MEDICAL SOCIETY OF THE STATE OF NEW YORK 2017 HOUSE OF DELEGATES

Report of the Reference Committee on Socio-Medical Economics

Presented by: Jennifer Congdon, MD, Chair

Mister Speaker and Members of the House of Delegates:

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 253 Violation of HIPAA Electronic Transaction Standards by Insurer Failure to Upload ICD-10 Revisions

2. Resolution 258 Amendments to the Workers' Compensation Law Section 110-a (Confidentiality of Workers' Compensation Records)

3. Resolution 261 New York State Insurance Fund Unfair Rule Changes

4. 2017 Sunset Review Report of The Medical Society of The State of New York's Committee on Socio-Medical Economics

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

5. Resolution 250 Treatment of Onychomycosis

6. Resolution 251 Reimbursement for In-office Administered Drug

7. Resolution 252 Peer to Peer Reviews by Insurers

8. Resolution 255 Office Based Surgery Reimbursement

9. Resolution 256 Arbitrary Deadlines for New York State Workers' Compensation Peer Review Response

10. Resolution 260 Correcting Workers' Compensation Board Policy

11. Resolution 263 *(LATE A)* Changes in Insurance Accepted by Pharmacies

12. Resolution 264 *(LATE C)* Prompt Response to Physician's Request for Authorization for Patient Care Services

RECOMMENDED NOT FOR ADOPTION

13. Resolution 254 ICD-10

14. Resolution 259 Worker's Compensation Physician Reimbursements

15. Resolution 262 Discrimination against Patients in Medicare Advantage Organizations

1. RESOLUTION 253 – VIOLATION OF HIPAA ELECTRONIC TRANSACTION STANDARDS BY INSURER FAILURE TO UPLOAD ICD-10 REVISIONS

THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 253 BE ADOPTED.

Resolution 253 asks that the Medical Society of the State of New York (MSSNY): 1) survey its members asking whether they have experienced claim denials, claims resubmission, or appeals because the insurer (federal, state or commercial) failed to upload the October 1, 2016, version of ICD-10 in a timely fashion; and 2) urge the American Medical Association (AMA) to present information on ICD-10 improper claim denials to the Centers for Medicare and Medicaid Services (CMS) and its Office of E-Health Standards & Services, to determine whether the insurers' failure to properly update their claims processing systems has constituted a violation of the HIPAA Electronic Transaction Standards and should trigger disciplinary or corrective actions to prevent these occurrences in the future.

Your Reference Committee heard supportive testimony regarding this resolution. The ICD-10 update was scheduled for update on October 1, 2016. However, many plans appeared to be unaware of the update and the delayed amendment to claims processing systems caused a variety of denials. Consequently, your Reference Committee believes that this delayed system update would have had national impact and we need to alert the AMA to insure that this inactivity does not occur with future updates. Therefore, your Reference Committee supports Resolution 253.

2. RESOLUTION 258 AMENDMENTS TO THE WORKERS' COMPENSATION LAW SECTION 110-A (CONFIDENTIALITY OF WORKERS' COMPENSATION RECORDS)

THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 258 BE ADOPTED.

Resolution 258 asks that the Medical Society of the State of New York (MSSNY) seek: 1) appropriate legislation or regulation to modify the Workers' Compensation Law, Section 110-a, Subsection 1 (a), which would allow a physician, or his legal representative, the ability to communicate with a member of the Workers' Compensation Board, in instances when there is apparent fraud committed by a Workers' Compensation claimant or other important information or irregularities relevant to the case; and 2) legislation or regulation to strengthen NYS Workers' Compensation Law and reduce potential fraud and abuse by amending Workers' Compensation Law 110-a Part h to enable physicians to report alleged discrepancies or apparent fraudulent activities by patients and allow the Workers' Compensation Board staff to annotate the WC Case file and alert the Workers' Compensation Fraud Inspector General.

Your Reference Committee heard significant testimony in support of this resolution. In the interests of cost containment and transparency, physicians should be able to report to the WCB when they suspect fraud or abuse being perpetrated against the WC system. Your Reference Committee supports this resolution.

3. RESOLUTION 261 NEW YORK STATE INSURANCE FUND UNFAIR RULE CHANGES

THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 261 BE ADOPTED.

Resolution 261 asks that MSSNY work with all relevant agencies, including Workers Compensation Board, to force New York State Insurance Fund to return to the policy of

providing physician offices both the status of the claim and body parts under that claim prior to the consultation occurring.

Your Reference Committee heard a great deal of testimony in support of this resolution. Around October 2016, the NYSIF has changed its internal rules – it will no longer tell a physician if a WC case is open, closed or retired. In addition, the NYSIF will no longer advise whether certain body parts are included in the WC claim. This policy change creates another burden on the physician practice. When this was brought to the attention of the WCB, the response was that while the preferred route is for the physician to call the carrier, a second option exists for obtaining the information regarding the status or compensability of a claim. Physicians may contact the WCB to obtain this information. Resolution 261 should be supported.

4. 2017 SUNSET REVIEW REPORT OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK'S COMMITTEE ON SOCIO-MEDICAL ECONOMICS

THE REFERENCE COMMITTEE RECOMMENDS THAT THE SUNSET REVIEW REPORT OF THE COMMITTEE ON SOCIO-MEDICAL ECONOMICS BE ADOPTED AND THE REPORT BE FILED.

5. RESOLUTION 250 – TREATMENT OF ONYCHOMYCOSIS

THE REFERENCE COMMITTEE RECOMMENDS THE FOLLOWING:

RECOMMENDATION A: THE THIRD RESOLVED OF RESOLUTION 250 BE AMENDED BY ADDITION AND DELETION.

Resolved, that the Medical Society of the State of New York (MSSNY) supports the treatment of onychomycosis by **all physicians and properly licensed providers including** ~~a qualified physician or~~ doctor**s** of podiatric medicine.

RECOMMENDATION B: RESOLUTION 250 BE ADOPTED AS AMENDED.

Resolution 250 asks that the Medical Society of the State of New York (MSSNY): 1) recognizes onychomycosis of the toenails as an infectious disease that may cause pain, reduce mobility, create ulcerations, and may cause secondary infections leading to serious health complications; 2) recognizes fungal infections of the toenail have a high incidence in the general public, and specifically at-risk diabetic patients, creating a public health issue; and 3) supports the treatment of onychomycosis by a qualified physician or doctor of podiatric medicine.

Your Reference Committee heard a great deal of testimony in support of the sentiments expressed in this resolution. The resolution is calling for the recognition of a condition and support for its treatment. Therefore, your Reference Committee supports Resolution 250 with amendments.

6. RESOLUTION 251 REIMBURSEMENT FOR IN-OFFICE ADMINISTERED DRUG

THE REFERENCE COMMITTEE RECOMMENDS THE FOLLOWING SUBSTITUTE RESOLUTION 251 IN LIEU OF RESOLUTION 251:

RESOLVED, that MSSNY take the necessary steps to ensure that in-office physician administered medications be reimbursed at no less than the cost of the medication,

which includes the cost of the purchase, storage, spoilage and professional administration.

Resolution 251 asks that 1) MSSNY take the necessary steps to insure that health care in-office provider administered medications be reimbursed at no less than the cost of the medication; and 2) in addition to the reimbursement for the medication there be payment for purchase, storage of said medications, and additional monies to pay for all supplies, staff and professional efforts.

Your Reference Committee heard significant testimony in support of this resolution. However, your Reference Committee decided that MSSNY's position be stated in one resolve.

7. RESOLUTION 252 PEER TO PEER REVIEWS BY INSURERS

THE REFERENCE COMMITTEE RECOMMENDS THE FOLLOWING SUBSTITUTE RESOLUTION 252 BE ADOPTED IN LIEU OF 252:

Resolved, that the Medical Society of the State of New York seek legislation to change peer to peer review by insurers to include evidence-based criteria publicly available and to be conducted by a physician of the same specialty and responded to the physician practice on a timely basis via fax or electronically. This legislation should also limit peer to peer and prior authorization reviews to only those cases that do not fall within the evidence based criteria.

Resolution 252 asks that MSSNY seek changes in the peer to peer reviews by insurers so that they be limited only to unusual requests, that the payor representative be board certified in the specialty in question, and that peer to peer requests be a written communication that can be responded to electronically or via fax.

Your Reference Committee heard a lot of testimony for the support of this resolution. However, in consideration of all t
he testimony given your Reference Committee offers the substitute resolution to capture the sentiments provided during the hearing.

8. RESOLUTION 255 OFFICE BASED SURGERY REIMBURSEMENT

THE REFERENCE COMMITTEE RECOMMENDS THE FOLLOWING SUBSTITUTE RESOLUTION 255 BE ADOPTED IN LIEU OF 255

RESOLVED, That the Medical Society of the State of New York seek legislation to require health plans to provide facility fee reimbursement to physicians and/or medical practices that obtained State-mandated accreditation for their office-based surgical suite(s); and be it further

RESOLVED, that the new legislation mandate that facility fee reimbursement paid to physicians and/or medical practices issued by the health plan be fair and equitable, which means that payment by plans be no less than 50% of the rate paid to Ambulatory Surgical Centers (ASCs) or Hospitals for the room use of the ER, OR, OPD or Clinic, which will enable the plans to realize cost containment savings by paying physicians and/or medical practices, rather than paying the full ASC or Hospital room use rate.

Resolution 255 states that 1) that payment for office based surgery (OBS) facility fees be made retroactive to 3 years from the last case performed by the practitioner at the OBS Facility and that the reimbursement be at least 50% of the reimbursement made to the hospital facility for a similar procedure-both retroactively as well as going forward; and 2) based on long term past inequities in payments for facility reimbursement fees between the hospital, ambulatory surgery centers and office based surgery by the insurance providers, we call for action by the Medical Society of the State of New York to establish legislative priorities based on this resolution that can inform state legislators to enact into law said resolution.

Your Reference Committee heard supportive testimony regarding this resolution. Currently, there is no legislation requiring health plans to pay for facility fees to physicians who have gone the through the burden and expense of obtaining accreditation for their office-based surgical suite. The substitute resolution clearly defines MSSNY's position on this vital subject. Therefore, your Reference Committee recommends adoption of substitute Resolution 255.

9. RESOLUTION 256 ARBITRARY DEADLINES FOR NEW YORK STATE WORKERS' COMPENSATION PEER REVIEW RESPONSE

RECOMMENDATION A: RESOLUTION 256 BE AMENDED BY ADDITION AND DELETION

RESOLVED, that the Medical Society State of New York require that if a ~~Workmen's~~ **Workers'** Compensation peer review is requested by either party that the peer review be scheduled at a mutually acceptable time.

RECOMMENDATION B: RESOLUTION 256 BE ADOPTED AS AMENDED

Your Reference Committee heard significant testimony for this resolution. Therefore, your Reference Committee supports adoption of Resolution 256 as amended.

10. RESOLUTION 260 CORRECTING WORKERS' COMPENSATION BOARD POLICY

THE REFERENCE COMMITTEE RECOMMENDS THAT SUBSTITUTE RESOLUTION 260 BE ADOPTED IN LIEU OF RESOLUTION 260

RESOLVED, that the Medical Society of the State of New York seek legislation to allow payment for services be made by the patient or the patient's private insurance when the patient and physician agree that additional treatment is necessary to improve impairment beyond the services that the Carrier's IME and the WC ALJ are willing to pay for under the Workers' Compensation Program.

Resolution 260 asks that 1) in accordance with longstanding principles of patient advocacy and treatment autonomy, in order to preserve the autonomous nature of the doctor-patient relationship, the Medical Society of the State of New York seek legislative action to ensure that non-physician personnel such as Workers' Compensation Administrative Law Judges and/or the courts not interfere with the doctor/patient relationship regarding medical judgment for treating an injured worker; and 2) MSSNY seek legislation to ensure that the decision to issue denials is not made by non-physician clerical personnel.

In researching this resolution in advance of the HOD, MSSNY staff questioned the staff of the Workers' Compensation Board (WCB or the Board). We find that the Board takes the position that the WCB is not making medical decisions nor interfering in the doctor-patient relationship.

Rather, a payment dispute is brought to the Board for a resolution. A dispute can arise from either the claimant or carrier, but the administrative process for resolving the dispute is the same.

The claimant's treating provider and the carrier's IME present medical evidence in response to the disputed issue. Based on the competent medical evidence, the WC Law Judge or the Board Panel issue a decision resolving the payment dispute. This is the process and procedure for resolving legal payment disputes, whether it is about surgery, treatments or medications.

In summary, non-medical personnel are not making medical decisions. Payment disputes are addressed and resolved in a legal venue, where both parties present medical evidence to a Judge. The Judge, based on the evidence, issues a decision regarding the payment.

Subsequently, the WCB staff provided the following added clarification of their position:

Treatment: Established Case
The e-mail response that you refer to was precipitated by concerns raised by MSSNY members that WC Judges were making medical decisions and interfering with the doctor-patient relationship. In that discussion, there was an assumption that the case has been established and that the dispute was whether the treatment should be reimbursed. The decision in the dispute is based on the competent medical evidence presented to the Judge by the treating provider and the carrier's IME.

After reviewing the medical evidence presented by both parties, the WC Law Judge or the Board Panel issue a decision resolving the dispute. If the physician and patient decide to proceed with the treatment under these circumstances, the physician is not permitted to bill the patient or accept payment from the patient and the carrier will not be held responsible for payment.

Treatment: Case Not Established
The issue between the patient and carrier/employer regarding whether or not the treatment is for an established injury or is casually related to work is very different from that addressed in our original discussion. If an injury or condition is not established or found not casually related, then the employer/WC carrier is not responsible for payment of treatment or services requested or provided. Under these specific circumstances, the patient and physician may proceed with treatment either as private pay or via the patient's private insurance, according to the coverage rules of the insurer.

In view of the WCB's position, your Reference Committee acknowledges that the nonmedical personnel are only deciding compensability/payment by the WC Program. The medical necessity for treatment is between the doctor and patient. If a treatment or service is deemed to be non-compensable by the Board, but the physician and patient choose to proceed, payment will either be the responsibility of the patient or the patient's health insurance plan.

Therefore, your Reference Committee recommends that substitute Resolution 260 be adopted.

11. Resolution 263 CHANGES IN INSURANCE ACCEPTED BY PHARMACIES *(LATE A)*

THE REFERENCE COMMITTEE RECOMMENDS THE FOLLOWING SUBSTITUTE RESOLUTION 263 BE ADOPTED IN LIEU OF RESOLUTION 263:

RESOLVED, that the Medical Society of the State of New York seek legislation that will require NYS pharmacies to contact all physicians and patients that are affected by the pharmacy's cessation of participation in a specific health insurance plan and require the transfer, with notice to the patient, of all new and pending prescription refills to a pharmacy that accepts the patients' insurance; and be it further

RESOLVED, that MSSNY seek the creation of a prescription clearing house that would reduce the existing hassles of the current system for patients, pharmacies and physicians.

Resolution 263 asks that the Medical Society of the State of New York (MSSNY): 1) work with the necessary entities to require that the pharmacies contact all providers who have sent them prescriptions within the past year with ample notification that they are no longer accepting certain insurance plans; and 2) recommend that regulations be passed to allow for the transfer of all pending prescription refills to a pharmacy that accepts their insurance.

Your Reference Committee heard some support for the sentiments expressed in the body of this resolution; but, believes that the substitute proffers a better representation of the action needed to obtain the desired result.

12. Resolution 264 *(LATE C)* — PROMPT RESPONSE TO PHYSICIAN'S REQUEST FOR AUTHORIZATION FOR PATIENT CARE SERVICES

THE REFERENCE COMMITTEE RECOMMENDS THE FOLLOWING:

RECOMMENDATION A: RESOLUTION 264 BE AMENDED BY ADDITION AND DELETION

RESOLVED, that MSSNY seek **legislation** ~~work with the New York State Department of Financial Services to create laws~~ and/or regulations requiring all insurance plans to respond to requests for services for the patient in one business day and if such response is not in **the** affirmative then the response **mus**t include~~s~~ **an** ~~physician's~~ option **for the physician** to access a fair appeal process.

RECOMMENDATION B: RESOLUTION 264 BE ADOPTED AS AMENDED

Your Reference Committee heard strong testimony in support of this resolution.

13. RESOLUTION 254 — ICD-10

THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 254 NOT BE ADOPTED.

Resolution 254 asks that MSSNY: 1) seek legislation and/or regulation to eliminate regular updates to ICD (including creation of new codes and the obsolescence of existing ones) in order to minimize the unnecessary disruption to physician practice work flow; and 2) the MSSNY delegation introduce a similar resolution at the AMA Annual House of Delegates meeting in June 2017.

Your Reference Committee heard some testimony regarding resolution. While MSSNY acknowledges the angst caused by some of the coding changes and updates needed to resolve claims, MSSNY is also cognizant that as medicine and technology advance, the codes used to identify advancements need to progress, as well. In addition, with the recommended and

anticipated adoption of Resolution 2017-253, it is expected that future disruptions caused by delays in coding updates should be alleviated. Therefore, your Reference Committee does not support Resolution 254.

14. RESOLUTION 259 WORKER'S COMPENSATION PHYSICIAN REIMBURSEMENTS

THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 259 NOT BE ADOPTED.

Resolution 259 asks that the Medical Society of the State of New York (MSSNY): 1) investigate the Workers' Compensation fee schedules by third party vendors; and 2) advocate for physicians to be paid the entire amount set by the Workers' Compensation fee schedule.

Your Reference Committee heard some testimony expressing concern about this resolution. However, this resolution deals with Diagnostic Treatment Networks (DTNs) under the NYS Workers' Compensation Program. The WCB adopted the use of DTNs back in 2012 governing the mandatory use of network radiologists (or other specialists) for MRIs and other diagnostic tests.

The DTN regulations were implemented by the WCB for the employer or carrier that has a contract with a diagnostic testing network or networks. The regulations requires an injured worker to utilize a provider or facility affiliated with such diagnostic testing network or networks as required by section 325-7.5 (d) of Subpart 325-7 of the WCB regulations. The creation of the DTNs had to do with cost containment for the services of a specialist in excess of a fee of $1,000.

The first resolve asks that MSSNY investigate the fees of these DTNs. Since the DTNs are contracted by the employer or WC carrier, MSSNY is not at liberty to investigate the fees of these contracted entities. In reference to the second resolve, MSSNY already advocates that physicians authorized by the WCB be paid in accordance with the WC physician fee schedule. Consequently, your Reference Committee cannot support Resolution 259.

15. RESOLUTION 262 DISCRIMINATION AGAINST PATIENTS IN MEDICARE ADVANTAGE ORGANIZATIONS

THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 262 NOT BE ADOPTED.

Resolution 262 asks that MSSNY:
A) examine the legality of the position taken by the Centers for Medicare and Medicaid Services (CMS), that if a Medicare Advantage Organization (MAO) has denied payment for services that would have been covered by fee-for-service Medicare, a physician's only recourse is arbitration or legal action – despite the provisions in 42 C.F.R.422.101(a), which state that:

1. MAOs are required to provide to their Medicare enrollees, those services that are covered under Medicare and are available to other fee-for-service Medicare beneficiaries in the geographic area covered by the plan; and

2. MAOs (both risk and cost plans) are required to abide by CMS regulations, national coverage decisions (NCDs), and local coverage determinations (LCDs) made by the Medicare Administrative Contractors (MACs) that have claims jurisdiction in the MAO's geographic area; and

B) seek case law or precedent requiring MAOs to fully adhere to 42 C.F.R 422.101(a) regardless of contract terms or in-house claims processing policies and bring such findings to the attention of the Centers for Medicaid & Medicare Services; and
C) bring this resolution to the American Medical Association and ask it to seek recourse from the Centers for Medicaid and Medicare Services to resolve discrimination against Medicare Advantage patients and the physicians who care for them.

Your Reference Committee heard little testimony relative to this resolution. The Centers for Medicare & Medicaid Services published a great deal of information on how to file an appeal if the beneficiary has original Medicare, a Medicare Advantage Plan or other Medicare health plan, or has a Medicare Prescription drug coverage plan. More information about these processes can be found on the following links:

https://www.medicare.gov/Pubs/pdf/11525.pdf

https://www.medicare.gov/claims-and-appeals/file-an-appeal/appeals.html

https://www.medicare.gov/claims-and-appeals/file-an-appeal/medicare-health-plan/medicare-health-plan-appeals.html

Therefore, your Reference Committee recommends that Resolution 262 not be adopted.

Your Chairman is grateful to the Reference Committee members, namely: Mary Ruth Buchness, MD, Charles Wiles, MD, Joseph DiPoala, Jr., MD, Greg Dash, MD, and, Olga Lisnyak, DO

Your Reference Committee expresses its appreciation to Regina McNally and Angela Gladkowski for their help in the preparation of this report.

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