The Excelsior

The News Magazine of The New York Regional Society of Plastic Surgeons

FALL 2012

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STEVE FALLEK, M.D.

PRESIDENT'S MESSAGE

After many years, 2 of my closest employees told me they were leaving to pursue sunnier climes.

This was no metaphor as they were leaving with new spouses for San Diego and Puerto Rico, respectively. I interviewed a few candidates, asked what I thought were relevant questions, and hired new staff. After a month, one of them told me point blank that I asked all the wrong questions and told her all the wrong aspects of the job. Since I liked her and it wasn't the first time I've been told I'm wrong, I asked what she meant. "This job isn't about setting up rooms or answering phones, it's about being a psychiatrist, professional hand holder, motivational coach, accountant, clairvoyant, traffic cop, barista, marriage counselor, IT professional and part time babysitter." I smiled since couldn't agree with her more. It's amazing how many different hats we have to wear and yes, they never taught any of this in medical school or training. It's always been said that doctors are bad businessmen since we never went to business school, but are we any better at any of these or any other aspects of our trade? So what are our options? I don't see many of us running to graduate school and there are few courses at either the national or local meetings so it's up to each of us individually to figure it out.

I think when we start out in practice our goals are pretty simple. Deliver good care, get great results, pay the bills, put the kids through college, etc. It's also been said that patients shouldn't care about their surgeon's personality but that they've done the most of the operation that you want. I disagree. My goal is certainly to get an excellent result but the longer I spend in practice the more I find it's not always about the result. How many of us have had unhappy patients with what we would consider an excellent surgical outcome? Or vice versa? It's about the patient's experience of the result. How many of us would recommend a restaurant with great food where there's an hour wait to sit, an uneven table that keeps moving, and a waiter we never see? Imagine now, you had to go back every week for a month. You'd probably quickly forget how good the food was. I don't think the bar in Cheers had the greatest beer on tap but Norm and the patrons kept coming back to the proverbial bar "where everybody knows your name". If it means buying a cup of decaf latte for a patient to be happy or not complaining when the same patient always shows up an hour late, so be it. I can't compete with the "cosmetic doctor" on price and hopefully I have a better result but we're going to at least make the experience more pleasant. I've had patients disappear for years, return, and then admit they went to a cheaper doctor. With gentle prodding, they admit that they just like it better in my office and feel more comfortable. To me, that's a great result.

It was the combined Board's excellent idea to set for our fall lecture program the subject as "Economic Controversies in Plastic Surgery". We have assembled a diverse and knowledgeable group of speakers in our society's first foray away from a scientific program. Hopefully it will fit at least one of the many hats you wear in practice. It has been a pleasure to serve as President of this wonderful institution and many thanks to the Board and to the membership. It has been a great learning experience and almost complete. Now if only someone can tell me how to answer the riddle of the post breast augmentation question, "Are they going to stay this size?" then I'll be done.

Thanks and best wishes,
Steve

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letter from the editor

Heads Up-Medicare is in the Spotlight

Welcome back from what I hope was a very enjoyable summer. As I write this column, Medicare is in the spotlight as the campaigns are in full swing for the upcoming November election. The candidates and their surrogates are spewing and spinning information, with totally different versions of the "truth" about various budget proposals, Medicare and ObamaCare. Naturally, these conflicting "facts" have spurred me to do some fact checking of my own. In doing so, I am asking "WHY" a lot.

Let me preface this article by confessing I have never been a fan of Medicare. My studies of its history and talking with docs who practiced before its implementation have led me to conclude that it has been harmful to the healthcare system in the US. I have provided a QR code which links to an article written by Alieta Eck, MD, President of Association of American Physicians and Surgeons (AAPS). The AAPS, in distinct contrast to the AMA, is dedicated to helping physicians continue to practice medicine autonomously, without outside interference and dictates. I urge each of you to consider becoming a member. This article details the birth of Medicare and its detrimental effects over time on our healthcare system.

These are some of the issues that puzzle me about Medicare. WHY do all seniors have to be on Medicare? Should it not be reserved for poor seniors who cannot pay for insurance? WHY does the government insist that all of us enroll in Medicare, when they exempt themselves from the program? I would much rather pay for private insurance than go on Medicare. WHY does the government withhold your Social Security payments if you refuse to go on Medicare? WHY, WHY, WHY? With the average Medicare recipient now withdrawing more from Medicare than they paid in, WHY are the Medicare costs of well-off seniors being paid for by young people who may not be as well off? Don't you get frustrated when a senior wearing a 5 carat diamond ring, with an apartment on Central Park West and a second home in Florida, who retired when they were 58, comes into your office and they are on Medicare? WHY are they on Medicare? These people are perfectly capable of taking care of themselves and do not need the US government and its taxpayers doing it for them. I am more than happy to fund care for seniors who are without financial means to take care of themselves. Personally, I believe community based programs better serve the needs of our fellow citizens as locally based groups are best equipped to assess and provide for the needs of its neighbors. However, if Medicare is necessary as a safety net for seniors whose communities cannot or will not provide for them, I am OK with it. Finally, and this is the kicker, WHY do our federal congressman and senators get, for their lifetime, a medical plan that is not Medicare? WHY, WHY, WHY? If Medicare is so great, and the average citizen must be on it, how come our elected representatives opted out of the system, why don't they want it for themselves? Very interesting I must say. On top of everything else, we all know Medicare is filled with waste, fraud and abuse at a time when every healthcare dollar counts and no one seems willing to tackle this problem. So to me, less people on Medicare equals less wasteful spending on healthcare.

According to the Congressional Budget Office, the fact of the matter is that Medicare will be bankrupt by 2020 if nothing is done to stabilize it financially. This means changes in the program must happen. Accepting this as fact is crucial so we can discuss rationale ways to move forward.

Now, with the election looming and campaigns using Medicare as political football, as physicians we need to be informed about the changes coming in Medicare and, importantly, we need to be able to discern the truth. Unfortunately, with both sides spinning the facts and in some cases telling outright lies, it is almost impossible to know the facts. It is important that we know the facts, and can tell who is truthful and who is not, as it helps us form an educated opinion about the best way to proceed forward.

As many of you know, I am very interested in the recently passed Health Care Law and I have spent considerable time trying to distill the facts and check whether claims made are in fact true. To the best of my ability here is what I know so far.

1. Both sides are talking about CUTS to Medicare. I hope everyone realizes that in the language of Washington, DC, "cuts" means "reducing the rate of growth". There are no cuts the way you and I think of cuts.

2. Those in favor of Obama's re-election often state that Ryan's budget, passed by the House, included cuts to Medicare. This is the so-called "Ryan did it too" defense. They also insinuate that Ryan's budget will be enacted by Romney. Officially, Romney's platform fully repeals Obamacare and does not include Ryan's budget proposal for Medicare. In fact, Romney's Health Care Plan preserves the $716 billion dollars cut from Medicare by Obama's Affordable Care Act (Obamacare).

3. Those in favor of Obamacare draw equivalency between Obama's cuts to Medicare and the Ryan budget's proposed cuts to Medicare. I am sure you remember the notorious ad which aired after Ryans's budget plan passed the House. Because his budget included cuts to Medicare, the opposition aired an ad showing a Ryan look-a-like dumping Granny out of her wheelchair and over the edge of a cliff (literally). It is true that Ryan's budget, like Obama's plan, makes cuts to Medicare. The key difference is that Ryan's cuts are used to increase the length of time Medicare will be solvent. Obama's law, however, cuts $716 billion dollars from Medicare and those monies are not used to preserve the solvency of Medicare but are used instead to fund, in part, a new $1.9 trillion dollar entitlement program; the monies were shifted from Medicare to Medicaid and to subsidize the new insurance exchanges. So if Ryan is shoving Granny off the cliff, so is Obama. The Affordable Care Act does nothing to stabilize Medicare and the 2020 insolvency date continues to loom ahead.

4. The ObamaCare plan's $716 billion dollar cuts to Medicare include, you guessed it, $415 billion in reduced payments to physicians and hospitals. Those in favor of the Affordable Care Act, defend the $415 billion in cuts, stating that the cuts will not adversely affect seniors because they do not affect the services received by seniors. In other words, Medicare will continue to pay for the same things that Medicare covers today. While this is true, on paper, it is not the whole story and here is where they are being deceptive. Medicare's own actuary estimates that up to 15% of hospitals participating in Medicare may have to close because of these cuts. I, for one, believe that if a hospital closes, the patients it serves are indeed adversely affected. In addition, we can anticipate that more physicians will opt out of Medicare or limit the number of Medicare patients they treat because they simply cannot afford to care for more Medicare patients. Under ObamaCare, Medicare reimbursement rates will fall below those of Medicaid within a decade. The problem of a decreased number of physicians participating in Medicare will be exacerbated by the number of increased citizens on Medicare, as baby boomers reach the age of 65. We can also anticipate that physicians will retire early as practicing in the healthcare environment becomes more of a struggle. Surveys are already showing that large numbers of physicians at the peak of their careers are considering early retirement. Anecdotally, one of the best general internists I know, in her 50s, recently announced her retirement because she cannot continue to practice medicine the way she wants to in the current healthcare economic environment. What a waste and a loss.

5. Those defending ObamaCare state that the $415 billion in cuts to hospitals and doctors will be made up by the hospitals and doctors increasing their productivity. Really? Most doctors I know are functioning at more than 100% capacity, with at least 12 hour work days and short office visit times, in order to make ends meet. I don't know about hospitals but physicians do not have excess productivity capacity.

6. Now, the $716 billion in reduced rate of spending also includes $156 billion cut from Medicare Advantage. This is actually interesting from a political standpoint in that nationwide, 24% of seniors are on Medicare Advantage. Also, in the swing states of Florida and Ohio, 32% and 34% of seniors respectively are on Medicare Advantage. Now, what is the problem with Medicare Advantage? The fact is that $1.14 is spent per Medicare Advantage senior for every $1.00 on plain Medicare senior. However, this is because the government MANDATED that the private insurers running Medicare Advantage provide extra options that are not available through standard Medicare. The government states that the private insurers running Medicare Advantage are unfairly profiting. However, economists calculate that if you take out the mandated extras, these privately run Medicare Advantage plans actually cost 9% less than government run Medicare.

7. Another oft stated "fact" is that the Republican plan is to privatize Medicare. The fact is that Ryan's budget proposes no changes to Medicare for those 55 years and older. In his original budget, which has been modified, for those 54 and younger, we would receive premium support and shop for our own insurance.

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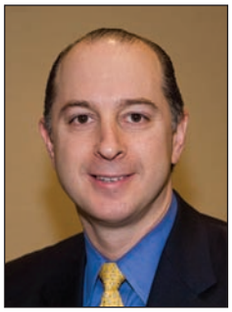
ALAN MATARASSO, M.D., CHAIRMAN
STEVEN WALLACH, M.D., CO-CHAIRMAN

SCIENTIFIC PROGRAM

Spring 2012 Meeting



The April 21, 2012 meeting was titled "Controversies in Liposuction and Minimally Invasive Surgery." We had three great presenters and a Nojorova Lecture given by Dr. Mary McGrath, a true "giant" in the field. Her lecture covered changes in the ACGME guidelines for residency training. She discussed the Milestones Project which requires certain milestones to be achieved in residency before completing the program. Competency has to be properly documented before finishing residency. In addition, the institutions supporting the residency, as opposed to the program itself, will be held accountable. It was all very interesting, but yet confusing as to how this competency will be measured. As Dr. McGrath conveyed, many questions still need to be resolved before implementing these changes.

Dr. Osvaldo Saldanha from Brazil presented the evolution of his abdominal contouring techniques incorporating aggressive liposuction with abdominoplasty. He reviewed the important historical contributions and the evolution of his technique from wide undermining of the abdomen to limited central undermining combined with aggressive liposuction. He reviewed his experience including the safety and lower complication rate since he changed his surgical approach. He showed great results.

Dr. Mark Jewel discussed non-invasive body contouring technology. He gave an excellent review of how heat impacts tissues, and reviewed the various technologies available. As for laser lipolysis, he felt that one has to be very cautious with the heat generated and felt that there is not enough hard data on the subject. In general, he felt that the outcome is probably no better than other modalities, and there is "more marketing than science." He thought that UAL should be reassessed because it is a good tool. In addition, when indicated for the right patient, he has performed preliminary studies using HIFU with nice results. He felt that cryolipolysis mainly affects the superficial fat and improves the area by 20-25%.

The final speaker was **Dr. John Millard.** Dr. Millard gave a wonderful, dynamic presentation on Hi-Def Vaser liposuction and fat injections. He reviewed the history of beauty using examples from the art world. He presented his concept of beauty and what he tries to achieve performing body contouring surgery. He reminded the audience that liposuction should not just be used to flatten areas but to contour and to create bulges and rounding to enhance the appearance and create what he felt was the artistic exaggerated results that we define as beautiful. His thought process was "out of the box" and reminded me of several leading speakers that just think differently but yet add a tremendous amount to our understanding to improve our plastic surgery results. Personally, I think he is on to something!

Our next scientific meeting will be November 10, 2012 entitled "Economic Controversies in Plastic Surgery". The speakers will be: Malcolm Paul, M.D., Robert Singer, M.D., Lloyd Krieger, M.D., Ms. Dana Jacoby, and Mr. Michael Mulkey.

Yours truly,
Steven Wallach, M.D.
Scientific Program Co-Chairperson

Osvaldo Saldanha, MD and his wife

Jennifer Capla, MD and Beth Aviva Preminger, MD

WILLIAM ROSENBLATT, M.D.

LEGISLATIVE UPDATE

Here is a summary of some of last sessions' activities that I thought would be of interest to Plastic Surgeons.

The I-Stop bill: (S. 7637/A. 10623) was passed the last session. It will affect all of you when you prescribe controlled substances. Within 1 year, there will be a "real time" prescription tracking system to provide enhanced information to prescribers and pharmacists concerning prescriptions obtained by patients for controlled substances. Prescribers, or their delegate, will have a duty to consult the database prior to prescribing Schedule II, III and IV medicines. Pharmacists will have access to the registry (which they do not currently).

This means that any time you write an Rx for a patient for more than 5 days of a narcotic, you will have to document that you checked the on line database. There are certain exceptions, but for your post op patients, most don't apply. I am sure you will see more regarding this regulation in the future.

Out of Network Bill: The New York State Senate unanimously passed legislation **(S. 7745, Hannon)** that would enact a number of provisions **to provide much needed transparency to patients and employers regarding the scope of their health insurance coverage when they pay for coverage that provides the right to see a physician outside of a plan's network**. This includes requiring a health insurance company offering a policy for out of network coverage to assure that there is significant coverage of such costs including offering at least one plan that will provide coverage of 80% of anticipated out-of-network costs--a major advocacy priority for MSSNY. While the bill did not pass the Assembly, passage by the Senate sets the stage for further discussions with the Legislature over the summer and fall. Next year there will be a big push to get this through.

Collective Negotiation Bills (S.3186, Hannon/A. 2474A, Canestrari) and (S. 7615, Hannon/ A. 2474B, Canestrari): Despite the strong support of organized medicine and the AFL-CIO, neither the statewide collective negotiation bill **(S.3186, Hannon/A. 2474A, Canestrari)** nor the demonstration collective negotiation bill **(S.7615, Hannon/A.2474B, Canestrari)** passed either House of the New York Legislature this year. This is largely due to the very strong opposition from the health insurance industry, the business community, and some major hospital associations. In addition, several negative press articles were published during the last week of session that increased lawmaker concerns regarding the possible inflationary impact of collective action on health care premium costs.

Breast Reconstruction Bill (S.3801-A, LaValle / A.7193-A,Cook): This bill provides for insurance coverage for breast reconstructive surgery after a patient has had a partial mastectomy, as is currently provided when a patient has had a full mastectomy. MSSNY has written in support of this bill. The bill was delivered to the Governor and he signed it into law.

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Steve Fallek, MD and John Millard, MD at the Spring 2012 meeting

FALL MEETING 2012

Economic Controversies in Plastic Surgery

SATURDAY NOVEMBER 10
8AM-1PM
LIGHT BREAKFAST
NEW YORK ACADEMY OF MEDICINE
1216 FIFTH AVENUE,
NEW YORK, NY

EDUCATIONAL OBJECTIVE:

The realm of plastic surgery has changed and now encompasses surgery as well as cosmetic medicine. This includes LASERs, injectables and neurotoxins. With this expansion has come a concomitant rise in numerous other plastic surgeons incorporating cosmetic procedures into their practices. There has also been a change in the marketing of plastic surgery and a rise in the use of the internet and on-line research in the arena of plastic surgery. Industry and manufacturers now also have a significant impact in publicizing plastic surgery. Concurrently there has been an unprecedented worldwide economic downturn. The purpose of this meeting will be to explore these factors on the practice of plastic surgery.

PRESENTATIONS

LLOYD KRIEGER, M.D.
Assistant Clinical Professor Division of Plastic Surgery-UCLA; Director-Rodeo Drive Plastic Surgery
"ObamaCare's Challenges and Opportunities for Plastic Surgeons"

ROBERT SINGER, M.D., FACS
Prior President-American Society for Aesthetic Plastic Surgery
"The Changing Marketplace: Historical Perspective, Where We Are, Where We are Going-Times are Tough"

MICHAEL MULKEY , JD
Director, Program Development Provista
"How to Effectively Leverage Your GPO (Group Purchasing Organization) to Manage Your Practice"

MALCOLM PAUL, M.D.
Clinical Professor of Surgery / Aesthetic and Plastic Surgery Institute, University of California, Irvine
"The Economy and the Evolution of a Sustainable Business Model in Aesthetic Plastic Surgery"

DANA JACOBY, MS
Senior Consultant with BSM Consulting specializing in strengthening revenue and profit in and across health systems
"Using Benchmark Reports to Improve Performance and Reduce Revenue Risk"

This program is certified for three CME credits. There is no registration fee for members of the NYRSPS and residents. Non-member registration fee is $200.

John Millard, MD, Mark Jewel, MD, Osvaldo Saldanha, MD and Mary McGrath, MD

SAVE THE DATE

Residents' Night

Monday March 11, 2013
5pm-8:30pm
New York Academy of Medicine
1216 Fifth Avenue, New York, NY

5:00-5:45pm
Cocktails and registration

5:45-6:15pm
Buffet dinner is served
(the buffet will remain open after 6:30)

6:30-8:00pm
Resident presentations; dinner & dessert eaten quietly during presentations

8:00pm
Judges deliberate;
Presentation of Lifetime Achievement Award

8:30pm
Evening concludes

Spring Meeting 2013

SAVE THE DATE

Saturday MAY 4, 2013

8am-1pm, Light Breakfast
New York Academy of Medicine
1216 Fifth Avenue, New York, NY

NYRSPS **WEBSITE**

WWW.PLASTICSURGERYNY.ORG

- Stay updated on Society actions and initiatives
- Register online for NYRSPS meetings
- Read the latest newsletter
- Find a colleague
- Encourage a colleague to join NYRSPS. Applications can be completed and submitted online
- Find the latest meeting information

SPRING MEETING 2012
Front row (left to right): John Millard, MD, Mark Jewel, MD, Osvaldo Saldahna, MD, Mary McGrath, MD and Peter Taub, MD.
Second Row (left to right): Steve Fallek, MD, David Abramson, MD, Tracy Pfeifer, MD and Steve Wallach, MD

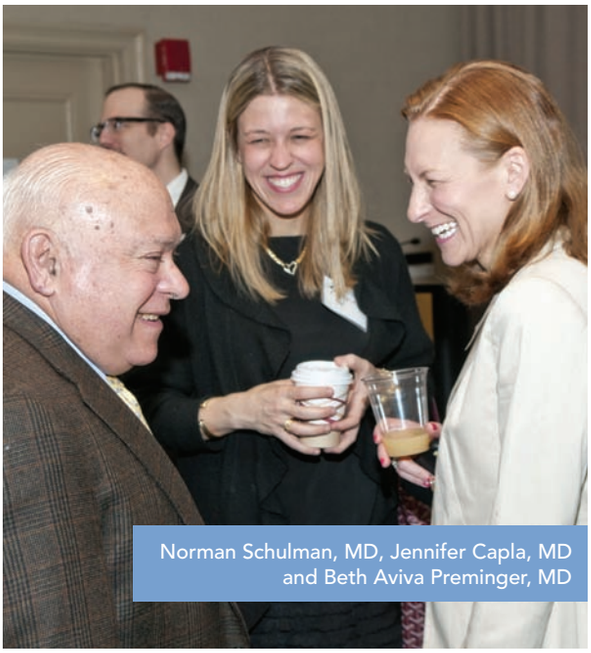
Legislative Update continued

REGRESSIVE MEDICAL LIABILITY BILLS: MSSNY successfully defeated legislation aggressively sought by trial lawyers to increase liability exposure against physicians and drive up the already unsustainably high cost of liability insurance coverage. There were multiple bills that would have increased our insurance, and as you all know, our costs actually decreased this year.

A bill that will be a big focus for MSSNY next year, and should be one for us too, is the **Truth in Advertising Bill- A.8410A (Morelle)/S.7455 (DeFrancisco)**- which would require health professionals to specify their professional credentials in all advertisements. If you state you are Board Certified, the name of the board has to be specified and the board must be recognized by ABMS or AOA or deemed an equivalent. This bill was moved to Senate Rules but has had no movement in the Assembly. MSSNY will push this next year.

I think we all owe MSSNY's legislative division, which is now lead by Liz Dears, our thanks for all of their work or our behalf. And we need to thank Gerry Conway, who retired this year for his years of dedicated service to medicine and our legislative agenda.

William Rosenblatt, M.D.
Past President, MSSNY
wbrosenblattM.D.@verizon.net



Norman Schulman, MD, Jennifer Capla, MD and Beth Aviva Preminger, MD

John Vaccaro, MD, Mark Jewel, MD, and Peter Taub, MD

Editors Letter continued

The argument is that this would create market forces which would lower health care costs. However, because the premium support is tied to the rate of inflation, and health care costs rise faster than the rate of inflation, those against this proposal state that ultimately seniors would pay more out of pocket. To counter this, Romney has proposed we would have the OPTION of electing a plan that is equivalent to that enjoyed by our Congressman and Senators (Good enough for them, good enough for me). Or we can select traditional Medicare.

8. Finally, regarding that pesky rumor of a 3.8% tax on the sale of your home that is included in the Affordable Care Act. There is a new 3.8% Medicare tax on investment income. It is not applied to all home sales. Here is how it works. Let's assume you are a couple. If you sell your home, you are allowed to deduct $500,000 of the sale profit from your adjusted gross income. If the profit of your sale is above $500,000, this is added to your adjusted gross income. Now, the new tax is applied to those couples earning $250,000 or more per year. So let's say that you sell your home for a profit of $700,000 and you make $300,000 per year. $200,000 ($700,000 minus $500,000) is added to $300,000 for total of $500,000. Now the new tax is applied to whichever of the following numbers is less. Either the $500,000 adjusted gross income OR the profit of $200,000 from home sale. In this case, you would pay 3.8% on $200,000. Bottom line, it is definitely a new tax on investment income, which includes profits from the sale of a home, that will be paid by some taxpayers.

Let us physicians be truth seekers as well as Americans who seek to improve and protect our patients and the US healthcare system.

Warm regards,
Tracy

Go to www.getscanlife.com to download scanner app for your smartphone. You need a Gmail account to access the content linked to this QR code. If you do not have one, email me at drtracypfeifer@gmail.com and I will email a copy to you.