MEDICAL SOCIETY OF THE STATE OF NEW YORK
EXECUTIVE HEADQUARTERS

TO: *MSSNY Council Members*

FROM: *Parag H. Mehta, MD*
MSSNY President

SUBJECT: *FOR APPROVAL - 2022 HOD Resolutions Referred to Council*

DATE: *June 23, 2022*

Below are 2022 HOD Resolutions that have been referred to Council with the recommended committee referrals:

Reference Committee on Governmental Affairs (A)
Resolution 50 – Non-Compete Agreements and Certain Restrictive Covenants in Professional Contracts
Recommended Committee:
Legislative & Physician Advocacy

Resolution 51 – Membership Option Tied to Medical Licensure
Recommended Committees:
Long Range Planning
General Membership

Resolution 57 – Unintended Consequences of Value Based Payment Models (Resolved 3 ONLY)
Recommended Committee:
Quality Improvement

Reference Committee on Governmental Affairs B
Resolution 101 – Creation of a New York State Independent Medical Practice Taskforce
Recommended Committee:
Legislative & Physician Advocacy

Resolution 111 – Case Management & Social Workers
Recommended Committee
Preventive Medicine

Reference Committee on Public Health and Education
Resolution 158 – Prescribing Therapeutics in Times of Limited Supplies
Recommended Committee:
Infectious Disease

Resolution 164 – Breast Cancer Screening/Clinical Breast Exam Coverage
Recommended Committee:
Heart, Lung & Cancer

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Reference Committee on Reports of Officers
Resolution 202 – MSSNY Best Practice Task Force
Recommended Committees:
General Membership
Long Range Planning

Reference Committee on Physician Payment & Practice
Resolution 258 – Pharmacogenetics Insurance Coverage
Recommended Committee:
Heart, Lung & Cancer

Resolution 260 – Concurrent Processing of Procedure Equipment
Recommended Committee:
Legislative & Physician Advocacy

Emergency Resolution 2 – Prior Authorizations by 'Denials Companies'
Recommended Committee
Legislative & Physician Advocacy

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution: 2022 - 50

Introduced By:	Monroe County Medical Society
Subject:	Non-compete Agreements and Certain Restrictive Covenants in Professional Contracts
Referred to:	Reference Committee on Governmental Affairs - **A**

Whereas, Healthcare industry is going through a phase of consolidation with mergers and acquisitions of health systems; and

Whereas, employed physicians have non-compete and certain restrictive covenants as part of their employment contracts which precludes them to practice within specified geographical distance from the location of their current employer; and

Whereas, Non-compete agreements hinder the ability of employed physician to change their job within the same city forcing them to move out of county or in some cases even out of state; and

Whereas, this portends unnecessary stress and affects mental wellbeing of physicians at different stages of their career leading to early burnout ; therefore, be it

RESOLVED, that MSSNY advocate for unanimous support of Senate Bill S6425 which addresses this issue.

References:
https://www.nysenate.gov/legislation/bills/2021/S6425

https://www.beckersasc.com/asc-news/noncompete-agreements-what-physicians-should-know-in-2022.html?utm_source=linkedin&utm_medium=social

Existing Policy

155.991 Restrictive Covenants
The Medical Society of the State of New York will support legislation that prohibits a "restrictive covenant" provision in a health system-physician employment contract or in a contract between a Management Services Organization (MSO) and a physician that limits the ability of such physician to deliver care in the same region after the physician leaves employment from such health system or leaves the medical practice that utilizes that MSO.

The Medical Society of the State of New York will conduct a survey of physicians to assess their support or opposition to legislation to prohibit all restrictive covenants. (HOD 2020-54 and 55, referred to Council, adopted 11/5/20)

165.856 Restrictive Covenants in Physician Employment Contracts:
MSSNY policy regarding restrictive covenants is that they are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of patients' choice of physician. (HOD 2011-112; Reaffirmed Council 11/29/2012)

The Medical Society of the State of New York should advocate for legislation to limit restrictive covenants contained within physician employment contracts between hospitals and a physician to employment with

other article twenty-eight entities. (HOD 2012-101; referred to, modified by and adopted by Council 2011-2012)

MEDICAL SOCIETY OF THE COUNTY OF QUEENS
House of Delegates

Resolutions 2022 - 51

Introduced by: Medical Society of the County of Queens

Subject: Membership Option Tied to Medical Licensure

Referred to: Reference Committee on Governmental Affairs - **A**

Whereas, membership in the Medical Society is critical to our mission; and

Whereas, dues structure is chaotic and unwieldy; and

Whereas, advocacy depends on numbers; and

Whereas, medical licensure has been tied to other government aims, e.g., OPMC funding; therefore be it

RESOLVED, that the Medical Society of the State of New York seek legislation/regulation to include an opt out membership fee to be determined tied to initial medical licensure and every renewal.

References: none submitted

Existing MSSNY Policy:

207.975 Medical Society Dues as Part of Biennial Registration
The Medical Society of the State of New York will investigate logistics of including MSSNY and County Medical Society opt-out dues in the New York State Department of Education biennial registration billing and payment. (HOD 2015-113; referred to, amended and adopted Council 11/5/2015)

160.998 Licensure Based on Professional Standards:
It is the position of the Medical Society of the State of New York that physician licensure be based solely upon professional standards, including training, education, ability, competence and moral fitness. The Society vigorously opposes any attempts to establish nonprofessional standards, such as acceptance of third-party payment, as a condition of medical licensure. (HOD 1989-6 ; Reaffirmed HOD 2013)

160.999 Licensure as a Prerequisite for Membership in the Medical Society of the State of New York:
At the present time there is no official State Society policy as to the requirement of licensure as prerequisite for membership. (Council 12/16/76; Modified and reaffirmed HOD 2013)

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2022 – 57

Introduced by:	New York County Medical Society
Subject:	Unintended Consequences of Value–Based Payment Models — Conflicts of Interest
Referred to:	Reference Committee on Governmental Affairs - **A**

Whereas, Value–based payment models that entail a shift of cost risk have led to a restructuring of medical care, financial relationships and incentives; and

Whereas, In order to reduce cost, there has been increased utilization of nurse practitioners and physicians' assistants, and the scope of practice of these non–physician practitioners has been expanded; and

Whereas, These developments have created conflicts of interest at multiple levels, and have the potential to precipitate a decline in the quality of care that patients receive; therefore be it

RESOLVED, That the Medical Society of the State of New York seek to amend the New York State Patient's Hospital Bill of Rights to include the following patient rights:

1. The right, at all points in the patient's care, to demand medical decisions that are informed by physicians;

2. The right to an unbiased medical opinion and all relevant medical information, including information about treatments or services that are not reimbursed by the patient's insurance company or may be better managed at another institution; and

3. The right to complete disclosure of physicians' financial conflicts of interest, that arise from insurance or employment contracts that could influence the care these physicians provide; and be it further

RESOLVED, That the Medical Society of the State of New York ask the American Medical Association to work for legislation creating a National Patient Bill of Rights including the above points.

Existing MSSNY Policy
No specific policy found

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2022 – 101

Introduced by:	Nassau County Medical Society
Subject:	Creation of a New York State Independent Medical Practice Taskforce
Referred to:	Reference Committee on Governmental Affairs – **B**

Whereas, the ability of the physician to autonomously provide care to a patient in the best way they see fit is a critical aspect in the delivery of optimal care; and

Whereas, there is extensive evidence that independent medical practices are often more efficient and less costly than employed physician practices; and

Whereas, many physicians want to be in independent medical practice; and

Whereas, even those physicians who are not in independent medical practices have much more leverage with their employers because of the existence of independent medical practice; and

Whereas, the ability for various physicians to practice medicine independently has become increasingly difficult; and

Whereas, the existence and sustainability of independent medical practices in New York State has been one of the reasons that New York is often considered one of the healthcare capitals of the world; therefore be it

RESOLVED, that MSSNY will advocate with the New York State government to create a taskforce to help maintain the sustainability of independent medical practices in the State of New York.

Existing MSSNY Policy

155.993 Report on the Preservation of Independent Medical Practice
MSSNY will issue a report every two years on its activities to preserve independent medical practice and will request that AMA issue a report communicating their efforts every two years as well. (HOD 2020-207)

110.982 Lowering Health Care Costs
MSSNY will continue to work together with the AMA to advocate for measures that help reduce healthcare costs including but not limited to the following areas:
(a) ensuring a health care delivery environment where physicians can have a meaningful choice of whether to be in private practice or health system-employed;
(b) ensuring meaningful patient choice of health insurance coverage options in all regions of New York State;
(c) increasing patient access to needed prescription medications and reducing PBM interference;
(d) reducing litigation;
(e) reducing administrative and regulatory burdens that interfere with patient care delivery.

MSSNY will continue to work together with the AMA to advocate for measures that help reduce healthcare costs including reducing obesity and managing chronic conditions.

MSSNY will continue to work together with the AMA to more fully educate legislators, the media and the public generally of data showing that spending on physician services represents only a small component of overall health care costs. (HOD 2020-63; referred to Council; substitute resolution amended and adopted by Council 1/14/21)

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2022 – 111

Introduced by:	Realba Rodriguez, MD Alan Diaz, MD As Individuals, Delegates, Bronx County
Subject:	Care Management and Social Workers
Referred to:	Reference Committee on Governmental Affairs - **B**

Whereas, health insurances use DRG-formulas to increase the severity of the patient illness hence maximally capitalizing on reimbursements; and

Whereas, the severity of disease has increased while the life expectancy, in many instances due to COVID, has decreased; and

Whereas, patients will be significantly in need of more coordination of care; consequently expecting from their physicians even more non-clinical work; and

Whereas, physician are at their wits end with the onus of clerical work; therefore be it

RESOLVED, That the New York State Insurance Commission requires that the Advance Care Plans have both Care Management and Social Worker services for every patient enrolled under their insurance.

Existing MSSNY Policy:
None found

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2022 – 158

Introduced by:	Ninth District Branch (Dutchess, Orange, Putnam, Rockland, Westchester Counties)
Subject:	Prescribing Therapeutics in Times of Limited Supplies
Referred to:	Reference Committee on Public Health & Education

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Whereas, the Medical Society of the State of New York does not have a position pertaining to the prescription of therapeutics in times of limited supplies; and

Whereas, there have been shortages of effective medications for the treatment of COVID-19 due to rapidly changing susceptibility of viral variants to available therapeutics (1) coupled with delays in the production of new ones (2); and

Whereas, Federal health authorities have indicated that prescribers should, during times of limited supplies of effective COVID-19 therapeutics, prioritize patients based on their level of risk for progressing to severe COVID-19 disease. (3); and

Whereas, the National Institute of Health's (NIH) COVID-19 Treatment Guidelines Panel describes tiered prioritization groups based on age, vaccination status, immune status, and clinical risk factors as set forth by the CDC (4); and

Whereas, the Center for Disease Control (CDC) has grouped clinical risk factors ("comorbidities") into four lists based on the quality of associated evidence, with the first supported by at least one meta-analysis or systemic review ("having evidence"), the second by observational studies, the third by case studies/reports, and the fourth by mixed evidence (5); and

Whereas, disproportionately high rates of COVID-19–associated illness and death have been observed among members of racial and ethnic minority groups (6); and

Whereas, although not listed by the CDC in its evidence-ranked clinical risk factor groupings, Health Departments in New York State and New York City have added race as a risk factor to be considered when prioritizing COVID-19 therapeutics (7) (8); and

Whereas, these health departments have asserted that the disproportionately high rates of COVID-19 associated illness and death among minorities result from "… longstanding systemic health and social inequities" (9), and cite "barriers imposed by structural racism (i.e. policies and institutional practices that perpetuate racial inequity) and White privilege" as reasons for racial health outcome disparities (10); and

Whereas, clinicians routinely consider race/genetics as disease risk factors when such consideration is biologically and/or evidence based (i.e.: Sickle Cell Anemia, Thalassemia); and

Whereas, longstanding traditions of medical ethics have established that physicians should render care unbiased by the patient's race, gender, or sexual orientation; and
Whereas, the absence of an accepted biologic, genetic and/or evidence basis for the

incorporation of race into decision making paradigms for COVID therapeutics in times of scarce resources encourages clinicians to prescribe such therapeutics as a means of redressing social inequities; and

Whereas, when not based upon biology or published evidence, a clinician prescribing using race-based criteria for the purpose of redressing social inequities sets a dangerous precedent for the future, when such practice may be invoked to justify prescribing for non-altruistic social causes; and

Whereas, at times of limited resources, a clinician prescribing COVID therapeutics to a minority patient instead of a non-minority patient to redress social inequities commits an injustice to the latter; therefore be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) create a policy pertaining to the prioritization of therapeutics in times of limited supply; and be it further

RESOLVED, That MSSNY adopt as its policy position that clinicians should prescribe therapeutics in times of scarce supply based solely on established clinical risk factors.; and be it further

RESOLVED, That MSSNY adopt as its policy position that prescribers should, if forced to ration therapeutics in times of scare supply, utilize a methodology such as a lottery or other chance-based process when patients have otherwise equal clinical risk factors for disease progression.

References:

1. The COVID-19 Treatment Guidelines Panel's Statement on Therapies for Nonhospitalized Patients with Mild to Moderate COVID-19. https://www.covid19treatmentguidelines.nih.gov. Accessed 2/7/22
2. COVID-19 Oral Antiviral Treatments Authorized and Severe Shortage of Oral Antiviral and Monoclonal Antibody Treatment Products. New York State Department of Health (NYS DOH) Memo 12/27/21 https://commerce.health.state.ny.us/hpn/ctrldocs/alrtview/postings/Oral_Antivirals_IHAN_12_1640652121347_0.27.21_Final.pdf
3. Op Cit #1
4. Op Cit #1
5. Underlying Medical Conditions Associated with Higher Risk for Severe COVID-19: Information for Healthcare Providers: https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/underlyingconditions.html. Accessed 2/7/22
6. Acosta AM, Garg S, Pham H, et al. Racial and ethnic disparities in rates of COVID-19–associated hospitalization, intensive care unit admission, and in-hospital death in the United States from March 2020 to February 2021. JAMA Netw Open 2021;4:e2130479.
7. Prioritization of Anti-SARS-CoV-2 Monoclonal Antibodies and Oral Antivirals for the Treatment of COVID-19 During Times of Resource Limitations: New York State Department of Health (NYS DOH) Memo 12/27/21
8. New York City Department of Health and Mental Hygiene: 2021 Health Advisory # 39
9. Op Cit #7

Existing MSSNY Policy:

312.986 Antiviral Medication During Catastrophic Epidemics

MSSNY will: (1) collaborate with all parties of interest, national and local, to assure that supplies of antiviral medication are sufficient and available; (2) urge state and local regulators to ensure that adequate anti-flu viral drugs will be available for distribution, not only to hospitals, health departments, and other such public agencies, but also to private pharmacies and physicians directly; and (3) through collaboration with the appropriate organizations and

agencies, seek to eliminate barriers to patients receiving appropriate medications for treatment and/or prevention of potential catastrophic influenza epidemics. (HOD 2007-166; amended and reaffirmed HOD 2018)

312.987 Flu Vaccine Distribution

MSSNY will: (1) support the policy that physicians' offices and/or clinics are the most appropriate sites for vaccinations; (2) support legislation or regulation that will ensure an adequate and timely supply of vaccines to physician offices and clinics; and (3) support legislation or regulation to ensure sufficient reimbursement to cover the cost of purchase, storage and administration of vaccinations. (HOD 2007-165; Modified and Reaffirmed HOD 2017)

312.990 Flu Vaccine Distribution

MSSNY urges the New York State Department of Health to control the disbursement of flu vaccine should another shortage occur and that the flu vaccine be preferentially routed to physicians' offices, medical clinics, hospitals and public health departments for distribution to the stratified population at the greatest risk first. MSSNY urge the New York State Health Department to take appropriate action so that in the event of another influenza vaccine shortage that vaccine lots can be easily located and recovered for redistribution as necessary. MSSNY support the concept that the high risk population, as defined by the Centers for Disease Control and Prevention, be immunized first. (HOD 2005-158; Reaffirmed HOD 2015)

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2022 - 164

Subject:	Breast Cancer Screening/Clinical Breast Exam Coverage
Introduced by:	Dutchess County Medical Society
Referred to:	Reference Committee on Public Health and Education

Whereas, Centers for Medicare and Medicaid Services, CMS, reimburses Internists and Family Physicians for a single physical at the time of medicare enrollment at the age of 65 with the Initial Preventive Physical Exam, IPPE ; and
Whereas, CMS does not reimburse for any further annual physical exams for medicare patients; and

Whereas, female patients no longer require annual cervical pap smears after the age of 65 if prior pap smears have been negative and they are not at higher risk for cervical cancer, as is applicable for the majority of medicare female patients; and

Whereas, female patients therefore opt to no longer see their gynecologists after the age of 65 as they no longer require a pap smear or have any active gynecological issues; and

Whereas, these female patients need an annual or biennial clinical breast exam and this should therefore be performed by their internist or family practitioner at their Annual Wellness Visits (AWV) or Subsequent Annual Wellness Visits (SAWV) after their initial IPPE; and

Whereas, an internist or family practitioner cannot bill for this clinical breast exam as part of this AWV or SAWV visit, even though this exam is critical and a part of the standard of care for breast cancer screening which includes both imaging and a clinical breast exam; and

Whereas, this policy by CMS is inconsistent and gender biased since a digital rectal exam for prostate cancer screening in men over 65 for Medicare patients is a covered procedure at the time of their AWV or SAWV appointment with their internist or family practitioner; therefore be it

RESOLVED, that the Medical Society of the State of New York (MSSNY) adopt a policy and position that supports clinical breast exams for female and at risk male Medicare patients at their Annual Wellness Visit (AWV) and Subsequent Annual Wellness Visit (SAWV) appointments and this exam be a covered procedure that is payable to the clinician by Centers for Medicare and Medicaid Services

References:

Existing MSSNY Policy:

125.995 Breast MRI for High Risk Women

The Medical Society of the State of new York supports the American Cancer Society and the American College of Radiology recommendation that screening breast MRI is indicated in patients who are at high risk for breast cancer in addition to mammography. (Council 1/12/2012)

125.996 Screening Programs and Interventions Most Beneficial in Improving the Overall Health of the Public:

MSSNY has long advocated for the rights of patients to have access to various screening services and interventions most beneficial in improving the overall health of the public. Obviously access to these important health care service recommendations is dependent upon the acceptance, agreement and availability of them by relevant private and public insurance entities, which is why MSSNY continues to support and advocate for insurance coverage for all of these screening programs. MSSNY Policy 125.996 was developed and put forward to the MSSNY Council in 2010 and was also reaffirmed by the MSSNY Council in 2011. These revisions pertained to various updates from medical specialties or organizations throughout the last ten years and represent only recommendation, but not practice guidelines, for physicians.

MSSNY supports and advocates for insurance coverage for all of these screening programs:

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5) ***Breast Cancer Screening Mammography and Appropriate Treatment***—All women should be evaluated for breast cancer risk no later than age 30. For women at average risk for developing breast cancer, annual mammography should begin at age 40. Mammographic screening should continue as long as a woman is in good health. Regular mammographic screening results in substantial reduction of breast cancer mortality across multiple studies. Women should be familiar with the known benefits, limitations, and risks of breast cancer screening. Women should also know how their breasts normally look and feel and report any breast changes to a health care provider right away. Breast ultrasound may be used for supplemental screening in addition to mammography in women with mammographically dense breasts. Some women – because of their family history, a genetic tendency, or certain other factors – should be screened with MRIs along with mammograms and may benefit from beginning to screen earlier than age 40. Women should consult with a health care provider about their risk for breast cancer and the best screening plan for them. (ACR, ACOG, NCCN, SBI, ASBrS).....

Breast:

Version 1.2019 Screening Guidelines, 05/17/19 NCCN

MRI is also indicated for patients with prior history of breast cancer, Gail risk >1.7%, 20% risk defined by personal history of LCIS or ADH/ALH, untested for familial TP53 mutation, untested for familial PTEN mutation. MRI is also a consideration for mutation carriers in the ATM, CDH1, CHEK2, NBN, NF1, and PALB2 genes.

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2022 – 202

Introduced by:	Suffolk County Medical Society
Subject:	MSSNY Best Practice Task Force
Referred to:	Reference Committee on Reports of Officers & Admin Matters

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Whereas, over time our Medical Society of The State of New York (MSSNY) continues to become a far more complex business than could have been imagined just a few years ago; and

Whereas, MSSNY engages a multitude of business relationships including staffing, engaging outside professionals, consultants and advisors, and the marketing of products and services to our members; and

Whereas, these relationships may serve our mission directly, support our operations, or provide sources of non-dues revenue; and

Whereas, the nature of these relationships often involve an 'intimacy' that develops between MSSNY and these business partners that provide insights into that partner's operations, markets, and trade secrets - and should the details of those insights be publicly disclosed might present difficulty for these (or prospective) partners; and

Whereas, as a membership organization, there is an inherent conflict between our members desire for transparency and their interests in the prosperity of the organization itself; therefore, be it

RESOLVED, that our Medical Society of The State of New York (MSSNY) convene a workgroup/task force to examine and to modernize MSSNY business practices - that might include creating an organizational chart, better define the respective roles of the trustees, elected leaders, Council, House of Delegates and our administrators - to maintain the business viability of MSSNY, while at the same time providing the proper transparency to its members.

Fiscal Note: $15,810. Covers one year of twelve 1.5 hour meetings, with seven hours of follow-up after each. Staff = one middle management plus one senior management.

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2022 – 258

Introduced by:	San San Wynn, MD As an Individual, Delegate Kings County
Subject:	Pharmacogenetics Insurance Coverage
Referred to:	Reference Committee on Socio-Medical Economics

Whereas, patients can developed severe side effects from 5FU chemotherapy and other prescription drugs; and

Whereas, a simple test for DPD (dihydropyrimidine dehydrogenase) enzyme deficiency which is extremely rare but complications from this with 5FU are devastating potentially; and

Whereas, we should recommend testing for this particular enzyme deficiency in patients who will be receiving 5FU & related chemotherapies would be medically prudent; and

Whereas, clinicians expose ourselves to potential litigation if we don't test for enzyme deficiencies prior to treatment with medications with known complications; and therefore be it

RESOLVED, that insurance companies should cover testing for enzyme deficiencies prior to administration of medications ; and be it further

RESOLVED, pharmaceutical companies create protocols for testing and informed consent forms to aid clinicians and patients to make informed decisions; and be it further

RESOLVED, all genetic testing and enzyme deficiencies should be covered if they impact potential life-saving treatment and severe morbidities if testing is not done.

References:

1. https://medlineplus.gov/lab-tests/pharmacogenetic-tests/
2. https://microbe.creativebiomart.net/enzyme-activity-assay-service.html?gclid=Cj0KCQiA3rKQBhCNARIsACUEW_YTOyym-_IF7QOtR1VgKtCqoZopJksbwPfzcZSjaFrr_hi8QiAHy-MaAkuDEALw_wcB
3. https://genesight.com/gene-test-mental-health-medications/?utm_source=google&utm_medium=cpc&utm_campaign=branded&utm_content=103375724152&utm_term=genesight%20testing%20results&gclid=Cj0KCQiA3rKQBhCNARIsACUEW_YTFwuL6uI7xJlM7RaeJGdLM6yySlUyeUJLIbGktzNyzPRF_ml55YYaAhDQEALw_wcB
4. https://pubmed.ncbi.nlm.nih.gov/14996240/

Existing MSSNY Policy:

105.995 Insurance Payment Mandate for Genetic Counseling

MSSNY will use our Commissioner of Communications to convey the need for board-certified genetic counseling to be included in the Affordable Care Act's Preventative Care Visit when a genetically-modifiable disease is being addressed, such as screening Papanicolaou or colonscopy screening, are included benefits of the preventative care visit. The Commissioner of Communications is to continue promotion of public health and prevention topics, thus creating public opinion and resultant public policy. (HOD 2020-251)

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

Resolution 2022 - 260

Subject:	Concurrent Processing of Procedure Codes
Introduced by:	Nassau County Medical Society
Referred to:	Reference Committee on Socio-Medical Economics

Whereas, procedures may often have multiple CPT codes associated with them; and

Whereas, insurers have traditionally processed payments for all the CPT procedure codes for a given procedure or surgery at the same time; and

Whereas, because of the passing of the federal No Surprises Act, starting for procedures performed in 2022 insurers have begun a new practice of processing payments for various codes of the same procedure separately; and

Whereas, providing separate payments of the codes of the same procedure at different times makes challenging codes via appeals or bundling codes through arbitration (if the provider is out of network) much more difficult; and

Whereas, this new insurance behavior serves no purpose other than to increase the burden on providers to collect payments for their services and to skirt the Congressionally intended bundling provisions in the No Surprises Act; therefore be it

RESOLVED, that MSSNY will advocate for a state law or regulation that requires insurers to pay all the CPT codes of a given procedure or operation at the same time; and be it further

RESOLVED, that MSSNY ask the AMA to advocate for federal law or regulation that requires insurers to pay all the CPT codes of a given procedure or operation at the same time.

Existing MSSNY Policy:

265.901 **New Federal Legislation re Prompt Payment and Amendment of New York State Prompt Payment Law**

MSSNY will work with the American Medical Association for the introduction of federal legislation that imposes a strong federal standard for prompt payment, following the AMA's recommendations which include:

1) requiring payment within 30 days for clean paper claims and 14 days for clean electronic claims;

2) imposing stiffer fines than those currently in state laws, for insurers that fail to comply with the federal prompt payment law;

3) requiring that interest be assessed on the amount of payment outstanding, and that interest increase with the length of time the claim has been delinquent;

4) requiring that the insurer absorb any fees and costs that the physician may incur due to the lack of prompt payment of the claim, provided that the physician can document that these fees or costs might not have been incurred if the claim had been paid within the mandated timeframe.

MSSNY also will work with the AMA for a federal law that:

1) sets a statutorily defined time limit for insurers to notify physicians that additional information is needed to process a claim;

2) requires the insurer to specify, in the notice, all problems with the claim and give the physician an opportunity to provide the information needed;
3) requires the insurer to pay any portion of a claim that is complete and uncontested.

Also, MSSNY will work towards amending New York's Prompt Payment Law to:
1) include all applicable provisions of the federal law mentioned above;
2) provide that where New York law is stronger than federal law or addresses an issue that is not part of federal law, the state law should take precedence. (HOD 2008-55; Reaffirmed HOD 2015 in lieu of res 62)

265.864 Prompt Payment

The Medical Society of the State of New York will work with the New York State Department of Financial Services to ensure prompt payment complaints from physicians against health insurers are resolved expeditiously, preferably within 30 days of the complaint; and MSSNY will advocate for legislation that would increase the current prompt payment interest penalty above the current 12% per year threshold. (HOD 2015-61; Reaffirmed HOD 2021-56)

265.871: Revision of AMA Current Procedure and Terminology (CPT) to reflect EHR/EMR documentation and work processes

MSSNY recommends that the AMA review the CPT coding guidelines with the aim of developing a new model of payment that reflects 21st century EHR technology, and that the AMA make immediate revisions to the current CPT practice performance reporting process aimed at preparing the infrastructure for new models of paying for the delivery care. (HOD 2013-268; Reaffirmed HOD 2021-252)

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 "pended" 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 2000-71; Reaffirmed HOD 2014; Reaffirmed HOD 2021-56)

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 2000-65; Reaffirmed HOD 2014)

265.987 AMA-CPT Coding

MSSNY endorses AMA-CPT as the standard accepted coding system in New York and that proper use of CPT by insurance carriers requires adherence to all of its rules and guidelines; and will recommend that the Insurance Superintendent and the New York State Legislature require health insurance carriers processing claims from New York physicians, including Workers' Compensation and No-Fault Carriers, to adhere to all CPT rules and guidelines, including code modifiers. MSSNY will request that the Insurance Superintendent make the necessary revisions of the inappropriate bundling edits in the software which erroneously processes claims from physicians and disallows legitimate claims for services. (HOD 1997-285; Reaffirmed HOD 2000-251, HOD 2000-257, HOD 2000-268, HOD 2003-268 & 278 and HOD 2005-254 & 276; Reaffirmed HOD 2013; Reaffirmed HOD 2021-252)

305.991 CPT Codes for Preauthorization Denials and Fair Compensation

MSSNY will advocate that the AMA include fair compensation based on CPT codes for appeal of wrongfully denied services in any Model Legislation and as a basis for all advocacy, including those for prior authorization reforms and that CPT codes must fully reflect the aggregated time and effort expanded by physician practices.

MSSNY will urge the AMA to have the AMA CPT Editorial Panel establish a CPT code which would account for administrative work involved in prior authorizations and that reflects the actual time expended by physician practices advocating on behalf of patients and complying with insurer requirements.
MSSNY will urge the AMA to have the AMA CPT Editorial Panel establish a CPT code which would account for administrative work that reflects the actual time expended by physician practices and their billing vendors in successfully appealing wrongful pre- and post-service denials. (HOD 2021-254 and 255

165.897 **MCOs Use of Pre-Payment Claim Reviews to Circumvent the New York State Prompt Payment Law:**

MSSNY will:
(1) using the Hassle Factor Form, solicit and compile examples of prepayment claim reviews initiated by managed care organizations where the physician has received no prior notification of aberrant coding or claim submission practices;
(2) review these examples to determine whether the managed care organizations are in violation of the New York State Prompt Payment Law or related regulatory directives, such as the New York State Insurance Department Regulation # 178 (11 NYCRR 217) (Prompt Payment of Health Insurance Claims) or Article 26 of the Unfair Claim Settlement Practices law (Section 2601); and
(3) urge the New York State Insurance Department to take appropriate action against these managed care organizations if it is determined that the MCOs are indeed in violation of the relevant statutes or regulations through their use of erroneous pre-payment reviews. (HOD 2007-253; Reaffirmed HOD 2017)

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 2000-257 & 268; Reaffirmed HOD 2014)

120.957 **Outsourcing of Claims:**

MSSNY will take all appropriate steps including, if necessary, the passage of legislation to assure that health insurance companies which subcontract with third party vendor(s) located in a foreign country for claims processing, utilization review or for any other service adhere to all appropriate federal and state legal requirements for the prompt adjudication of claims for payment, utilization review and patient information privacy. (HOD 2009-105; Reaffirmed HOD 2019)

130.987 **Health System Reform - MSSNY Principles:**

MSSNY is sensitive to the compelling circumstances generating the movement towards health care system reform in New York State and nationally. The Society is cognizant of the need to control health care costs while advocating the provision of health insurance coverage to the entire population of this state, including our 2.5 million citizens who are currently uninsured. While cost controls are the primary factor influencing the reform process, MSSNY believes that access and quality are equally essential objectives which must not be compromised by any

planned system restructuring. In fact, cost control cannot be achieved if either access or quality is not satisfactorily addressed.

MSSNY believes that eventual stability of the state health care delivery system must be fundamentally predicated upon: (1) Universal access to high quality care for all New Yorkers; (2) Redirection of economies derived from renovation of a flawed system with its significant inefficiencies and frequent misallocation of resources to a more cost-effective service delivery structure; (3) Finance reform in conjunction with a price competitive market-based pluralistic system; (4) Meaningful physician input concerning relevant key aspects of any system reform.

Consequently, MSSNY believes that the following principles should be embodied in any reform of the state health care delivery system: (1) All New Yorkers regardless of health and income status should have access to high quality, affordable and basic health care; (2) Comprehensive health care reform should be achieved through a collective partnership encompassing the consumer, business, labor, health provider, health insurance and government sectors which would build on the positive elements of our current pluralistic health care system; (3) An independent health care access oversight authority comprised of pertinent private and public sector representatives should be established to monitor and assess the quality of care provided under the reform; (4) Health system reform should provide sufficient tax and financial incentives to create an environment of consumer cost consciousness which would compel vigorous price competition among health care insurers; (5) Competition among insurers should be predicated on required offering of the standard benefits program developed under the auspices of the proposed independent health care access oversight authority; (6) Individuals should have the right and responsibility to obtain, at minimum a standard benefits package, and finance a portion of cost of their care according to their means. State government and employer contributions should supplement the purchase of such insurance as appropriate, with tax incentives provided to employees and employers for the purchase of the lowest priced comparable coverage among insurers (as identified by the independent authority). Coverage beyond the standard package may be procured at additional cost, but without tax relief for the purchaser; (7) State financing, coupled with the necessary federal Medicaid/Medicare waivers, should be provided for the purchase of a standard benefits package by the indigent, elderly, uninsured and unemployed; (8) Health insurance system reform should be designed to: (a) Aid small business in the provision of health insurance to their employees; (b) Promote community rating; (c) Eliminate preexisting condition exclusions; (d) Guarantee renewability and portability; (e) Control premium increases; (f) Guarantee consumer choice of insurer, inclusive of programs providing freedom of choice of physicians; (9) Medical liability tort reform, including limitations on non-economic damages, should be enacted in concert with health care system restructuring to mitigate the costly practice of defensive medicine, while continuing to protect the legitimate interests of the patient community; (10) Practice parameters should be developed by physicians experts as useful educational tools for assuring the delivery of quality care and providing an affirmative defense in legal actions premised upon physician negligence; (11) Electronic claims processing (unrelated to a single payor authority) in conjunction with the development of a uniform claim form should be achieved in an effort to mitigate the current high administrative costs of health insurance operations; (12) Reimbursements for a defined service should be the same regardless of the site of that service (office, home, hospital settings, etc.) thereby establishing ambulatory care payment parity; (13) The residents of New York State should assume greater responsibility for their health by the imposition of financial sanctions directed toward mitigating unhealthy behaviors, taking appropriate preventive measures, and making conscientious cost effective determinations concerning the utilization of health care services; (14) The system must be structured to induce all insurers to function in the most cost-effective manner possible so as to ensure the mitigation of administrative costs, and application of the maximum amount possible of the premium dollar to health care benefits; (15) All providers of health care should be committed to adhering to the highest standards in the provision of patient care and interaction with health insurers. (16)

Organized medicine, as represented by MSSNY, should be authorized to represent physician interests in negotiating the establishment of fees with insurers and other payors. (17) MSSNY is committed to organize physicians into an integrated risk-sharing entity in order to offer an alternative to capitated plans and to permit private practicing physicians to compete effectively in the managed care/managed competition arena in both the public and private payor market. (Council 6/3/93; Reaffirmed HOD 01-256; Reaffirmed HOD 2011 and also Reaffirmed AMA Substitute Resolution 203, Health System Reform Legislation (below); Reaffirmed HOD 2021):
RESOLVED, That our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
Health insurance coverage for all Americans;
Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps;
Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials;
Investments and incentives for quality improvement and prevention and wellness initiatives;
Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care;
Implementation of medical liability reforms to reduce the cost of defensive medicine; and
Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens; and be it further

265.839 Non-Payment and Audit Takebacks by CMS

Through legislation and/or regulation, the Medical Society of the State of New York will seek policies opposing nonpayment of claims due to minor wording or clinically insignificant documentation inconsistencies, extrapolation of overpayments based on minor consistencies and denial of bundled payments based on minor wording or clinically insignificant documentation inconsistencies. This resolution will also be sent to the AMA. (HOD 2018-253)

265.870: Development of A Fair and Transparent Recoupment Process to be Used by Third Party Payers for Physicians

MSSNY will support legislation in New York State that mandates third party payers develop a standardized transparent recoupment process similar to the process outlined in CR6183 Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), and that prohibits third party payers from suspending payments to physicians without credible evidence of fraud and abuse. (HOD 2013-269)

MEDICAL SOCIETY OF THE STATE OF NEW YORK
House of Delegates

EMERGENCY RESOLUTION 2022-2

Introduced by: Fifth and Sixth District Branches

Subject: Prior Authorizations by 'Denials Companies'

Referred to: HOD

Whereas, many payers in NY State have effectively outsourced the process of patient care denials to third party companies which function as 'denial companies' examples of which would include Evicore and Magellan, among others. This outsourcing pathway was developed specifically to functions as a 'shell game' where denials occur, but the payers themselves can plead that they are not culpable for the denials, and

Whereas, these denials have increased in number, frequency, and inflexibility over the past 6 months to a year, and

Whereas, these denial companies function outside of the bounds, rules, and regulations of the NY state Department of Financial Services and have been developed in an effort to shield the denials process from state regulators and to minimize the ability of physicians to push back against inappropriate hurdles to patient care, and

Whereas, in a large number of cases the uncompensated time and resource requirements on physicians and their staff takes more time than the procedure or care being denied. These time and resource cost to a physician represent a real cost to the business of running a practice and are uncompensated by the companies demanding the peer to peer review while simultaneously not costing the denial company. These denials companies derive a net positive cash flow by denying care with no current financial factors pushing back against their practice of denial, and

Whereas, this financial, time, and resource burden is threatening to make many practices lose their ability to be fiscally sound and will therefore threaten loss of physician practices, and

Whereas, many denials companies make decisions on incomplete records, by physicians not of similar specialty, and often not current with modern standards of care and when a decision is made to deny a request for care the denials companies place an arbitrary standard that the case may not be resubmitted for 60 to 90 days. This has a very negative impact on timely and appropriate medical care, and

Whereas, MSSNY has enacted some similar policy to address these issues in the past but the current practice issues have worsened, the current resolutions seek to more firmly define MSSNY policy. Related MSSNY prior policy would include: MSSNY policy 265.902 approved in 2008 and reaffirmed in 2018, MSSNY policy 305.991 approved in 2021, MSSNY policy 120.897 approved in 2020, and MSSNY policy 120.945 approved in 2012 and reaffirmed in 2020, therefore, be it

Resolved, all peer to peer patient care reviews must be a 'true' peer to peer. The peer to peer reviews must be performed by a physician, and that physician must hold a current NY medical license and be Board Certified in the same specialty as the care providing physician, and when appropriate the physicians representing the care denial organization must be subspecialty Board certified in a field germane to the care request, and be it further

Resolved, peer to peer time lines may not be unreasonable. Any mandated time line for a care providing physician must allow for a peer to peer to occur within two weeks of the care providing physician being notified of the requirement for a peer to peer. The time chosen must be one that is convenient for the care providing physician being mandated to have a peer to peer by the denial company, and be it further

Resolved, all companies / organizations that are de facto functioning as 'denial agents' for payers need to be immediately brought under the auspices of the NY state Department of Financial Services and as such become subject to all rules and regulations for health care payers, and be it further

Resolved, that physicians have the right to recoup for their currently uncompensated time and resources required to schedule and complete a peer to peer review to address a denial of patient care by charging a fee $200 per hour of time required to address the peer to peer request with a minimum compensation of $100 per peer to peer to be paid to the care providing physician office by the denials company, and be it further

Resolved, physicians performing a peer to peer on behalf of the denials company must have all records germane to the case, and have reviewed the entirety of these records prior to meeting with the care providing physician for a peer to peer, failure to do so would result in the care providing physician having the case found in their favor without further denial, and be it further

Resolved, that in the event of a denial finding after a peer to peer, or any other reason for a denial, there may not be a time limit placed on resubmitting a request for care, and be it further

Resolved, that any physician working on behalf of a denials company will become personally, medically and legally responsible for any lapse in care, failures of care, or negative outcomes that arise due to denials of, or delays in, care as directed by the care providing physician, and be it further

Resolved, that MSSNY push aggressively for legislative action on all of these resolves during the next legislative session, and be it further

Resolved, that MSSNY bring this to the AMA to develop a national agenda on this issue