YOU MAY HAVE RECENTLY ASKED YOURSELF THE FOLLOWING QUESTION:
WHAT HAVE MY MEDICAL SOCIETIES DONE FOR ME IN THE LAST 9 MONTHS?

HERE ARE SOME ANSWERS:

- Medical malpractice premiums -- **frozen for 2nd straight year**
- $400 increase in physician registration fee -- **defeated**
- Physician procedure surcharge of 9.63% -- **rejected**
- Enactment of meaningful managed care reforms (faster payment; added time for claims submission; restrictions on plans’ ability to cut fee schedules mid contract; and protections for patients needing specialized care) -- **enacted**
- Medicare 10.6% fee reduction -- **defeated**
- Ingenix out-of-network scheme -- **exposed and toppled**
- Medicaid fees for primary care -- **enhanced**
- Due process in professional discipline—**upheld and expanded**
- Practice expansions for non-physician providers -- **defeated**
- Medicaid incentives for e-prescribing -- **approved**
- $110M appropriated for Health Information Technology
- For-Profit HMOs taxed $107M to contribute to healthcare system

Your medical societies will continue to work to achieve desperately needed medical liability reform on the state level, and will continue the highly acclaimed media campaign to convince the public of the need for fundamental tort reform.

We will continue to work for legislation to permit physicians to collectively negotiate with health plans. At the federal level, we’ll continue to work for fair Medicare reimbursement and needed reform of grossly unfair health insurer practices. Our position is simple. Any health system reform package that gets enacted in Washington must address these issues as well as the liability issues which have for so long gone unaddressed.

HERE ARE A FEW MORE QUESTIONS TO ASK YOURSELF:
DO YOU THINK WITHOUT YOUR MEDICAL SOCIETIES THESE ACCOMPLISHMENTS WOULD HAVE HAPPENED?
WHERE WILL MEDICINE BE WITHOUT PHYSICIANS AND PATIENTS BEING REPRESENTED?
MEMBERSHIP IN ORGANIZED MEDICINE IS THE ONLY ANSWER!
RENEW YOUR MEMBERSHIP TODAY AND ENCOURAGE A COLLEAGUE TO JOIN.
GET INVOLVED. TOGETHER WE MAKE A DIFFERENCE!
SAVE THE DATES:
Tuesday, March 9, 2010
MSSNY State Legislative Day, Albany, New York
The SCMS in conjunction with MSSNY and all other county societies across the state, will be traveling to Albany on March 9th, as part of the Annual State Legislative Day Program. This is YOUR opportunity to meet face to face with your elected officials in Albany. Please mark your calendar and plan to let your voice be heard!

Friday, April 16 – Sunday, April 18, 2010
MSSNY House of Delegates

TO ALL MEMBERS
Please notify the SCMS of any changes in your office address, telephone number, fax number or Email Address etc. This will enable us to maintain accurate and updated information on all of our members. We use your office information to refer new patients both by telephone inquiries and our online physician locator. We also use this information to relay important legislative, public health and practice information to you. If your information has changed please email Donna DelVecchio at scms3@optonline.net or call the office at 631-851-1400.

Call the SCMS if you think you qualify for Life Membership based upon the following definition:
“Life Membership: Life Membership maybe granted to an active member in good standing who has completely withdrawn from the active practice of medicine and who has been a member in good standing for the ten consecutive years prior to the attainment of the age of sixty-seven years or an active member in good standing who continues in the active practice of medicine and who has been a member in good standing for the ten consecutive years prior to the attainment of the age of seventy-two years, or an active member in good standing for ten consecutive years or more who is permanently disabled.: The Suffolk County Medical Society, Inc, Bylaws, Revised 2000, Chapter II (d).

Suffolk County Medical Society
Suffolk Academy of Medicine
1767 Veterans Memorial Highway, Suite 14
Islandia, New York 11749
Phone: 631-851-1400 | Fax: 631-851-1212
Please email suggestions, questions or comments to scms2@optonline.net
CHECK OUR EXPANDED ONLINE VERSION OF THE BULLETIN AT WWW.SCMS-SAM.ORG
A lot has happened over the last three months, since I was installed as your president in June. The health care reform debate has been raging full-steam over the past few months. There have been various amendments, changes and new proposals to the various bills in Washington. The executive committee has studied and reviewed these with pertinent input from the AMA and the Medical Society of the State of New York. The Bills – HR3200 and HR3459 are works in progress, and I am sure we will never know all the back-office dealings that go into a final bill before it’s presented. U.S. Senate Financial Committee Chairman, Max Baucus (D - Montana) released a health care system reform proposal this past week, which proposes individual health insurance coverage mandate subsidies for patients who can not afford coverage, does not include a public option, and creates the formation of non-profit, member-owned (co-op) health insurance plans.

The American Medical Association made a statement to the Democratic Steering and Policy Committee of the United States House of Representatives regarding the urgent need for enacting health care reform, dated 09/15/09. They outline seven critical elements, including:

1. Providing affordable health insurance coverage for all Americans.
2. Enact insurance market reforms that expand choice of affordable coverage and eliminate pre-existing conditions.
3. Assure that health care decisions are made by patients and their physicians – not by insurance companies or government officials.
4. Provide investments and create incentives for quality improvement, prevention and wellness initiatives.
5. Repeal the Medicare Physician Payment Formula that will trigger steep cuts and threaten seniors’ access to care.
6. Implement medical liability reforms to reduce the cost of defensive medicine.
7. Streamline and standardize insurance claims requirements to eliminate unnecessary costs and administrative burdens.

In President Obama’s recent speech to the joint session of Congress, he put health care liability reform back on the table. In his September 17, 2009 memorandum to the Secretary of Health and Human Services, the President requested that the Secretary announce within 30 days of the memorandum, that the Department will make available demonstration grants to the states, localities and health systems for the development, implementation and evaluation of alternatives to our current medical liability system, consistent with the goals and core commitments of the memorandum. However, these are non-specific fixes and we believe that the AMA should not sign off on this proposal – unless there is definitive medical liability reform. Your leadership understands that this is a golden opportunity for medical liability reform that has to be achieved on a national level that would bypass our frustrating experience in New York State.

We have met with Congressman Tim Bishop, and a representative of Senator Charles Schumer to let our opinions be known that medical liability reform must be included in any bill, as far as the physicians are concerned. To get a more accurate idea of the feelings of our membership, we are finalizing the results of a survey, which polled our membership regarding various important issues, including what was thought of a public option, the need for tort reform or other issues they feel are important. For those of you who participated in the survey thank you for your input. Results will be posted on our website.

Although healthcare reform is top priority of all organized medicine, a lot of other things have been going on in Suffolk County. We heard a presentation from Transparent Health, a membership organization for the uninsured. Members pay a monthly fee per individual or household; and for this they get a list of participating doctors who agree to take 100% of Medicare fees up front. However, on January 1st 2010, physicians’ fees face a minimum across-the-board cut of 21% in Medicare payments, and this 21% will grow to 40% in the cumulative cuts by 2016 – unless the outdated update formula based on SGR is repealed. Unfortunately, Medicare fees have become the benchmark for private insurance, as well as this membership plan. But, Medicare fees are updated rarely, and do not even keep pace with inflation and are artificially low. However, this plan is an attempt to deal with the patients who have no insurance but usually have incomes too high for federal assistance.
We welcome the appointment of a new health care commissioner and wish Dr. Chaudhry the best in his new endeavors.

We are expecting an increase in the occurrence of H1N1 and seasonal influenzas, now that fall has begun and the school year has started. A vaccine will be available in mid-to-late October, which will be publicly funded and controlled. A list of the groups recommended for vaccination is available on the Suffolk County Health Department website http://www.suffolkcountyny.gov/departments/healthservices/H1N1.aspx. Also important to us is that health care workers with direct patient contact will be required to have the seasonal influenza vaccine by 11/30/09. We must also have to be vaccination against H1N1 influenza. However, the deadline has not been determined. Please follow our website for continuing updates regarding this. Please refer to the Medical Society of the State of New York Newsletter Volume 64, #8, September 2009 or their website www.mssny.org, which answers all the questions regarding H1N1 influenza.

I would like to thank Doctors Robert and Phyllis Scher for the recent barbeque on September 13, 2009, for the medical students at Stony Brook, where the students had a chance to meet “up close and personal” the members of the Executive Committee. I unfortunately could not attend this, as I was away in Nicaragua, but I have attended them in the past and this is a very important part of our Society – to welcome and introduce ourselves to the future new physician members.

I have met with Senator Kenneth La Valle regarding a free health clinic in Suffolk County and I would like to thank the board at Blanca’s House for their research and hard work in finding various legislation that currently exists in New York State that would allow a clinic to proceed. We are still looking into obtaining information on liability issues regarding this.

I would like to especially thank Stuart Friedman and the staff at Suffolk County Medical Society, as well as the Executive Committee for all the hard work they have done during this very difficult time – in dealing with a voluminous amount of information which is constantly changing. We have to digest and translate the information into a coherent opinion that will be presented to our various legislative representatives. Obviously, there is a full-court press to have health care reform done by the end of the year. We should keep current on all of the issues, so that we can generate a unified response. Please let us know how you feel about the Society and what it is doing – by going to our website. www.scms-sam.org for timely and up to date information. Together we can make a difference! Thank you.

We Have Moved:
Orthopedic Spine Care of Long Island
Paul Alongi, M.D.& Arnold M. Schwartz, M.D.
206 East Jericho Turnpike
Huntington Station, NY 11746

It Is With Deep Regret We Announce the Passing of:
Maurizio Savoiardo, M.D.,
Joseph J. Lambert, M.D.
A Message From Robert A. Scher, M.D.

A funny thing happened to me while talking with an employee of the XYZ Health Care Organization. A few weeks prior, they requested medical records. I wanted to know the reason for the request, while acknowledging their contractual right to do so. It seems that every time I send a claim for a consultation, they request the record for review. In a written response, I suggested that this could be a learning experience for us both, since there was in place a suggestion of transparency from prior lawsuits and perhaps they were willing to live up to their part of the bargain. Shortly after I sent the note, I received a reply denying the claim for lack of information.

I was correct in assuming that the consultation request was the culprit, according to the employee who again requested the records. It seems that XYZ Health Care in turn owns the company who scrutinizes their claims and selects claims for examination. The name of this company is Ingenix.

The employee did not know the basis for the claim being kicked out for exam. I asked for the criteria used as a threshold for examination and against what peer group I was being measured? No response was forthcoming and I asked if that information could be obtained.

Ingenix is a name that should be known to each and every one of you. At the suggestion of MSSNY, Attorney General Cuomo looked into the relationship between Ingenix and United Health Group in the area of setting UCR fees. United Health Group settled a suit against them for inappropriately setting lowered UCR fees through Ingenix, which is a wholly owned subsidiary of the company. Part of the settlement was monetary and part of the settlement called for increased transparency.

The present saga has not ended as of yet and perhaps will do so by the next Bulletin. The facts just seem to strike a familiar cord.

In the New York Times (9/25/09) there is a report under the byline of Gardiner Harris and David M. Halbfinger concerning the FDA and congressional influence. The lead sentence notes the FDA as stating that four New Jersey congressmen and its own former commissioner unduly influenced the process that led to its decision last year to approve a patch for injured knees. The agency's deputy commissioner indicated there were problems with the integrity of the agency's decision-making process. The crux of the problem is congressional pressure on behalf of a constituent company. Somehow $35,000.00 changed hands in the form of contributions. The FDA requested the Institute of Medicine review the FDA process for approval of medical devices.

In a July issue of the Times there was an article about a “slowdown” in the influence industry indicating many of the most influential lobbying firms have seen their revenue decline. In the same article it is noted that a few firms with Democratic ties have done well. Firms with names like Podesta (the brother of the Obama administration’s transition chief), Elmendorf (aide to Richard Gephardt) and Gephardt himself have seen income rises of up to 200% or more.

The point here is that influence peddlers abound whether it be a Republican or Democratic administration, within the congress or without and we should acknowledge this influence when thinking about the changes to come.

I would like to address some of the issues on the table in the present health care change environs. What is positive for physicians in HR 3200?

1. 97% of the legal non-elderly population will have coverage. This coverage will be mainly private insurance based.
2. Medical liability: There are financial incentives to qualifying states that enact certificate of merit and early offer programs. Not a lot but something.
3. Physician payment:
   a. $228.5 billion is allocated to repeal SGR and provide Medicare Economic Index update for 2010.
   b. Eliminate all SGR debt (each time Congress has cancelled a decrease in physician payment we incur a debt as the process is budget neutral).
   c. New expenditure targets with higher utilization growth allowances than SGR
   d. Excludes cost of physician administered drugs and laboratory services from new targets
   e. Targets reset each five years (if we incur further debt this is wiped away each five years)(continued on pg 6)
4. Primary care: $6.4 billion in new money to increase payment rates for primary care physicians without offsetting pay-
ment cuts for other docs. Primary care will increase by 5% starting in 2011 with a 10% increase in physician shortage
areas. Primary care payments under Medicaid will be phased up to 100% of Medicare rates by 2012.
5. Medical Home: Expands testing of alternative Medicare systems with $1.8 billion pilot money.
6. Physicians in relatively low Medicare spending areas have $500 million for bonus payments. A poor thing that is in-
cluded is exclusion for physician owned hospitals. There are amendments to counter this.

HR 3200 on the whole seems to be a plausible starting vehicle. As you know the bill’s passage through the house is just
one step. There are amendments to be filed and the AMA has many of these just waiting. Medical liability, anti trust, and
physician negotiation are all areas of concern. Others are administrative simplification, private contracting and more.
The AMA gave an indication that it felt HR 3200 was a good starting point. It did not, per se, endorse the public option.
As I see it, it told President Obama and Congress that it would consider all aspects of the bill. The AMA knows that there
is no one monolithic physician’s viewpoint on any controversial aspect of this endeavor. However, in order to protect
you it has to be at a vantage point where it is informed and can influence the decisions to whatever extent possible. That
is why they must be at the table. You and I know that the final outcome will be decided at 11:59 p.m. on the day before
the vote. Your voice must be there and the AMA is your recognized voice. The AMA House of Delegates is your House.
Charlie (Charles Rothberg, MD) and I are your paths to this house. Call The Suffolk County Medical Society at 631-851-
1400 to give your input.

A copy of the AMA review of HR 3200 can be found on the AMA website http://www.ama-assn.org/ama1/pub/upload/
mm/399/hsr-faq-gme-workforce.pdf.

Bob

MANDATORY FLU & H1N1 VACCINATION OF HEALTH CARE PROVIDERS

On August 13, 2009, the New York State Department of Health issued an emergency regulation which requires that all per-
sonnel in health care settings, including hospitals, receive vaccination against influenza by November 30, 2009 unless they
have a medical contraindication to the vaccination.

The New York State Department of Health Mandatory Vaccination Requirements:

- All hospital staff who have more than incidental patient contact shall be vaccinated against seasonal influenza by
  November 30, 2009. They must also be vaccinated against H1N1 influenza, however, details have not yet been
  finalized.
- Medical exemptions will be accepted but must be authorized by a Physician, PA or NP. The reasons for a medical
  exemption are limited to an anaphylactic hypersensitivity to eggs or Guillain Barre Syndrome within six weeks fol-
  lowing a previous dose of influenza vaccine.
- The regulation does not allow for any religious or dietary exemptions to vaccinations.
- Hospital staff physicians who are not vaccinated by November 30th for seasonal influenza are subject to suspen-
  sion until they are either vaccinated or supply appropriate paper work from their physician certifying vaccination
  or a medical exemption. A similar suspension will occur for the H1N1 influenza vaccination when the NYSDOH
  issues the mandatory deadline.

The entire regulation can be found on the following web site:
http://www.health.state.ny.us/regulations/emergency/docs/2009-08-
13_health_care_personnel_influenza_vaccination_requirements.pdf
With the health care debate still raging on, it appears that the side-shows have assumed center stage. A discussion that initially was about improving access to and limiting the financial devastation from a health care episode has devolved, as ideological and special interests have co-opted the discussion. It is becoming more evident that it will be up to the physician community to re-focus the discussion.

I have been a supporter of the AMA and MSSNY strategy to support HR 3200, the House bill that proposes a public option (a term I prefer to ‘government option’) as well as an SGR fix. I have also been supportive of those specialty societies who have come out in opposition to this legislation for legitimate and specialty related reasons. Let me be clear, I don’t think HR 3200 is a perfect bill, nor did I ever think it would be enacted as introduced.

Our ‘support,’ in my view, is a policy tool by means of which physicians can place our profession’s imprint upon the final legislation. If we support the bill then we can influence final legislation. If we oppose the bill, we are relegated to the back of the line amid its other opponents. Our ‘support’ provides the elected leaders with some necessary momentum. Our issues gain far greater traction than if we had framed them in a vacuum outside of the legislative process. This, in my view, is the role of the omnibus medical societies (AMA and MSSNY).

The role of the specialty societies is well illustrated by the experience of the NYS Anesthesia Society. The Anesthesia Society and its executive director are charged with representation of the interests of its members, the anesthesiologists. Their opposition to HR 3200 is well grounded in that payment for anesthesia services is inadequate under Medicare methodology and more so than is payment for other physician services. Under HR 3200, as it was introduced, delivery of anesthesia services could not be sustained.

The Anesthesia Society’s opposition to HR 3200, in the face of the omnibus’ organizations support, has allowed the dialog to progress, while at the same time assuring that the anesthesiologists were not thrown under the bus.

As it is the county medical society that interfaces directly with the membership, its role differs from that of the specialty society or that of the state and national omnibus society. (It also differs in that it interfaces only with the local congressman and only indirectly with the administration.) The role of the county society is to convey the member’s views and concerns to the elected leaders and to the omnibus societies. They accomplish this by informing and being informed by membership, not by endorsing or condemning a policy. My colleague in the Monroe County Medical Society, Stephanie Siegrist, M.D., put it like this, “I breathed a sigh of relief when I realized that solving national health reform was not our local job! We’re just preparing to help our members deal ... It will be interesting to watch/participate in the next steps as a ... member of (the) larger organizations.”

I have to say, I am most pleased with the physician discourse both in favor of and in opposition to the AMA strategy. The opposition levies many legitimate criticisms. The most difficult to deflect involve the administration’s current approach to payment reform antitrust relief and liability relief.

The critics argue that it is an unreasonable expectation that physicians accept broad payment reform (such as a public option, or an invigorated Independent Medicare Advisory Council (IMAC)) while obtaining only ‘pilot projects’ on the important issues of antitrust and liability.

The President has issued the following directive:

In 1999, the Congress authorized the Agency for Healthcare Research and

Quality, which is located within the Department of Health and Human Services, to support demonstration projects and to evaluate the effectiveness of projects regarding all aspects of health care, including medical liability. I hereby request that you announce, within 30 days of this memorandum, that the Department will make available demonstration grants to States, localities, and health systems for the development, implementation, and evaluation of alternatives to our current medical liability system, consistent with the goals and core commitments outlined above.

The (much-ballyhooed) Congressional Budget Office (CBO) has projected the budget impact of health care reform at 3.5% of total health care spending in the 10-year period following implementation of HR 3200. The same non-partisan CBO issued a report on medical liability in January 2004! They examined the experience of the 40 states that employed restrictions on malpractice awards such as caps on non-economic damages, limiting attorney fees, reducing the statute of limitations, etc. The report observed “evidence from the states indicates that premiums for malpractice insurance are lower when tort liability is restricted than they would be otherwise.”

The report stated that malpractice cost represents 2% of health care spending, before accounting for the behavioral impact of ‘defensive medicine.’ On ‘defensive medicine,’ the CBO acknowledges the reduction in spending cited by Kessler and McClellan in 1996 on acute MI and ischemic heart disease in states with tort reform. But then the CBO becomes fixated in that their own application of McClellan’s methods to a broader set of ailments failed to demonstrate this reduction. (Hint - could it be that some ailments are just better suited to the benefits of liability reform - after all, the liability companies themselves have long identified specialty specific differences in the liability risk.)

(Continued on pg 8)
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The report concluded (tragically) that available evidence does not make a strong case that restricting medical liability would have a significant impact on economic efficiency (value to society for the health care dollar). My response:

- To those who would rely on the conclusion of the CBO’s 2004 report – if you reform liability (2% of spending, before calculating the cost of defensive medicine) you are more than one half of the way to health care reform (3.5%)!
- Shame on you if you are the legislator whose own inability to reform medical liability results in inadequate health care reform, when the money is within reach.

The effect of liability reform, especially caps on non-economic damages, has been well demonstrated. Why engage in a pilot project at this time?
Don’t allow the politicians to kick the can down the road. I would urge physicians and like-minded legislators that this is the time for reform and not for projects.

COUNCILOR’S PAGE:
Charles Rothberg, M.D.
(continued from pg 7)
A MESSAGE FROM YOUR EXECUTIVE DIRECTOR
Stuart S. Friedman, MPS

The health care reform debate in Washington is continuing at a very rapid pace. It is clear that the status quo is unacceptable. We cannot let health care reform be crafted in a manner that suits our political adversaries. The voices of the medical profession must be communicated loud and clear. Physicians must remain united in achieving the ultimate goal of providing the best quality health care for all patients. As Stephen Coccaro, MD, Suffolk County Medical Society president has stated, “the medical profession has positioned itself to influence the process of change.” Meaningful input has already been provided which is believed to have resulted in President Obama acknowledging that “defensive medicine has contributed to unnecessary costs.” As you are aware, the President has directed HHS Secretary Sebelius to move forward on initiatives that would test medical liability reform pilot projects in different states. Everyday physicians across the country are forced to consider the broken medical liability system when making medical decisions, resulting in defensive medicine which adds to unnecessary and increased health costs. While it unfortunately does not appear that caps on non economic damages will be part of the discussion, and that the President’s directive is not exactly what we were hoping for, we are encouraged that there finally is recognition that the medical liability system is broken and needs immediate address.

We must concentrate our efforts on assuring that the flawed SGR (sustainable growth rate) formula used to reimburse Medicare providers be eliminated and replaced with a more equitable and reasonable methodology, in addition to dramatically curtailing the excess profiteering by the health insurance industry at the expense of patients and providers. Additionally, there must be a level playing field to allow physicians to collectively negotiate with health insurance carriers.

Rest assured, your interests and those of your patients are being conveyed throughout the legislative process taking place. Regardless of your political party affiliation, the ultimate goal is to ensure that the final bill improves the health care system for patients and all the dedicated physicians who care for them on a daily basis.

By now, you should have all received your 2010 dues statement for the Suffolk County Medical Society and the Medical Society of the State. Thank you for your past dedication and continued support. We urge you to please renew as promptly as possible. This past year we were able to achieve major victories for physicians throughout New York State as outlined on the front cover. These achievements have saved each physician in New York State thousands of dollars. However, far more remains to be done. Your ongoing support is more crucial than ever because of the recent economic downturn which has exacerbated efforts by government to severely constrain the cost of health care.

Every physician in the State must realize that as organizations, like the county and state societies lose members, they gradually lose that political influence and clout which they enjoy in Albany and Washington. Their (our) ability to effectuate meaningful change will be eventually diminish to the point where we become irrelevant. If you think things are bad now, imagine how much worse they could be if the medical societies were not there to fight on your behalf and behalf of all of your patients. A point of fact is that our membership numbers are declining. Physicians are getting older, retiring and dying. If new members do not join or current members stop paying dues, all the successes previously cited will disappear. What will that mean for physicians in Suffolk County? Will you be able to continue to stay in practice? While it is true that we have not yet been successful in obtaining true medical liability reform, we have been able to head off many bills that would have definitely made things a whole lot worse for you.

I implore every member to continue to pay dues and to encourage your nonmember colleagues to join you. The trial lawyers, health insurance companies, and non physician providers all support their advocacy organizations. Physicians must do the same! TOGETHER WE MAKE A DIFFERENCE!
Suffolk County has a long, proud history of tobacco control efforts. We were among the first jurisdictions in the United States to limit the number and type of public places where smoking is allowed. In retrospect, groundbreaking legislation which prohibited smoking in only half of workplace lunchrooms or only in portions of restaurants did little to protect public health. As the science progressed and the dangers of exposure to Environmental Tobacco Smoke (ETS) became better documented, however, so did the commitment of public health professionals and elected officials to protect the health of Suffolk’s residents. In fact, Suffolk proposed progressive Clean Indoor Air laws which prohibited smoking in workplaces, including restaurants (with a phase-in period for bars), before New York State enacted its landmark legislation in 2003.

Suffolk County’s Health Commissioners have a long history of recognizing that smoking is more than just a matter of choice. The addiction to nicotine has been shown to rival addictions to cocaine and heroin. While laws restricting tobacco use were being implemented, the Suffolk County Department of Health Services responded by providing tobacco cessation classes for residents eager to break their addiction. Beginning in the 1980’s, cessation classes were scheduled in communities throughout Suffolk. As restrictions in health department facilities tightened even more than public places, we also offered cessation for our own employees. Programs were usually poorly attended, however, with most smokers thinking they could quit “cold turkey.” We now know that without support, behavior modification and/or pharmaceutical intervention, the success rate for quitting long term is going to be very low, less than 10 percent.

In the late 1990s, a Master Settlement Agreement was reached between 46 states and the tobacco industry. The tobacco industry agreed to reimburse these states for Medicaid expenditures used to treat tobacco-related diseases. Payments to states are expected to amount to $246 billion over the first 25 years of the settlement. Suffolk’s share through New York State has fluctuated between $19 million and $25 million per year.

During the early years of the settlement, Suffolk County elected officials budgeted 20 percent of the settlement dollars to a comprehensive tobacco control program. That figure was based on the Centers for Disease Control and Prevention’s projection of allocations needed to reduce tobacco use in its Best Practice’s document.

Using the CDC’s recommendations, the Department of Health Services developed the Learn to Be...Tobacco Free program, which included all elements shown to reduce tobacco use and prevent initiation among children. One of the major components of the program was the creation of a special unit of personnel dedicated to tobacco cessation. Modeled on a combination of successful cessation programs and incorporating a medical protocol, the redesigned cessation program was launched in 2000. Six-week classes met weekly and were set up throughout the County. Education, behavior modification and individual quit plans are the major elements of this comprehensive program. A nurse practitioner assesses and counsels each participant who chooses pharmaceutical intervention, which is usually chosen by an overwhelming majority of clients. In order to be considered medically eligible for pharmaceuticals, each participant’s primary care provider must also consent to the treatment. Medications are prescribed and dispensed at classes and by appointment in our offices.

At the very beginning, demand for the program was higher than could be met by staff. During the first few years, wait times to attend a class were often 3 or 4 months but have since improved. As of this date, more than 14,000 residents have joined a cessation class. The retention rate of those who successfully completed the program is more than 70 percent, higher than is seen by other programs around the country. Demand is now waning as the rate of tobacco use continues to drop dramatically.

The majority of classes are held at libraries, hospitals and the Department’s own community health centers. Classes are also scheduled at worksites to accommodate large numbers of employees who smoke or a work force for which transportation is a problem.

Last year, the office began offering support groups for those who completed the program. Relapse rates for smoking are traditionally very high so support programs help those who have quit to remain smoke-free and encourages those who have relapsed to try again.

For the first time, community assessment documents periodically required by New York State’s Department of Health - a Community Health Assessment, prepared by local health departments, and a Community Service Plan, prepared by each hospital - are both due at the same time, September 2009. We have used this unique opportunity to work together on our plans to improve the health of as many of Suffolk’s residents as possible. Tobacco cessation was chosen as one of two efforts in this collaboration and its working group was chaired by the department’s Director of Health Education and comprised hospital representatives and community based organizations involved in tobacco control. The group developed a template for hospitals to use in setting a tobacco control policy that included a timeline for implementation of a smoke-free campus, helping staff and patients become smoke-free and providing community based programs. The group plans to meet on a regular basis to continue the important groundwork laid thus far.

Our work is not yet finished. Suffolk continues to be a leader in setting policy and providing services designed to help residents live smoke-free and to protect them from exposure to ETS. As proof, one need only look at pending legislation in the County banning the use of e-cigarettes in all areas where smoking is prohibited. E-cigarettes are a relatively new product and are being marketed to smokers by some retailers as a replacement for cigarettes that can be used where smoking is banned. This is just one example of how quickly this County responds to any potential threat to public health.

For more information about the Department’s cessation programs, please call Lori Benincasa at 853-3015.
Dear New Yorker,

Governor David A. Paterson urged health care providers to pre-register to receive the novel H1N1 vaccine for their patients. In just two weeks the federal Centers for Disease Control and Prevention (CDC) is expected to begin shipping this vaccine to states. We want to make sure that health care providers in New York State are set up to receive the vaccine so that it can reach high-priority patients as soon as possible,” said Governor Paterson.

Governor Paterson noted that the State Department of Health (DOH) is coordinating the distribution of novel H1N1 flu vaccine in New York State, with the assistance of county health departments. Health care providers who want to provide vaccine for their patients must pre-register now on the DOH website.

DOH recently provided instructions to pediatric and adult health care providers outside of New York City on how to register to receive the novel H1N1 vaccine, and such providers can find more information on DOH’s website at www.nyhealth.gov. Health care providers within New York City should contact the New York City Department of Health and Mental Hygiene for instructions on how to receive the vaccine.

Governor Paterson urged all New Yorkers to get vaccinated now for seasonal flu and urged high-risk priority groups to be first in line to get the new H1N1 flu vaccine when it becomes available. “With the reopening of colleges and public schools, more people are spending time indoors in close quarters,” said Governor Paterson. “Not surprisingly, we are beginning to receive reports of flu outbreaks in colleges as well as individual cases in communities. I encourage all New Yorkers to get their seasonal influenza shot now. Individuals in high-risk priority groups should also make plans to get the new H1N1 vaccine as soon as it is available.”

The priority groups established by the CDC include pregnant women, health care workers, caregivers and household contacts of infants less than six months of age, children and young people between six months and 24 years of age, and individuals between the ages 25 of 64 who have underlying medical conditions. As more vaccine becomes available, other New Yorkers will be able to get vaccinated. The vaccine will be distributed through many community sites across the State.

Earlier this week, the federal Food and Drug Administration (FDA) approved four novel H1N1 vaccines that will be distributed nationally. The FDA also reported that, based on clinical studies, it is likely that adults will only need one dose of the vaccine.

According to the CDC, limited supplies of novel H1N1 vaccine may be available in the first week of October, one week earlier than expected. Approximately 45 million additional doses will then become available in mid-October, followed by more shipments each week. New York State expects to receive 6 to 7 percent of the total national vaccine supply, based on population.

“We must do everything within our power to ensure the health and well-being of our families,” said Governor Paterson. “As we enter the influenza season, New Yorkers can be confident that their government is working around the clock to limit the impact of novel H1N1 flu to the greatest degree possible. Over the last several months, State agencies have been working to develop comprehensive plans to minimize the effects of the virus and they are implementing these plans now.”

To help New Yorkers obtain the most up-to-date information on novel H1N1 flu, DOH will post weekly updates on its website at www.nyhealth.gov. DOH recently posted many new educational resources on novel H1N1 flu on this site, including advice for students and parents, family caregivers, individuals at high risk for complications from the flu, employers, health care providers and others.

DOH has also launched a new mass media campaign to encourage the public’s participation in slowing the spread of the flu. On September 13, a 60-second radio Public Service Announcement (PSA) began airing on radio stations. A 30-second TV PSA will begin airing shortly. The PSAs can be downloaded from the DOH website. Each of us plays an important role in reducing the spread of the flu,” said Governor Paterson. “I urge all New Yorkers to follow the common-sense measures we have recommended in order to stay healthy.”

These measures include:
- Getting the seasonal flu vaccine now.
- Getting the novel H1N1 vaccine when it becomes available to you, according to the priority groups established by CDC.
- Washing hands often with soap and water or using alcohol-based hand sanitizers when you aren’t near a sink.
- Avoiding close contact with people who are ill.
- Staying home from work or school when sick.
- Coughing and sneezing into a tissue or your sleeve, not your hands.

Keeping hands away from your eyes, nose and mouth. More information about seasonal and novel H1N1 influenza is available on DOH’s website at www.nyhealth.gov. The Governor’s Office of Public Health http://www.cc.state.ny.us/view.cfm?view=D30023B6-A4E0-F071-D62F620F95281A67_C4327761-F8B6-728D-A4D9D603CAE03535
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AMA Issues New Codes for H1N1 Vaccinations

With both seasonal influenza and H1N1 influenza circulating this flu season, the American Medical Association has expedited the publication of new health care codes specific to the H1N1 vaccine product.

The new Category I Current Procedural Terminology (CPT) codes issued by the AMA will streamline the reporting and reimbursement procedure for physicians and health care providers who are expected to administer nearly 200 million doses of the H1N1 vaccine in the United States. In consultation with the U.S. Department of Health and Human Services, the AMA CPT Editorial Panel created code 90470 to report H1N1 immunization administration and counseling. Code 90663 was revised by the CPT Editorial Panel to refer specifically to the H1N1 vaccine product. Both, revised code 90663 and 90470 are effective immediately.

For quick reference, the two codes are below:

90470 -- H1N1 immunization administration (intramuscular, intranasal), including counseling when performed
90663 -- Influenza virus vaccine, pandemic formulation, H1N1

New Regulations on Breaches of Security Involving Medical Information

New regulations requiring health care professionals, health plans, and other entities covered by the Health Insurance Portability and Accountability Act (HIPAA) to notify individuals when their health information is breached were issued by the U.S. Department of Health and Human Services (HHS). The regulations went into effect September 23, 2009.

The regulations, developed by the HHS Office for Civil Rights (OCR), require health care professionals and other HIPAA covered entities to promptly notify affected individuals of a breach, as well as the HHS Secretary and the media in cases where a breach affects more than 500 individuals. Breaches affecting fewer than 500 individuals will be reported to the HHS Secretary on an annual basis. The regulations also require business associates of covered entities to notify the covered entity of breaches at or by the business associate.

The regulations were developed after considering public comment received in response to an April 2009 request for information and after close consultation with the Federal Trade Commission (FTC), which has issued companion breach notification regulations that apply to vendors of personal health records and certain others not covered by HIPAA.

To determine when information is “unsecured” and notification is required by the HHS and FTC rules, HHS is also issuing in the same document as the regulations an update to its guidance specifying encryption and destruction as the technologies and methodologies that render protected health information unusable, unreadable, or indecipherable to unauthorized individuals. Entities subject to the HHS and FTC regulations that secure health information as specified by the guidance through encryption or destruction are relieved from having to notify in the event of a breach of such information.

For more information, visit the HHS Office for Civil Rights web site at http://www.hhs.gov/ocr/hipaa/

Free Voluntary Fraud and Abuse Compliance Program

For many years, the OIG of HHS has recommended that medical practices adopt Fraud and Abuse Compliance Programs. The programs are “voluntary,” but there are advantages to put these programs in place. A Compliance Program, if carried out in the ordinary course of business, can demonstrate a good faith effort. It can reduce the possibility that HHS can find a practice to be guilty of “intentional wrongdoing” or “reckless disregard.” A medical practice can be made to pay refunds if it bills improperly, even if in error. However, there can be far more serious penalties if the government can demonstrate that a medical practice is guilty of intentional wrongdoing or that it intentionally was ignorant of the laws. By having a Fraud and Abuse Compliance Program in place, a medical practice may be able to demonstrate that it made a good faith effort to comply with fraud and abuse laws. Among the elements of a fraud and abuse compliance program:

- Articulate a standard that members of the medical group and employees are expected to abide by accepted standards of conduct, to be honest, and to comply with fraud and abuse laws.
- Articulate procedures of the compliance plan; employee training; discipline of employees who violate compliance plan;
- Periodic monitoring and auditing; screening of employees; and a
- Compliance officer who is trained in issues of fraud and abuse.

Again a compliance program is “voluntary.” The benefit is that it may document the efforts to comply. This can reduce penalties, and convince the government not to charge a medical practice with “intentional wrongdoing” or “willful neglect.” The Centers for Medicare and Medicaid’s (CMS) web-based training module on Fraud and Abuse can be accessed by going to the following website http://www.cms.hhs.gov/MLNGenInfo. Once on the page, scroll down Related Links Inside CMS and click on Web Based Training (WBT) Modules. When this page comes up, you will see a box in the lower left-hand side of the screen. Scroll down to the item titled Medicare Fraud and Abuse – April 2007. This is CMS’ training module for F&A, it is 85 minutes in duration, it is provided for free, it provides 1.5 Continuing Education Units (CEUs) by the American Academy of Professional Coders, it can be taken by various members of the practices’ staff and it will provide a CMS certificate upon completion of the web-based course.
If you have not heard of “Diversified Collection Services” (“DCS”) of Livermore, California by now, you will over the next few months. DCS is the Medicare Recovery Auditor Contractor (affectionately called the “RAC”) for New York State. Heretofore, Providers were audited by the fiscal intermediary or some governmental agency “just doing their job.” Now, the RAC brings Providers “audits on steroids.” This is primarily due to the RAC getting a 12.45% contingency commission for each dollar of overpayment as well as underpayment it finds. This being the case, claims will be thoroughly scrutinized.

Taking you on an inside tour of RAC, you will note that there are two types of RAC reviews: one automated and the other complex. The automated review consists of desk review of claims while the complex review requires the Provider to submit medical records to the RAC. Fortunately, the RAC does have some limitations:

1. The RAC can only go back to claims paid on or after October 1, 2007.
2. The RAC “look back period” is limited to 3 years from the date the claim was filed.
3. The RACs are also limited in the number of charts they can request from physicians.

For instance, a solo practitioner can be asked for 10 medical records each 45 day period per NPI number. While a larger practice (16 or more) are required to submit not more than 50 medical records per 45 day period per NPI. Additionally, the RACs will accept digital medical records which will definitely cut down on the cost of producing required records.

One of the benefits of the RAC contingency fee for the Provider is that if the RAC looses any of its findings at any Provider appeal level, the RAC must return its contingency fee to CMS. Therefore, the RAC will want to be “sure of its findings.” To this end, the RAC will offer the Provider an opportunity to discuss the alleged improper finding with the RAC auditors. (This opportunity is not extended in traditional Medicare audits). This being the case when a Provider has a strong argument to make to the RAC, it should be presented formally in coordination with the Provider’s counsel.

The Provider should realize that they do not get selected for a RAC audit as a matter of pure “routine”. DCS does not have unlimited resources and it will have to be selective to whom it audits if it intends to earn a profit. Thus, you can bet that when you get a RAC audit letter there is some “evidence” that you are over billing. This “evidence” is generally that you are exceeding your peer group average in the billing at a particular CPT code.

Bolstered by the success of the RAC pilot program, CMS had established a similar team to audit Medicaid claims. The Medicaid Integrity Contractors (MIC) will enter an area that was traditionally left to the State’s Medicaid Fraud Control Units. The MICs are part of the Medicaid Integrity Program and will bolster State recovery efforts. MICs come in three “flavors” – Review – Audit – Educate. The “Review MIC” will review Providers’ billing records and select targets for detailed audit by the “Audit MIC.” The Provider’s record will be reviewed and looking for overpayments. These overpayments may not be solely in the area of fraud but will concentrate on abusive practices as well. The Education MIC will address Providers on program integrity and quality of care issues.

You should also remember that RACs and MICs must send their findings over to the OIG/FBI for investigation when they find evidence of potential criminal (intentional) conduct. To guard against this event and possible targeting by these new entities, a prudent Provider should take the following action:

1. Check to see what claims are being denied. Is there a pattern? If so, ascertain what is causing the claims to be rejected.
2. Do you have a billing staff chief who knows what he or she is doing?
3. Do you send that person to training courses? Is that person up on the latest CPT codes?
4. Do you engage in internal self-audit by employing a certified coding professional to come in and do a spot check of your billings?
5. Do you have a compliance program?
6. Do you keep up with the latest action being taken by the Office of Inspector General?

Most Providers do not set out to steal from Medicare/Medicaid; rather Providers are not aware of or just simply ignore the Medicare/Medicaid billing rules. For instance:

- If you bill for a “consult,” do you have a referral from a PCP and do you send out a report?
- If you bill for critical care medicine, do you document the time spent with the patient?
- Does the chart support a level 5 E/M? In short, it is better to get your house in order than have a RAC or a MIC do it for you.
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SAVINGS TIPS FOR YOUR EXISTING LIFE INSURANCE PORTFOLIO

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These dramatic savings have occurred due to intensive competition in the insurance industry. The following summarizes some of these changes:

1) Dramatic Savings On Term Insurance Rates:

   The most aggressive savings have taken place in the term insurance arena. In many cases, older term policies that have been in existence for maybe 10 or 15 years can be replaced with plans that can sometimes save you 30% to 40% of the premium!!!!

   In addition to premium reductions, insurers now offer 5, 10, 15, 20, and even 30 year fixed premium term programs based upon the individual needs of the applicant.

   Savings Tip: Reapply for a cost reduction and simultaneously lock in a fixed term premium period, based upon your business or personal needs.

2) Guaranteed Universal Insurance Programs:

   These insurance programs differ from their predecessors in that they offer guaranteed death benefits for a given period and premium. Unlike term insurance, they can be guaranteed for your entire life. The unforeseen variables of a reduction in interest rates or an increase in company operating costs that ultimately affects future premiums and death benefits can be completely eliminated.

   Savings Tip: Check to see if your permanent insurance programs include a guaranteed death benefit by calling your insurer and asking for a “guaranteed illustration.” Review the illustration with an insurance professional to determine your options.

3) Savings For New Classifications of Insureds:

   Most insurers have generously discounted the premiums of many policies for those applicants who are in excellent health. Even for those who are not in the best of shape, insurance rates due to reductions in mortality experience costs and operating expenses, have also declined. However, these savings would not apply to someone whose health has deteriorated significantly and is considered uninsurable.

   Savings Tip: If you’ve lost weight, stopped smoking, your health has improved or even stayed the same from when you previously purchased your insurance plan, this might be the time to reapply to obtain a cost reduction in your insurance program.

Additional Savings Tips:

   a. Never drop existing coverage until new coverage is obtained and bound.

   b. Take your time in evaluating which plan makes the most sense for you and your business or family.

   c. Try to choose a plan that can be flexible to accommodate your changing needs. For example, selecting a 20-year term plan with a conversion feature allows you the option to retain the plan your entire life by conversion.

   d. Use the internet to obtain pricing and product information.

   e. Don’t “go it alone” – work with an insurance professional to help you make an informed and educated decision regarding your insurance options.

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SUFFOLK COUNTY MEDICAL SOCIETY MEMBERS IN THE NEWS

September 9, 2009 Newsday
Michael Fracchia, director of orthopedic surgery at John T. Mather Memorial Hospital in Port Jefferson, will receive its Theodore Roosevelt Award for contributions to the hospital community. Fracchia, of Belle Terre, is also the director of surgical education for Pennsylvania-based Aesculap Implant Systems and has contributed to the design of joint replacement implants. He is a member of the Suffolk County Medical Society and is the county delegate to the New York State Society of Orthopedic Surgeons.

September 9, 2009 By MERLE ENGLISH. Special to Newsday
More than 2,200 pounds of equipment have been shipped and another 3,200 pounds were being put in the luggage of 64 Long Island professionals who planned to fly to Nicaragua to give free medical care to many of that country's poor.

Physicians, nurses, gynecologists, plastic surgeons and other specialists will set up a clinic at Gaspar de Silvio Hospital in Rivas, a city of some 40,000 people.

The hospital has screened 400 children and adults to receive treatment for cleft lip and palate, burns, fused fingers, hernia, gastrointestinal conditions and other problems.

"We get there Saturday night, and we'll be operating by 2 o'clock Sunday," said Galo Burbano of Manorville, chief nurse anesthetist at Long Island Anesthesia in Rocky Point, who is leading the group.

It includes about 20 doctors from St. Charles Hospital and John T. Mather Memorial Hospital, both in Port Jefferson; Stony Brook University Hospital; Brookhaven Memorial Hospital Medical Center in East Patchogue; and Eastern Long Island Hospital in Greenport. They will be joined by six doctors from off the Island, and other medical staff.

All are volunteers offering their services through Blanca's House, an organization named for his mother that Burbano, 46, founded in 2007 to serve sick people in developing countries who can't afford medical care.

Initially intended to give back to Ecuador, Burbano's homeland, Blanca's House grew out of trips to Guayaquil and other cities in Ecuador that Burbano and other Long Island medical volunteers made from 2006 to 2008 with Healing the Children, an international, medical volunteer organization.

On three visits to one of the cities, Babahoyo, Blanca's House staffed a seven-story clinic donated by Babahoyo native Dr. Rafael Hernandez, a physician at Franklin Hospital Medical Center in Valley Stream.

Participants are motivated by their patients' "endless expressions of gratitude and warm and loving appreciation," according to Sheila Casamassima of Port Jefferson Station, a surgical coordinator for Suffolk Plastic Surgeons.

Dr. Stephen Coccaro, chief of plastic surgery at St. Charles, has "wanted to do something for people less fortunate" since medical school. "Besides working with a great team, there's nothing like having a kid that couldn't feed because of a cleft lip, and after an hour's operation he can eat," said Coccaro, a co-founder of Blanca's House.

The contingent bound for Nicaragua for a week is the organization's biggest so far. About 50 volunteers make the Ecuador trips. Each pays $1,200 for the week- to 10-day stays. Working 12- to 14-hour days, they serve about 300 people each time.

"Everybody helps. Everybody's amazing," Burbano said.

Blanca's House relies on donations of supplies from hospitals, drug companies, corporations and individuals. "Everything you could use in a hospital, we get," Burbano said. Donated toys and clothing make up care packages for schools. Fundraisers and gifts help to buy medications and cover the $1,500 monthly administration cost. The group can be reached at P.O. Box 363, Hicksville, N.Y. 11802-0362.

At the heart of the operation is Burbano, who was born in Guayaquil and came to the United States with his parents when he was 8.

He said he didn't understand the concept of giving when his mother would "feed 16 people at dinner, give them jobs and help them with immigration papers. I was often butting heads with her."

Were his mother alive, "I think she'd be tickled pink," Burbano said, "because I'm doing all the things I told her not to do."
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- 100% of people with Medicare have access to a MA plan with maximum out-of-pocket cost limit less than or equal to $3,400
- 18 PDPs have $0 deductibles
- $19.50 is the lowest monthly premium for a PDP
- $67.20 is the lowest monthly premium for a PDP with any generic coverage in the Coverage Gap
- 11 PDPs have a premium of $0 for people who qualify for Extra Help

Plan costs and coverage change each year, so all people with Medicare should check to make sure their plan still meets their needs and budget. There may be a Medicare health or drug plan available with better coverage or a lower deductible in 2010.

Important Dates in 2010

October
- Watch your mail for notices from Medicare, Social Security, and health and drug plans with information about changes in 2010
- Compare plans online at www.medicare.gov starting October 15

November
- “Medicare & You” 2010 arrives in your mail
- Open Enrollment starts November 15

December
- Open Enrollment ends December 31

ALL PEOPLE WITH MEDICARE SHOULD:
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This versatile building has two wings that are zoned separately for heating and CAC. They can be used as independent offices for two practices or as one larger office. The first floor features an attractive waiting room with a sloped ceiling and high hats. The windowed reception area has easy access to the file room. Each wing contains a consult room, three exam rooms and a large handicap equipped bathroom. One wing features a large room currently being used as a lab. This room could be subdivided into two more exam rooms.

The second floor has a private entrance and is separately zoned for heat and air conditioning. The second floor includes two rooms, a cedar closet, and a full bathroom. This can also be used as an income producing apartment.

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