New York State Society of Pathologists Bi-Annual Report

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In this newsletter...

- Message from the President
- April 17, 2010 CME program
- New Members
- NYS Board of Medicine proposal
- Fee Schedules: a brief history and update
- NY State Liability Reform update
- A word from the editor

This issue marks the return of the NYSSPath after a year long absence. During that time much has happened, including the loss of our major source of income, a contract with Beckman that was tied to their quality control program. The relationship started many years ago, when interlaboratory comparisons were new and pathologists in New York were approached to manage the data reduction. These pathologists generously asked that any honorariums be given to the state pathology society.

With the loss of this money, the NYSSPath leadership must look at our expenses, which far exceed our income from annual dues, and make some adjustments in priorities. Currently, we give financial support to fellows and residents to the CAP's House of Delegates and Residents Forum, respectively, and to a delegate to the MSSNY HOD. We offer an excellent annual CME program free to members. And we work with the CAP in Albany to influence issues of concern to New York patients, laboratories, and pathologists.

In a cost cutting move, this newsletter will no longer be sent in paper form to our members. When new issues are placed on our website, we will notify members by email. Both members and non-members may ask for this email notification by emailing our administrative assistant, Barbara Birkeland, at blkbirk@att.net.

MESSAGE FROM THE PRESIDENT

David Crossland, MD

These days, it seems that everyone's attention is fixed on events in Washington, DC. This is understandable, but unfortunate, because vitally important health care debates are ongoing in nearly every statehouse across our nation. No where has this been more true than here in New York.

This past year, your state pathology society played an important role in changing the onerous lab tech licensure law to recognize histotechnologists. We also helped forestall potentially disastrous patient notification requirements for clinical labs. We enjoy a more effective voice in Albany than we have ever had, in large part because of our growing collaboration with CAP's outstanding state legislative affairs team.

But there have been setbacks: we fell one vote short in the NYS Senate on a bill that would have required out-of-state labs to compete on a more level playing field with in-state labs. Our membership as a percentage of NYS-licensed pathologists continues to dwindle. And our Society's contract with Beckman / Coulter Corporation — historically our principal source of revenue — has ended.

MESSAGE FROM THE PRESIDENT *(continued)*

This year, and in future years, NYSSPath must confront larger challenges despite diminished resources. We must strike a new balance between education and advocacy. We must increase patient and payer awareness of what we do and why it is valuable. We must halt the depredation of POD labs and reduce the unfair advantages enjoyed by big, out-of-state, commercial labs. We must reach out to — and where possible, partner more closely with — our state-level peer organizations. We must craft a sustainable economic plan for our Society's future. And we must increase our active membership or risk irrelevance.

Our nation's federal system requires pathologists to fight their legislative and regulatory battles on two levels: state and national. We cannot expect CAP to fight all these battles for us. MSSNY has been a valuable ally, but as POD labs have proven, we cannot always rely on them. No, we must be willing to become our own advocates, especially for in-state issues like proficiency testing, regulation and inspection, reimbursement, and scope of practice. Recognizing this, CAP encourages *every* American pathologist to become active in their respective state pathology societies.

Likewise, I exhort every resident, fellow, and attending pathologist in New York State to begin or renew membership in NYSSPath. In return, I promise fulfilling educational experiences at our Annual Meeting — as well as continued efforts on your behalf in Albany. Without your sustaining participation and financial support, I fear my successors will not be able to make these same promises.

2010 CME PROGRAM

Rana Samuel, MD — Program Chair

NYSSPath's 2010 CME program will be held Saturday, April 17 at The Hilton Garden Inn in East Syracuse. The program will begin with registration at 8:00 am and end at 4:30 pm.

As usual, the focus is on information that will update and improve the diagnostic skills of the community hospital-based pathologist, but residents and academic pathologists will also benefit from attendance. This year's speakers include two respected individuals, Dr. Mehrotra and Mr. Neafie, both of whom were formerly with the AFIP (Armed Forces Institute of Pathology) and are now with AIP Laboratories, a division of Bostwick Laboratories.

This year's speakers and their lecture titles are as follows:

- **Rana Samuel, MD**, Buffalo VA, "Evidence-based Red Cell Transfusions"
- **Anupamjit Mehrotra, MD**, AIP Laboratories, "Gastritis: An Update on Classification, Grading and Staging"
- **Ronald Neafie, MS**, AIP Laboratories, SCHLEIFSTEIN LECTURE, "Infectious Disease Histopathology"

NEW MEMBERS

The following physicians have applied for membership in NYSSPath over the past year. Our current policy is to publish their names in this newsletter, soliciting over the three months following publication any information as to why such applicants should not be approved for membership.

Please contact our administrative assistant, Barbara Birkeland, at blkbirk@att.net if there are errors in this listing, including errors of omission.

Jennifer J Findeis-Hosey, MD (junior member)
University of Rochester Medical Center, Rochester, NY

John M Fisk, MD (regular member)
Buffalo General Hospital, Buffalo, NY

Muzaffar N Khan, MB, BS (regular member)
St Elizabeth Medical Center, Utica, NY

Asghar H Naqvi, MD (regular member)
Baldwinsville, NY

Xiaolan Ou, MD (regular member)
ACM Lab, Rochester, NY

Syed Saeed Zaman, MD (regular member)
St Elizabeth Medical Center, Utica, NY

BOARD OF MEDICINE PROPOSAL

The Medical Society of the State of New York (MSSNY) apparently has successfully convinced the NYS Board of Medicine to change the most onerous aspects of recently proposed licensure changes. The original BOM proposal would have mandated that all applicants for licensure in NYS need to pass all three steps of the USMLE and have successfully completed three progressive, sequential years in a certified residency of a single specialty. Those physicians who are currently licensed by the state of New York, in order to maintain that license, would have had to show evidence of continued competence by: 1) certification/maintenance of certification by AMBS or AOA; 2) active hospital practice in an accredited hospital of sufficient volume to measure quality; 3) at least 50 hours of Category 1 AACME-approved CME; or 4) deemed equivalence by a special committee of the Board of Medicine. The proposed date of implementation of medical licensure changes is 1/1/2013.

BOARD OF MEDICINE PROPOSAL *(continued)*

In January, 2010, the Medical Society of the State of New York (MSSNY), along with important stakeholders, met with the Board of Medicine Chair, Board Executive Secretary, and Associate Commissioner of the State Education Department, Office of the Professions. As a result of this meeting, the Board of Medicine has agreed to remove that portion of the proposal regarding maintenance of licensure for physicians. In addition, they have indicated that they will consider a compromise position on resident licensure, allowing licensure after 2 years of training rather than the 3 years originally proposed. They also indicated that they may also make the requirement for IMGs two years, which would be one year less than is currently required, and would make IMG status comparable to U. S. Medical Graduates. MSSNY continues to work with the State Education Department to resolve this issue.

FEE SCHEDULES: A BRIEF HISTORY AND UPDATE

If you, assuming you are an average pathologist, have any idea of how looking through a microscope translates into a bill to the patient's medical insurer and eventually into money in your bank account, then you are likely aware of the annual battles over the past 7 years to prevent decreases in physician payment from Medicare. Medicare payments account for about 30% of the average physician's revenue and it is a good idea for every pathologist to ask their billing manager what the percentage is for their pathology practice. However, this battle to avoid fee schedule decreases not only affects what Medicare pays you for your professional services, but affects payment from the private insurers as these payers often state their fees as a percentage of the Medicare fee schedules or in terms of relative value units, which also directly relates to the Medicare fee schedule.

The Balanced Budge Act of 1997 attempted to control Medicare spending, specifically the money paid to physicians, by introducing the Sustainable Growth Rate (SGR) formula. This now infamous formula established an annual target for money paid for physicians' services by linking it to the growth of the gross domestic product (GDP). If actual expenditures were greater than this target for a given year, then Medicare was to lower physician payment the next year to recover the difference.

Since 2003, this use of the formula has resulted in numbers that should have led to Medicare rate decreases to physicians. And every year, organized medicine has successfully lobbied Congress to pass "patches" that overrode the planned fee decreases and, instead, enact small increased every year except 2007. However, the differences between targeted and actual spending continue to accumulate over the years, and for 2010 the accumulated scheduled reduction for physician services was a rather significant 21.2%.

At the time this newsletter is being written in February of 2010, Congress has voted to delay the schedule 2010 pay cut from January 1 to March 1, so the intense lobbying continues.

What organized medicine really wants is to "fix" the SGR, meaning replace it with something that reflects actual costs to medical practices. However, a previous House Democratic proposal to repeal the SGR had an estimated price tag of $200 billion over 10 years- a politically unpalatable thought. While not exactly a fixed SGR, currently both the Senate and the House have proposals that would exempt a five-year Medicare pay freeze from a newly approved "pay-go" budgeting rule. This anti-deficit rule mandates that Congress must pay for any new appropriations by either raising taxes or cutting expenditures elsewhere. This exemption is estimated to cost $82 billion.

It should come as no surprise that hospitals are also caught in the squeeze of constant threats of decreased payments from federal and private insurance plans. Hospitals were hoping that a federal health plan, by covering more of the uninsured, would go along way in reimbursing them for what is otherwise unpaid care provided for by hospitals. This national bill, which includes charity care as well as money that could not be collected from patients, was around $36 billion in 2008. The number of uninsured in the country is currently about 49 million. The Urban Institute estimates that this number could go as high as 58 million by 2014. With the title of "Millions of unemployed face years without jobs", a recent article in the New York Times stated that currently 15 million people are officially jobless and 6.3 million people have been out of work for more than 6 months.

The bottom line is that regardless of your personal position on federal health care, or federal government programs in general, these issues affect the federal budget and will affect your professional practice of medicine.

NEW YORK STATE MEDICAL LIABILITY REFORM UPDATE

The Medical Society of the State of New York (MSSNY) reports that identical medical liability reform legislation as been introduced in both in the Senate (by the Senate Health Committee Ranking Member Kemp Hannon, S.6799) and in the Assembly (A.6184, Schimminger). Until the Legislature and Governor enacted legislation to freeze medical liability premiums in each of the last two legislative sessions, physician medical liability premiums had gone up 55-80% between 2003 and 2008.

MSSNY notes the provisions contained within the bill would include a $250,000 cap on non-economic damages in medical liability actions; would require a physician consulted for a Certificate of Merit necessary for the initiation of a lawsuit to sign an

NEW YORK STATE MEDICAL LIABILITY REFORM UPDATE *(continued)*

affidavit; would assure that defendants in medical liability actions are only responsible for their proportionate share of fault; and would require the disclosure of the identity of an expert witness who will testify in a medical liability action. The disclosure of the identity of the plaintiff's expert witnesses would allow a physician defendant to research the background and expertise of the expert rather than the current "trial by ambush" that is currently allowed in New York's civil trials (such behavior on criminal trials would be seen as prosecutorial misconduct).

In December of last year, MSSNY noted that physicians throughout New York State got strong support for medical liability in the testimony by Kenneth Adams, president and CEO of the Business Council of New York State at a public hearing in Albany conducted by the State Senate's Insurance, Health and Codes Committees. Mr. Adams said that "Reform of the medical malpractice system would lower health care costs and help restore New York's economy". Adams further stated that the Business Council is calling upon the legislature for a $250,000 cap on non-economic damages, a $500,000 cap for punitive damages and reform of the joint-and-several liability laws. The Business Council, like MSSNY, is a member of New Yorkers for Lawsuit Reform, which last month released the results of an independent study that "finds that New York's legal system is among the worst in the nation." MSSNY hopes that with the support of the business community, the tide may be turning.

A WORD FROM THE EDITOR

Linda J. Trapkin, DO

You cannot control the winds, but you can adjust the sails.

The College of American Pathologists is struggling mightily to save our profession from within and without. The CAP's leaders are expressing this effort as a "transformation" of the specialty and that pathologists can no longer do business as usual. The practice of pathology as a predominantly histopathologically driven medical practice is being challenged by molecular techniques. And changing business models are assaulting the status quo as never before - personal and professional lives are being "inconvenienced" as one pathologist complained while others are being completely disrupted.

A recent article in the "American Journal of Surgical Pathology" from Drs. Lauwers, Black-Schaeffer, and Salto-Telliz (2010; 34:115-117) urges "practicing surgical pathologists not only to be aware of molecular techniques, but also to be engaged in interpreting and reporting the multiple tests which are already available in clinical practice, making tissue pathologists active members of the emerging therapeutic pathology paradigm." They envision the creation of a "modern, molecular-savvy surgical pathology work force" by fully integrating molecular diagnostics into classical morphology (which already has integrated immunohistochemical stains). The article almost begs pathologists to wake up and smell the coffee. This is the same message in the CAP's campaign for transformation.

I offer an example of making a change. Even if you are a pathologist in a small community hospital, you probably read urine cytologies. Have you educated yourself about FISH technology and approached any of the myriad of commercial labs out there that are willing to do a TC/PC split with you? If you are not familiar with this term, you should become intimately familiar with it soon. A TC/PC arrangement for urine FISH testing would mean that the commercial (or academic) lab would perform and bill for the technical component (TC) and allow you to interpret and bill for the professional component (PC). Don't say "the hospital doesn't market our services very well." You, not the hospital, should be talking to your urologists and discussing the proper indications for reflex FISH testing and then incorporating the entire interpretation (cytologic and FISH) into your report. If you don't do this, you will hasten the erosion of your practice as the commercial labs market to the medical offices directly for urine cytology with FISH testing. As molecular testing grows, the CAP believes it imperative that pathologists take ownership of the technology by incorporating this information into our diagnostic reports. Change is in the wind, and those who don't adjust their sails will be blown away.