

MEDICAL SOCIETY OF THE STATE OF NEW YORK 2016 HOUSE OF DELEGATES

Report of the Reference Committee on Socio-Medical Economics

Presented by: Nabil Kiridly, MD, Chair

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**Mister Speaker and Members of the House of Delegates:**

Your Reference Committee recommends the following consent calendar for acceptance:

**RECOMMENDED FOR ADOPTION**

1. Resolution 252 – Unknown Diagnosis Coding under ICD-10
2. Resolution 253 – Development of a CPT Code for PMP Look-Up
3. Resolution 254 – Centralized Insurance Registry
4. Resolution 255 – Improving Medical Insurance Customer Service
5. Resolution 258 - Transfer of Insureds to Other Carriers without Proper Notification
6. Resolution 266 - Medicare Advantage Plans and Delayed Claim Payments  
Due to System Issues
7. Resolution 269 (Late A) - CMS Revalidation of Medicare Billing Privileges
8. 2016 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**

9. Resolution 259 – Deleting State or Federally-Mandated Coverage
10. Resolution 260 – Private Insurers and Managed Care Organizations  
Pre-authorization/Pre-certification Protocols  
AND  
Resolution 261 - Require Clear Instructions for Prior Authorization Procedure
11. Resolution 263 – Continued Surgical Care
12. Resolution 264 - Ensuring Physicians Get a Fair Share of Bundled Payments

**RECOMMENDED NOT FOR ADOPTION**

13. Resolution 251 - NYS Private Payor Medical Necessity Guidelines
14. Resolution 257 – Medicaid and Child Health Plus Renewals
15. Resolution 265 – Arbitrary Relative Value Decisions by CMS
16. Resolution 267 – Statute of Limitations for Medicare and RAC “Lookbacks”
17. Resolution 268 – Mobility Impairment Increases Risk of Illness

1 1. RESOLUTION 252 – UNKNOWN DIAGNOSIS CODING UNDER ICD-10

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3 **THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 252 BE ADOPTED.**

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5 Resolution 252 asks that the Medical Society of the State of New York (MSSNY) to:

6 1) ask the Centers for Medicare and Medicaid Services (CMS) to enforce *Unknown Diagnosis*  
7 *Coding and ICD-10 Policy* with private insurers and managed care organizations, in that such  
8 policy is mandatory for all entities that are covered by the Health Insurance Portability and  
9 Accountability (HIPAA) law, but is being ignored by private insurers and managed care  
10 organizations;

11 2) urge the Centers for Medicare and Medicaid Services (CMS) to require all private and  
12 managed care insurers to formally adopt CMS's longstanding policy (reflected in ICD-10), that if  
13 a physician (A) does not know the diagnosis at the start of an encounter; (B) has not established  
14 a definitive diagnosis by the end of the encounter; and (C) is facing a "probable," "suspected,"  
15 "questionable," "rule-out," or "working diagnosis" scenario, then it is acceptable for him or her to  
16 report codes for signs, symptoms, abnormal test results, exposure to communicable disease, or  
17 other reason for the visit; and

18 3) urge CMS to require private and managed care insurers to adopt CMS's policy (reflected in  
19 ICD-10) that when the physician does not have enough clinical information about a particular  
20 health condition to assign a more specific code (e.g. if he or she suspects a diagnosis of  
21 pneumonia but by the end of the encounter has not determined the underlying cause of the  
22 pneumonia -- bacterial, et al), it is acceptable to report the appropriate "unspecified" code.

23  
24 Your Reference Committee Heard a great deal of testimony in support of the sentiments  
25 expressed in this resolution. Many times, patients will present with signs and/or symptoms but  
26 the diagnosis is not defined and it is necessary to use an unspecified code when the specific  
27 condition is unknown at the time of the patient's encounter. Therefore, your Reference  
28 Committee strongly supports Resolution 252.

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30 2. RESOLUTION 253 – DEVELOPMENT OF A CPT CODE FOR PMP LOOK-UP

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32 **THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 253 BE ADOPTED.**

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34 Resolution 253 asks that since the 2013 New York State requirement that physicians must  
35 check the Department of Health (DOH) Prescription Monitoring Program (PMP) registry, prior to  
36 prescribing or dispensing any Schedule II, III or IV controlled substances, a process which is not  
37 currently reimbursable but involves physicians' time and medical judgment in consideration of  
38 providing controlled prescription medications, that the New York Delegation submit a resolution  
39 to the 2016 Annual AMA House of Delegates, calling for the development by the AMA and CMS  
40 of a Current Procedural Terminology (CPT) code so physicians in all States can be  
41 appropriately paid for their time and effort in consulting the PMP registry.

42  
43 Your Reference Committee heard supportive testimony regarding this resolution. Although  
44 PMP is currently mandated in NYS, most other states have similar laws or regulations requiring  
45 physicians and other prescribers to look up patients' prescription history in a PMP database.  
46 Consequently, your Reference Committee believes that this PMP activity will become a  
47 nationwide procedure for medical practices. The AMA's development of a procedure code for  
48 billing could help to assuage the burden of this unfunded mandate. Therefore, your Reference  
49 Committee supports Resolution 253.

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3. RESOLUTION 254 – CENTRALIZED INSURANCE REGISTRY

**THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 254 BE ADOPTED.**

Resolution 254 asks that the Medical Society of the State of New York (MSSNY) seek policy by the New York State Department of Health -- Office of Health Insurance Programs to establish a centralized system of insurance eligibility accessible to all providers.

Your Reference Committee heard testimony in support of this resolution. Your Reference Committee is aware that there are several entities that provide patient enrollment information for a variety of health plans and insurers in NYS. However, we recently learned of a health plan that provides its own online patient eligibility. So, the umbrella entity is no longer allowing free access to the health plan's enrollment system for the purposes of obtaining patient insurance eligibility. The entity is now expecting all physicians to pay a monthly fee for this information. If more health plans move in this direction and physicians are required to pay fees or review various websites to verify patient eligibility, this will become very time consuming and costly for most medical practices. Therefore, your Reference Committee agrees that the State of New York should develop a centralized system for patient insurance eligibility.

4. RESOLUTION 255 – IMPROVING MEDICAL INSURANCE CUSTOMER SERVICE

**THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 255 BE ADOPTED.**

Resolution 255 asks that the Medical Society of the State of New York (MSSNY) seek regulation or legislation such that:

- 1) all coverage information be made available to health insurance customer service agents to review with patients during phone conversations;
- 2) all insured be furnished copies of their coverage directly through the insurer upon request; and
- 3) a copy of an insured's policy be made available through the online login at all times.

Your Reference Committee heard significant testimony in support of this resolution. In the interests of interoperability and transparency, patients should be aware of their complete coverage rules relative to their health insurance. Your Reference Committee supports this resolution.

5. RESOLUTION 258 - TRANSFER OF INSURED TO OTHER CARRIERS WITHOUT PROPER NOTIFICATION

**THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 258 BE ADOPTED.**

Resolution 258 asks that MSSNY work with the appropriate state agencies to enact regulation banning the transfer of insureds or contract terms changes without appropriate and easy to understand written notice of at least 90 days prior to the planned transfer.

Your Reference heard a great deal of testimony in support of this resolution. We currently have a similar policy on this topic. However, this resolution calls for the patients/insured to receive written notice 90 days prior to any changes. This resolution should be supported.

1 6. RESOLUTION 266 - MEDICARE ADVANTAGE PLANS AND DELAYED CLAIM  
2 PAYMENTS DUE TO SYSTEM ISSUES

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4 **THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 266 BE ADOPTED**

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6 Resolution 266 asks that the Medical Society of the State of New York (MSSNY) urge

- 7 1) the Centers for Medicare and Medicaid Services (CMS) to create specific, concrete  
8 guidelines applicable to any Medicare Advantage Plan (MAP) whose “transition” of its  
9 system, or update of its claims processing system, could harm physician practices  
10 financially;
- 11 2) that any such guidelines from the Centers for Medicare and Medicaid Services (CMS)  
12 impose punitive penalties (including payment of interest on delayed claim payments, and  
13 additional corrective actions), when an insurer’s “transition” of its system, and/or update of  
14 its claims-processing system, has led to (A) significantly delayed claim payments beyond the  
15 30 days required by most contracts with Medicare Advantage Plans (MAPs); (B) improper  
16 adjudication of previously paid claims; and/or (C) improper denials followed by overpayment  
17 recoveries; and
- 18 3) the Centers for Medicare and Medicaid Services (CMS), as part of CMS’s punitive penalties  
19 and corrective actions, to require that when any Medicare Advantage Plan (MAP) has  
20 modified its system or updated its claim processing system that MAP should establish  
21 special service units, dedicated to resolving disputes and paying properly whenever the  
22 MAP’s system changes have led to (A) significantly delayed claim payments; (B) improper  
23 adjudication of previously paid claims; and/or (C) improper denials and then subsequent  
24 overpayment recoveries.

25  
26 Your Reference Committee heard significant support for this resolution. MSSNY currently has a  
27 similar policy on this topic of system delays. However, our policy only addressed traditional  
28 Medicare fee-for-service plans. This resolution calls for MSSNY to expand our existing policy to  
29 address Medicare Advantage Plans, as well. Therefore, this resolution should be adopted.

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32 7. Resolution 269 (Late A) - CMS Revalidation of Medicare Billing Privileges

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34 **THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 269 BE ADOPTED**

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36 Resolution 269 asks that MSSNY advocate that the Centers for Medicare and Medicaid  
37 Services (CMS) adopt the practice of sending revalidation notices to physicians using certified  
38 mail with return receipt, thus ensuring that such notices are actually sent by CMS and received  
39 by the physician; and that the New York delegation to the American Medical Association submit  
40 this Resolution to the AMA House of Delegates Annual 2016 Meeting urging similar advocacy  
41 by the American Medical Association.

42  
43 Your Reference Committee heard substantial testimony concerning this resolution. This  
44 resolution is very important and vital since this is the first time that CMS has said that if  
45 deactivation occurs, patients cannot be billed for services provided to Medicare patients during  
46 the period between deactivation and reactivation. Charges for services rendered during this  
47 period are the provider’s liability.

48  
49 For information, CMS has created a link for all practitioners to see if they are up for  
50 revalidation. It is <https://data.cms.gov/revalidation>  
51 Those due for revalidation will display a revalidation due date, all other providers/suppliers not  
52 up for revalidation will display a “TBD” (To Be Determined) in the due date field. The

1 revalidation due date will be posted up to 6 months in advance of the revalidation due date to  
2 provide sufficient notice and time for the provider/supplier to comply. The file will be updated  
3 periodically.  
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5 8. 2016 SUNSET REVIEW REPORT OF THE MEDICAL SOCIETY OF THE STATE OF NEW  
6 YORK'S COMMITTEE ON SOCIO-MEDICAL ECONOMICS  
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8 **THE REFERENCE COMMITTEE RECOMMENDS THAT THE SUNSET REVIEW REPORT OF**  
9 **THE COMMITTEE ON SOCIO-MEDICAL ECONOMICS BE ADOPTED AND THE REPORT**  
10 **BE FILED.**  
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12 9. RESOLUTION 259 – DELETING STATE OR FEDERALLY-MANDATED COVERAGE  
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14 **THE REFERENCE COMMITTEE RECOMMENDS THE FOLLOWING:**  
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16 **RECOMMENDATION A: RESOLUTION 259 BE AMENDED BY ADDITION AND DELETION.**  
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18 RESOLVED, that MSSNY seek **state federal** regulation or legislation that prohibits self-insured  
19 health insurance companies from deleting coverage mandated by government.  
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21 **RECOMMENDATION B: RESOLUTION 259 BE ADOPTED AS AMENDED.**  
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23 Your Reference Committee heard some testimony relative to this resolution. However, self-  
24 insured health plans are governed by the U.S. Department of Labor (DOL) and are not under  
25 state jurisdiction. Therefore, the resolution needs to be amended to seek federal regulation or  
26 legislation.  
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29 10. RESOLUTION 260 – PRIVATE INSURERS AND MANAGED CARE ORGANIZATIONS  
30 PRE-AUTHORIZATION/PRE-CERTIFICATION PROTOCOLS  
31 AND  
32 RESOLUTION 261 - REQUIRE CLEAR INSTRUCTIONS FOR PRIOR  
33 AUTHORIZATION PROCEDURE  
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35 **THE REFERENCE COMMITTEE RECOMMENDS THAT SUBSTITUTE RESOLUTION 260 BE**  
36 **ADOPTED IN LIEU OF RESOLUTIONS 260 AND 261**  
37

38 RESOLVED, that the Medical Society of the State of New York (MSSNY) seek legislation or  
39 regulation applying to all insurers:  
40

- 41 • **Requireing** insurance companies to provide clear instructions in a timely manner on the  
42 procedure for obtaining a prior authorization.
- 43 • Requiring that for each plan or product, the insurer post on its website a complete list of  
44 services requiring pre-certification/pre-authorization;
- 45 • Requiring that after a physician has telephoned a customer service representative (CSR)  
46 to determine whether a service requires pre-certification/pre-authorization, the insurer  
47 send the physician, by fax or e-mail, a written confirmation of the CSR's verbal  
48 statement;
- 49 • Forbidding the insurer to deny a claim solely for lack of an electronic pre-  
50 authorization/pre-certification request, if (a) if the CSR has stated verbally that the

1 service does not require pre-authorization/pre-certification but that statement was  
2 inaccurate, and (b) the physician, relying on the CSR's verbal statement, has failed to  
3 submit an electronic pre-authorization/pre-certification request; and  
4 • **If preauthorization is not required, a physician can request from the insurance**  
5 **company a predetermination about whether a particular procedure will be covered**  
6 **for a particular patient, and the predetermination, in writing, is binding.**  
7

8 Resolution 260 asks that the Medical Society of the State of New York (MSSNY) seek  
9 legislation or regulation applying to all insurers: Requiring that for each plan or product, the  
10 insurer post on its website a complete list of services requiring pre-certification/pre-  
11 authorization; Requiring that after a physician has telephoned a customer service representative  
12 (CSR) to determine whether a service requires pre-certification/pre-authorization, the insurer  
13 send the physician, by fax or e-mail, a written confirmation of the CSR's verbal statement; and  
14 Forbidding the insurer to deny a claim solely for lack of an electronic pre- authorization/pre-  
15 certification request, if (A) if the CSR has stated verbally that the service does not require pre-  
16 authorization/pre-certification but that statement was inaccurate, and (B) the physician, relying  
17 on the CSR's verbal statement, has failed to submit an electronic pre-authorization/pre-  
18 certification request.

19 AND

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21 Resolution 261 asks that the Medical Society of the State New York seek regulation to require  
22 insurance companies to provide clear instructions in a timely manner on the procedure for  
23 obtaining a prior authorization.  
24

25 Your Reference Committee heard testimony for the support of both resolutions, which  
26 complement each other. Your Reference Committee, in recognition of transparency and clear  
27 instructions decided to take the resolve of Resolution 261 and add it as the first bullet of  
28 Resolution 260. In addition based on testimony, your Reference Committee agreed to accept  
29 the fifth bullet as a friendly amendment, thus creating Substitute Resolution 260.  
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31 11. RESOLUTION 263 - CONTINUED SURGICAL CARE

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33 **THE REFERENCE COMMITTEE RECOMMENDS THE FOLLOWING:**

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35 **RECOMMENDATION A: RESOLUTION 263 BE AMENDED BY DELETION**

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37 Resolution 263 asks that The Medical Society of the State of New York (MSSNY) seek:  
38 1) legislation/regulation which would allow a physician who has performed an initial surgical  
39 procedure, to continue to follow the patient and perform any necessary "follow  
40 up"~~reconstructive~~ surgery, regardless of the physician's change in participation status;  
41 2) that any follow-up/~~reconstructive~~ surgery performed by a physician whose participation  
42 status changed from when the initial surgery was performed, be reimbursed on an out-of-  
43 network basis; and  
44 3) that MSSNY forward this resolution to the AMA for implementation on a national level.  
45

46 **RECOMMENDATION B: RESOLUTION 259 BE ADOPTED AS AMENDED.**

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48 Your Reference Committee heard supportive testimony regarding this resolution. Current NYS  
49 law permits the insured to continue an ongoing course of treatment with the insured's current  
50 health care provider during a transitional period of up to ninety days from the notice of  
51 disaffiliation only if the health care provider agrees to accept reimbursement at the rates  
52 established by the insurer as payment in full. Resolution 263 is specific to surgical procedures

1 that might require continued treatment and possible ongoing surgery. In these instances, non-  
2 network physicians should be able to bill the plan which non-renewed or terminated the  
3 physician's contract at an out-of-network basis. Therefore, your Reference Committee  
4 recommends adoption of Resolution 263.

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6 12. RESOLUTION 264 - ENSURING PHYSICIANS GET A FAIR SHARE OF BUNDLED  
7 PAYMENTS

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9 **THE REFERENCE COMMITTEE RECOMMENDS THAT THE FOLLOWING SUBSTITUTE**  
10 **RESOLUTION 264 BE ADOPTED IN LIEU OF RESOLUTION 164**

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12 **Resolved, that MSSNY pursue regulation or legislation in the State of New York to fairly**  
13 **compensate the voluntary/private physicians for the work that they do at the hospital and**  
14 **share the bundled payment with the voluntary/private physician at least in the same**  
15 **proportion to the employed physicians in the same geographic area.**

16  
17 Resolution 264 asks that MSSNY pursue regulation or legislation in the State of New York that  
18 would require hospitals to compensate their voluntary/private physicians for work they do at the  
19 hospital and share their bundled technical payments with the physician, as would be done for  
20 employed physicians of the same or similar specialties in the same 50 mile geographic region.

21  
22 Your Reference Committee heard significant testimony for this resolution. With the transition to  
23 Value Based (VB) payment methodologies and bundled payments, plans see a greater cost  
24 savings for themselves when having to make only one payment for a patient encounter or  
25 course of treatment. These VB modalities and bundled payments tend to leave the  
26 reimbursement of these payments up to the discretion of the facilities and practitioners involved  
27 in the treatment of the patient. There needs to be some assurance that practitioners are paid  
28 fairly commensurate with the actual care and treatment of the patient. Therefore, your  
29 Reference Committee supports adoption of Resolution 264.

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31 13. RESOLUTION 251 - NYS PRIVATE PAYOR MEDICAL NECESSITY GUIDELINES

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33 **THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 251 NOT BE**  
34 **ADOPTED.**

35  
36 Resolution 251 asks that MSSNY support legislation and/or regulation that requires insurance  
37 companies to use, as a minimum standard, specialty society guidelines for determination of  
38 medical necessity and where specialty society guidelines do not exist, insurance companies  
39 shall abide by Centers for Medicare and Medicaid Services guidelines as a minimum standard.

40  
41 Your Reference Committee heard some testimony regarding resolution. While MSSNY has  
42 policies that mention acceptance of specialty society practice guidelines, your Reference  
43 Committee believes that the sentiments of this resolution are in conflict with our policy. Your  
44 Reference Committee agrees that physicians must be allowed to provide the quality care that in  
45 their medical judgement will result in the best outcome for their patients. Therefore, your  
46 Reference Committee does not support Resolution 251.

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14. RESOLUTION 257 – MEDICAID AND CHILD HEALTH PLUS RENEWALS

**THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 257 NOT BE ADOPTED.**

Resolution 257 asks that the Medical Society of the State of New York (MSSNY) seek policy by the New York State Department of Health -- Office of Health Insurance Programs to contact the insureds in Medicaid and Child Health Plus programs via e-mail and mail as to the status of their insurance renewals.

In researching this resolution, your Reference Committee learned from the NYS DOH Office of Health Insurance Programs that if the recipient became eligible through the health exchange (online Marketplace), they have the option for email or mail communication. For recipients eligible through the local district, they would receive mail communication. Your Reference Committee believes that the intent of this resolution is satisfied with the adoption of Resolution 254 which seeks the creation of a Centralized Insurance Registry. In addition, since NYS DOH Office of Health Insurance Programs already complies with the sentiment of this resolution, the resolution does not need to be adopted.

15. RESOLUTION 265 – ARBITRARY RELATIVE VALUE DECISIONS BY CMS

**THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 265 NOT BE ADOPTED.**

Resolution 265 asks that the Medical Society of the State of New York (MSSNY) 1) work with other state medical and specialty societies and the national specialty societies, to obtain federal legislation imposing new checks and balances on decisions made by the Centers for Medicare and Medicaid Services (CMS) concerning relative values and other issues; and 2) working with other state and specialty medical societies and the national specialty societies, explore the possibility of suing CMS for using its unchecked power to make unilateral decisions about relative values and other issues, to discriminate against specific groups and ration health care.

Your Reference Committee appreciates the sentiments expressed within the body of this resolution. However, Title 42 USC §1395w-4 Payment for physicians' services (i) (1) of federal law states "There shall be no administrative or judicial review under section 1395ff of this title or otherwise of ... (B) the determination of relative values and relative value units under subsection (c) of this section, including adjustments under subsections (c)(2)(F), (c)(2)(H), and (c)(2)(I) of this section and section 13515(b) of the Omnibus Budget Reconciliation Act of 1993..."

MSSNY's General Counsel provided examples of case law whereby the courts agreed that existing federal law precludes judicial review of the determination of relative values and relative value units. Therefore, your Reference Committee recommends that Resolution 265 not be adopted.



1 16. RESOLUTION 267 – STATUTE OF LIMITATIONS FOR MEDICARE AND RAC  
2 “LOOKBACKS”

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4 **THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 267 NOT BE**  
5 **ADOPTED.**

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7 Resolution 267 asks that MSSNY ask the AMA to work with Medicare to reduce the “Lookback”  
8 period to 2 ½ years.

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10 Your Reference Committee heard little testimony relative to this resolution. The Federal  
11 Register published on February 12, 2016 contained the following: Final Rule Medicare  
12 program; Reporting and Returning of Overpayments. The full document on this subject can be  
13 found at the following link:

14 [https://www.federalregister.gov/articles/2016/02/12/2016-02789/medicare-program-reporting-](https://www.federalregister.gov/articles/2016/02/12/2016-02789/medicare-program-reporting-and-returning-of-overpayments)  
15 [and-returning-of-overpayments](https://www.federalregister.gov/articles/2016/02/12/2016-02789/medicare-program-reporting-and-returning-of-overpayments)

16 The proposed rule provided a 10 year look back period. In the Final rule, HHS has adopted a 6  
17 year look back period. The commentary at page 7671 identifies that many commenters  
18 (including the AMA) recommended a 3 year or 4 year look back period. The good news is that  
19 the 10 year look back period was not adopted in the Final Rule. The bad news is HHS decided  
20 to adopt a 6 year look back, which is still pretty long.

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22 On a related matter, the AMA was instrumental in having CMS rethink the RAC Program so that  
23 now, the RACs are limited to a 3 year look back period in their audits.

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26 17. RESOLUTION 268 – MOBILITY IMPAIRMENT INCREASES RISK OF ILLNESS

27  
28 **THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 268 NOT BE**  
29 **ADOPTED.**

30 Resolution 268 asks that the Medical Society of the State of New York (MSSNY), 1) request that  
31 the American Medical Association (AMA) work with CMS to change their policies that calls  
32 dystrophic nails cosmetic problems, which sends the wrong message to patients and doctors;  
33 and 2) that MSSNY request the AMA to work with CMS to pay for investigative treatments that  
34 have less frequent and/or less severe adverse effects; including laser therapy, new formulations  
35 of topical agents (including efinaconazole) and new delivery systems of terbinafine.

36  
37 Your Reference Committee was informed that there are specific conditions that might justify  
38 coverage for dystrophic nails. CMS’ policy outlines that if there is pain or the patient has a  
39 systemic condition(s) that results in severe circulatory embarrassment or areas of diminished  
40 sensation in the patient’s legs or feet, routine foot care may be covered. Therefore, your  
41 Reference Committee recommends that Resolution 268 not be adopted.

1 Your Chairman is grateful to the Reference Committee members, namely: Nabil Kiridly, MD,  
2 Mohammad Akhtaruzzaman, MD, Suresh Sharma, MD, Thomas Sterry, MD, Joseph  
3 DiPoala, Jr., MD, and Jennifer Congdon, MD

4 Your Reference Committee expresses its appreciation to Regina McNally and Dawn Dratel for  
5 their help in the preparation of this report.

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Nabil Kiridly, MD, Chair

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Mohammad Akhtaruzzaman, MD

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Joseph DiPoala, Jr., MD

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Jennifer Congdon, MD

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