

**2014 Sunset Review of MSSNY Policy and Position Statements
Socio-Medical Economics**

110.000 HEALTH CARE DELIVERY SYSTEMS:

(See also Health System Reform, 130.000; Managed Care, 165.000)

110.999 Primary Care Services, Access to: It is the position of MSSNY that a patient's access to primary care services provided by a physician should not be limited by the specialty or subspecialty designation of the physician, but should be determined by the training, competence, and experience of the physician to provide primary care services, and that health plans should allow physicians with the appropriate qualifications to elect to provide primary, specialty and subspecialty care services. (Council 12/15/94)

RECOMMENDATION: Reaffirm

120.000 HEALTH INSURANCE COVERAGE:

(See also Abortion and Reproductive Rights, 5.000; Alcohol and Alcoholism, 20.000; Reimbursement, 265.000)

120.975 Home Visits: That MSSNY work to assure appropriate reimbursement for rendering care to homebound individuals. (HOD 04-64)

RECOMMENDATION: Reaffirm

120.976 Geriatric Care: That MSSNY work to assure appropriate reimbursement by all payors for care provided to the elderly. (HOD 04-62)

RECOMMENDATION: Reaffirm

120.977 Patients' Out of Pocket Financial Responsibility for Emergency Room Services Provided: MSSNY takes the position that when an out of network physician provides care in an emergency room, no patient out of network deductible/co-pay should apply. (HOD 04-74)

RECOMMENDATION: Sunset

120.981 Standardized Referral Form: MSSNY will work with the appropriate state agencies to develop a standardized specialist referral form (similar to the HCFA 1500, which has been accepted as a universal medical claim form); and will seek legislation to require that Managed Care Organizations doing business in New York State use such as a uniform referral form. (HOD 00-274)

RECOMMENDATION: Sunset

120.982 "Bare Bones" Health Insurance Policies: MSSNY will urge the New York State Insurance Department to refuse to permit minimalist health insurance policies, commonly known as "bare bones" policies to be offered for sale in New York. (HOD 00-74)

RECOMMENDATION: Sunset

120.985 Call for the Closure of Wellcare of New York: MSSNY will take immediate steps calling for the New York State Insurance Commissioner to close down Wellcare of NY the most insolvent HMO in New York, and guarantee transfer of subscribers to equitable health care plans, and MSSNY will work to ensure that the New York

State Insurance Superintendent: (a) regularly evaluates the financial viability of health care plans operating in New York State, (b) intervene when it is determined that fiscal insolvency of a plan is imminent to protect and to ensure that all providers are reimbursed for outstanding claims prior to any action taken to sell, rehabilitate or dissolve the plan and its assets, and (c) when insolvency is imminent to take actions to assure the insurability and continuation of coverage for all beneficiary/covered lives in the plan prior to any action taken to sell, rehabilitate or dissolve the plan or its assets. (HOD 99-99)

RECOMMENDATION: Sunset

120.987 **Multiple Product Lines:** MSSNY through the American Medical Association will seek Federal Legislative action to challenge health insurers who mandate the commitment of physicians to all (or multiple) product lines under a single contractual agreement as a condition for their participation with such organizations. (Council 12/18/97)

RECOMMENDATION: Reaffirm

120.990 **Physician Notification of Insurance Payments Made Directly to Patients:** MSSNY will seek legal or regulatory action to require that insurance carriers be mandated to notify physicians of the amount and date of insurance claim payments made directly to their subscribers, regardless of the physician's participation status in the plan. (HOD 98-52)

RECOMMENDATION: Reaffirm

120.996 **Standardized Insurance Claim Forms:** MSSNY is seeking appropriate legislative or regulatory reform to require third party carriers to adopt and use a standardized health insurance claim format. (HOD 93-67)

RECOMMENDATION: Sunset

120.997 **Truth in Health Insurance:** MSSNY takes the position that all health insurance literature and contracts should be mandated to use a standardized form, written in laymen's terms (easy to understand language), wherein excluded diseases, diagnoses, and medical procedures are appropriately identified in policies of contract holders. As a means of allowing subscribers to make informed decisions concerning their health insurance choices, the Medical Society of the State of New York is urging the New York State Insurance Department to support legislation which would amend the insurance law in relation to the adoption of current procedural terminology for use by health insurers, as well as requiring insurers to release information on the mode of payment in addition to the actual reimbursement for services rendered to enrolled subscribers. (HOD 92-37)

RECOMMENDATION: Reaffirm

130.000 **HEALTH SYSTEM REFORM:**
(See also Education, 85.000; Health Care Delivery Systems, 110.000;
Managed Care, 165.000; Reimbursement, 265.000)

130.985 **All Self-Insured Programs To Have Same Standards As Other Insurers:** Medical Society of the State of New York will petition the appropriated legislative bodies and regulatory agencies to mandate that all self-insured programs be held to the same requirements, coverages and other standards as those to which HMOs, commercial insurers and governmental insurers are held; and will petition

the American Medical Association to urge appropriate legislative bodies and regulatory agencies to pursue similar legislation/regulation at the Federal level. (HOD 97-61)

RECOMMENDATION: Reaffirm

- 130.986** **Timely Return of Properly Endorsed Third Party Payor Contracts to Participating Physicians:** The Medical Society of the State of New York will seek appropriate legislative or regulatory action to require that upon receipt of physician-signed contracts by the health maintenance organization or insurance plan for participation in such plans, the HMO or insurance plan must be required to return a fully executed contract to the physician within 30 days of completion of such organization's credentialing of the physician. Such legislation shall require the HMO or insurer to provide notice to the physician within 120 days of submission of the physician's signed contract of any additional information necessary to the completion of the physician credentialing process; and shall require that HMOs or insurers shall have no more than 30 days from receipt of all necessary credentialing information to complete the credentialing process. (HOD 97-59)

RECOMMENDATION: Reaffirm

- 130.996** **Single Payor Reimbursement System - Opposition To:** MSSNY is opposed to universal health care proposals with single-payor reimbursement systems. It reaffirms the position reflected in its Universal Health Plan (UHP) Proposal for improving the U.S. Health Care System which call for: (1) Retention of the present multiple payor system with tighter oversight mechanisms to enhance administrative controls and cost efficiencies; (2) Free-market competition as a stabilizing factor in choosing among a multiplicity of health insurers offering a standard and appropriate benefits package. (HOD 92-13)

RECOMMENDATION: Reaffirm

- 165.000** **MANAGED CARE:**
(See also Health Care Delivery Systems, 110.000; Health System Reform, 130.000; Health Information Technology, 117.000; Licensure, 160.000; Medicare, 195.000; Reimbursement, 265.000; Rights and Responsibilities of Physicians, 270.000; Utilization Review, 310.000; Workers' Compensation, 325.000)

- 165.916** **Patient Responsibility for Services Denied by Managed Care Organizations due to Coverage Parameters:** MSSNY encourages all managed care organizations licensed in this state, to adopt a policy allowing participating physicians to bill patients for those services that have been denied due to the company's internal coverage parameters, provided that the patient knew in advance that the procedure would not be covered and still chose to have the procedure performed. (Council 6/3/04)

RECOMMENDATION: Reaffirm

- 165.928** **Rejection of Milliman & Robertson as Standard of Care:** MSSNY formally rejects the Milliman & Robertson guidelines as a standard of care. (HOD 00-273)

RECOMMENDATION: Reaffirm

- 165.931** **Managed Care Organizations Should Supply Complete Fee Schedules and Should Include Cost of Living Adjustment (COLA) Guarantees in Contracts:**

MSSNY will seek legislative/regulatory relief (a) to require managed care organizations (MCOs) to provide physicians, as a condition of new or continued participation, with complete fee schedules, including past fee schedules; (b) to require managed care organizations (MCOs) to include in physician contracts a Cost of Living Adjustment (COLA) provision guaranteeing an upward adjustment of fee schedules when the physician's overhead increases, similar to a Resource-Based Relative Value fee schedule. (HOD 00-266)

RECOMMENDATION: Sunset

165.932 **Health Care Plans:** MSSNY will seek regulation and/or legislation that once a health care plan has sold its product to a consumer, the health care plan is not permitted to limit the territory it covers during the policy term. (HOD 00-254)

RECOMMENDATION: Reaffirm

165.933 **Downcoding:** MSSNY will seek legislative relief to (a) preclude down-coding and/or bundling of any medically necessary service by health care plans doing business in New York State and Computer Sciences Corporation/Medicaid; (b) prevent health care plans and Computer Sciences Corporation/Medicaid from the down-coding of medical services without first obtaining, at the expense of the health care plan, copies of patients' medical record and justifying the change in reimbursement; (c) prevent health care plans and Computer Sciences Corporation/Medicaid from requiring automatic and mandatory submission of medical record documentation for Evaluation and Management (E&M) codes at the time of claim submission. (HOD 00-253)

RECOMMENDATION: Reaffirm

165.935 **HMO Carve-outs:** MSSNY will introduce legislation which would provide every citizen of this state with the ability to access all of the services provided by his physician when such physician is a member of his health care plan's panel of physicians, or in the case of policies which provide for out-of-network coverage, is a physician licensed in the State of New York. (HOD 00-90)

RECOMMENDATION: Sunset

165.936 **Mandated Use of Hospitals by Managed Care Companies:** MSSNY will seek passage of state legislation which would prohibit managed care companies and hospitals from mandating that physicians participating in their plans use a hospital list instead of being able to follow their own patients when those patients are hospitalized. (HOD 00-85; Reaffirmed HOD 04-57)

RECOMMENDATION: Sunset

165.938 **Patient's Choice:** MSSNY will seek New York and Federal legislation which requires a health care plan to permit patients to access, without restriction, any and all providers participating with the plan who provide medical or diagnostic services. (HOD 00-63)

RECOMMENDATION: Reaffirm

165.939 **Insurance Company Participating Provider Networks:** MSSNY will pursue a legislative remedy to ensure that when any health care plan entity publishes a list of participating providers as part of an advertising campaign to enroll new members for a future time period (or upcoming coverage period), that said list accurately reflect the physicians who **will** be participating during the time period

the insurance will be in effect and not merely the physicians who are currently participating as of the time of the advertising campaign. (HOD 00-62)

RECOMMENDATION: Reaffirm

165.942 **Education About HMOs as Payors for Health Care:** MSSNY will urge the American Medical Association to better educate the lay public, and executive and legislative branches of the government, about the percentage of premium dollars expended by Health Maintenance Organizations on health care (i.e. the medical loss ratio). (HOD 99-204)

RECOMMENDATION: Sunset

165.943 **Require Health Insurance Carriers to Report Medical Loss Data that Reflects All Levels of Managed Care Subcontracting:** MSSNY shall take all steps necessary to ensure that the New York State Department of Health and the New York State Insurance Department promulgate regulations requiring HMOs and health care insurers to include in their calculation of medical loss data only payments for patient care and to exclude from the calculation of medical loss data and funds retained by “carve out” managed care companies under contract with an HMO or health care insurer for administration and profit. (HOD 99-265)

RECOMMENDATION: Sunset

165.944 **HMO Requirements that Physician Providers Use Only Approved Laboratories:** MSSNY will inform HMOs that physicians should be allowed to use laboratories of their choice for all patients, and MSSNY shall seek legislative action that would require HMOs to refrain from interfering with the practice of medicine by making it mandatory to use specific clinical and anatomic pathology laboratories. (HOD 99-95)

RECOMMENDATION: Sunset

165.949 **Quarterly Publication of Supplementary Provider Lists for HMO Subscribers:** MSSNY will seek regulatory or legislative action to require that insurance plans and health maintenance organizations in New York State distribute on a quarterly basis an updated supplementary list of providers to their subscribers. This regulation or legislation should also include a requirement that insurance plans and health maintenance organizations provide to their patients in an annual directory and, in any update to said directory, a listing of participating physicians in all of the specialties for which the plan has approved the physician. MSSNY will seek to establish through legislation an increased penalty for insurance plans and health maintenance organizations that do not comply with these provisions. (HOD 99-66; Reaffirmed HOD 00-81)

RECOMMENDATION: Sunset

165.950 **Require that HMO Subscribers Select a Primary Care Physician Within 30 Days or be Assigned One by the Plan, as per the Requirements of the NYS Medicaid Managed Care Guidelines Issued by the NYS Department of Health:** MSSNY will seek regulatory or legal action to require that if HMO subscribers do not select a primary care physician within thirty days, they be assigned one by the plan, similar to the current guidelines utilized by the NYS Department of Health governing Medicaid Managed Care Plans; and such regulatory or legal action should also require that HMOs inform each enrollee of the name, address, and

telephone number of the primary care physician to whom the enrollee has been assigned and of the enrollee's right to select a different primary care physician. MSSNY will seek regulatory or legal action to require that payment of the capitated amount to the primary care physician begin at the time of selection or assignment. (HOD 99-62)

RECOMMENDATION: Reaffirm

165.956 **Disclosure of Conversion Options by Medicare Managed Care Organizations to Prospective Enrollees Previously Covered by Employer-Sponsored Insurance Contracts:** MSSNY will urge the AMA to support federal legislation that would require Medicare Managed Care Organizations to provide complete, comprehensible and accurate disclosure of information to prospective enrollees. Such disclosure to prospective enrollees must include advantages as well as disadvantages, especially the inability of beneficiaries to return to their former employer group health plan coverage, and the possible restriction of their access to physicians, hospitals and other services. MSSNY will also ask the AMA to urge HCFA to develop clear and concise guidelines concerning the content of the presentations made by agents of MCOs and other insurers and that such guidelines be monitored by HCFA for strict adherence by MCOs, subject to penalties for any purposeful misleading or inaccurate information. (HOD 98-274)

RECOMMENDATION: Sunset

165.958 **Crediting Capitated Payment:** MSSNY will advocate for legislation and/or regulations requiring managed care plans (a) to begin capitated payments to the physician starting from the date of which the patient enrolls in the managed care plan; (b) that the enrollee designate a primary care physician in a timely manner and (c) that the physician be notified of such selection. (HOD 98-83)

RECOMMENDATION: Reaffirm

165.960 **Capitation:** The Medical Society of the State of New York will seek legislation or regulation which (a) defines acceptable financial risk arrangements between physicians and managed care plans to minimize the potential for the reduction or limitation of appropriate access to medically necessary services; and (b) ensures that managed care plan enrollees be entitled to know the type of financial risk arrangement health plans have in place for their providers. (HOD 98-72; Reaffirmed HOD 99-268)

RECOMMENDATION: Reaffirm

165.962 **State Control Over Changes in Health Insurance Coverage and Reimbursement:** MSSNY will seek the enactment of legislation that (a) requires that physicians receive specific notice of the compensation terms proffered by managed care plans, including a detailed statement of the precise terms by which monies will be paid and (b) requires that physicians be routinely informed of the method by which the amount of a withhold or a bonus will be calculated, the date upon which payment will be made and a description of the records relied upon to calculate the withhold or bonus and (c) requires scrutiny of managed care plans financial statements by appropriate state agencies when a managed care plan fails to return funds withheld from physicians in a given year to determine if the retention of funds by the managed care plan is, indeed, justified and (d) if retention

of funds is determined to be unjustified, said agencies direct the managed care plan to return the withhold with appropriate interest and penalties, and (e) inform beneficiaries when benefits are changed. (HOD 98-60)

RECOMMENDATION: Reaffirm

165.966 **Uniform Application Form, Uniform Encounter Form:** MSSNY supports the establishment and use of a uniform application and a uniform encounter form to be used by all HMOs, IPOs, HPOs and IPAs. (HOD 97-273)

RECOMMENDATION: Reaffirm

165.967 **Managed Care Organizations to Standardize Pre-Certification:** MSSNY will encourage managed care organizations to standardize pre-certification procedures and time limits for HMOs to respond to pre-certification requests for patient care regardless of the time of day or day of week. (HOD 97-254)

RECOMMENDATION: Reaffirm

165.970 **DEA Numbers Should Not Be Used As A Means Of Physician Identification:** MSSNY will advise and encourage New York State physicians not to release their DEA numbers except where required for prescribing narcotics and other Schedules II-V drugs; and will advise all MCOs of this policy. In the event that MCOs persist in using the DEA number as a means of physician identification, MSSNY will vigorously pursue appropriate legislative or regulatory relief and will ask the AMA to pursue similar legislation or regulatory relief. (HOD 97-107; Reaffirmed HOD 00-60)

RECOMMENDATION: Reaffirm

165.971 **Retrospective Denial of Insurance Claims:** MSSNY will seek legislation which would amend subdivision (4) of section 4903 of the public health law and subdivision (d) of section 4903 of the insurance law which require health maintenance organizations and insurers to “make a utilization review determination involving a health care service which has been delivered within 30 days of receipt of the ‘necessary information’” to further require that in no event shall such determination be made later than 90 days from the submission of the claim. (HOD 97-97)

RECOMMENDATION: Reaffirm

165.973 **Patient Access to Physicians No Longer On Plan:** MSSNY will seek legislation which would enable enrollees to a managed care plan to continue to receive care from the enrollee’s current physician for up to one year or the balance of their policy period, whichever is longer, where the physician has left or has been terminated by the plan provided that the termination is not related to imminent harm to patient care, a determination of fraud or a final disciplinary action and provided further that the physician continues to accept reimbursement from the managed care plan at the rates applicable prior to the termination or departure of such physician from the plan and adheres to the plan’s quality assurance and utilization review requirements. (HOD 97-93)

RECOMMENDATION: Reaffirm

165.982 **Changes in the Bundling of Medical Services by Managed Care Plans:** It is MSSNY's position that when a patient sees a physician for evaluation and management of an illness, whether primary care or consultation, and the physician also performs a procedure which helps in the diagnosis or treatment of that illness, the physician should be paid for both the evaluation and management code and the procedure code. When a physician sees a patient to perform a pre-scheduled procedure, cognitive services are considered part of the performance of the procedure and the physician should be paid only for the procedure. The supporting rationale for this policy is embodied in two separate functions; (a) the evaluation of the problem and decision to perform a procedure; and (b) the performance and interpretation of the procedure. These functions could often be performed on separate days, but, for reasons of good medicine, expedited care and patient/physician convenience, it is often preferable to perform the procedure on the same day as the evaluation and management visit. It would, therefore, be inappropriate under these circumstances to either unnecessarily require the patient to have the procedure performed on another day or to deprive the physician of equitable payment for the proper provision of both services on the same day. (Council 12/19/96; Reaffirmed HOD 00-257 & 268)

RECOMMENDATION: Reaffirm

165.983 **Redefining the Roles, Obligations and Responsibilities of Insurance Companies which Utilize Capitation as a Means of Physician Reimbursement:** MSSNY will seek legislation requiring managed care organizations to assume appropriate risk while at the same time: (a) providing an adequate proportion of premium dollars dedicated to medical care; (b) providing for equitable physician reimbursements; (c) reducing excessive MCO profit margins. (Council 12/19/96)

RECOMMENDATION: Reaffirm

165.984 **Prior Authorization for Procedures Under Managed Care: Limits on Time Requirements:** MSSNY supports the requirement that managed care organizations implement and comply with written procedures to assure that entities that conduct utilization review: (1) provide adequate access to its review staff by a toll-free or collect call phone line, at a minimum, from 8:00 a.m. of each standard business day; (2) establishment of written procedures for receiving or redirecting after-hour calls either in person or by recording; and (3) having a mechanism to receive timely call backs from providers. (HOD 96-76)

RECOMMENDATION: Reaffirm

165.988 **Specialty Rosters in Managed Care:** All managed care organizations should be required to maintain full rosters of medical specialists, representing all the specialties approved by the American Board of Medical Specialties and the American Osteopathic Board of Medical Specialties or otherwise provide access outside the managed care organizations to the full range of medical specialists as needed. (HOD 96-78)

RECOMMENDATION: Reaffirm

165.989 **Retrospective Denial of Pre-Certified Services by Managed Care:** The practice of retrospective denial of payment for care which has been pre-certified by an insurer, except when false or fraudulent information has knowingly been given to

the insurer by the physician, hospital or ancillary service provider to obtain pre-certification should be banned. (HOD 96-90)

RECOMMENDATION: Reaffirm

165.990 **Profits and Administrative Costs of Managed Care Organizations:** MSSNY supports legislation which would require public disclosure by managed care organizations of the percentage of premium dollars expended on health services, administrative services and plan marketing, and takes the position that such organizations be required to disclose the percentage of premium dollars retained as profit. (HOD 95-94)

RECOMMENDATION: Sunset

165.992 **Utilization Review Management:** MSSNY affirms the following position with regard to Utilization Review Management applicable to managed care entities who utilize down-coding, site of service payment reductions, and restrictive patient referral policies as a means of economic disincentives as follows: Physicians who are trained and/or Board Certified in their practice should be allowed to perform and be reimbursed for services if they are medically indicated. Any managed care plan implementing utilization review or management programs should establish an appeals process whereby physicians, other health care providers and patients may challenge policies restricting access to specific services and decisions to deny coverage for services. Such individuals must have the right to have reviewed any coverage denial based on medical necessity by a physician who is of the same specialty and has appropriate expertise and experience in the field. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services, or site of services, should be licensed to practice medicine and actively practicing in New York State and should be professionally and individually accountable for his or her decisions. The medical protocols and review criteria used by managed care plans in any utilization review or management program must be developed by practicing physicians. Managed care plans should be required to disclose to physicians, on request, the screening and review criteria, weighing elements, and computer algorithms used in the review process, as well as how they were developed. A physician of the same specialty must be involved in any decision by a utilization review or management program to deny or reduce coverage for services based on questions of medical necessity. A physician whose services are being reviewed for medical necessity should be provided the identity and credentials of the reviewing physician on request. The reviewed physician should also have the opportunity to speak with a reviewer. (Council 9/22/95; Reaffirmed HOD 00-79 & 80)

RECOMMENDATION: Reaffirm

165.993 **Emergency Services at Specialty Centers - Equity Coverage by Managed Care Entities:** It is the position of MSSNY that those managed medical care organizations that limit or restrict fiscal coverage to certain hospitals and physicians make an exception for emergent critical care case situations (such as extensive burns, neonatal spinal injuries, multi-organ/extensive trauma) that are sent to the appropriate specialty centers pursuant to guidelines established by organized medicine, and State or Federal policy, rules and regulations. MSSNY strongly opposes any attempt by a managed care entity or third party payer to delay, to deny payments, or to reduce payments when a patient is sent, on an emergent basis, to a designated specialty center and will disseminate this position

to the membership and the New York State Health Maintenance Organization Council. (HOD 94-274)

RECOMMENDATION: Reaffirm

165.994 **Policy on Managed Care:** MSSNY affirms the following policy as adopted by the Council on January 23, 1986, and amended by the Committee on Interspecialty on January 13, 1994: (1) No single pattern of health care delivery is necessarily suited to all patients or to all physicians; and that (2) The traditional fee-for-service, the HMO, the HMO-IPA, and PPO concepts are valid and acceptable health care delivery systems; but (3) There must be available multiple delivery mechanisms among which both the patient and the physician can truly exercise the right of free choice of how they will receive and disburse quality medical care; and that (4) Any managed care plan is urged to cover in its basic policy all medically necessary procedures for all ICD-9 illnesses; medical, surgical, psychiatric and addictive. In the presence of such parity, cost factors may be dealt with by practice parameters, by utilization criteria and review, and by sliding scales of co-insurance and deductibles, not by limiting areas or specialties of care; and that (5) Employers should contribute equitable amounts for each employee's health benefit plan, regardless of the plan selected; and that (6) Fair market competition among all systems of health care delivery shall continue to be MSSNY policy (similar to AMA policy) with the potential growth of health care delivery systems being determined not by governmental intercession or entrepreneurial considerations, but by the number of people who prefer this mode of delivery. In addition, MSSNY recognizes both closed panel plans and open panel plans as valid and acceptable health care delivery modalities, consistent with the foregoing MSSNY policy statement.

MSSNY affirms the following AMA policy statements on managed care encompassing: (1) Case Management; (2) Financial Incentives and Disincentives; (3) Selective Contracting; (4) Physician Governance of Managed Care Program Policies:

1) Case Management (a) Case Management Health plans using the preferred provider concept should not use coverage arrangements which impair the continuity of patient's care across different treatment settings. (b) With the increased specialization of modern health care, it is advantageous to have one individual with overall responsibility for coordinating the medical care of the patient. The physician is best suited by professional preparation to assume this leadership role. (c) The Primary goal of high-cost management or benefits management programs should be to help to arrange for the services most appropriate to the patient's needs; cost containment is a legitimate but secondary objective. In developing an alternative treatment plan, the benefits manager should work closely with the patient, attending physician, and other relevant health professionals involved in the patient's care. (d) Any health plan which makes available a benefits management program for individual patients should not make payment for services contingent upon a patient's participation in the program or upon adherence to treatment recommendations. (AMA Policy 285.998)

2) Financial Incentives and Disincentives (a) Any financial arrangements that may tend to limit the services offered to patients, or contractual provisions that may restrict referral or treatment options, should be fully disclosed to prospective

enrollees by plans utilizing such arrangements. (b) Physicians must disclose any financial inducements or contractual agreements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or restrict referral or treatment options. Physicians may satisfy their disclosure obligations by assuring that the managed care plan makes adequate disclosure to patients enrolled in the plan. Physicians must also inform their patients of medically appropriate treatment options regardless of cost or the extent of their coverage. (c) Physicians should have the right to enter into whatever contractual arrangements with health care systems they deem desirable and necessary, but should be aware of the potential for some types of systems to create conflicts of interest because of financial incentives to withhold medically indicated services. Physicians must not allow such financial incentives to influence their judgment of appropriate therapeutic alternatives or deny their patients access to appropriate services based on such inducements. (d) Physician payments that provide an incentive to limit the utilization of services should not link financial rewards with individual treatment decisions over periods of time insufficient to identify patterns of care or expose the physicians to excessive financial risk for services provided by physicians or institutions to whom he or she refers patients for diagnosis or treatment. When risk-sharing arrangements are relied upon to deter excess utilization, physician incentive payments should be based on performance of groups of physicians rather than individual physicians, and should be based over short periods of time. (e) Alternative private health benefit plans, with different schedules of deductibles, coinsurance and premiums, should be available to enrollees so that they are aware of the financial trade-offs associated with different plans. Both private and public third party payment systems should use deductibles and coinsurance as financial incentives for health care recipients to use health care resources in an appropriate manner. However, cost-sharing should not result in an undue financial burden for the health care recipient, and should not act to prevent access to needed care. (f) Physicians, other health professionals, and third party payors through their reimbursement policies, should continue to encourage use of the least expensive care setting in which medical and surgical services can be provided safely and effectively with no detriment to quality. (AMA Policy 285.998)

3) Selective Contracting (a) Health plans or networks should provide public notice within their geographic service areas when applications for participation are being accepted. (AMA 285.998) (b) Physicians should have the right to apply to any health care plan or network in which they desire to participate and to have that application judged on the basis of objective criteria that are available to both applicants and enrollees. (AMA CMS Report B, A-93) (c) Those managed care plans that contract with selected physicians to furnish care should utilize selection criteria based primarily on professional competence and quality of care. Any economic criteria used in such selective contracting should have a demonstrated positive relationship to the quality and appropriateness of care and to professional competency. (AMA Policy 285.997) (d) Managed care plans that contract with selected providers should have an established appeals mechanism by which any provider willing to abide by terms of the plan contract could challenge a decision to deny the provider's application for participation in the plan. (AMA Policy 285.997) (e) All managed contracts should expressly require the managed care plan to provide meaningful due process protections, in order to prevent wrongful and arbitrary contract terminations that leave the physicians without means of redress. (AMA Policy 285.996) (f) Prior to initiation of actions leading to termination or non-

renewal of a physician's participation contract for any reason, the physician shall be given notice specifying the grounds for termination or non-renewal, a defined process for appeal, and an opportunity to initiate and complete remedial activities except in cases where harm to patients is imminent or an action by a state medical board or other government agency effectively limits the physician's ability to practice medicine. (AMA CMS Report B, A-43) (g) All "hold harmless" clauses in managed care contracts should be explicitly identified as such. Physicians should consider consulting with legal counsel prior to contracting with a managed care entity to prevent the imposition of unfair liability upon the physician. (AMA Policy 285.995) (h) Physicians should have the right to enter into whatever contractual arrangements with managed care plans they deem desirable and necessary, but should be aware of the potential for some types of plans to create conflicts of interest because of financial incentives to withhold medically indicated services. (AMA Policy 285.998)

4) Physician Governance of Managed Care Programs' Policies (a) The medical protocols and review criteria used in any utilization review or utilization management programs must be developed by physicians. (AMA Policy 285.998)

In addition it is the position of MSSNY that quality assurance policies and any medical protocols be governed by practicing physicians. Credentialing of physicians is directly related to utilization review and quality assurance, and should, therefore, be operated in accordance with policies determined by physicians. (Council 3/10/94)

RECOMMENDATION: Reaffirm

175.000 MEDICAID:
(See also Drugs and Medications, 75.000; Health Insurance Coverage, 120.000, Medicare, 195.000; Professional Medical Conduct, 250.000; Reimbursement, 265.000)

175.988 New York State Department of Health Office of Medicaid Management Medicaid Fee Increase: MSSNY and all of its component county medical societies will work together to affect ongoing changes in Medicaid fee schedules to make it a program more attractive to physicians, ultimately improving patient care. (HOD 00-64; Reaffirmed Council 6/3/04)

RECOMMENDATION: Reaffirm

175.990 Standing Orders: Since (a) the Medicaid Program does not currently recognize a standing orders protocol which is widely accepted by other insurers and (b) it becomes inefficient and burdensome for physicians to provide original signatures on all laboratory test requisitions, MSSNY will urge the Office of Medicaid Management of the NYS Department of Health to:

- Eliminate the requirement for original physician signatures, except the first signature, on each laboratory test requisition and allow standing orders for such tests involving chronic patient conditions (which may include, but not be limited to, diabetes (Glucose, Hemoglobin A1C/Glycohemoglobin), chemotherapy (CBC, Platelets), heart conditions (Prothrombin Time, Digoxin)

substance abuse monitoring by a licensed treatment facility, any other condition deemed chronic in the reasonable judgment of a physician, etc.);

- Allow the initial standing order containing an original physician signature to be valid for up to six months, after which time it must be renewed;
- Enable physicians to designate staff members to sign the laboratory test requisitions on their behalf so long as the physicians formally acknowledge ultimate responsibility for the ordered tests;
- Develop a similar protocol for electronically ordered laboratory tests
- Interact the MSSNY, the Advisor on Practice Parameters Partnership and the NYS Clinical Laboratory Association (NYSCLA) to develop a listing of acceptable chronic conditions for the application of standing orders;
- Interact with MSSNY and NYSCLA to develop an appropriate mechanism for the implementation of a standing orders protocol for laboratory test requisitions. (Council 2/4/98)

RECOMMENDATION: Reaffirm

- 175.991** **Public Health Mandate Funding:** Fee schedules for immunizations under public funding mechanisms such as Medicaid should be modified to include additional reimbursement to help defray physicians' expenditures for compliance with State and City mandates which increase physicians' operating costs. (HOD 97-268)

RECOMMENDATION: Reaffirm

- 175.992** **Site of Service Differential Payment Policy:** MSSNY reaffirms its position calling for the elimination of the highly objectionable Medicaid site of service differential payment policy for similar services provided in physicians' offices as compared to hospital settings; particularly as the state-proposed Medicaid Managed Care Demonstration unfolds. (Council 12/19/96)

RECOMMENDATION: Reaffirm

- 175.993** **Nine-Tier Reimbursement Structure for HIV Care:** MSSNY endorses the Nine-Tier structure for HIV Care under Medicaid which will result in a more consistent and realistic reimbursement structure for the care needs of patients with HIV/AIDS. (Council 12/19/96)

RECOMMENDATION: Sunset

- 175.997** **Utilization and Audits:** MSSNY is working with the New York State Department of Social Services and the New York State Department of Health to establish protocols against inappropriate utilization of Medicaid services and commensurate expenditures and to address the needs for: (1) Clear utilization of services parameters for dissemination to the physician community to guide physicians in the provision of health care under the Medical Assistance Program; (2) Development of more palatable and equitable methodologies to ensure appropriateness in audit investigations through mutually agreeable physician peer review activities and any disputes arising from such a peer review process. (Council 12/19/92)

RECOMMENDATION: Reaffirm

175.998 **Fraud and Abuse Audit Control Activities:** MSSNY is cognizant of the realities surrounding health insurance audit and utilization review activities to ensure justifiable expenditures of private or public funds for claimed medical services. The Society is, nevertheless, deeply concerned by reports of inappropriate and inequitable Medicaid fraud and abuse investigations in New York State.

MSSNY asserts that any such fraud and abuse investigations motivated by established recoupment targets and bonus incentives by investigating state and federal entities is highly unethical, immoral, and contrary to the principles of fairness that are inherent in the American administrative and judicial system, and that have come to be rightfully expected by the medical community and the public at large. In acknowledging that not all individuals seek to fulfill the highest aspirations of their particular professions, MSSNY believes that any such individuals in medical practice who subscribe to substandard principles of medicine and ethics in interacting with health insurance programs should be treated accordingly. However, since MSSNY is confident that such practitioners comprise a decided minority of the state's medical community, the Society logically expects the New York State Department of Social Services (NYSDSS) Fraud and Abuse/Audit Control Divisions, the New York State Attorney General's Office, and the Office of the Inspector General to conduct legitimate Medicaid fraud and abuse investigation in an ethical and moral manner that ensures: (1) Equitable and meaningful due process for those medical professionals whose services are under review or investigation; (2) Appropriate classification of Medicaid audits so that cases basically involving the following are not unduly labeled as fraudulent activities and, thus, pursued accordingly: (a) Lack of adequate documentation of services; (b) Simple billing irregularities; or (c) Other billing errors (3) Physician safeguards against occurrences of unwarranted prosecutions by investigating agencies through: (a) Utilization of medical experts to corroborate substandard medical practices and justify Medicaid investigations; (b) Provision of pertinent guidelines to physicians for proper conformance with Medicaid requirements; (4) Retention of sufficient physician participation in the Medicaid program to guarantee access to quality health care for medically needy recipient (5) Physician immunity against harassment and victimization by overzealous reviewers to the detriment of their well-being, community standing, and professional careers; with such reviewers being answerable for their unwarranted actions; (6) Physician immunity against undue harassment and pursuit by reviewers on the basis of state budgetary constraints or bureaucratically devised recoupment targets and bonus plan incentives; (7) Physician entitlement to reasonable compensation by the investigating state or federal agencies for legal costs incurred by exonerated practitioners for compelled involvement in arbitrary fraud and abuse or audit control activities. In summary, it is the position of the Medical Society of the State of New York that no medical practitioner in the State of New York be subjected to the traumatic, intimidating and career-threatening activities of state and federal agencies, or any other health insurance entities, unless there is absolute and unimpeachable evidence of serious wrongdoing to warrant such focused pursuit. (Council 1/31/91)

RECOMMENDATION: Reaffirm

195.000 **MEDICARE:**

(See also Drug Dispensing, 70.000; Drugs and Medications, 75.000; Health Insurance Coverage, 120.000; Health System Reform, 130.000; Medicaid, 175.000; Peer Review, 225.000)

- 195.974 **Medicare MCO's, CMS Operational Policy Letter #46, and the Proposed Handover of the Medicare Program to Private and Managed Care Insurers:** MSSNY reaffirm our policy as stated in resolution 2003-272 and gather data to submit to the Center for Medicare and Medicaid Services (CMS) that documents that Medicare Managed Care Plans are not following CMS Operational Policy Letter # 46; and urge that Medicare Managed Care Plans inform their providers and their potential members in writing of any standard Medicare procedures that they will not cover. (HOD 04-256)

RECOMMENDATION: Sunset

- 195.982 **Elimination of \$75.00 Charge for Purchase of Medicare E.D.E.N. Relay/Gold Software for Electronic Billing:** MSSNY will seek legislative or regulatory relief to ensure that all health plans doing business in the State of New York eliminate any charges to physicians for software and/or transmission capability in an effort to encourage electronic claim submissions. (HOD 00-270)

RECOMMENDATION: Sunset

- 195.983 **Medicare "Fraud and Abuse":** MSSNY will urge the appropriate federal and state agencies to acknowledge that the characterization of any billing errors as "fraud" to be libelous and offensive.

MSSNY objects to the heavy handed techniques of search and seizure, with guns drawn and without formal charges levied, as tactics of a totalitarian police state;

MSSNY will demand that Congressional inquiry address these concerns, which give the perception that the physicians are "*GUILTY UNTIL PROVEN INNOCENT*," with open public hearings at the earliest opportunity.

MSSNY objects to and rejects "statistical analysis" that attempt to claim that a physician's billing or practice is aberrant by use of flawed methodologies, and will advocate to stop the use and extrapolation of this data as "fraud and abuse.

MSSNY will seek legislation, in concert with the AMA, directing the Health Care Financing Administration (HCFA) to remove the notations of fraud reporting announcements from all mailings to Medicare beneficiaries in order to prevent erosion of the physician/patient relationship. (HOD 00-255)

RECOMMENDATION: Reaffirm

- 195.984 **Proposed CAC Policies:** MSSNY will make available on its website for members only: a) the draft medical policies under consideration by the Medicare Carriers Advisory Committee (CAC) for review and comments; b) a listing of the CAC Specialty Society representatives who may be contacted by their colleagues on proposed CAC medical policies. (Council 5/20/99)

RECOMMENDATION: Sunset

195.985 **Repealing Restrictions on Private Medicare Contracting:** MSSNY will support and lobby on behalf of related bills HR 2497 (Representative Archer) and S.1194 (Senator Kyl), which would amend Title XVIII of the Social Security Act to clarify the right of physicians and other health care providers to enter into private contracts with Medicare beneficiaries for: a) the provision of health services for which no payment is sought under the Medicare program; b) the right to privately contract with beneficiaries without physicians having to opt out of the program for two (2) years. MSSNY will introduce a resolution to the 1999 Annual Meeting of the AMA House of Delegates calling for the Association to support and lobby on behalf of related bills HR 2497 and S.1194. (HOD 99-271)

RECOMMENDATION: Reaffirm

195.986 **System for Checking Eligibility of Patients in Medicare HMOs:** MSSNY will urge HCFA to adopt the procedures of other third-party carriers that do not consider the release of information that the patient is insured by a particular insurance company as confidential information and to require Medicare carriers to develop a carrier-level on-the-spot eligibility check system for Medicare beneficiaries. (HOD 98-269)

RECOMMENDATION: Sunset

195.988 **Comparative Performance Reports (CPRs):** MSSNY will urge HCFA Region II, and call upon the AMA as well, to urge the HCFA Central Office to annually require the carriers to provide Comparative Performance Reports (CPRs) to all physicians furnishing Evaluation and Management Services under Medicare. (Council 12/18/97.)

RECOMMENDATION: Sunset

195.989 **Physicians' Appeals of Medicare Hearing:** MSSNY will interact with HCFA in preparing and distributing formal guidelines for carriers and physicians to follow through the entire Administrative Law Judge Hearing process. These guidelines will properly identify all the appropriate actions that physicians must take in order to guarantee their rights of due process and preclude unwarranted and spurious denials of Administrative Law Judge Hearings based on a physician's failure to follow established protocols that have, heretofore, never been formally distributed to the physicians' community. (HOD 97-274)

RECOMMENDATION: Sunset

195.990 **Patient's Choice In Continuing a Physician/Patient Relationship:** MSSNY will advocate that all providers of Medicare health care coverage be required to provide that all Medicare recipients enrolling in an HMO have the name of their physician on their enrollment form at the time of the enrollment to prevent confusion after the fact; and that MSSNY similarly advocates that if a patient finds out that his/her physician is not on the panel of the HMO to which a patient has enrolled that the patient be allowed to disenroll from the HMO. (HOD 97-272)

RECOMMENDATION: Sunset

195.992 **Beneficiary Identification System:** In view of the current physician inability to verify beneficiary coverage under a closed-panel physician Medicare Managed Care Program (MCP), MSSNY takes the position that the Health Care Financing Administration should be urged to: (1) Establish an expedient beneficiary identification system via current technological means such as employed by the

NYS Medicaid Program (i.e., the Electronic Medicaid Eligibility Verification System (EMEVS), featuring “swipe card” technology to verify patients’ Medicaid coverage under a Managed care system; (2) Require Medicare Managed Care Programs to provide identification cards designate beneficiary’s coverage under the managed care plan; (3) Provide a dedicated telephone line to enable physicians to expeditiously verify beneficiaries’ coverage under a managed care system. (Council 9/7/95; Reaffirmed HOD 00-272)

RECOMMENDATION: Sunset

195.993 **Durable Medical Equipment Providers, Prohibition of Solicitation of Patients:** MSSNY reaffirms the concept that physicians are solely responsible for the medical needs of their patients and should be the initiators of orders for durable medical equipment supplies. In support of this reaffirmation, MSSNY will seek the reintroduction, amendment, and enactment of Section 133 of US Senate Bill (S.1668), to prohibit unsolicited contacts by Durable Medical Equipment suppliers to Medicare beneficiaries and has sought the support of the American Medical Association for the enactment of this legislation. (HOD 94-261)

RECOMMENDATION: Sunset

195.994 **Electronic Paper Claims:** While the Medical Society strongly encourages physician involvement in the emerging electronic claims transmission initiative, it strongly supports the prerogative of physicians to choose the most suitable and practical modality of claims submission for their practices and has urged the AMA to seek appropriate legislative relief from the unfair and discriminatory federal requirements mandating Medicare carriers to delay payment of paper claims for at least 27 days. (HOD 93-2)

RECOMMENDATION: Sunset

195.995 **Extrapolation Methodology in Medicare and Medicaid Postpayment Review:** MSSNY is: (1) Petitioning the AMA to urge HCFA to adopt a policy that Medicare carriers just provide data which justify the statistical validity of their findings when any extrapolation technique is used in a Medicare post-payment audit and review process prior to any request for return of monies paid to physicians; (2) Seeking statutory changes in the Medicare and Medicaid laws to prevent the application of the extrapolation methodology in order to ensure due process for physicians whose medical records and billing procedures are under review; (3) Educating physicians in concert with local county medical societies about the potential abuses by Medicare and Medicaid administrators in carrying out reviews, and identifying legal resources which can be called upon by individual physicians for legal assistance and/or defense in cases of alleged Medicare/Medicaid fraud and abuse or overpayment. (HOD 92-5 & 92-76)

RECOMMENDATION: Reaffirm

195.999 **Mandatory Acceptance of Medicare Assignment:** MSSNY opposes mandatory assignment for payment for Medicare services. (HOD 83-45; HOD 90-46)

RECOMMENDATION: Reaffirm

240.000 **PRACTICE MANAGEMENT:
(See Vaccines, 312.000)**

240.991 **Translation Services:** That further research is necessary on how the use of interpreters -- both those who are trained and those who are not -- impacts patient care (2) treating physicians shall respect and assist their patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive (3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication -- including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations -- to aid LEP patients' involvement in meaningful decisions about their care, and (4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires, and that when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements. (HOD 04-61)

RECOMMENDATION: Sunset

240.992 **Patient Responsibilities:** MSSNY has adopted the following principles of patient responsibility: (1) Good communication is essential to a successful physician-patient relationship. To the extent possible, patients have a responsibility to express their concerns clearly to their physicians and be honest. (2) Patients have a responsibility to provide a complete medical history, to the extent possible, including information about past illnesses, medications, hospitalizations, family history of illness and other matters relating to present health. (3) In addition to explaining known medical background to their physician, patients have a responsibility to request information or clarification about their health status or treatment when they do not fully understand what has been described. (4) Once patients and physicians agree upon the goals of therapy, patients have a responsibility to cooperate with the treatment plan. Compliance with physician instructions is often essential to public and individual safety. Patients also have a responsibility to disclose whether previously agreed upon treatments are being followed and to indicate when they would like to reconsider the treatment plan. (5) Patients generally have a responsibility to meet their financial obligations with regard to medical care or to discuss financial hardships with their physicians. Patients should be cognizant of the costs associated with using a limited resource like health care and should try to use medical resources judiciously. (6) Patients should discuss end of life decisions with their physicians and make their wishes known. Such a discussion might also include writing an advance directive. (7) Patients should be committed to health maintenance through health-enhancing behavior. Illness can often be prevented by a healthy lifestyle, and patients must take personal responsibility when they are able to avert the development of disease. (8) Patients should also have an active interest in the effects of their conduct on others and refrain from behavior that unreasonably places the health of others at risk. Patients should inquire as to the means and likelihood of infectious disease transmission and act upon that information which can best prevent further transmission. (9) Patients should discuss organ donation with their physicians and make applicable provisions. Patients who are part of an organ allocation system and await needed treatment or transplant should not try to go outside or manipulate the system. A fair system of allocation should be answered with public trust and an awareness of limited resources. (10) Patients should not initiate or

participate in fraudulent health care, and should report illegal or unethical behavior to the appropriate law enforcement authorities, licensing boards, or medical societies. (AMA Policy H-140.953 CEJA Rep. A, A-93; MSSNY Council 11/2/00)

RECOMMENDATION: Reaffirm

240.993 **Patient's Responsibility for Keeping Their Appointments:** It is MSSNY's policy that it is the patient's responsibility to keep their follow-up and other assigned appointments. (Council 11/2/00)

RECOMMENDATION: Reaffirm

240.994 **Reimbursement for Missed Appointment:** MSSNY, consistent with the current opinions of the AMA Council on Ethical and Judicial Affairs, Section 8.01, reaffirms the position that "A physician may charge a patient for a missed appointment or for one not canceled 24 hours in advance if the patient is fully advised that the physician will make such a charge. The practice, however, should be resorted to infrequently and always with the utmost consideration for the patient and his/her circumstances." (HOD 96-263; Reaffirmed HOD 04-274)

RECOMMENDATION: Reaffirm

240.995 **COLA (Commission of Office Laboratory Accreditation):** MSSNY is taking the following actions with regard to COLA: (1) Endorsement of the accreditation program for laboratories of the Commission on Office Laboratory Accreditation (COLA); (2) Publicizing of information about COLA. (3) Encouragement of physicians to seek clinical laboratory accreditations through COLA as their peer review alternative to federal certification under CLIA 88. (4) Encouragement of the New York State Department of Health to grant the Commission on Office Laboratory Accreditation approval under the state laboratory licensure law and regulations. (HOD 96-181)

RECOMMENDATION: Sunset

240.996 **Fee Differentials:** MSSNY affirms the principle of equitable reimbursement to rural area physicians by all health insurance carriers in order to encourage establishment of physician practices in these traditionally medically underserved areas of the State. MSSNY encourages the retention and recruitment of physicians in rural and other underserved areas of New York State by removing the disincentive of lower fee schedules for physicians practicing in such areas. (HOD 91-41)

RECOMMENDATION: Reaffirm

265.000 **REIMBURSEMENT:**
(See also Abortion and Reproductive Rights, 5.000; Managed Care, 165.000; Medicare, 195.000; Nursing Homes, 217.000; Surgery, 295.000; Vaccines, 312.000; Workers' Compensation, 325.000)

265.925 **Pay Physicians for Emergency Room Call:** MSSNY urges hospitals to compensate physicians for being "on emergency room call" unless they choose to work voluntarily. (Council 6/3/04)

RECOMMENDATION: Reaffirm

265.926 **Single Set of Rules for Physician Reimbursement:** MSSNY recommends that there be only one set of rules, policies and regulations relating to quality medical care, physician reimbursement, and coverage issues in any future systems of physician reimbursement. (HOD 04-253)

RECOMMENDATION: Sunset

265.927 **Patients' Out of Pocket Financial Responsibility for Emergency Room Services Provided:** MSSNY opposes efforts, including legislation and regulation, to prevent an out-of-network physician who provides emergency care to a patient from receiving their full charge and that no patient out of network deductible/co-pay should apply. (HOD 04-74)

RECOMMENDATION: Reaffirm

265.952 **HCFA Evaluation and Management Codes - Modifier 25:** MSSNY will urge HCFA to revise the new policy on Modifier 25 since the original RBRVS study calculated the standard Evaluation and Management (E&M) visit of 99213 with a Work Relative Value of 1.0. Since the original standard E&M visit had a Work Relative Value of 1.0, a Work Relative Value of 1.0 should be added to every procedure for which HCFA assumes has an inherent E&M component for proper compensation to physicians. (Council 3/13/00)

RECOMMENDATION: Sunset

265.953 **Reimbursement for Baclofen Pump:** MSSNY will seek legislation to expand the Medicaid reimbursement formula for the Baclofen pump insertions to include the cost of the pump as an outlier in the DRG fee for this procedure. (HOD 00-281)

RECOMMENDATION: Reaffirm

265.955 **Managed Care Organizations Should Disclose Their UCR Calculation Methodology:** MSSNY will seek legislative/regulatory relief to require managed care organizations (MCOs) to provide physicians and other parties, as a condition of new or continued participation, with the calculation methodology that they use in establishing the UCRs (usual, customary and reasonable charges) that make up their fee schedules, to include the baseline data and other qualifying factors such as carrier-derived or adjusted geographical adjustments and patient demographic data. (HOD 00-267)

RECOMMENDATION: Sunset

265.959 **Insurance Companies Should Reimburse Physicians for Telephone Time with Pharmacies:** MSSNY will seek regulatory or legislative action to (a) require health care plans doing business in New York State to recognize, as a separate service, through the existing AMA-CPT coding nomenclature, telephone calls communicating with family members, medical entities, pharmacies, benefit management companies, case managers, and others as required for patient management and care; (b) require health care plans in New York State to disclose in the health plan's benefit package that telephone management services for patients, as well as the time spent placing the phone call(s) is a separate service and specify whether the service is a covered or non-covered service.

If telephone management for patients, and the time spent making the phone call(s) is deemed to be a noncovered service, MSSNY will seek regulatory or legislative relief which would require health care plans to honor an Advance Notification

Agreement between the physician and the patient through a formal Waiver of Liability, whereby payment for this service becomes the responsibility of the patient.

MSSNY will seek regulatory or legislative action mandating the provision of toll-free telephone and FAX numbers for physician use by all health care plans, products and mail order pharmacies doing business in New York State. Said legislation or regulation to include a provision that the waiting time for physicians and their office staff required by the payers to use these toll-free telephone numbers be no more than five (5) to ten (10) minutes. (HOD 00-252)

RECOMMENDATION: Reaffirm

265.960 **Reimbursement of Accutane:** MSSNY will urge the New York State Insurance Department to require insurance companies to reimburse for Accutane without forcing the physician to first prescribe unnecessary and potentially dangerous antibiotics. (HOD 00-167)

RECOMMENDATION: Reaffirm

265.962 **Enhancements to the Prompt Payment Law:** MSSNY will seek enhancements to the current Prompt Payment Law stipulating that when additional information has been requested and received from a physician and/or patient, that the health care plan requesting the information be required to process and pay that claim within a specified (reasonable) period of time, or be subject to severe monetary penalties.

Once an HMO places a claim in a “pending” category (awaiting additional information), the HMO should be required to continue written communications with the physician and/or patient, on a periodic basis (i.e., every 30, 60 or 90 days) until the requested documentation has been received. (HOD 00-71)

RECOMMENDATION: Reaffirm

265.965 **Physician Appeal’s Mechanisms for Down Coded or Denied Claims:** MSSNY will seek legislation and/or regulation to ensure that physicians have an appropriate appeals mechanism which third party payors should make available to physicians when claims have been denied or “down coded” by such payors. Such legislation and/or regulation should require (a) all payors to notify the physicians of the appropriate appeals mechanism to be utilized when a claim is denied or “down coded” and (b) all third party payors to provide physicians with a clear and accurate explanation on all claims that have been denied or “down coded”. (HOD 00-66)

RECOMMENDATION: Reaffirm

265.966 **Circumvention of the Prompt Payment Law in New York State:** MSSNY will seek amendment to the present Prompt Payment legislation to impose penalties on those carriers that have been determined to be circumventing the Prompt Payment law by “forcing claims to payment” to meet the prescribed deadlines and then demanding refunds well after the claims have been paid. (HOD 00-65)

RECOMMENDATION: Reaffirm

265.967 **Recognition of Modifier 25:** MSSNY will urge HCFA to revise the new policy on Modifier 25 since the original RBRVS study calculated the standard Evaluation and Management (E&M) visit of 99213 with a Work Relative Value of 1.0. Since the original standard E&M visit had a Work Relative Value of 1.0, a Work Relative

Value of 1.0 should be added to every procedure for which HCFA assumes has an inherent E&M component for proper compensation to physicians. (Council 3/13/00)

RECOMMENDATION: Sunset

265.968 **Pre-Authorization Denials:** MSSNY has adopted as policy, the following statement deeming partial approval of requested physician treatment regimens by managed care organizations and/or other health insurers as constituting denials of care, and to urge the endorsement and effectuation of this position by the New York State Department of Health, the New York State Department of Insurance, and the New York State Office of the Attorney General and, if necessary, seek legislation to implement this policy.

It is the position of the Medical Society of the State of New York that:

- physician-requested treatment regimens only *partially* approved by managed care plans and/or other health insurers, be deemed as *denials of medical care* in conformance with present law, regardless of whether *some* of the requested care was authorized by the insurers;
- the appropriate state agencies charged with regulating and monitoring the activities of managed care plans and other health insurers, should prohibit these entities from circumventing the fundamental premise and spirit of the present law addressing denials of medical care which would (and should) encompass partial approvals of physician-requested care.
- Insurers be mandated to provide physicians and patients with timely written notifications of such adverse determinations so that they may rightly access internal and external appeals mechanisms on the premise that partially approved medical services are in actuality reductions in physician requested treatment regimens and, thus, constitute denials of medically necessary care. (Council 1/20/00)

RECOMMENDATION: Sunset

265.972 **Responsibility for Carrier Errors on “Explanation of Benefits” Forms:** MSSNY will ask the American Medical Association at A-99 to point out the Health Care Financing Administration that patient allegations resulting from carrier errors on explanation of benefits forms neither constitute fraud and abuse nor prove that their patient “investigator” program is working; and that carriers should be required to correct and pay the costs for correction of their “keystroke” or “administrative” errors on these forms as well as to notify the patient of the error. (HOD 99-274)

RECOMMENDATION: Sunset

265.973 **Physician Responsibility for County Nursing Service:** MSSNY will seek federal and state legislative or regulatory relief requiring Medicare and other insurers based in this state to hold Nursing Service Agencies responsible for their billing practices and for the care decisions they make that either deviate from physician instructions, are devoid of related physician input, or are violative of HCFA guidelines. Physicians will be held harmless when their Home Health Certification and Plan of Care Forms (HCFA 485 form) differ from by the actual services rendered by the Nursing agencies, and MSSNY shall pursue every

available avenue at both the state level and nationally through our representation with the American Medical Association to protect physicians from being held responsible for care provision and billing beyond their control pertaining to Nursing services. (HOD 99-273)

RECOMMENDATION: Reaffirm

265.974 **Support of MSSNY President Ralph Schlossman’s Response to HCFA’s “Fraud Seminars”**: MSSNY will strongly supports opposition to Health Care Financing Administration launched fraud seminars, because of the chilling effect it will have on the practice of medicine. (HOD 99-266)

RECOMMENDATION: Sunset

265.976 **Cost of Living Increases to Physician**: MSSNY will seek the introduction of appropriate state legislation calling for the levels of physician payments by public and private health insurers to be annually adjusted with a cost of living increase tied to the Department of Labor cost of living index, with this increase remaining independent of adjustments made for any rising costs of providing services. (HOD 99-255)

RECOMMENDATION: Reaffirm

265.978 **Reimbursement for Assistance at Surgery**: MSSNY shall seek the introduction of legislation requiring HMO’s and all other third party payers operating in New York State to reimburse for assistance at surgery based on the guidelines of the American College of Surgeons and/or when determined by the operating surgeon that one is required to insure the safety of the patient. (HOD 99-260)

RECOMMENDATION: Sunset

265.982 **Reimbursement Moratorium on Merged Health Maintenance Organizations**: MSSNY will seek appropriate legislation which, in the event of a merger or consolidation of one or more health maintenance organizations, would impose a one-year moratorium after the announcement of a new fee schedule, thereby precluding the lowering of reimbursement to participating physicians for this one-year period. (HOD 98-273)

RECOMMENDATION: Reaffirm

265.983 **The Prudent Physician Paradigm**: It is MSSNY’s position that if a physician excises a clinically suspicious skin lesion, the insurer should be held liable for payment for the surgical procedure regardless of the subsequent pathology report.

MSSNY will request legislative or regulatory action that when a physician performs an indicated procedure based on a presumptive diagnosis, the third party payor reimburse the physician performing the procedure regardless of the final diagnosis. (HOD 98-271)

RECOMMENDATION: Reaffirm

265.984 **Amend Managed Care Payment Policy for X-Ray Examinations**: MSSNY will include, as part of its legislative program, a bill to require managed care companies operating within the State of New York to amend their policies to pay for x-ray examinations and other ancillary services performed at the site where consultation or treatment is being rendered, when such examinations and services are indicated and appropriate in order to prevent hardship to the patient. (HOD 98-270)

RECOMMENDATION: Sunset

265.985 **Third Party Fee Schedule:** MSSNY will seek legislation at both state levels and national levels that would mandate insurers to make available their complete fee schedules, coding policies, and utilization review protocols to physicians prior to signing a participant contract and whenever any changes are made to the foregoing. (HOD 98-262)

RECOMMENDATION: Reaffirm

265.986 **Physician Due Process in Managed Care:** Should a physician participant in one plan of an Insurance Company be denied access to other newly evolved plans that Insurance Company offers, the reason for such must be provided in writing and an appeals process be established to review that decision in a timely fashion. (Council 12/18/97)

RECOMMENDATION: Reaffirm

265.989 **Changes In Reimbursement Rates And Payment Of Benefits Policies Of Insurance Carriers Without Recourse By Participating Physicians:** MSSNY will actively seek, through legislation or whatever regulatory means necessary, the establishment of a mechanism whereby HMOs and other health insurers licensed in the State of New York be required to: (a) include in their annual financial reports to the Superintendent of Insurance any proposed changes in reimbursement schedules and withholds for physicians participation in their plans; (b) include in their participating physician agreements an anniversary date indicating the duration that the contracted fees, withholds, and payment policies will remain in effect. (HOD 97-270)

RECOMMENDATION: Reaffirm

265.990 **Denial of Claims:** MSSNY will seek to have legislation introduced that will require carriers to send a copy of their examiner's report to the treating physician with a provision that the denial cannot be issued until seven working days have passed from the time the report is mailed to the treating physician. (HOD 97-263)

RECOMMENDATION: Reaffirm

265.991 **Physicians Should Be Informed By The Third Party Payor Of The Reason For The Denial Of the Claim:** MSSNY will seek the appropriate legislative or regulatory means to require that all third party payors, licensed to operate in New York State, be required to provide in a timely manner to the physicians with a rejected claim notice with an indication of the reason and the codes indicating why the claim was rejected. (HOD 97-260)

RECOMMENDATION: Reaffirm

265.994 **Determination of Where Medically Necessary Services Are to be Provided to Patients Enrolled in Managed Care Entities:** MSSNY has adopted the position that in the event that a patient enrolled in a managed care program is referred to the emergency room of a local hospital following direct or verbal contact with a participating physician, this visit be covered and reimbursable whether categorized as emergent or not. (HOD 94-262)

RECOMMENDATION: Reaffirm

265.995 **Balance Billing - Benefits in Health System Reform:** MSSNY supports the position that the practice of Balance Billing is in the best interest of: (1) Patients who will assume personal responsibility for a portion of their health care cost, and (2) Physicians and other providers who will be able to bill for an appropriate fee, yet still be subject to being monitored for such billing, and (3) Payers, government or other, who will have reduced financial liability, thus reducing the cost to third party payers.

MSSNY endorses the position that health system reform proposals include a provision that patients be free to contract with physicians of their choice to obtain medical services regardless of the insurance reimbursement. (HOD 94-218)

RECOMMENDATION: Reaffirm

305.000 **UNIVERSAL CODE FOR REPORTING MEDICAL SERVICES:**

305.998 **HCFA Provision of Coding Information Free of Charge:** MSSNY will seek federal legislation requiring the Health Care Financing Administration (HCFA), via the U.S. Government Printing Office, to provide physicians, free-of-charge, all the coding information including nomenclature for all procedure codes, diagnosis codes, laboratory procedure codes and fee schedules, and National Correct Coding Initiative (CCI) material, necessary to correctly complete HCFA claim forms, and MSSNY will present this resolution to the American Medical Association House of Delegates for its consideration and adoption. (HOD 00-263)

RECOMMENDATION: Sunset

310.000 **UTILIZATION REVIEW:**

310.995 **Independent Medical Examiners:** MSSNY will legislation to create a pool of physicians in each specialty to act as Independent Medical Examiners (IMEs) for all third party payers doing business in New York State who request such a service in order to determine the need for further or continued medical treatment.

MSSNY will urge the Office of the Insurance Commissioner assign IMEs from the pool to conduct physical examinations and review medical records on a purely rotating basis so there is no bias in the selection of the IMEs; or, alternatively, select an independent organization, such as the Empire Foundation, to administer such an IME program with fees to be paid by the insurers. (HOD 00-280)

RECOMMENDATION: Reaffirm

310.997 **Arbitration in Cases of Third-Party Audits:** MSSNY will seek legislation or regulation for the development of an independent arbitration panel to handle requests for refunds by third-party payers arising from audits of physicians' practices. (HOD 98-265)

RECOMMENDATION: Reaffirm

310.998 **Third Party Audits of Physicians with Subsequent Billing of Physicians for Tests Deemed Inappropriate:** MSSNY will urge the appropriate state and federal regulatory agencies to regulate third party payers' medical practice audits such that these audits focus on providing education and improving the quality of care, and not be used for financial or punitive activities. MSSNY will work to ensure outcomes of all medical practice audit processes would be governed by rules of

due process which will be available for all physicians who participate in third party audits. (HOD 98-255)

RECOMMENDATION: Reaffirm

325.000 WORKERS' COMPENSATION:
(See also Reimbursement, 265.000; Utilization Review 310.000)

325.968 Workers' Compensation Panels: MSSNY continue to work with the Workers' Compensation Board to encourage the enlistment of physicians to serve on arbitration panels. (HOD 04-258)

RECOMMENDATION: Reaffirm

325.974 Modification of Workers' Compensation Law Sections 110A and 32: MSSNY will seek through legislation, regulation, or whatever means necessary, amendments to the NYS WC Law Sections 110A and 32 regarding the physician's ability to be listed as a *Party in Interest*. (Council 11/2/00)

RECOMMENDATION: Reaffirm

325.975 Surgical Ground Rule Number 5: MSSNY will seek through legislation, regulation, or whatever means necessary, the amendment to the NYS WC Schedule of Medical Fees modifying Surgical Ground Rule Number 5, as follows, to better reflect the current state of medicine and surgery and to allow injured workers to achieve maximum benefit of procedures available:

"When multiple procedures, unrelated to the major procedure and adding significant time or complexity are provided at the same operative session, payment is for the procedure with the highest allowance plus half of the lesser procedures up to a total maximum of twice the higher fee. The same rule applies for bilateral procedures when such are not specifically identified in the schedule." (Council 11/2/00)

RECOMMENDATION: Sunset

325.976 Clarification in Workers' Compensation Board Regulations Pertaining to the Performance of Independent Medical Examinations in NYS: MSSNY will seek the following clarifications in the anticipated Workers' Compensation Board regulations pertaining to the performance of IMEs in New York State:

- (1) The regulations should clarify that performance of IMEs should be conducted by NYS licensed physicians who are:
 - A. Board Certified in accordance with the specialty boards recognized by the American Board of Medical Specialties (ABMS) and the American Osteopathic Association (AOA) (i.e. C-Ratings)
- (2) Increased costs with regard to copying or mailing of the IME reports need to be considered compensable by the WC employer/carrier. (Council 11/2/00)

RECOMMENDATION: Sunset

325.977 Caps for Maximum Medical Improvement Exams (MMIEs)(i.e. AMA-CPT Codes 99455 and 99456): MSSNY will seek legislation, regulation, or whatever means necessary, the adoption of the following chart by the Workers'

Compensation Board for MMIEs provided within the State of New York for injured claimants.

MMIE Standard, established patient	99455	\$250.00
MMIE Extended, established patient	99455-22	\$375.00
MMIE Standard, new patient	99456	\$375.00
MMIE Extended, new patient	99456-22	\$499.00

MSSNY will seek the inclusion of payment consideration by the WCB in the Official NYWC Medical Fee Schedule for Review of Records either by a fee or *By Report* designation under AMA-CPT Code 99080. (Council 11/2/00)

RECOMMENDATION: Sunset

325.978 **Timely Processing of Claims:** MSSNY will petition the New York State legislature, using all available resources and alliances it deems necessary – including HANYS and the New York State Bar Association – to amend the current Worker’s Compensation law as follows: 1) Within 90 days of a claim having been filed, there must be a hearing or an interim hearing before issues are finally resolved to determine if a case is likely to be worker’s compensable under the law; 2) To allow for interim payment to the claimant patient; 3) To allow for interim payment to those who provided medical care to the patient; and 4) That these interim determinations shall not replace any final determinations in the adjudication process. (HOD 00-286)

RECOMMENDATION: Sunset

325.979 **Additional Workers’ Compensation Billing Codes:** MSSNY will petition the New York State Worker’s Compensation Board to establish billing codes to allow physicians to bill for their time when reviewing reports and charts, writing reports, or communicating on the telephone about a case.

MSSNY will encourage the NYS Worker’s Compensation Board to work together with MSSNY to establish the fee structure for billing codes to allow physicians to bill for their time when reviewing reports and charts, writing reports, or communicating on the telephone about a case.

MSSNY will urge the NYS Worker’s Compensation Board to direct all worker’s compensation carriers in New York State, including the New York State Insurance Fund, to honor and pay for billing codes to allow physicians to bill for their time when reviewing reports and charts, writing reports, or communicating on the telephone about a case. (HOD 00-285)

RECOMMENDATION: Sunset

325.980 **Role of a Physical Therapist in Electrodiagnostic Medicine:** MSSNY will request that the Workers’ Compensation Board request a specific statement from the Department of Education regarding the role of a physical therapist in the performance of electro-diagnostic testing, specifically as it relates to diagnosis and needle electromyography;

MSSNY will request that the Workers' Compensation Board consider the role of physical therapists in electro-diagnostic testing, be limited to technicians under direct supervision of a physician. Additionally, on the basis of the Practice Act for Physical Therapists, which does not permit diagnosis by a physical therapist, and does not specify permission to insert a needle into muscles, that physical therapists not be allowed to perform, interpret and diagnose, independent of a physician.

MSSNY will act to ensure the adherence and enforcement of specific scope of practice laws annotated by the New York State Education Department for each of the 38 professions licensed in the State of New York. (HOD 00-283)

RECOMMENDATION: Sunset

325.981 **Workers' Compensation Claims Reimbursement:** MSSNY will seek legislation and/or regulation to: (a) mandate that the Workers' Compensation Board resolve any question of liability for injury of a worker within a thirty-day period from the initial submission of the required 48-hour medical report; (b) mandate that the private payers' time restriction for claim submission in cases of questionable liability be waived; (c) require a claimant's private health insurance plan to pay the claim within 45 days on presentation of a Workers' Compensation and/or No-Fault Auto denial. (HOD 00-277)

RECOMMENDATION: Sunset

325.982 **Augmentation of Damages in Workers' Compensation Arbitration Cases:** MSSNY will urge the Workers' Compensation Board to amend its new streamlined appeals process, requiring that: (1) If a carrier makes misrepresentations to the Board concerning timely and proper receipt of bills, such misrepresentation be considered an act of bad faith, subjecting the carrier to judgment of treble damages; and (2) If a carrier fails to comply with a decision of the Board, such failure likewise be considered an act of bad faith, subjecting the carrier to judgment of treble damages. (HOD 00-275)

RECOMMENDATION: Reaffirm

325.983 **Timely Authorizations of Procedures:** MSSNY will work with the appropriate agencies to require health care plans to provide adequate staffing/personnel to support the volume of incoming requests for authorizations via telephone in a timely fashion so that the waiting time for answering said calls does not exceed 5 to 10 minutes; MSSNY will work with the appropriate state agencies to require health care plans to accept requests for authorizations by electronic transmission in lieu of telephone requests, and MSSNY will work with the appropriate agencies to ensure that the response time to requests for authorization submitted via FAX not exceed 1 (one) business day. (HOD 00-259)

RECOMMENDATION: Reaffirm

325.984 **Increase in Workers' Compensation Arbitration Fees:** MSSNY will negotiate with the Workers' Compensation Board a payment increase from \$300 up to \$500 per session for physicians serving on Arbitration Panels in view of the inordinate amount of time physicians often expend at the arbitration sessions. (Council 5/20/99)

RECOMMENDATION: Sunset

325.985 **Timely Authorizations:** MSSNY will urge the New York State Department of Insurance and the New York State Workers Compensation Board to require insurance companies to provide a mechanism for authorizing requests for medical or surgical services in a timely fashion and that such an approval mechanism be available 24 hours a day, seven days a week. A response to a requested authorization will be returned within 24 hours for in-hospital care and 7 days for outpatient care.
(HOD 99-272)

RECOMMENDATION: Reaffirm

325.986 **Hearing Outcomes in Workers' Compensation Cases:** MSSNY will urge the New York State Workers' Compensation Board to enforce its current regulation that deems the physician as "an interested party," and requires the concurrent provision of notices of dates and time of pending hearings to physicians, claimants and representatives, as well as outcomes of any hearing of the Board within 15 days. (HOD 99-270)

RECOMMENDATION: Reaffirm

325.987 **Receipt of Bill in Workers' Compensation Cases:** MSSNY shall urge the Workers' Compensation Board to adopt rulings predicated on the following premises:

- That faxed documentation of submitted bills, on C-4 forms or HCFA 1500 forms or other viable forms of appropriate acknowledgement to the State Insurance Fund, New York City Law Department and WC Carriers for reimbursement of physician provided services be sufficient to substantiate their previous filings on a timely basis;
- That in the event of arising disputes concerning the timeliness of filings, any postmarked certified receipts provided be considered as final evidence that bills on claim forms have been timely and received by the State Insurance Fund, New York City Law Department and WC carriers;

Such legislation will empower the Workers' Compensation Board to have direct regulatory authority and oversight of the WC activities of the State Insurance Fund (presently overseen by the Office of the Governor), New York City Law Department and WC Carriers to remediate the prevailing intolerable impasse reflected in the ability of these entities to essentially function independently of appropriate Board recommendations and directives, much to the detriment of authorized physicians providing legitimate services under the program. (HOD 99-269)

RECOMMENDATION: Sunset

325.988 **Repeal Of Increased Fees For Workers' Compensation Arbitration:** MSSNY will urge the Chairman of Workers' Compensation Board to: (a) re-evaluate the recently increased WC arbitration fee structure, which tends to preclude physicians from entering the arbitration process, particularly for disputed bills of lower amounts involving multiple patients; (b) reduce the fees to levels permitting enhanced physician access to the system; and in conjunction with the foregoing request, will urge the Chairman to reintroduce legislation calling for a "desk

arbitration” process wherein disputed bills of \$500 or less may be promptly arbitrated by a neutral physician arbiter of the appropriate physician discipline consistent with the claims under review, and at commensurately reduced registration fees. Also, MSSNY will request the Workers’ Compensation Board to share the details/fees associated with such a recommended process with the MSSNY Committee on Workers’ Compensation and Occupational Health for its timely review, input, and recommendations. (HOD 97-265)

RECOMMENDATION: Sunset

325.989 **Treating Physician Is A Party At Interest:** MSSNY will request that the Chairman of the Workers’ Compensation Board issue a regulation that states that the treating physician is a party at interest, and order the presiding judge at a hearing at which matters pertaining to medical care are discussed to expeditiously send to the treating physician, or other treating professional person, a copy of the decision promulgated. (HOD 97-264)

RECOMMENDATION: Sunset

325.990 **Payment Of Interest To Physicians By Health Insurers For Claims Exceeding 30 Days:** MSSNY strongly supports the introduction of appropriate legislation to require all health insurers in this State, including HMOs, to pay a statutory interest penalty in an amount no less than that currently provided pursuant to the Workers’ Compensation law on all unpaid claims submitted by health care providers in which liability has become reasonably clear, such penalty to commence 30 days after billing. (HOD 97-70)

RECOMMENDATION: Sunset

325.992 **Work Hardening Program Ground Rules and Medical Fee Schedule:** MSSNY approves the Work Hardening Program Ground Rules and Medical Fee Schedule as promulgated by the Workers’ Compensation Board for inclusion in the Workers’ Compensation Schedule of Medical Fee as follows: Definition: (1) Work Hardening Programs are interdisciplinary, goal-specific, vocationally driven treatment programs designed to maximize the likelihood of return to work through functional, behavioral, and vocational management. (2) Not all claimants require these programs to reach a level of function which will allow successful return to work. (3) Only those programs which meet all of the specific guidelines will be defined as Work Hardening Programs. (4) Programs will be reimbursed per the fee schedule after meeting all other requirements. Pre-Admission Criteria: (1) All claimants must complete a pre-program assessment including a Functional Capacity Evaluation (FCE) and Vocational Evaluation. (2) The goal of the program is return to work, therefore for all anticipated returns to previous employment or placement with a new employer, the following must be provided. (a) Specific written critical job demands and/or job site analysis; (b) Verified written employment opportunities. Evaluation Process: (1) Initial screening evaluation is performed by the treatment team consisting of: (a) Physical Therapy and/or Occupational Therapy PLUS (b) Psychology/Psychiatry and/or Vocational Rehabilitation, or other providers suitable by scope of practice as determined in the State Education Law. (2) The outcome of this evaluation will be: (a) Recommendation of release to return to work (b) Acceptance into the program with an Individual Written Rehabilitation Plan stating specific goals and recommended services (c) Rejection from program for specific reasons (d) Referral back to provider for medical evaluation (e) Recommendation of

vocational rehabilitation, either by referral to and acceptance by VESID, or by other providers if approved by the carrier. (3) Claimants being treated by an attending provider who is not a physician must be referred to a physician authorized by the NYSWCB to provide care to injured claimants, who will provide a written prescription for evaluation and treatment. Programs Providers: Claimants will be provided with the availability of the following providers as determined by the needs of the claimant: (a) A minimum of two (2) of the following: Physical Therapist, Occupational Therapist, Vocational Rehabilitation Counselor, Psychologist/Psychiatrist, or other provider suitable by scope of practice as determined in the State Education Law; in addition to a Case Manager, either internal or external to the program. (b) Providers who can provide initial medical evaluation, participation in the development of the treatment plan, and coordination of work restrictions and discharge planning with the recommendation of specialists in Physical Medicine and Rehabilitation. Discharge Criteria: (1) Discharge criteria must be provided to all claimants in writing prior to initiation of treatment at the time program goals are determined. (2) Voluntary discharge is achieved by: (a) Meeting program goals; (b) Early return to work (c) Acute or worsening medical conditions (d) The claimant declining further treatment. (3) Non-voluntary discharge may be necessary in cases of: (a) Failure to comply with program policies (b) Absenteeism (c) Lack of demonstrable benefit from treatment (4) Non-voluntary discharge requires written documentation of prior and repeated counseling of the claimant, and immediate notification of the employer, insurer, case manager, and referring and attending (if different) provider. (5) Under all circumstance of voluntary and non-voluntary discharge, the claimant will return to the referring attending provider for release from program. (6) The attending provider must sign a release to return to work when the program goals are achieved. Program Evaluation: (1) Programs are subject to disclosure and evaluation as permitted by local and state health care agencies and other appropriate individuals or groups in the state of New York, including issues of: (a) Written policies and procedures (b) Program implementation (c) Maintenance of medical records (d) Outcomes achieved (e) Site design and equipment (f) Affiliations with non-site based providers (g) Admission and discharge criteria. (2) Programs must provide insurers and referring providers with: (a) Initial interdisciplinary team evaluation report (b) Proposed treatment plan (c) Progress reports at weekly intervals (d) the opportunity to attend team meetings (e) Final discharge summary report (f) Any of the information described in section above. Integration of Vocational Rehabilitation Services: (1) Work Hardening Programs are vocationally directed and driven rehabilitation services. The vocational rehabilitation counselor serves to: (a) Coordinate efforts between the claimant, program, and employer (b) Obtain job descriptions and critical job demands from the employer (c) Gather and provide information to the treatment team (d) Educate employers toward work tasks and work-site design (e) Assist claimants toward appropriate employment opportunities within their safe maximal capabilities. (2) Programs that do not retain the services of vocational rehabilitation counselors on a full time basis may utilize private rehabilitation agencies, specialists provided by insurance carriers, or VESID. These individuals are required to make continuous on-site contact with claimants and program providers, including participation in team meetings. (3) The qualifications for serving as a vocational rehabilitation counselor with respect to Work Hardening Programs shall be determined by the Director of Rehabilitation and Social Services of the State of New York Workers' Compensation Board. Vocational rehabilitation counselors should

be reimbursed at the usual and customary rate currently paid by insurers in each region. **Program Duration:** Work hardening programs will be provided on the following time schedule. (a) Daily treatment, full or partial days, with fee differential (b) Minimum of ten (10) treatment days and maximum of thirty (30) treatment days, subject to carrier prior approval (c) Treatment to be completed within six (6) consecutive weeks (d) Any additional treatment days beyond thirty (30) upon approval by the carrier. **Fee Schedule:** Fees for work hardening programs will be paid in accordance with the medical fee schedule, with written prior approval by the carrier, utilizing the following guidelines: (a) In all cases, for both voluntary and non-voluntary discharge, payment is for the actual duration of treatment provided (b) Payment differential for partial and full day program (c) CPT codes 97545 and 97546 will be reimbursed for Work Hardening Programs as described above only (d) Non-multidisciplinary “work conditioning” programs will be reimbursed utilizing existing PT, OT, and Physical Medicine codes (e) Psychology /psychiatry services as requested in the Individual Written Rehabilitation Plan and approved by the carrier will be billed separately from codes 97545 and 97546, in accordance with the appropriate fee schedules (f) Payment for external case managers and vocational rehabilitation counselors will be the responsibility of the carrier, exclusive of program codes 97545 and 97546 (g) Billing will not exceed eight (8) hours for any given treatment day.

97545 - Work Hardening, First two (2) hours*

	<u>RVU</u>	<u>Conv.</u>	<u>Total Fee</u>
Region I			
MD	14.0	6.49	\$ 90.86
PT/OT	14.0	5.91	\$ 82.74
Region II			
MD	14.0	6.80	\$ 95.20
PT/OT	14.0	6.20	\$ 86.80
Region III			
MD	14.0	7.78	\$108.92
PT/OT	14.0	7.09	\$ 99.26
Region IV			
MD	14.0	8.45	\$118.30
PT/OT	14.0	7.70	\$107.80

* Although CPT Code 97545 is for first two (2) hours, for this program the code shall be used for the first four (4) hours, doubling the listed fee.

97546 - Work Hardening, each additional hour

	<u>RVU</u>	<u>Conv.</u>	<u>Total Fee</u>
Region I			
MD	3.3	6.49	\$ 21.42
PT/OT	3.3	5.91	\$ 19.50
Region II			

MD	3.3	6.80	\$ 22.44
PT/OT	3.3	6.20	\$ 20.46

Region III

MD	3.3	7.78	\$ 25.67
PT/OT	3.3	7.09	\$ 23.40

Region IV

MD	3.3	8.45	\$ 27.89
PT/OT	3.3	7.70	\$ 25.41

(Council 7/18/96)

RECOMMENDATION: Sunset

- 325.993** **Prescription of Lenses:** MSSNY approves an amendment to the Workers' Compensation Schedule of Medical Fees in the appropriate section of the Medicine Ground Rules, as follows: "Prescription of lenses may be deferred to a subsequent visit and is reported separately and may be billed as a separate item. This is based on medical necessity and documentation which will usually pertain to the final submitted Attending Ophthalmologist's Report." (Council 7/18/96)

RECOMMENDATION: Sunset

- 325.994** **Billing for Interpretation of Plain Film X-Ray Examinations Performed on Emergency Department Patients Covered by Worker's Compensation During "Off Hours:"** MSSNY accepts HCFA's policy covering Medicare patients as it appears in the Federal Register regarding payment to the specialist who performs the review and written interpretation of the radiograph at the time of treatment. However, all other conditions of the policy must also be adhered to. The stipulations include: (a) When a radiologist is available at the time of the performance of the study and treatment, the radiologist's bill for the performance of the "interpretation and report" of the examination will be the bill that is paid. The availability of teleradiography will be equivalent to that of a radiologist being present. When "interpretation and report," which is a written report should be distinguished from a "review" of the radiograph by the treating practitioner. The performance of an actual "interpretation and written report" is payable, whereas a "review" without a formal written report is not a reimbursable procedure. The ability to perform this interpretation function will need to be in conformity with medical staff bylaws, credentialing criteria, and procedure for delineation of privileges at each individual hospital and will have to be agreed to by the governing bodies of each institution. Furthermore, MSSNY maintains the following: (1) There can only be one formal, official examination report in the patient's medical records. (2) Radiologists, by virtue of their training, experience, are best qualified to perform this function. Comprehensive comparison with prior exams and review of prior reports are also best performed by radiologists. Radiologist, in addition, perform elaborate quality management services as well as monitor radiation protection at hospitals as required by JCAHO, managed care organizations, the New York State Department of Health, and other various accrediting bodies. (3) Radiologist, who are not involved in the primary evaluation and in the treatment of the patient, are in a good position to provide the most objective and unbiased analysis after taking into account evidence on the film or lack thereof and correlation with the clinical history provided. An interdisciplinary look at the problem provides an element of "peer review" which is in the best interest of patient care. (4) Institutions, in

recognition of the radiologist's qualifications to perform such interpretations as well as administrative functions, have engaged in exclusive contracts with radiology groups to perform such services. (5) There should only be one bill submitted for each service. Third party payers should not be confronted with the dilemma of deciding which of two or possibly more bills to pay. The mechanics and logistics of determining which specialty should be billing for a given procedure needs to be defined at each individual institution. (6) There is increasing emphasis on appropriate utilization of imaging studies both to optimize patient care and control escalating health care costs. As institutions and practitioners enter into various risk-sharing arrangements to provide health care, hospitals are increasingly seeking out guidance and advice from radiologists in the utilization review process and development of clinical pathways. It is important to have the radiologists involved at the point of service. It is in the best interest of all practitioners for such services to be not only appropriately utilized, but also to allow for appropriate compensation to all involved. (7) Despite its current relative unpopularity in the political and economic climate, specialization adds to the quality of care. (8) In the interest of rendering the best possible medical care, in cases of multi-system injury or trauma, the radiologist should be responsible for performing the interpretation of **all** studies. Thus, the patient's entire medical status can be evaluated and correlated rather than single isolated organ systems or localized sites of injury as would be the case when multiple individual specialists are involved. Radiologists will evaluate all anatomy on the films, not just localized areas or organ systems of clinical concern. Under these circumstances, again, the radiologist should have the right to bill for such services. MSSNY also suggests adding in Section 13 of the Radiology Ground Rules: The interpretation of radiologic procedures and the formal written report of that interpretation be performed by a radiologist. In the event that a radiologist is not in house and not available by teleradiography, the treating physician may render the interpretation and provide a formal report. That physician can then bill for this service with the modifier 26 provided that this report is the official part of the medical record. (Council 7/18/96)

RECOMMENDATION: Sunset

325.995 Uniform Fee Schedule in Workers' Compensation/No-Fault Cases: It is the policy of MSSNY that in keeping with one of the basic elements of the Medicare Resource Based Relative Value Scale (RBRVS) system, the payment modality of all other Workers' Compensation programs throughout the country, that the President acting under the provision of Section 13 of the Workers' Compensation Law, will urge the Chairperson of the Workers' Compensation Board to promulgate the planned revision of the Workers' Compensation Schedule of Medical Fees in a modality which will ensure that all qualified physicians responsible for rendering medical care under its provisions to receive the same payment for identical services performed by them. The President of MSSNY shall oversee a study of the revised fee schedule by the designated subcommittee(s) of the MSSNY Committee on Workers' Compensation and Occupational Health and the MSSNY Committee on Interspecialty to: (a) make recommendations for changes to the Workers' Compensation Medical Payment Schedule in the best interest of injured workers'; (b) provide fair and equitable reimbursements for physician services rendered without any payment differentials as presently exist in the current Workers' Compensation Schedule of Medical Fees; (c) urge that a revised payment schedule should be established and devoid of any constraints inherent in a budget neutrality application. (HOD 95-255)

RECOMMENDATION: Sunset

- 325.997** **Differential Payment Based on Specialty Board Certification and Scope of Practice:** It is the position of MSSNY that the differential payment policy based on specialty board certification and scope of practice be maintained under the applicable sections of the revised Workers' Compensation schedule of Medical Fees.
(Council 11/10/94)

RECOMMENDATION: Sunset

- 325.998** **Physician Assistants, Payments for Services Under the Workers' Compensation Program:** MSSNY has adopted the following Guidelines relative to WC payments to employing physicians for patient care provided *their* Physician Assistants:

A. General Rules: (1) Care must be rendered under the supervision of a physician who is authorized to care for Workers' Compensation patients. (2) The term "supervise" within the meaning of this recommendation encompasses the Medicare supervision requirement, i.e., that where state law enables (as in New York State): a) the services of non-physicians must be rendered under the physician's direct supervision; b) direct personal supervision in the office setting does not mean that the physician must be present in the same room with the PA. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the PA is performing services. In this instance, reimbursement should be made at the normal physician payment level, i.e., as if the physician had provided the service. (3) The bill for care must be rendered by the physician, with the ensuing payment for the PA service made directly to the physician employer.

B. Management of new patient or an old patient with a new Workers' Compensation problem: (1) If the physician supervises the physician assistant's evaluation, payment should be made at the physician's normal Worker's compensation level for the PA services rendered in the out-patient office setting. (2) Similar to Medicare Regulations which provide that where on-site direct physician supervision is not available in rural areas which meet the definition of Health Professional Shortage Areas (HPSAs) and the physician assistant providing patient care is only able to communicate with a physician supervisor by telephone or other effective means of communication, payment for this service should be made at three-quarters (3/4) of the Physician Payment Schedule. (3) A physician's assistant is not permitted to care for a new problem under the Workers' Compensation Program without discussing the findings in person or by telephone with a responsible physician prior to instituting treatment. No payment should be made for care provided by the PA that does not meet this requirement.

C. Follow-up care of a patient with a compensable problem: (1) If the physician supervises the physician assistant's evaluation, payment should be made at the physician's normal reimbursement level for the PA services rendered in the out-patient setting. (2) Similar to Medicare regulations which provide that where on-site direct physician supervision is *not* available in rural areas which meet the definition of Health Professional Shortage Areas (HPSAs) and the physician

assistant providing the patient care is only able to communicate with a physician supervisor by telephone or other effective means of communication, payment for this service should be made at three-quarters (3/4) of the Physician Payment Schedule.

D. Services of physician assistants providing assistance at surgery will be paid at two-thirds (2/3) of the physician's WC surgical assistant payment percentage, i.e., two-thirds of twenty percent (2/3 of 20%).

E. Services of physician assistants performing surgical procedures within the scope of the supervising physician's practice and that are paid as line items under the Workers' Compensation Fee Schedule be paid at two-thirds (2/3) of the physician surgical payments. (Council 9/22/94)

Subsequent to the above approval, the Council approved the following recommendation of the Committee on Workers' Compensation and Occupational Health:

That MSSNY accepts the WCB suggested change in the above proposed protocol for payment of PA assistance at surgery from 2/3 of 20% of the Surgical Allowance (i.e. 13.4%) to 65% of 16% of the surgical allowance (i.e. 10.4%) as essentially provided under the Medicare program. (Council 3/9/95)

RECOMMENDATION: Sunset