherence to certain evidence-based clinical-practice guidelines a safe harbor from medical liability litigation. “The bipartisan Saving Lives, Saving Costs Act is a practical way to bring down the skyrocketing cost of health care, and to make the system work better for patients that people from both parties can get behind,” said Bera in a press release. “As a doctor, I know that physicians want to do what’s best for their patients, and promoting evidence-based medicine will help us do that.” HCLA and Protect Patients Now appreciate Congressmen Barr’s and Bera’s efforts to address the ongoing problems with our medical liability system, and look forward to working with them to make improvements in the legislation in the future.

Leading in Liability Payouts Leaves Patients Behind
Last year, aggressive personal injury lawyers in New York contributed to massive medical liability payouts, potentially increasing costs and reducing access to care as fewer physicians choose to practice in such a litigious environment. Liability lawsuit awards paid out almost $690 million in New York in 2013, nearly twice the amount paid out in Pennsylvania, where $357 million was paid. The study by Diederich Healthcare, a medical liability insurer, was reported by the Washington Post and details the year over year changes in liability costs and payouts.

According to the study, 2013 was the first year since 2003 that there was an increase in both total payout amounts and total number of payouts – evoking memories of medical liability crises that saw physicians fleeing highly litigious states, such as Texas before it enacted its reforms. Not coincidentally, per capita payouts in New York and Pennsylvania are now more than 12 and eight times higher, respectively, than in Texas.

It remains clear that much more needs to be done to reign in medical lawsuit abuse through effective reform of our broken liability system. Only through these efforts at both the state and federal level will we be able to create a system that truly provides justice for patients and health care providers alike.

New York is the Clear Leader in Medical Malpractice Awards
Medical malpractice lawsuits paid out more in New York last year than in any other state — and by a huge margin. Awards in malpractice lawsuits paid out roughly $690 million in New York last year, nearly twice that of second-ranked Pennsylvania, which saw $357 million in payouts, according to government data compiled by Jeremy Gower of Diederich Healthcare, a medical malpractice insurer. New York is also the clear leader on per capita payouts, averaging $39 per resident with Pennsylvania trailing at $25 per resident.

Malpractice lawsuits have long prompted controversy among policymakers. Some argue they drive up insurance rates and make it difficult to be a physician while others say they’re necessary to protect consumers. This past Thursday, the Florida Supreme Court said the state legislature manufactured an “alleged medical malpractice crisis” and threw out limits on payouts in some wrongful death lawsuits, according to the Miami Herald. And lawyers and industry groups are collecting signatures to get a measure to increase the cap on the ballot in California.

Caps on malpractice awards have been overturned in at least nine other states, according to year-old data from PIAA, an insurance industry trade association. And only 15 states lack caps altogether. (New York and Pennsylvania are among them, according to the American College of Emergency Physicians.) Payouts overall rose 4.7 percent between 2012 and 2013 to $3.7 billion, according to Gower’s compilation of government data.
Newest Member of the Bronx County Medical Society
Panagiota (Peggy) Korenis, MD
Forensic Psychiatrist and Attending Psychiatrist
Bronx Lebanon Hospital Center. Peggy joined us at the annual meeting on March 5th and gave birth to her beautiful son 2 days later...
Both were in attendance for the 11th Annual Doctors Recognition Day on March 26, 2014. Congratulations

Peggy presented her poster at the 11th Annual Doctors Day on March 26th

The Bronx County Medical Society Centennial Celebration will be held on Sunday, October 12, 2014 at the New York Botanical Garden
Please Mark Your Calendar and Plan to Join us – details to follow

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BRONX COUNTY MEDICAL SOCIETY UPCOMING MEETINGS AND EVENTS
CHECK THE BOX(S) FOR THE MEETING(S) YOU WISH TO ATTEND

☐ Wednesday, May 14, 2014 Annual Meeting
  Bronx County Medical Society Annual Meeting
  Time: 6:00 PM Registration/Cocktails 6:30 PM
  Dinner followed by the Educational Program
  Place: Mario’s Restaurant - 2342 Arthur Avenue, Bronx, NY 10458
Sponsored by: TBA

☐ Wednesday, June 4, 2014 President’s Dinner & Educational Program
  In honor of, Louis C. Rose, MD
  Time: 6:30 PM Sharp
  Place: Pine Bar & Grill 1634 Eastchester Rd, Bronx, NY 10461 - (718) 319-0900
Sponsored by: TBA

The Presidents Dinner Program - We will have a sponsor who will present a short educational program and will cover the cost of the dinner. I asked all members to forward a small donation ($25 per person) so that I can purchase a suitable gift for Dr. Rose who has done an outstanding job this year…

LAST NAME: FIRST:

ADDRESS: CITY: ZIP CODE:

PHONE FAX EMAIL:

CHECK THE BOX(S) FOR THE MEETING(S) YOU WISH TO ATTEND

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Bronx, NY 10463

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Program Administrator
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Phone: 1-800-333-5440 - FAX: 1-800-462-1121
insurance@sellersinsurance.com - www.sellersinsurance.com

Underwritten by: Life Insurance Company of Boston & New York, New Rochelle, NY. This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. The expected benefit ratio for this policy is 60%. This ratio is the portion of future premiums which the company expects to return as benefits, when averaged over all people with this policy. See the Product Brochure and/or Policy Form DIC-N (0900) NY for details concerning policy benefits, limitations and exclusions.

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