Fall 2017

The CADUCEUS

Dutchess County Medical Society ● PO Box 496 Rhinebeck, NY 12572 ● 845-452-2140

Dr. Yogita Kashyap Joins Poughkeepsie Plastic Surgery Practice

Yogita Kashyap, M.D., a Manhattan oculofacial plastic surgeon specializing exclusively in cosmetic and reconstructive proce- dures of the eyes, eyelids, and surrounding structures, has joined facial plastic surgeon Dr. Manoj T. Abraham's Poughkeepsie practice Facial Plastic Reconstructive & Laser Surgery, PLLC and Oasis Medispa. Dr. Kashyap is a Board Certified Diplomat of the American Board of Ophthalmology. She completed her Ophthalmology residency training at The New York Eye and Ear Infirmary and then went on to an advanced fellowship in Oculoplastic & Reconstructive Surgery at The New York Eye and Ear Infirmary of Mount Sinai (NYEE).She received her undergraduate degree from the University of Pennsylvania. While a fellow at NYEE, Dr. Kashyap served as clinical instructor to ophthalmology and plastic surgery residents as well as visiting medical students. She also teaches oculofacial plastic surgery as needed in the operating room and clinic to ophthalmology residents at Montefiore Residency Programs. Dr. Kashyap attends numerous conferences each year to stay abreast of the latest cosmetic techniques and products.

Dr. Kashyap is an active member of the American Academy of Ophthalmology, New York State Ophthalmologic Society and Women in Ophthalmology. Dr. Kashyap has presented at the annual meetings of the American Academy of Ophthalmology. She also volunteers annually with the Volunteer Health Program at the Institute for Latin American Concern (ILAC) in Santiago, Dominican Republic, performing oculoplastic and reconstructive procedures for the underserved.

Dr. Kashyap joins a world class team at Facial Plastic Reconstructive & Laser Surgery and Oasis Medispa, which now represents a full complement of plastic surgery specialties (facial, body and now eye) as well as a full-service medispa. This includes aestheticians, massage therapists, physician assistant Ryan Young PA-C; Manhattan body surgeon Dr. Dana Khuthaila MD FRCSC FACS who specializes in breast and body contour- ing; Dr. Michael Bassiri, who specializes exclusively in cosmetic and reconstructive procedures of the nose, face and neck; and owner facial plastic surgeon Dr. Manoj T. Abraham MD FACS, who is regularly listed by Castle Connolly and named to Hudson Valley Magazine's 2016 Top Doctor's List.

In This Issue…….. **PAGE**

Annual Meeting and Program

Wednesday, September 20, 2017

The Grandview

176 Rinaldi Blvd.
Poughkeepsie, NY 12601
(845) 486-4700

6:00 – 7:00 pm
Networking Reception

7:00 pm
Formal Dinner/Dancing
Installation of 2017-2019 Medical Society Officers

Special Recognition:

50 Year Citation Award[/-\=;
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Bits & Pieces

Ulster Financial Payroll Processing is Available at 20% Discount To Members

Ulster Financial Payroll, a subsidiary of Ulster Savings Bank, is offering a 20% discount on payroll processing services to all Dutchess County Medical Society members. This service is available to all size practices. If you currently subscribe to the service, the discount is still available to you, as long as you do not already have an Ulster Financial Payroll discount. If you would like to subscribe to Ulster Financial Payroll, call the Dutchess County Medical Society at 845-452-2140 for more information.

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NYS Department of Health's Bureau of Narcotics Enforcement Provides FAQs for Mandatory Prescriber Education

The New York State Department of Health's Bureau of Narcotic Enforcement has released an Frequently Asked Questions (FAQs) for the required attestation for the mandatory three hours of continuing medical education requirement. This educational requirement, issued under Public Health Law, required prescribers licensed under Title Eight of the Education Law, who hold a DEA license, to take three hours of CME in pain management, palliative care and addiction by July 1, 2017 and every three years after that.

The three-hour course work or training must include the following eight New York State statutory requirements: New York State and federal requirements for prescribing controlled substances; pain management; appropriate prescribing; managing acute pain, palliative medicine; prevention, screening and signs of addiction; responses to abuse and addiction; and end-of-life care. The NYS Department of Health's Bureau of Narcotics Enforcement has listed the Medical Society of the State of New York is listed as an accrediting organization to provide the Pain Management, Palliative Care and Addiction course.

Attestation Process

Prescribers must attest to the completion of a minimum three hours of course work or training in all eight topic areas.

The FAQs indicated that a prescriber with a Health Commerce System (HCS) account will attest online using the Narcotic Education Attestation Tracker (NEAT) application. Prescribers should only attest after completion of at least three hours of course work or training covering all eight topics. The prescriber will not receive a notice or certification upon submission of the attestation. Prescribers may perform a screen print or track their attestation within the NEAT applications. Prescribers are required to keep documentation of completion of their course working for a minimum of six years for audit purposes.

There will be a separate written instruction document for accessing NEAT on the BNE web page. The attestation documentation should be available in the first part of April. BNE's webpage is https://www.health.ny.gov/professionals/narcotic.

Prescribers without an HCS account may obtain one by clicking **here**.

Prescribers that do not have access to a computer can request a paper attestation form by calling the Bureau of Narcotic Enforcement (BNE) toll-free at 1-866-811-7957. They may then complete the form and return it by mail to the address provided on the form.

Exemption Process

In certain limited circumstances the Department of Health may grant exemptions to the required course work to individual prescribers who clearly demonstrate to DOH that there is no need to complete such training. According to the FAQs, exemptions will not be based solely upon economic hardship, technological limitation, prescribing volume, practice area, specialty or board certification. There will be separate written instruction posted shortly on the BNE web page for this process.

ABN, Form CMS-R-131 Renewal

The Advance Beneficiary Notice of Non-coverage (ABN), Form CMS-R-131, and form instructions have been approved by the Office of Management and Budget (OMB) for renewal. While there are no changes to the form itself, providers should take note of the newly incorporated expiration date. The effective date for use of this ABN form is 60 days from this announcement. More information on the ABN and the ABN form instructions can be found at:

FFS ABN - Centers for Medicare & Medicaid Services

DR LAW - Kern Augustine Article

Efforts to Reduce Opioid Addiction are on the Rise

Question: What is the current response to the Opioid Addiction Problem?

Answer: Opioid addiction, including the abuse of illegal drugs such as heroin and prescription pharmaceuticals, is drawing more attention on both the state and national levels. In New Jersey, Governor Christie has made numerous public comments about the severity of the problem, and limits on physicians' prescribing have been introduced. Recently, rumors have spread that President Trump is expected to appoint Christie to spearhead a Federal panel on opioid addiction during a meeting scheduled at the White House for March 29, 2017.

Current news reports now confirm these rumors, as it is being widely reported that the President has appointed Christie to head a special commission to advise the Executive Branch regarding what can, and should, be done to try to stem what has been described as a national opioid addiction epidemic. The Centers for Disease Control and Prevention ("CDC") report that, since 1999, the number of deaths involving opioids has quadrupled, and estimates that 91 Americans die each day as a result of opioid addiction. According to the CDC, between 2000 and 2015, 500,000 people died from drug overdoses, with the majority of these deaths due to opioids, and these deaths affect all socioeconomic groups.

The budget recently released by the Trump Administration calls for a $500 million increase above 2016 levels to fund drug treatment and expand opioid misuse prevention efforts. It remains to be seen exactly what form these efforts may take, but recent experience suggests that prescription drugs, and the physicians who prescribe them, will be a major focus of these efforts.

Weekly Charting Tip:

In an interaction with one of our readers, it became apparent that something needs to be stressed concerning EMR. Do not even think of "changing" your original record at a later date. Besides being fraudulent and unethical, any change can be easily tracked from the log of the computer program. The proper way of correcting a mistake or adding something that was left out, is via an addendum. The addendum should be clearly labeled as such and should be dated and e-signed on the date that the addendum is being added. Attempting to change a record in EMR is just plain foolish and dangerous! A word to the wise!

See you next time! - Larry Kobak, Esq. DPM

Justice Department Investigating Large Insurers for Medicare Fraud

Question: How is the Justice Department alleging that large insurers defrauded Medicare?

Answer: According to a *Reuters* report, the Justice Department is looking into claims that four health insurers – Health Net, Aetna, Cigna, and Humana – defrauded Medicare Advantage ("MA") by claiming that patients were treated for illnesses they either never had or were never treated for. A former United Health executive brought a False Claims Act whistleblower case against the insurers, which was filed under seal in 2011.

The lawsuit accuses the insurers of defrauding the United States of hundreds of millions – and likely billions – of dollars through claims for payments from the Medicare healthcare program for the elderly. The lawsuit centered on "risk adjustment" payments that Medicare makes to managed-care plans to offset the increased costs associated with treating patients with multiple or serious health conditions. The lawsuit claimed that, in seeking those payments, the insurers falsely claimed that patients were treated for diagnoses they did not have or were not treated for.

Under the False Claims Act, whistleblowers can sue companies on the government's behalf to recover taxpayer money paid out based on fraudulent claims. If successful, whistleblowers receive a percentage of the recovery. A government decision to intervene is typically a major boost to such cases. When it initially intervened in the case in February, the Justice Department said it was declining to pursue claims against other insurers named in the lawsuit besides UnitedHealth. But on Tuesday, the Justice Department filed a "corrected notice" of intervention, saying that, due to ongoing investigations of Health Net, Aetna, Bravo and Humana, it could not make a decision whether or not to proceed against them at this time.

Weekly Charting Tip:

In order to comply with three different federal laws, it is very important that you document the *fair market value (FMV)* and *commercial reasonableness* of the "arrangement" at issue. Fair Market Value is "the value in arm's length transactions, consistent with the general market value". In other words, if I were a stranger, and I wanted a similarly situated arrangement, what would it be worth? There are professional people who actually will prepare a FMV report for you. This is the safest way of doing it. What do rents go for in the same area for a similar amount of space? You can factor in closeness to public transportation, parking lots and the like. Commercial reasonableness encompasses both the series and payment for them. Is it reasonable to pay a neurologist say $300,000 for the 40 hours a week you are offering? That depends on the location and what is expected of the neurologist. Areas with many neurologists tend to offer less. Rural areas may offer more. Think supply and demand. If a deal is too good to be true, it probably is! Until next week. –Larry Kobak, Esq., LKobak@DrLaw.com

The AMA has been collecting a list of supporting organizations for the Prior Authorization and Utilization Management Reform Principles. DCMS will be among the list of supporters of these principles listed on the AMA website

Prior Authorization and Utilization Management Reform Principles

Patient-centered care has emerged as a major common goal across the health care industry. By empowering patients to play an active role in their care and assume a pivotal role in developing an individualized treatment plan to meet their health care needs, this care model can increase patients' satisfaction with provided services and ultimately improve treatment quality and outcomes.

Yet despite these clear advantages to adopting patient-centered care, health care providers and patients often face significant obstacles in putting this concept into practice. Utilization management programs, such as prior authorization and step therapy, can create significant barriers for patients by delaying the start or continuation of necessary treatment and negatively affecting patient health outcomes. The very manual, time-consuming processes used in these programs burden providers (physician practices, pharmacies and hospitals) and divert valuable resources away from direct patient care. However, health plans and benefit managers contend that utilization management programs are employed to control costs and ensure appropriate treatment.

Recognizing the investment that the health insurance industry will continue to place in these programs, a multi-stakeholder group representing patients, physicians, hospitals and pharmacists (see organizations listed in left column) has developed the following principles on utilization management programs to reduce the negative impact they have on patients, providers and the health care system. This group strongly urges health plans, benefit managers and any other party conducting utilization management ("utilization review entities"), as well as accreditation organizations, to apply the following principles to utilization management programs for both medical and pharmacy benefits. We believe adherence to these principles will ensure that patients have timely access to treatment and reduce administrative costs to the health care system.

Clinical Validity

Principle #1: Any utilization management program applied to a service, device or drug should be based on accurate and up-to-date clinical criteria and never cost alone. The referenced clinical information should be readily available to the prescribing/ordering provider and the public.

Principle #2: Utilization management programs should allow for flexibility, including the timely overriding of step therapy requirements and appeal of prior authorization denials.

Principle #3: Utilization review entities should offer an appeals system for their utilization management programs that allows a prescribing/ordering provider direct access, such as a toll-free number, to a provider of the same training and specialty/subspecialty for discussion of medical necessity issues.

Continuity of Care

Principle #4: Utilization review entities should offer a minimum of a 60-day grace period for any step- therapy or prior authorization protocols for patients who are already stabilized on a particular treatment upon enrollment in the plan. During this period, any medical treatment or drug regimen should not be interrupted while the utilization management requirements (e.g., prior authorization, step therapy overrides, formulary exceptions, etc.) are addressed.

Principle #5: A drug or medical service that is removed Many patients carefully review formularies and coverage restrictions prior to purchasing a health plan product in order to ensure they select coverage that best meets their medical and financial needs. Unanticipated changes to a formulary or coverage restriction throughout the plan year can negatively impact patients' access to needed medical care and unfairly reduce the value patients receive for their paid premiums.verage restrictions after the beneficiary enrollment period has ended should be covered without restrictions for the duration of the benefit year.

Principle #6: A prior authorization approval should be valid for the duration of the prescribed/ordered course of treatment.

Principle #7: No utilization review entity should require patients to repeat step therapy protocols or retry therapies failed under other benefit plans before qualifying for coverage of a current effective therapy.

Transparency and Fairness

Principle #8: Utilization review entities should publically disclose, in a searchable electronic format, patient-specific utilization management requirements, including prior authorization, step therapy, and formulary restrictions with patient cost-sharing information, applied to individual drugs and medical services. Such information should be accurate and current and include an effec-

tive date in order to be relied upon by providers and patients, including prospective patients engaged in the enrollment process. Additionally, utilization review entities should clearly communicate to prescribing/ordering providers what supporting documentation is needed to complete every prior authorization and step therapy override request

Principle #9: Utilization review entities should provide, and vendors should display, accurate, patient- specific, and up-to-date formularies that include prior authorization and step therapy requirements in electronic health record (EHR) systems for purposes that include e-prescribing.

Principle #10: Utilization review entities should make statistics regarding prior authorization approval and denial rates available on their website (or another publically available website) in a readily accessible format. The statistics shall include but are not limited to the following categories related to prior authorization requests:

1. Health care provider type/specialty; Medication, diagnostic test or procedure; Indication;
2. Total annual prior authorization requests, approvals and denials;
3. Reasons for denial such as, but not limited to, medical necessity or incomplete prior authorization submission; and
4. Denials overturned upon appeal.

These data should inform efforts to refine and improve utilization management programs.

Principle #11: Utilization review entities should provide detailed explanations for prior authorization or step therapy override denials, including an indication of any missing information. All utilization review denials should include the clinical rationale for the adverse determination (e.g., national medical specialty society guidelines, peer-reviewed clinical literature, etc.), provide the plan's covered alternative treatment and detail the provider's appeal rights.

Timely Access and Administrative Efficiency

Principle #12: A utilization review entity requiring health care providers to adhere to prior authorization protocols should accept and respond to prior authorization and step-therapy override requests exclusively through secure electronic transmissions using the standard electronic transactions for pharmacy and medical services benefits. Facsimile, proprietary payer web-based portals, telephone discussions and nonstandard electronic forms shall not be considered electronic transmissions.

Principle #13: Eligibility and all other medical policy coverage determinations should be performed as part of the prior authorization process. Patients and physicians should be able to rely on an authorization as a commitment to coverage and payment of the corresponding claim.

Principle #14: In order to allow sufficient time for care delivery, a utilization review entity should not revoke, limit, condition or restrict coverage for authorized care provided within 45 business days from the date authorization was received.

Principle #15: If a utilization review entity requires prior authorization for non-urgent care, the entity should make a determination and notify the provider within 48 hours of obtaining all necessary information. For urgent care, the determination should be made within 24 hours of obtaining all necessary information.

Principle #16: Should a provider determine the need for an expedited appeal, a decision on such an appeal should be communicated by the utilization review entity to the provider and patient within 24 hours. Providers and patients should be notified of decisions on all other appeals within 10 calendar days. All appeal decisions should be made by a provider who (a) is of the same specialty, and subspecialty, whenever possible, as the prescribing/ordering provider and (b) was not involved in the initial adverse determination.

Principle #17: Prior authorization should never be required for emergency care.

Principle #18: Utilization review entities are encouraged to standardize criteria across the industry to promote uniformity and reduce administrative burdens.

Alternatives and Exemptions

Principle #19: Health plans should restrict utilization management programs to "outlier" providers whose prescribing or ordering patterns differ significantly from their peers after adjusting for patient mix and other relevant factors.

Principle #20: Health plans should offer providers/practices at least one physician-driven, clinically based alternative to prior authorization, such as but not limited to "gold-card" or "preferred provider" programs or attestation of use of appropriate use criteria, clinical decision support systems or clinical pathways.

Principle #21: A provider that contracts with a health plan to participate in a financial risk-sharing payment plan should be exempt from prior authorization and step-therapy requirements for services covered under the plan's benefits.

To see source and related info, go to https://wire.ama-assn.org/ama-news/21-principles-reform-prior-authorization-requirements

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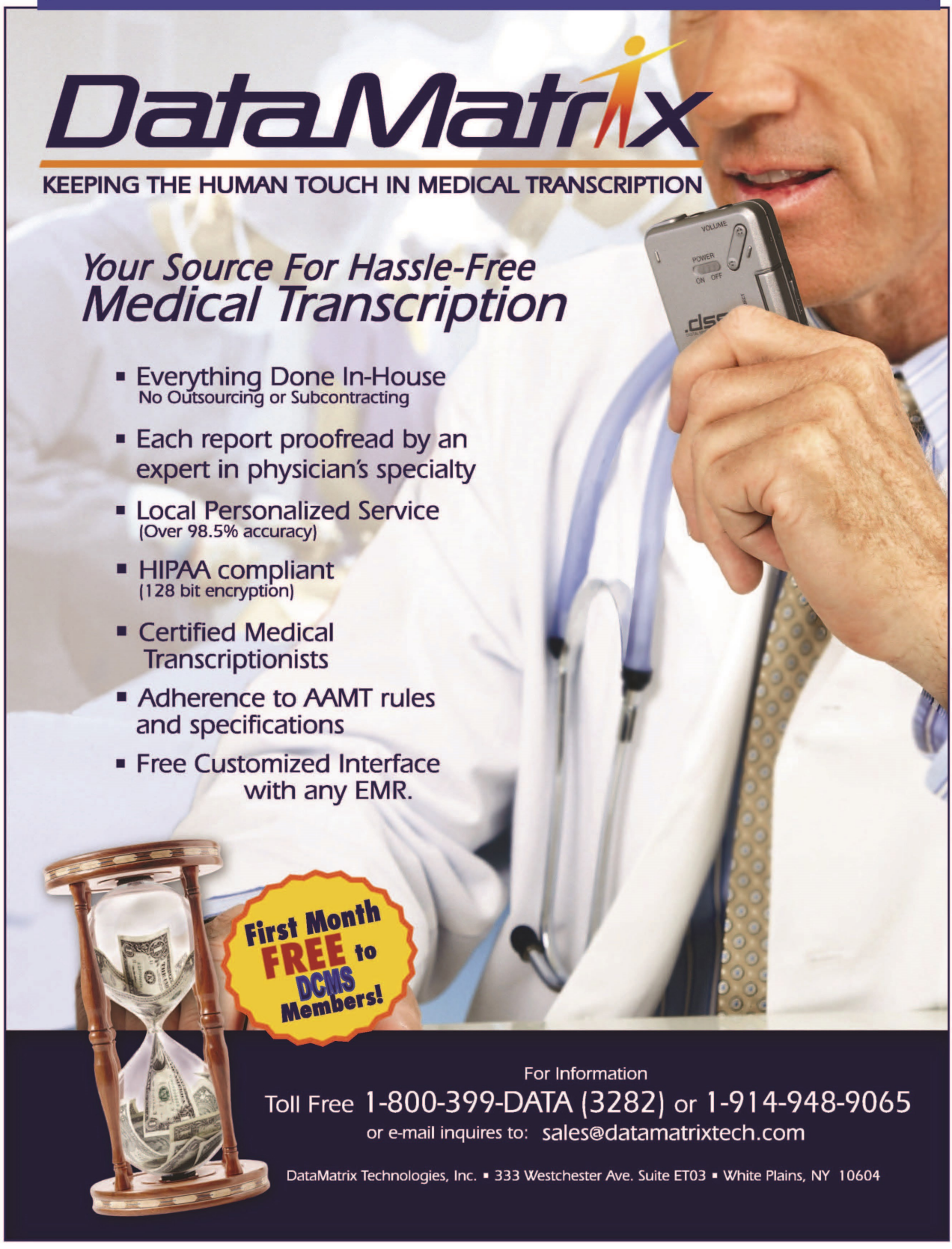

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