

# *The New York State Pediatrician*

OFFICIAL E-NEWSLETTER OF DISTRICT II, AMERICAN ACADEMY OF PEDIATRICS

## Practice Management Issues

Winter 2009

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## Coding Corner



The AAP has lots of ways to find out all the tidbits of information you need to know in order to be a great coder. In today's tough economic times, you want to be the best coder you can be, in order to get paid for the services you render. Starting with the AAP Website [www.aap.org](http://www.aap.org), sign into the member center and click on "Practice Management Online." A second resource that helps me quite a bit is SOAPM (Section on Administration and Practice Management).

Joining is a pittance, and you have instant access to the best practice managers in the country...other pediatricians! There you can join a listserv (it's beneficial to make a new email address for this) and get instant answers to any question on your mind. You won't be sorry.

Some pediatricians don't bother to read National AAP coding advice because they claim it not to be New York specific. I feel your pain. Many times I have read advice and known full well that my local payers wouldn't respond to some billing strategies. In the "Coding Corner" we promise to give you billing advice that you can use which is guaranteed to be in a New York state of mind!

### **Diagnosis Obesity 278.00**

Many physicians tell me that they do not treat obesity, or use it as a lone diagnosis because it is often denied by payers. A recent analysis by our group showed that this code was paid 63 out of 70 times. It seems that payers have finally realized that obesity is a real disease and want us to treat it.

## 96110 Developmental Screening

I can't believe how under used this code is! Aside from recent reports that a few large payers will no longer pay for this code, many still will. Use this code with a modifier - 59 when in conjunction with an office visit. 96110 is most commonly used with the following NYS approved screening tools: M-CHAT, ASQ (Ages and Stages), PEDS, EPDS (Edinburgh Postpartal depression screen), PSC (Pediatric Symptom Checklist), and Vanderbilt (ADHD Questionnaires).

*By Marc Lashley, MD, FAAP (NY Chapter 2)*

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## Negotiating with Insurers: Is "Win-Win" the Correct Approach?



I think that we would all agree that most pediatricians are nice people. We tend to avoid conflict and will usually try to do the fair and right thing in our business dealings. But the question arises: is this a useful approach when dealing with insurance company issues?

The classic book, "Getting to Yes" by Fisher and Ury out of Harvard, details this approach to negotiation. The goal is to put yourself in your opponent's shoes and give them something that they want in return for something you want (this is highly simplified for this discussion). By doing so, everyone can "win" and it will be easier to get from NO to YES. By using this technique, negotiation can be quickly brought to a successful conclusion with both sides feeling satisfied and seeing the value that the other side brings to the table. For most situations, this is the best way to negotiate, particularly when you value a relationship with your opponent.

Unfortunately, this seems to be the only technique people remember about this valuable book. There is another chapter devoted to identifying the type of negotiation in which you are actually involved. The Win-Win scenario is only valid at times when both parties value the other and want to have an ongoing and useful relationship. The corporate culture of a business is the basis for much of its negotiating style. Some insurers are indeed interested in win-win relationships. They are impressed by the value you bring to the table and if you can convince them that it is worth it, they will agree to higher payments.

However, within the insurance industry, there are some companies that have no such cultural bias. Their negotiating style is what Fisher and Ury called the "street fight." In a street fight negotiation, there is no interest whatsoever in an ongoing relationship. There is no interest in a give and take of value. This type of negotiation is better characterized as a "win-lose" negotiation.

Historically, we pediatricians have approached all of our negotiations with payers as "win-win" propositions. The problem with our insurance relationships is that we are

actually in a “street fight” negotiation and fail to realize it. When a street fighter confronts a win-win pediatric negotiator, the street fighter will always prevail because the pediatrician thinks that the payer is actually interested in having their opponent come away satisfied. They will prevail because the pediatrician thinks that the payer sees value in an ongoing relationship. Pediatricians will make a reasonable proposal, which will then be used as a “ceiling” by the street fighter. We will offer concessions that are taken, but nothing offered in return. They win. We lose.

In a street fight, the only currency is power and the resolve to do what is necessary and/or walk away. Those items are notoriously lacking when pediatricians negotiate with payers. When you deal with bullies, being reasonable is viewed not as a virtue, but as a fatal weakness. The bully will always continue to press for more while giving nothing of value in return.

It is far past time for all of us pediatricians to take a street fight mentality with payers who take such an attitude with us. It is time to draw some lines in the sand which we will not cross. Payers listen far better when they realize that you are tough, that you mean business, and that you will do whatever is necessary to get what you want. The best negotiations often happen AFTER the letter of withdrawal from the plan.

When you enter into negotiation with payers, the first thing to do is to identify the type of negotiation that you are involved in. The next thing to do is act accordingly. Sadly, when it comes to some in the insurance industry, nice guys often do indeed finish last.

***By Herschel R. Lessin, MD, FAAP (NY Chapter 3)***

*Dr. Lessin is a founding member of The Children’s Medical Group, PLLC, a group of 22 pediatricians in 7 offices, and is a Certified Managed Care Executive. He is the SOAPM liaison to COPAM. He has been in full time private practice for 25 years, speaks nationally on medical business issues, and is a member of the Board of Directors of a not for profit regional health insurer with more than \$2 billion in premium.*

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## Pediatric Councils

### Chapter Based Advocates for Pediatricians



A “Pediatric Council” is a forum that facilitates communication between pediatricians and health insurance plans in order to improve the quality of and access to health care for children, obtain more appropriate coverage for pediatric services, and simplify and expedite health plan claims adjudication.

### **NY Chapter 1 Pediatric Councils**

#### **Albany Pediatric Council**

The Albany Pediatric Council has just been formed. Meetings with CDPHP and MVP will occur in the near future.

### **Buffalo Pediatric Council**

The Buffalo Area Pediatric Society was formed approximately 2 years ago and is chaired by Michael Terranova, MD. Its many accomplishments include the following:

- Established a mechanism to alert insurers of vaccine company price increases
- Initiated payment of administration fees and their current monetary value
- Addressed the issue of sub-standard pediatric care at urgent care centers, which inhibits the medical home concept
- Consistently opposes retail Based Clinics
- Documented the inadequacies in payment for newborn hospital services; insurers responded with either increased payments or an agreement to reinvestigate this issue
- Insurers are collaborating with NYS and private grants to standardize quality measures, and in the future this may lead to more coherent programs
- Insurers will pay for 30 month and yearly Well Child Care visits for patients 3 years-21 years old

### **Rochester Pediatric Council**

The Rochester Area Pediatric Council, chaired by Edward Lewis, MD, has been meeting since 2006. Representatives from Rochester Individual Practice Association, Monroe Plan for Medical Care, Preferred Care/MVP, Excellus BlueCross BlueShield and pediatricians from the Rochester and Southern Tier areas regularly attend the meetings. The agenda allows for IPA and health plan reports as well as updates from pediatricians. Discussion items have included-timely response to vaccine pricing increases, consideration of payment for telephone codes and other non face-to-face codes, as well as quality concerns related to the care delivered at urgent care centers. As a result of these discussions, a process is now in place to monitor vaccine price increases and health plans are taking a closer look at the credentialing process and patient outcomes at urgent care centers.

### **NY Chapter 2 and 3 Pediatric Council**

The NY Chapter 2 and 3 Pediatric Council, chaired by Steven Goldstein, MD, and Evelyn Ha, MD, has been busy these past few months, meeting with Empire three times and with United Healthcare once. The council was successful in making these companies aware of the struggles that pediatricians face every day. Specifically, we referenced and made them aware of the fact that pediatricians are called upon to do so much more these days in the area of mental health. The Pediatric Council has made it clear that pediatricians have been caring for the mental health needs of their patients and should be well compensated for the excellent care they are giving:

The Pediatric Council has done a good job of opening up the communication process between the pediatrician and the health insurer. In addition to mental health, other issues that were discussed included:

- Immunization issues (adequate and timely payment)
- Bright Futures and what the insurer expects from the pediatrician
- Lack of fee schedules (United)
- Childhood Obesity and how to code for it

- Importance of documentation when getting paid
- Lack of Provider Reps (both companies are re-instating these reps)
- Why referrals cannot be done online (Empire)

We have taken some important steps in developing ongoing positive relationships with both United and Empire. The Pediatric Council will continue to work hard to improve the practice of pediatrics and the health of our patients.

***By Michael Terranova, MD, FAAP (NY Chapter 1),  
Nancy Adams, Elie Ward, and George Dunkel***

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## Making Your Retirement Plans Fit



Many physicians mistakenly shy away from establishing a Tax Qualified Retirement plan. Over the years we have heard numerous reasons for this, the most popular being fear of the loss of control to a big corporate trustee, being forced to give large sums of money to their employees and exorbitant fees to keep a plan running. While these concerns are real, they aren't entirely accurate...let me explain.

Retirement plans can be divided into two categories: Qualified and Non-Qualified. Let's focus on the Qualified plans, since these are designed to offer the greatest income tax savings.

Retirement plans are designed and controlled by the business owner(s). There is rarely a need to have anyone other than the owner(s) in a position of control. This includes the overall plan design as well as the underlying investment selections, although most owners choose to have outside help with the investment selection.

At a cost typically under \$2,000 to set-up, and frequently half of that annually to maintain, the tax savings realized by establishing the plan is often greater than the maintenance and cost for employees combined!

Qualified plans can be divided in two groups: Defined Contribution Plans (Profit Sharing, Money Purchase, Cross-Tested) and Defined Benefit Plans.

As the name would indicate, the Defined Contribution plan revolves around a specified contribution level, a percentage of compensation. One common myth with retirement plans is that "What I do for myself I must do for all my employees." There are some plan designs that operate in this manner...everyone is treated equally. However, New Comparability plans utilize a series of testing formulas so that the benefits are equitable, not equal. The person making more money usually gets a greater contribution. In essence, the lion's share of the contribution goes to the person making the greater income!

Defined Benefit plans forgo the specified contribution calculations, in favor of solving for a target amount of income at retirement. This type of plan favors those closer to retirement since there are fewer years in which to accumulate the necessary wealth. A medical practice population where the physicians are older than most of the

employees is ideal and can allow for substantial plan contributions with most of the dollars going to the older owners!

So why go through this headache? A Qualified Plan is an excellent tool to utilize in converting business wealth to personal wealth. You can often accomplish multiple objectives using a well designed plan.

Consider this, maybe you have other objectives in addition to saving money for retirement or getting a tax deduction. Maybe you need to find a way to fund a Buy Sell Agreement, or you wish to enhance your estate plan using retirement plan assets. Since a retirement plan can be funded using many different assets classes, it can accomplish many things! Yes, a retirement plan can invest in stocks, bonds, mutual funds, cash and CD's but in addition, it can invest in a host of insurance based products for the benefit of the physicians, their spouses and all their employees. You can use the same dollars more than once: by contributing towards retirement income, funding pre-retirement death benefits for a shareholder's agreement for the partners, providing funding in the event of the loss of a key man, and/or liquidity for estate planning needs!

Fast forward...you now have a creative plan that favors you and your family, gives that extra tax-deduction you been craving, provides for your family's security or pays estate taxes if you die early, and doesn't cost an arm and a leg to maintain...you've accumulated a sizable amount of wealth that Uncle Sam hasn't gotten his hands on, yet, but you aren't ready to die...what's next?

If not planned properly, these assets left to your heirs, can be seriously confiscated by the ravaging effects estate and income tax. For many physicians, misjudging the value of their estate, which includes retirement assets, can result in double taxation of the assets being passed on to their children (estate tax and income tax). This can result in leaving as little as twenty cents on the dollar to their family, with the rest going to the tax man.

So just how do you spend all this money? As you are probably well aware, the dollars you spend from a retirement plan are taxed as ordinary income in the year you take it. Many individuals fall prey to the notion and myth that all individuals will be in a lower tax bracket at retirement. While that may be true for some people, most that have spent their working years building a medical practice and creating wealth will likely be in the same or an even greater tax bracket at retirement. By integrating complementary strategies, it is often possible to create a more tax advantaged means of accessing these dollars.

Many individuals don't examine the efficiency of distribution of these assets until it's time actually to use them. That is likely a mistake. There can be many advantages to outlining some possible exit strategies as early as possible. It doesn't mean you have to use them, but it's nice to know you have some excellent options for down the road.

As always, should you have any questions, concerns, or require additional information regarding a new or existing retirement plan, do not hesitate to contact us at 516-677-6240, email us at [info@HDCI.biz](mailto:info@HDCI.biz), or visit us on the web at [www.HDCI.biz](http://www.HDCI.biz).

**By Jay E. Hochheiser, CFP**  
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## Information for Kinship Families

### The New York State Kinship Navigator



You can help the families in your practice who are taking care of kin children. These are families who have taken in grandchildren, nieces and or nephews, or other children who are related, but not part of their nuclear families.

The NYS Kinship Navigator provides information and referrals for grandparents and other relatives raising children. Close to 400,000 children are in the care of kinship families across the state. The Kinship Navigator works to inform all kinship families about resources and financial assistance that can help them care for their children.

Children and caregivers have a wide range of special challenges related to the:

1. causes for placement of children in kinship,
2. caregiver's ability to provide care, and
3. kinship families' relationships with birth parents.

Additionally, kinship families have special legal issues regarding visitation, guardianship, custody, adoption, medical decision-making, planning for the future, as well as issues regarding obtaining public assistance and social security benefits.

The NYS Kinship Navigator informs caregivers about these issues and helps them to find local resources.

**We are asking you to help us reach out to kinship families.** Here are links to three publications suitable for posting or distributing in your office.

- Professional flyer (with information for service providers):  
[http://www.nysnavigator.org/files/sf/flyers/kinship\\_navigator.pdf](http://www.nysnavigator.org/files/sf/flyers/kinship_navigator.pdf)
- Caregiver flyer (to post in your office):  
[http://www.nysnavigator.org/files/sf/flyers/client\\_flyer\(8x11\).pdf](http://www.nysnavigator.org/files/sf/flyers/client_flyer(8x11).pdf)
- Poster (to post in your office):  
[http://www.nysnavigator.org/files/sf/flyers/client\\_flyer\(11x17\).pdf](http://www.nysnavigator.org/files/sf/flyers/client_flyer(11x17).pdf)

Please take a moment to visit [www.nysnavigator.org](http://www.nysnavigator.org) and view kinship specific publications. If you have kinship families in your practice, you can help them get the help and information they need by telling your staff about our services and placing our materials in your office. If you would like to receive any of the publications you see on the internet via mail, please contact the Kinship Navigator at 585-232-1840 ext 330 or by email at [gwallace@cfcrochester.org](mailto:gwallace@cfcrochester.org).

Helping the Kinship Navigator to reach kin families can only enhance the well being of both children and caregivers. Your office can partner with the Navigator by creating an easy bridge for families to reach the information and services that will help them raise happier healthier children.

# PROS

## Pediatric Research in Office Settings



High costs, long hours with low reimbursement, tough competition for patients, and a ridiculous cost of living are a grim fact of life for pediatricians in New York. Why would anyone want to donate free time and energy to the AAP's Pediatric Research in Office Settings (PROS) network? However, participation in this practice-based research network can not only enhance your pediatric practice and improve care for your own patients, but can do so for all children everywhere.

There are three important studies actively seeking practices that not only contribute to the pediatric knowledge base, but also offer free benefits to you and your practice's patients as well:

1. **BMI<sup>2</sup>** - Brief Motivational Interviewing to Reduce Body Mass Index. Brief Motivational Interviewing to Reduce Child BMI<sup>2</sup> - BMI<sup>2</sup> is a study designed to test interventions addressing the key barriers to obesity counseling in pediatric primary care. Practitioners in this study receive training in ways to help parents change behavior that promise to transform the way pediatricians practice.
2. **CEASE** – Clinical Effort Against Secondhand Smoke Exposure. PROS is looking for practitioners in New York to study techniques in reducing secondhand smoke exposure of pediatric patients and learning smoking cessation counseling techniques and available local tobacco treatment resources for parents.
3. **SSCIB** – Secondary Sexual Characteristics in Boys – a large national cross-sectional study to determine the degree and frequency of pubertal characteristics in young boys in North America to determine the prevalence of these characteristics at different ages among various racial and ethnic groups. There has been no large scale or remotely recent work in this area since James M. Tanner's studies in a handful of institutionalized children in the late 1960's.

One group, one practice, one person can make a difference. Do you want to help develop evidence that leads to a change in pediatric practice? Do you want to have a real impact on the care of children? Then please join PROS. Any pediatric practice or clinic with at least one AAP member is eligible to join. (This includes resident groups and hospital based practices as long as there is a supervising pediatrician who is an AAP member and has joined PROS.)

For more information, go to <http://www.aap.org/PROS/>, or call PROS Project Assistant Norma De Santiago at (800) 433-9016 ext. 7623, or you can contact your local **Chapter PROS Coordinator:**

### **NY Chapter 1**

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## NY Chapter 3

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**By Paul Lee, MD, FAAP (NY Chapter 2)**

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## Retrospective Audits: How to Avoid Them



There is perhaps no more frustrating moment in a physician's career than when a health plan or managed care company notifies them that, after the physician has spent countless hours and expended endless efforts to get paid fifty or sixty cents on the dollar, the payor is now suddenly demanding that some exorbitant amount of money be "repaid" to the payor. The basis for such a demand? The payor has reviewed as few as six charts, isolated what it interprets as a pattern of inappropriate billing, takes the amount involved and *extrapolates* that amount to extend over a randomly selected number of past years. The result? A "discrepancy" of several dollars quickly becomes a demand for several hundred thousand dollars. While couched as a "retrospective audit" or a "probe review," many physicians have simply termed it as legalized extortion.

Understanding how these audits come about is a key first step in avoiding their potential wrath. The triggering event in most cases is a simple computer analysis that identifies those physicians who are billing and/or coding differently than their supposed peers, labels those physicians as "outliers" and refers them for additional scrutiny. To avoid these initial steps, physicians must first come realize that just as accountants are needed to manage the complexities of the Tax Code, today's billing and coding systems dictate the need for specialized assistance. The traditional model of relying exclusively on staff who bill and/or code in a certain fashion because "we've always done it this way" or because "this is how other practices are doing it" is outdated, risky and self-defeating. Even a simple "snap-shot" review of current billing practices, done on an annual basis by a certified coder, can provide valuable insight into what methods are current areas of scrutiny, what trends are developing with one's peers and/or what can be done to keep the practice in the mainstream. Advice from any billing resource should be provided verbally (any written reports could be discoverable in any future proceedings) and should be provided directly to the physicians involved.

Physicians must also understand that even the smallest of amounts in dispute can generate extremely large demands for repayment. If a discrepancy is noted by the computer review, that notation triggers "additional scrutiny" of the practice. While neither statistically valid nor based upon a truly random sample, even the smallest of discrepancies provides the reviewer with a simple method to demand exorbitant monies be "repaid" to the payor. The basic "repayment formula":

$$\begin{array}{c} \text{Claimed Overpayment} \\ \times \\ \text{Rate of Code Usage} \\ \times \\ \hline \text{Number Of Years Enrolled} \\ \hline \text{DEMAND} \end{array}$$

Using this formula, even a billing discrepancy of only \$2.00 can bring about an enormous demand

$$\begin{array}{c} \text{Claimed Overpayment - \$2.00} \\ \times \\ \text{Rate of Code Usage – eight per day, 40 per week, 2000 per year} \\ \times \\ \hline \text{Number of Years Enrolled – 12} \\ \hline \text{DEMAND - \$48,000.00} \end{array}$$

In consideration of such a potentially draconian impact, the need to secure expert, up to date advice has never been more paramount. For the very reason physicians rely upon an accountant to understand and keep abreast of the ever changing tax laws, they can no longer expect their staff to hold sufficient expertise to properly conduct their billing and coding. From Medicare's Fraud and Abuse Bulletins to the never ending stream of Policy and Procedure Manual updates of every health plan and managed care company, the amount of information to be digested is simply overwhelming. To expect general office staff to properly manage that information is both unrealistic and extremely risky. Just as accountants steer taxpayers away from IRS "red-flags" and identify inappropriate deductions, a certified coder focuses on what each payor's particular demands are and what issues might trigger (and thereby avoid) an audit or targeted review.

Moreover, just as every taxpayer understands the need to obtain (and retain) receipts in order to support their tax deductions, today's physician must understand the critical need to create (and retain) a medical record which adequately supports their billing claims. There are ample "short-cuts" to creating a record that will not only withstand audit scrutiny but will also deny payors the ability to reject future, individual claims for payment. From simple pre-printed forms, through digital transcription to an electronic medical record, ample resources exist that can document the level of services rendered, confirm the medical necessity for those services and bar both retrospective repayment demands and prospective denials of payment.

Physicians who are willing to realize that billing and coding in today's medical practice management environment are so obscenely complex that they require ongoing advice from expert specialists will have taken an enormous first step in avoiding coming under review and the potentially devastating impact of a retrospective audit.

Should any physician, or a member of a medical office staff, have any questions regarding retrospective audits, they can contact either Mr. Schoppmann or Mr. Levy at 1-800-445-4564.

**By Michael J. Schoppmann, Esq.**  
**Mathew J. Levy, Esq.**  
*Kern Augustine Conroy & Schoppmann, P.C.*  
*Counsel, The American Academy of Pediatrics*

# *Agenda*

## *AAP District II's* **Annual Legislative Day in Albany** **Tuesday, February 24, 2009**

The Fort Orange Club • 110 Washington Avenue • Albany, NY  
*Directions:* <http://www.fortorangeclub.com/directions/>

**Register Online at:**

<http://www.ny2aap.org/cgi-script/CSMailto/forms/legisdayalbanyfeb2009.htm>

- 8:30 am Registration/Breakfast  
Welcome/Moderator – Henry Schaeffer, MD, FAAP, District II Chair
- 9:00 am Joseph Baker, Secretary for Health & Human Services
- 9:30 am Deborah Bachrach, Deputy Commissioner, Office of Health Insurance Programs & Foster Gesten, Office of Medicaid
- 9:50 am Guthrie S. Birkhead, MD, Deputy Commissioner, Center for Community Health, Office of Public Health
- 10:10 am Troy Oeshner, Deputy Commissioner, Office of Insurance
- 10:30 am Assemblyman Richard Gottfried, Chair, Assembly Health Committee
- 10:50 am Thomas Duane, Chair, Senate Health Committee
- 11:10 am Questions & Answers
- 12:00 pm Review of District II Talking Points and Materials – Elie Ward/George Dunkel
- 12:30 pm Lunch
- Afternoon - Scheduled visits with legislators

# The Extra Strength of PRI Reassurance

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