Policy Manual

Revised – February 2018

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VALUES STATEMENTS (01)

01.01 Mission Statement

The Louisiana State Medical Society is the trusted advocate for physicians in the state of Louisiana.

Authority Note: Approved as Action of the BOG 2016; reaffirmed as policy HOD 2017

01.02 Vision Statement

To promote excellence in the practice of medicine.

Authority Note: Approved as Action of the BOG 2016; reaffirmed as policy HOD 2017

ABORTION (10)

10.01 Abortion - General Policy

The LSMS affirms the physician oath to preserve life. LSMS general policy on abortion includes the following guidelines: (1) Elective abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of the state of Louisiana. (2) No physician or other licensed medical professionals should be required to perform an act violative of good medical judgment. Neither physician, nor licensed medical professionals should be required to perform any act that violates personally held moral principles. In these circumstances, good medical practice requires only that the physician or other licensed medical professionals withdraw from the case, so long as the withdrawal is consistent with good medical practice. (3) The LSMS encourages its physician members to offer counseling to expectant mothers in accepting and coping with the stresses of pregnancy to assure their patients have access to appropriate information regarding alternatives to abortion.

Authority Note: R29-91; reaffirmed R101-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

10.02 Abortion - Public Funding

The LSMS opposes Medicaid and the Louisiana Department of Health and Hospitals funding of abortions.

Authority Note: LR1-80; reaffirmed R101-2000; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) (20)

20.01 AIDS - Discrimination Against Patients

All patients should have competent and humane medical care and the LSMS discourages discrimination or denial of medical care on the basis of a known or suspected AIDS diagnosis.

Authority Note: R24-87; amended R101-97; amended R101-06; reaffirmed R101-11; reaffirmed R101-16

20.02 AIDS - Prevention

Public funding should be provided in an amount sufficient to (a) provide counseling and testing for AIDS, (b) conduct research necessary to find a cure and develop an effective vaccine, (c) perform studies to evaluate the efficiency of counseling and education programs on changing behavior, and (d) assist in the care of AIDS patients that cannot afford care or that cannot find appropriate facilities for treatment.

Authority Note: R41-89; amended R101-99; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

20.03 AIDS - Guidelines for Diagnosis & Treatment

The LSMS supports the use of CDC guidelines, CDC and LSMS web sites, the National Institutes for Health (NIH), the U.S. Public Health Services, state and local public health entities, and other available and appropriate scientific resources for the purpose of obtaining the most current, up-to-date information regarding the diagnosis, treatment and management of HIV and AIDS.

Authority Note: R303-98; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

20.04 AIDS - HIV Testing of Pregnant Women

Physicians should offer HIV testing to all pregnant women.

Authority Notes R308-95; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

20.05 AIDS - Human Immunodeficiency Virus (HIV) Screening in Pregnancy

The LSMS supports Center for Disease Control and National Institutes of Health positions on counseling, screening and treatment of HIV in pregnant women and their newborns, in order to decrease the rates of vertical transmission of HIV from mother to fetus. The LSMS supports removal of the written informed consent requirement in Louisiana for HIV testing, allowing testing to occur after appropriate discussion of benefits/risks between the patient and her physician, under the confidential patient-physician relationship.

Authority Note: R204-2000; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

20.06 AIDS - Post exposure Chemoprophylaxis

People needing post exposure chemoprophylaxis be encouraged to start medications as soon as possible, and be referred to an appropriate physician for follow-up within 72 hours. The LSMS recommends that post exposure chemoprophylaxis be reported to the Post Exposure Prophylaxis Registry.

Authority Note: R303-96; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

20.07 AIDS - Health Care Workers Safety

The LSMS supports requiring confidential disclosure to all treating health care personnel of the presence of any inpatient or outpatient HIV positive diagnosis or treatment so that health care personnel may be aware that patients they are treating are HIV positive in order that precautions may be taken to protect treating health care providers and prevent inadvertently exposing other patients to the virus.

Authority Note: R16-91; amended R101-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

20.08 AIDS - Education in Schools

The LSMS endorses the actions of health educators and physicians in their efforts to teach age-appropriate AIDS education within the elementary, middle and high schools of Louisiana.

Editorial Note: Also see Public Health Education (255)
Authority Note: R21-89; reaffirmed 1999; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

20.09 AIDS - Reporting of HIV as a Communicable and a Sexually Transmitted Disease

The LSMS supports reporting of HIV infections to the State Health Department as other communicable, sexually transmitted diseases are reported.

Authority Note: R19-91; reaffirmed R101-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

CANCER (30)

30.01 Cancer - Funding for the Tumor Registry

The LSMS supports continuous funding at adequate levels for the Louisiana Tumor Registry and the Cancer and Lung Trust Fund as established by law. The LSMS continue to support the Cancer and Lung Trust Fund Board in all its efforts regarding the advancement of cancer research in Louisiana.

Authority Note: R404-94; reaffirmed R302-98; reaffirmed R101-06; reaffirmed R101-11; *reaffirmed R101-16*

30.02 Cancer - Discharge of Known Carcinogens

The LSMS supports the prohibition of the discharge of any known carcinogen in any significant amount as so designated by the Federal Environmental Protection Agency into the *waters of the state* which is so classified by the Louisiana DEQ as *drinking water*, *primary contact recreation water, and fish and shellfish culture water*.

Editorial Note: Also see Public Health/ Environmental Health (242)
Authority Note: R26-87; amended R101-97; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

CHEMICAL DEPENDENCE (40)

40.01 Chemical Dependence - Warnings Against Abuse of Alcohol

All places where alcohol is sold should be required to post signs warning that (1) drinking alcoholic beverages during pregnancy can cause birth defects and (2) excessive consumption of alcoholic beverages results in impaired ability to drive vehicles, operate machinery and may cause health problems.

Authority Note: R7-91; reaffirmed R101-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

40.02 Chemical Dependence - Driving While Intoxicated

The LSMS position is:
(1) Reduce the blood alcohol concentration (BAC) for drivers to 0.04 percent (40mg/dl).
(2) Support state legislation to immediately confiscate drivers' licenses from individuals found to be above the legal BAC.
(3) Support increased taxes on alcoholic beverages based on alcohol content to fund comprehensive alcohol addiction programs

Authority Note: R63-90; amended R101-2000; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

40.03 Chemical Dependence - Insurance Coverage for Treatment of Chemical Dependency

The LSMS supports provisions in insurance policies to allow for the policyholder to select benefits for the treatment of chemical dependency.

Authority Note: R19-90; reaffirmed R101-2000; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

40.04 Chemical Dependence - Drug Abuse

The LSMS recognizes the deleterious effects that drug abuse has upon our patients and our communities. The LSMS condemns the use of illicit drugs and the misuse of prescription drugs. The LSMS supports the establishment of drug treatment centers for people battling drug addiction, stronger mandatory sentences for multiple convictions of drug dealers, drug education and anti-drug programs in the schools and in the work place. The LSMS urges its members and the members of the LSMS Alliance to be active volunteers locally to assist in any manner possible to stem this growing epidemic.

Authority Note: R36-90; amended R101-2000; reaffirmed R101-10; reaffirmed as amended R103-15; reaffirmed R101-16

40.05 Chemical Dependence - Anabolic Steroid Use by High School Students

The LSMS position is the use of anabolic steroids by high school students is a form of substance abuse and therefore, represents a serious medical problem posing unacceptable risks to these students.

Authority Note: R305-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

40.06 Chemical Dependence - Reverse Current DEA Agent of Practitioner Regulations

The LSMS opposes the current "DEA Agent of Practitioner" rules by the Drug Enforcement Agency and the Department of Justice because although well-intentioned, such activity can jeopardize the delivery of health care for the elderly and place physicians in legal jeopardy by shifting the oversight of nursing home and long term care facility personnel from their employers to physicians and the physicians' DEA licenses.

Authority Note: R123-11; reaffirmed R101-16

DURABLE MEDICAL EQUIPMENT (50)

50.01 Durable Medical Equipment – General Policy

The LSMS opposes the direct solicitation of patients by durable medical equipment companies in all instances where payment is contingent upon the certification of necessity by physician prescription and urges physicians to be knowledgeable about issues relevant to the inappropriate promotion by manufacturers of durable medical equipment and the contribution of such promotion to the unnecessary expenditure of health care dollars.

Authority Note: R30-91; reaffirmed R101-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

EMERGENCY MEDICAL SERVICES (60)

60.01 Emergency Medical Services - General Policy

The LSMS recognizes and supports the EMS Task Force as the advisory body directing the expansion and improvement of EMS in Louisiana. The LSMS supports improvements and expansion of EMS medical control, higher education standards, improved educational opportunities, pediatric EMS standardization. The LSMS supports legislative provisions which will authorize and provide funding for the Bureau of EMS to perform the functions described above.

Authority Note: R211-93; reaffirmed R101-03; and sub R101-08; reaffirmed as amended R102-13; reaffirmed R101-18

60.02 Emergency Medical Services - Bureau of Emergency Medical Services

The LSMS supports the efforts of the Department of Health and Hospitals to provide statutory authority to the Bureau of Emergency Medical Services to serve as lead agency for the EMS program. The LSMS supports establishment of a certification commission within the Department, Office of Public Health/Bureau of Emergency Medical Services to promulgate rules and regulations for the practice of certified pre-hospital care providers and that the fees currently being paid by advanced level applicants to the Louisiana State Board of Medical Examiners be used to support this program under the Bureau of Emergency Medical Services.

Authority Note:R224-96; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

60.03 Emergency Medical Services - Expanded Emergency Medicine Training

The LSMS strongly believes is emergency medicine is an essential service and supports the growth of emergency medicine residency programs in the state in order to provide a continuing supply of well-trained emergency physicians to care for the people of Louisiana.

Authority Note: R203-94; reaffirmed R101-04; reaffirmed R101-10; reaffirmed as amended R101-15

60.04 Emergency Medical Services - Community Emergency Medical Services

Protection from liability in civil suits should be established for parish medical societies and individuals serving on their committees who work with emergency medical services systems in the performance of their duties regarding the approval of protocols for their locale.

Authority Note: R6-87; amended R101-97; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

60.05 Emergency Medical Services – Louisiana Emergency Response Network

The LSMS supports the development and maintenance of systems of care coordination for patients who are suddenly stricken by serious traumatic injury or time-sensitive illness such as heart attack and stroke. Such systems should provide access to adequate trauma and time sensitive disease care for all citizens of Louisiana, should be available in all geographical areas of the state, and should be capable of utilizing both the state hospital system and private hospitals and both public and private ambulance services.

The LSMS encourages private hospitals and the state hospital system to assess resources at every hospital as they relate to licensing and designation as a Level I, II, or III Trauma Center. The LSMS supports the establishment and maintenance of geographic regions of the state in which planning for trauma systems should be coordinated.

The LSMS encourages the Louisiana Emergency Response Network (LERN) to collaborate with parish and local authorities and other interested parties in the development and maintenance of statewide systems of care coordination for patients suddenly stricken by serious traumatic injury or time-sensitive illness such as heart attack and stroke.

AuthorityNote:R213-92; reaffirmed R101-02; reaffirmed R101-07; reaffirmed as amended R102-12; reaffirmed as amended R104-17

ETHICS (70)

End of Life (71)

71.01 End of Life - Terminally Ill Patients

The LSMS guidelines in caring for the terminally ill:
(l) Patient autonomy requires that physicians must respect the decision of a patient who possesses decision-making capability to forego life-sustaining treatment. Physicians should encourage their patients to document their wishes regarding the use of life-prolonging medical treatment.
(2) Physicians have an obligation to address pain and suffering in the terminally ill patient.

(3) Physicians should never participate in the active administration of any agent for the purpose of terminating a patient's life, nor provide any medication, technique, or advice necessary for the termination of life, including referral to a physician who would assist in the termination of life.

Authority Note: R43-92; reaffirmed R101-02; reaffirmed R101-07; reaffirmed R102-12; reaffirmed R204-16

71.02 End of Life – Advanced Care Planning

The LSMS supports education for all health care providers, including physicians, and students in all of the health care provider professions, regarding the importance of developing advanced care plans, using resources available in the schools of all of the health professions in Louisiana, the Louisiana state health professional licensing boards, and all Louisiana health professional associations, which are offering continuing health professional education.

Authority Note: R302-17

71.03 End of Life - End-of-Life Documentation

The documentation of End-of-Life information should be voluntary and used at the discretion of the physician.

Authority Note: R23-85; amended 1995; reaffirmed R101-03 and sub R101-08; reaffirmed as amended R102-13; reaffirmed R101-18

71.04 End of Life - Do Not Resuscitate Orders

The LSMS supports the following positions regarding Do Not Resuscitate orders:
(1) A decision by a health care provider regarding the application of a previously placed Do Not Resuscitate (DNR) order is within the context of the physician-patient relationship or the scope of activities which a hospital is licensed to perform.
(2) A decision by a health care provider regarding the application of a previously placed Do Not Resuscitate (DNR) order is a health care or professional service rendered, or which should be rendered, by the health care provider, to the patient.
(3) A decision by a health care provider regarding the application of a previously placed Do Not Resuscitate (DNR) order is a matter of professional skill exercised by the health care provider, and involves an assessment of the patient's condition
(4) Judgments regarding the patient's condition, the appropriate medical treatment, the existence, validity, and applicability of previously expressed wishes of the patient or the patient's surrogate, and whether the current circumstances cast ambiguity upon the validity and application of the DNR order; and that such judgments fall exclusively within the purview and authority of the law of medical malpractice.
(5) Any action concerning a decision regarding the applicability of a previously placed Do Not Resuscitate (DNR) order should not be considered as a matter of intentional tort, strict liability, or general negligence; but rather should be a matter subject to the Louisiana Medical Malpractice Act or the Malpractice Liability for State Services Act, and subject to review by the medical review panel.

Authority Note: R302-12, 1st, 2nd, 3rd, 4th, and 5th resolves; reaffirmed R104-17

71.05 End of Life – Physicians' Role as a Healer

The LSMS believes that physician assisted suicide and euthanasia are fundamentally inconsistent with the physician's role as a healer.

Authority Note: R204-16

Physicians Gifts (72)

72.01 Physicians Gifts - Guidelines for Gifts to Physicians

The LSMS adopts the AMA CEJA opinion 8.061: To avoid the acceptance of inappropriate gifts, physicians should observe the following guidelines:
(1) Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function. Cash payments should not be accepted. The use of drug samples for personal or family use is permissible as long as these practices do not interfere with patient access to drug samples. It would not be acceptable for non-retired physicians to request free pharmaceuticals for personal use or use by family members.
(2) Individual gifts of minimal value are permissible as long as the gifts are related to the physician's work (eg, pens and notepads).
(3) The AMA Council on Ethical and Judicial Affairs defines a legitimate *conference* or *meeting* as any activity, held at an appropriate location, where (a) the gathering is primarily dedicated, in both time and effort, to promoting objective scientific and educational activities and discourse (one or more educational presentation(s) should be the highlight of the gathering), and (b) the main incentive for bringing attendees together is to further their knowledge on the topic(s) being presented. An appropriate disclosure of financial support or conflict of interest should be made.
(4) Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Since the giving of a subsidy directly to a physician by a company's representative may create a relationship that could influence the use of the company's products, any subsidy should be accepted by the conference's sponsor who in turn can use the money to reduce the conference's registration fee. Payments to defray the costs of a conference should not be accepted directly from the company by the physicians attending the conference.

(5) Subsidies from industry should not be accepted directly or indirectly to pay for the costs of travel, lodging, or other personal expenses of physicians attending conferences or meetings, nor should subsidies be accepted to compensate for the physicians' time. Subsidies for hospitality should not be accepted outside of modest meals or social events held as a part of a conference or meeting. It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging, and meal expenses. It is also appropriate for consultants who provide genuine services to receive reasonable compensation and to accept reimbursement for reasonable travel, lodging, and meal expenses. Token consulting or advisory arrangements cannot be used to justify the compensation of physicians for their time or their travel, lodging, and other out-of-pocket expenses.
(6) Scholarship or other special funds to permit medical students, residents, and fellows to attend carefully selected educational conferences may be permissible as long as the selection of students, residents, or fellows who will receive the funds is made by the academic or training institution. Carefully selected educational conferences are generally defined as the major educational, scientific or policy-making meetings of national, regional, or specialty medical associations.
(7) No gifts should be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physician's prescribing practices. In addition, when companies underwrite medical conferences or lectures other than their own, responsibility for and control over the selection of content, faculty, educational methods, and materials should not belong to the organizers of the conferences or lectures.

Authority Note: R115-03, reaffirmed sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

HEALTH CARE DELIVERY MODELS (80)

80.01 Health Care Delivery Models - Direct Primary Care

The LSMS supports alternative practice models such as Direct Primary Care, which allow physicians to practice medicine in a manner which reduces burdens and administrative overhead created by third party payors.

Authority Note: Added R305-14

80.02 Health Care Delivery Models - Incentives for Individual Participation

The LSMS position is that incentives should be created to encourage participation by individuals in a pluralistic system of financing and delivery of healthcare.

Authority Note: SubR115-11, 2nd resolve; reaffirmed R101-16

80.03 Health Care Delivery Models - Guiding Principles of Accountable Care Organizations

LSMS policy is that Accountable Care Organizations be considered one of the options in a pluralistic health care system. Additionally, the LSMS adopts as policy the AMA Principles for Accountable Care Organizations as adopted by the AMA House of Delegates Interim 2010 Meeting. it be LSMS policy that Accountable Care Organizations be considered one of the options in a pluralistic health care system.

1. Guiding Principle – The goal of an Accountable Care Organization (ACO) is to increase access to care, improve the quality of care and ensure the efficient delivery of care. Within an ACO, a physician's primary ethical and professional obligation is the well-being and safety of the patient.

2. ACO Governance – ACOs must be physician-led and encourage an environment of collaboration among physicians. ACOs must be physician-led to ensure that a physician's medical decisions are not based on commercial interests but rather on professional medical judgment that puts patients' interests first.

Medical decisions should be made by physicians. ACOs must be operationally structured and governed by an appropriate number of physicians to ensure that medical decisions are made by physicians (rather than lay entities) and place patients' interests first. Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician or physician-controlled entity. The AMA supports true collaborative efforts between physicians, hospitals and other

qualified providers to form ACOs as long as the governance of those arrangements ensure that physicians control medical issues.

The ACO should be governed by a board of directors that is elected by the ACO professionals. Any physician-entity [e.g., Independent Physician Association (IPA), Medical Group, etc.] that contracts with, or is otherwise part of, the ACO should be physician-controlled and governed by an elected board of directors.
The ACO's physician leaders should be licensed in the state in which the ACO operates and in the active practice of medicine in the ACO's service area.

Where a hospital is part of an ACO, the governing board of the ACO should be separate, and independent from the hospital governing board.
3. Physician and patient participation in an ACO should be voluntary. Patient participation in an ACO should be voluntary rather than a mandatory assignment to an ACO by Medicare. Any physician organization (including an organization that bills on behalf of physicians under a single tax identification number) or any other entity that creates an ACO must obtain the written affirmative consent of each physician to participate in the ACO. Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid or a private payer or being admitted to a hospital medical staff.

4. The savings and revenues of an ACO should be retained for patient care services and distributed to the ACO participants.

5. Flexibility in patient referral and antitrust laws. The federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs. This is particularly important for physicians in small- and medium-sized practices who may want to remain independent but otherwise integrate and collaborate with other physicians (i.e., so-called virtual integration) for purposes of participating in the ACO. The ACA explicitly authorizes the Secretary to waive requirements under the Civil Monetary Penalties statute, the Anti-Kickback statute, and the Ethics in Patient Referrals (Stark) law. The Secretary should establish a full range of waivers and safe harbors that will enable independent physicians to use existing or new organizational structures to participate as ACOs. In addition, the Secretary should work with the Federal Trade Commission to provide explicit exceptions to the antitrust laws for ACO participants. Physicians cannot completely transform their practices only for their Medicare patients, and antitrust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO and CMS so that any new organizational structures that are created to participate in the program do not suddenly become illegal simply because the shared savings program does not continue.

6. Additional resources should be provided up-front in order to encourage ACO development. CMS's Center for Medicare and Medicaid Innovation (CMI) should provide grants to physicians in order to finance up-front costs of creating an ACO. ACO incentives must be aligned with the physician or physician group's risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo-small group practices requires time and resources and the outcome is unknown. Providing additional resources for the up-front costs will encourage the development of ACOs since the "shared savings" model only provides for potential savings at the back-end, which may discourage the creation of ACOs (particularly among independent physicians and in rural communities).

7. The ACO spending benchmark should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.

The ACO spending benchmark, which will be based on historical spending patterns in the ACO's service area and negotiated between Medicare and the ACO, must be risk-adjusted in order to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill.

The ACO benchmark should be risk-adjusted for the socioeconomic and health status of the patients that are assigned to each ACO, such as income/poverty level, insurance status prior to Medicare enrollment, race, and ethnicity and health status. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicare eligibility.

The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating cost factors (i.e., hospital wage index) and physician HIT costs.

The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.

In addition to the shared savings earned by ACOs, ACOs that spend less than the national average per Medicare beneficiary should be provided an additional bonus payment. Many physicians and physician groups have worked hard over the years to establish systems and practices to lower their costs below the national per Medicare beneficiary expenditures. Accordingly, these practices may not be able to achieve significant additional shared savings to incentivize them to create or join ACOs. A bonus payment for spending below the national average would encourage these practices to create ACOs and continue to use resources appropriately and efficiently.

8. The quality performance standards required to be established by the Secretary must be consistent with AMA policy regarding quality. The ACO quality reporting program must meet the AMA principles for quality reporting, including the use of nationally-accepted, physician specialty-validated clinical measures developed by the AMA-specialty society quality consortium; the inclusion of a sufficient number of patients to produce statistically valid quality information; appropriate attribution methodology; risk adjustment; and the right for physicians to appeal inaccurate quality reports and have them corrected. There must also be timely notification and feedback provided to physicians regarding the quality measures and results.

9. An ACO must be afforded procedural due process with respect to the Secretary's discretion to terminate an agreement with an ACO for failure to meet the quality performance standards.

10. ACOs should be allowed to use different payment models. While the ACO shared-savings program is limited to the traditional Medicare fee-for-service reimbursement methodology, the Secretary has discretion to establish ACO demonstration projects. ACOs must be given a variety of payment options and allowed to simultaneously employ different payment methods, including fee-for-service, capitation, partial capitation, medical homes, care management fees, and shared savings. Any capitation payments must be risk-adjusted.

11. The Consumer Assessment Of Healthcare Providers And Systems (CAHPS) Patient Satisfaction Survey should be used as a tool to determine patient satisfaction and whether an ACO meets the patient-centeredness criteria required by the ACO law.

12. Interoperable Health Information Technology and Electronic Health Record Systems are key to the success of ACOs. Medicare must ensure systems are interoperable to allow physicians and institutions to effectively communicate and coordinate care and report on quality.

13. If an ACO bears risk like a risk bearing organization, the ACO must abide by the financial solvency standards pertaining to risk-bearing organizations.

HEALTH CARE FACILITES (90)

90.01 Health Care Facilities - Physician Ownership of Medical Facilities

Physician ownership of medical facilities must always conform to existing state and federal laws and physician owners should follow applicable ethical guidelines.

Authority Note: R18-88, amended R101-98, amended R101-06, reaffirmed R101-11; reaffirmed R101-16

90.02 Health Care Facilities - Violence in Healthcare Facilities

It is the policy of the LSMS that optimal patient care can only be achieved when patients, healthcare workers and all other persons in healthcare facilities are protected against violent acts occurring within healthcare facilities. Further, the policy of the LSMS is to encourage adoption of policies and laws that provide a maximum category of offense and criminal penalty against individuals who commit violent acts against healthcare workers in healthcare facilities.

Authority Note: Added R304-14

90.03 Health Care Facilities - Code Situation in Health Care Facilities

The LSMS supports the inclusion of coverage in Louisiana's Good Samaritan Laws of services rendered in a code situation in a health care facility by physicians who are not the attending or consulting physicians to the patient.

Authority Note: R210-93, reaffirmed R101-03, reaffirmed sub R101-08; reaffirmed R102-13; reaffirmed R101-18

Hospitals; Organized Medical Staff (91)

91.01 Hospitals; Organized Medical Staff - Guidelines for Hospital Medical Staffs

The LSMS supports the following guidelines characterizing the relationship between hospitals and their medical staffs:
(1) Hospital privileges should be established according to the bylaws of the medical staff, which includes the concept of quality peer review
(2) Physicians should provide medical care based on the traditional patient-physician relationship.
(3) Renewal of hospital privileges should be based on demonstrated competence and ethical behavior.
(4) Physician members of hospital medical staffs shall have the due process rights of a fair hearing and appellate review regardless of any personal service contract whenever a hospital denies reappointment to the medical staff, terminates the privileges of a physician, or takes any adverse action against a physician.

Authority Note: R15-84; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed as amended R103-B-13; reaffirmed R101-18

91.02 Hospitals; Organized Medical Staff - Legal Guidelines for Hospital Medical Staffs

The LSMS supports the following legal guidelines for hospital medical staffs:
1) Hospital medical staffs should retain legal counsel that is independent from the hospital's attorney, especially concerning such matters as medical staff bylaws and contracts.
2) Members of medical staffs should periodically review hospital staff bylaws. The LSMS urges its members to be alert to any proposed changes in the hospital constitutions and bylaws which might impact a physician's ability to practice medicine.
3) Hospital medical staffs should have the freedom of professional association and right of clinical practice among members of such hospital medical staffs concurrent with an exclusive contract for physician specialty services.
4) A lawful strike may be considered in the face of unjust policy when government or employers refuse meaningful discussions or negotiations and when the striking physicians are motivated by issues of justice and liberty.

Authority Note: R39-8; reaffirmed 199; amended R101-03; reaffirmed sub R101-08; reaffirmed as amended R103-B-13; amended R303-16

91.03 Hospitals; Organized Medical Staff - Physician Credentialing

Credentialing of a physician should be determined solely on professional competence based on relevant clinical training and skills, practice experience, and malpractice history; not economic performance factors such as physician Medicare prospective pricing profiles, physician costs to hospital revenue streams, physician hospital charge information, DRG profiles, volume indicators or any other such criteria.

Authority Note: R303-9; reaffirmed R101-02; reaffirmed R101-07; reaffirmed R102-12; reaffirmed R103-17

91.04 Hospitals; Organized Medical Staff - Medical Staff Self-Governance

The LSMS supports laws which clearly establish the independent status of the medical staff and sets forth medical staff basic rights and responsibilities.

Authority Note: R211-04; reaffirmed R101-10; reaffirmed R101-15

91.05 Hospitals; Organized Medical Staff - Age Limits on Active Medical Staffs

The LSMS opposes the practice of using age as a factor in determining hospital medical staff membership.

Authority Note: R504-94; reaffirmed R101-04; reaffirmed R101-10; reaffirmed R101-15

91.06 Hospitals; Organized Medical Staff - Conflict of Interest on Medical Staffs

Candidates for election or appointment to medical staff offices, department or committee chairs, or the medical executive committee, should disclose to the medical staff, prior to the election or appointment, the existence of any personal, professional or financial affiliations or responsibilities on behalf of the medical staff; and encourages hospital medical staffs to incorporate a disclosure of interest provision in their medical staff Bylaws.

Authority Note: R409-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

91.07 Hospitals; Organized Medical Staff - Drug Screening/Testing of Medical Staff Members

The LSMS opposes mandatory random and no-cause drug and alcohol screening and testing of medical staff members affiliated with hospitals and managed care plans by those entities and strongly encourage hospital medical staffs to incorporate into their substance abuse policy the requirement to refer a physician to the Physician's Health Program of Louisiana for assessment and/or evaluation when there is a reasonable basis to suspect that the physician may be impaired.

Authority Note: R113-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

91.08 Hospitals; Organized Medical Staff - Restrictions on the Medical Staff

The LSMS opposes hospital contracts for physician services rendered within hospital departments or services that exclude the right to practice of other members of the medical staff, that is, the rendering of medical services, and the billing therefore, by physicians who are members of the medical staff who have been credentialed within the scope of practice of such departments or services by the medical staff.

Editorial Note: Also see Scope of Practice (250)
Authority Note: R38-85, reaffirmed 1995, reaffirmed R101-06, reaffirmed R101-11; reaffirmed R101-16

91.09 Hospitals; Organized Medical Staff - Medical Staff Leadership Positions

The LSMS supports as a requirement of a physician functioning as medical director or any other medical staff position in any licensed health care facility in Louisiana to maintain an unrestricted Louisiana license to practice medicine.

Authority Note: R113-04; reaffirmed R101-10; reaffirmed as amended R101-15

91.10 Hospitals; Organized Medical Staff - Hospital Privileges and Limited Health Care Practitioners

The LSMS recommends all medical staffs incorporate provisions in their bylaws for the voluntary sponsorship and agreement to supervise by a qualified member of the medical staff as a prerequisite for admission of limited licensed health care practitioners to the staff granting clinical privileges. The admission of patients for services provided by the limited licensed health care practitioners should be processed through a qualified physician willing to sponsor and supervise the limited licensed health care practitioner.

Authority Note: R47-84; reaffirmed R sub 101-04; reaffirmed R 101-10; reaffirmed R101-15

91.11 Hospitals; Organized Medical Staff - Payments to Medical Staff Officers

Any salaries paid to medical staff officers for duties related to the offices held should be made from funds derived from the medical staff membership of the involved hospital.

Authority Note: R56-90; reaffirmed R101-2000; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

91.12 Hospitals; Organized Medical Staff - Hospital Violence and Security

The LSMS supports initiatives to develop sound integrated hospital security, policy and procedures and staff training to combat violence in hospitals.

Authority Note: R102-15

Nursing Homes (92)

92.01 Nursing Homes - Reimbursement for Multiple Nursing Home Visits

The LSMS opposes the nursing home multiple visit reimbursement policy of CMS and supports its repeal through administrative channels. The American Medical Association should pursue administrative, legislative or legal action to change this policy.

Authority Note: R64-90; reaffirmed R101-2000; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

92.02 Nursing Homes - Pharmaceutical Company Rebates for Nursing Home Pharmacies

The LSMS opposes allowing nursing home pharmacies from receiving pharmaceutical company rebates for soliciting nursing home physicians to utilize specific drugs based on purely economic reasons while disregarding quality, or clinical effectiveness of other drugs.

Authority Note: R204-04; reaffirmed R101-10; reaffirmed as amended R101-15

92.03 Nursing Homes – Payment of Co-pays and Deductibles

The LSMS supports requiring that individuals who are dually eligible for Medicare and Medicaid to pay reasonable deductibles and copays for nursing home care.

Authority Note: R102-15

Retail Health Clinics (93)

93.01 Retail Health Clinics - Retail Health Clinics

The LSMS supports the eight guidelines established by the AMA on June 13, 2006 for the operation of in-store Retail Health Clinics. For retail health clinics operating in Louisiana, the medical providers of such health clinics should adhere to the same standard of medical care as other licensed health care providers in the state and be subject to the licensure and oversight authority of the Louisiana State Board of Medical Examiners.

The LSMS supports policies which require retail health clinics to disclose in a conspicuous manner the name of the collaborating physician associated with the retail clinic and whether the physician is licensed and domiciled in Louisiana.

Authority Note: R127-06; reaffirmed R101-11; amended R303-14

HEALTH CARE REFORM (100)

100.01 Health Care Reform – Repeal of the Patient Protection and Affordable Care Act (PPACA)

It is LSMS policy to support all efforts to repeal the Patient Protection and Affordable Care Act and to support initiation of a new national effort to reform health care.

Authority Note: R211-11; reaffirmed R101-16

100.02 Health Care Reform - Opposition to Individual Mandate

The LSMS opposes any requirement or mandate by state or federal government that individuals purchase health insurance.

Authority Note: SubR115-11; 3rd resolve; reaffirmed R101-16

100.03 Health Care Reform - Single-Payer Health Care System

The LSMS opposes the establishment of a single-payer health care system and supports a pluralistic, market based approach to the provision of health care services.

Authority Note: R301-94; reaffirmed sub R101-04; reaffirmed R114-10; 2nd resolve; reaffirmed R215-11; reaffirmed R101-16

100.04 LSMS Access to Better Care Plan

The LSMS supports the principals of our Access to Better Care proposal for reforming Medicaid, which includes pluralistic options including but not limited to: defined contribution plans, Medicaid Advantage plans, vouchers, and Medicaid medical savings accounts.

Editorial Note: Access to Better Care Plan located in Appendix B
Authority Note: R105-18

100.05 Health Care Reform - Health System Reform in Louisiana

The LSMS concurs with recommendations contained in the Pricewaterhouse Coopers *Report on Louisiana Healthcare Delivery and Financing System* specifically concerning health system reform and adopts the following position statement:
a) Health system reform in Louisiana must be statewide ensuring equitable access to quality care and elimination of the two-tiered delivery system.
b) There must be adequate funding mechanisms to ensure the delivery of quality care, preferably systems in which the dollars follow the patient.
c) Graduate medical education must be preserved as part of health system reform and should include academic medical centers as an integral part of the medical education system.
d) Health Access Louisiana is an effective vehicle to accomplish health system coverage reform, and would allow academic medical centers to compete in the health care marketplace.

Authority Note: R105-06; reaffirmed R101-11; reaffirmed R101-16

100.06 Health Care Reform - Health Access Louisiana

A proposal for health coverage reform in Louisiana. The proposal contains the following key elements.

Financing issues

The dislocation caused by the 2005 hurricanes revealed underlying weaknesses of Louisiana's (and by extension America's), over-reliance on employment-based insurance as the basic principle for organizing health care financing. The clear lesson, again for other states as well as Louisiana, is that subsidizing institutions to provide charity care is a decidedly inferior and inflexible alternative when compared with using those same funds to expand health insurance coverage.

Overview of proposed reforms

Element 1: Create a market mechanism for making health insurance truly personal and portable for all residents, and more readily available to workers with non-traditional employment situations.

Element 2: Create mechanisms for aggregating premium payments from multiple funding sources to pay for coverage offered through a Health Insurance Exchange that encourages a competitive market place where patients can choose among health insurance plans and providers (amended R114-10)
Element 3: Provide coverage for state and local government employees through the Louisiana Insurance Exchange.
Element 4: Create a new statewide health insurance risk transfer pool to ensure adequate and fair cross-subsidization of high-risk individuals.
Element 5: Redirect existing subsidies to cover low-income uninsured.
Element 6: Seek support for creating a federal health care financing demonstration project that builds on Louisiana's reform efforts.

Conclusion

Louisiana has been presented with a unique opportunity to convert the health care crisis imposed on the state by Hurricanes Katrina and Rita into significant and lasting improvements in the health care system. Health Access Louisiana also has significant implications beyond the state. Indeed it could become a model for positive health reform throughout the entire country. As such, Louisiana policymakers should seek the active support and cooperation of the federal government in the reform plan.

Editorial Note: Health Access Louisiana plan located in Appendix C
Authority Note: reaffirmed R101-11; reaffirmed R101-16

100.07 Health Care Reform - Pluralistic Delivery System

The LSMS supports all individuals having healthcare coverage/financing in the maintenance of a pluralistic delivery, coverage and financing system in the public and private sectors and the adoption of reform measures that build on the strengths of these separate but inter-related delivery systems.

Authority Note: R302-94; reaffirmed R101-06; reaffirmed R101-11 and SubR115-11; 1st resolve; reaffirmed R101-16

100.08 Health Care Reform - Federal Health Care Programs

The LSMS affirms its belief in the superiority of private medical care in a pluralistic system and supports continued efforts to correct deficiencies in federal health programs. The LSMS opposes restrictions on non-participating physicians' medical practices and on patient freedom of choice by such mechanisms as limitations on balance billing and prohibitions on private opt out arrangements between physicians and patients.

Authority Note: R308-93; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed as amended R103-B-13

100.09 Health Care Reform - Health System Reform

The LSMS supports a policy of pluralism in our health care delivery system and includes the principles of security, simplicity, savings, choice, quality, and responsibility for health system reform.
(1). The LSMS supports a pluralistic system of health care delivery wherein patients have multiple choices of health care financing mechanisms in an open market setting free of government approved advantages created to favor any one or more mechanisms.
(2). The LSMS supports freedom of choice of health and medical care delivery settings for patients and physicians.
(3). The LSMS supports the right of physicians to choose their own specialty of practice and opposes any quota system to force physicians into a particular specialty or mode of practice. (4). The LSMS urges the American Medical Association and the specialty societies to work together to preserve and expand the right of patients to choose their physician, delivery setting and method of financing of health care and the right of physicians to choose their practice setting and compensation arrangement.
(5) The LSMS supports the position of value and cost effectiveness instead of draconian cost containments, making our health care delivery system accountable to patients instead of to government, insurance companies, employers, hospitals or physicians.

The LSMS advocates the term health system reform to characterize needed changes to our health care delivery system.

Authority Note: R301/302-93; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed as amended R103-B-13; reaffirmed as amended R101-18

100.10 Health Care Reform - Price Controls

The LSMS is opposed to the imposition of price controls in our health care delivery system whether through fee controls, global budgets, expenditure targets, premium caps, percentage of payroll caps or any other method of price controls and supports the establishment of a more effective medical market to achieve cost effectiveness in our health care delivery system.

Authority Note: R303-93; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R103-13; reaffirmed R101-18

100.11 Health Care Reform - Cost Effective Health Care System

The LSMS supports the following principles for achieving a realistic functional approach to a market system method of achieving cost-effectiveness in health care:

a. Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients' interests first, is clearly a more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system.

b. Individuals should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system.

c. In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees information on the amount of payment provided toward each type of service identified as a covered benefit.

d. Federal and/or state legislation should authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements, and could include the input of the state medical society and the AMA Council on Ethical and Judicial Affairs.

e. Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice.

f. Efforts should continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront.

Authority Note: R406-97, reaffirmed R101-06, reaffirmed R101-11; reaffirmed R101-16; amended R107-17; reaffirmed R101-18

100.12 Health Care Reform - Individually Owned Health Coverage System

The LSMS supports the creation of an employee based health coverage system which provides freedom of choice to employees and their families in selecting and changing healthcare coverage. The LSMS supports the elimination of the current tax bias against individually owned and individually chosen health coverage plans and supports federal-state legislation and AMA proposals/resolutions to help create an economic market for family owned plans with a fair premium rating system independent of employer or government mandates.

Authority Note: R205-98; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

100.13 Health Care Reform - Medical Home

The LSMS opposes any health system reform that includes the concept of a medical home that is clearly not physician directed and does not maintain the physician as the primary health care provider.

Authority Note: R115-10 and R114-10 final phrase; reaffirmed R215-11; reaffirmed R101-16

100.14 Health Care Reform - Individual Incentives for Healthy Lifestyles

The LSMS supports federal and state tax initiatives, as well as third party payer and employer-based incentives for individuals to improve their healthy lifestyles which may include: reduced insurance premiums or premium credits for healthy lifestyle activities vs. increased premiums for poor lifestyle choices; subsidized Health Savings Accounts based on healthy choices; time off from work; providing diet management, smoking cessation or exercise courses at work; or other mechanisms to encourage healthy behavior. Additionally, the LSMS position is that patients should be provided with incentives for economical choices in health care, e.g. via HSA's funded with debit cards provided on an economic sliding scale, and lower premiums for healthy lifestyle choices (weight, annual examinations, regular exercise, etc.)

Authority Note: R207-10; R212-12 4th resolve, reaffirmed as amended R103-17

100.15 Health Care Reform - State Funding

The LSMS supports any legislative initiative to remove dedications of public funding in an effort to mitigate budget reductions to healthcare when the state experiences budget shortfalls.

Authority Note: R107-13; reaffirmed as amended and adopted as policy R102-15

100.16 Health Care Reform – Benefit Payment Schedule Plan

The LSMS supports the inclusion of the Benefit Payment Schedule Plan as one option in a pluralistic system of health care financing. The LSMS defines a Benefit Payment Schedule Plan as a type of health insurance in which the insurer makes a payment for covered services according to a schedule of benefits; the physician, hospital or other providers charge a fee for those services and it is up to the patient and the provider to determine what to do about any difference between the fee and the payment.

Authority Note: R108-17

100.17 Health Care Reform – Network Adequacy

The LSMS supports the following principals related to network adequacy.

1. State regulators should serve as the primary enforcer of network adequacy requirements.
2. Any provider terminations without cause should be handled prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. However, new physicians may be added to the network at any time.
3. Requiring health insurers to submit and make publicly available reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; and consumer complaints received.

4. Requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
5. Regulation and legislation to require that out-of-network expenses count toward a participant's annual deductible and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies.
6. Development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate state regulatory authorities.
7. Legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited.

Authority Note: R401-17

HEALTH INFORMATION (110)

110.01 Health Information - ICD-10 Transparency and Conversion

The policy of the LSMS is to oppose the required replacement of the ICD-9CM code set with the ICD-10CM code set for identifying and reporting diagnosis and procedures and to advocate for the halt of implementation of ICD-10CM due to the gross impediment to patient care ICD-10CM will impose.

Authority Note: Added R406-14

110.02 Health Information - Third Party Requests for Patient Information

Third party insurance administrators should be required to furnish the physician with a properly executed release of information as required by law prior to the physician's release of any medical reports, x-rays or other information regarding the patient's diagnosis and treatment.

Authority Note: R10-89; referred to BOG 1999; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R102-13; reaffirmed R101-18

110.03 Health Information - Funding of Health Information Exchanges

The LSMS opposes physician funding to operate health information exchange systems.

Authority Note: R207-11; reaffirmed R101-16

110.04 Health Information - Electronic Health Records Meaningful Use

The LSMS supports an exception for physicians practicing in rural and HPSA areas of Louisiana from having to meet the requirement of meaningful use which mandates the use of secure electronic communication with patients, and direct the AMA Delegation submit a resolution to request the AMA seek changes in federal law to permit such an exception for Louisiana physicians in rural areas.

Authority Note: R406-15

Medical Records (111)

111.01 Medical Records - Retention of Medical Records

In conformity with Louisiana Revised Statue 40:1299.96 A. (3)(a) Medical and dental records shall be retained by a physician or dentist in the original, microfilmed, or similarly reproduced form for a minimum period of six years from the date a patient is last treated by a physician or dentist. (b) Graphic matter, images, X-ray films, and like matter that were necessary to produce a diagnostic or therapeutic report shall be retained, preserved and properly stored by a physician or dentist in the original, microfilmed or similarly reproduced form for a minimum period of three years from the date a patient is last treated by the physician or dentist. Such graphic matter, images, X-ray film, and like matter shall be retained for a longer period when requested in writing by the patient.

Authority Note: 1981; amended R120-99; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

111.02 Medical Records - Disposition of Deceased Physicians' Medical Records

Upon the death of a physician, all medical records shall be retained in the original, microfilmed or similarly reproduced form for a minimum of 6 years from the date the patient was last treated by the physician, as stated in LA. R. S. 40:1299.96. Graphic matter, images, x-ray films and like matter shall be retained in the original, microfilmed or similarly reproduced form for a minimum of three years from the date the patient is last treated by the physician, as stated in LA.R.S. 40:1299.96. After six years or three years as the case may be, the records may be destroyed, in an appropriate manner. A copy of this statute can be obtained from the LSMS Legal Affairs Department. A sample letter that the succession of the deceased physician may send to patients relative to transferring records to a new treating physician and/or destroying records can be obtained from the LSMS Legal Affairs Department.

Authority Note: R56-79; amended R118-2000; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

111.03 Medical Records - Release of Autopsy Report to Attending Physician

Coroner's statements and autopsy reports are considered an integral part of the deceased patient's medical record and copies should be provided to the deceased patient's family designated physicians of record.

Authority Note: R203-98; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

HEALTH INSURANCE (120)

120.01 Health Insurance - Health Care Coverage for All Americans

The LSMS supports the concept of health care coverage for all Americans.

Authority Note: R405-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

120.02 Health Insurance - Standardization of Claims Handling Procedures

Claims handling procedures should be standardized to ensure that claims are appropriately entered into the system and/or logged as received. Significant penalties should be imposed for inappropriate handling of claims by health plans that failed to document receipt of claims whether or not eligible for immediate payment.

Authority Note: R221-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

120.03 Health Insurance - Physician Utilization Review Decisions

Any physician making utilization review decisions on the medical necessity or appropriateness of care affecting the diagnosis or treatment of a patient in Louisiana must have a license to practice medicine in Louisiana.

Authority Note: R206-97; amended R101-06; reaffirmed R101-11; reaffirmed R101-16

120.04 Health Insurance - Clinical Decision-Making by Third Party Payors

The LSMS opposes the regulation of health care via prospective evaluation by third party private insurance carriers who seek to evaluate medical necessity of patient medical/surgical care and use these determinations to limit their financial liability for medical treatment recommended to the individual patient by his or her treating physician. The LSMS policy is that non-physicians appointed by insurance companies to give medical advice to patients be appropriately licensed by the appropriate licensing agency.

Authority Note: R43-85; reaffirmed R101-03; reaffirmed sub R101-08; R204-06; abandoned as directive but reaffirmed as policy SubR102-11; reaffirmed R101-16

120.05 Health Insurance - Voluntary Health Insurance Purchasing Co-Op

The LSMS supports the establishment of a health insurance co-op to improve access to insurance for small business employees.

Authority Note: R210-96; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

120.06 Health Insurance - Pre-Admission Certification

The LSMS opposes the concept of pre-admission certification.

Authority Note: R17-84; reaffirmed R101-03 and sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

120.07 Health Insurance - Employer Mandate

The LSMS recognizes employer provided insurance as one of the important options for financing health care coverage but it should not be mandated.

Authority Note: R303-94; reaffirmed R101-04; reaffirmed R101-10; reaffirmed R101-15

120.08 Health Insurance - Any Willing Provider

The LSMS supports laws and/or regulations that would prohibit a health insurance issuer from refusing to allow a doctor of medicine or osteopathic medicine, who is located within the coverage area of the health insurance issuer and is willing to accept the contract terms and conditions of participation, to join the panel of the issuer as a participating provider.

Authority Note: R206-03; reaffirmed sub R101-08; reaffirmed as amended R103-B-13; reaffirmed R101-18

Eligibility, Benefits & Coverage (121)

121.01 Eligibility, Benefits & Coverage - Patient Protections

The LSMS supports the following patient protections being included in contracts issued by health insurance issuers:

(1) Health plans be required to provide prospective enrollees/patients with information regarding: (a) coverage provisions and exclusions;
(b) prior authorization or other review requirements;
(c) financial arrangements that would limit the services offered, restrict referral options, and establish incentives not to deliver certain services;
(d) plan limitations and the impact of any limitations upon an enrollee; and
(e) enrollee satisfaction statistics.

(2) Patients have a choice of physicians and different types of health plans
(3) Patients have the right to change physicians.
(4) Patients can submit an appeal on cases where they object to medical decisions made by third party payers regarding their health care.
(5) Patients who choose a plan that restricts access to physicians may purchase a point of service option to see any physician outside the plan.
(6) Patient or physician requests for prior authorization of a service must be answered within two business days, with personnel available for same day responses regarding questions of medical necessity.

Authority Note: SR211-94; reaffirmed R101-04; reaffirmed R101-10; reaffirmed as amended R101-15

121.02 Eligibility, Benefits & Coverage - Insurance Coverage Transparency

Health insurance plans and managed care plans should make clearly known to patients the extent of coverage available under their policies. The LSMS position is that health plans should be required to provide prospective enrollees/patients with information regarding: a) coverage provisions and exclusions b) prior authorization or other review requirements c) any financial arrangements that would limit services by restricting referral options or any disincentives to deliver certain services d) plan limitations and the impact of any limitations on the enrollee e) and a simple comparison of health plans.

Authority Note: R205-99; reaffirmed R101-06; reaffirmed R101-11; R212-12 2nd resolve; reaffirmed as amended R103-17

121.03 Eligibility, Benefits & Coverage - Maternity Care

The LSMS supports insurance coverage that will:
(1) require insurers offering maternity benefits to provide for minimum of forty-eight (48) hours of inpatient care for normal vaginal delivery and for a minimum ninety-six (96) hours or inpatient care for a mother and infant following a cesarean delivery;
(2) acknowledge that the discharge of mother and newborn allow for the discretion of their physician's judgment according to the prevailing standard of care rather than according to economic consideration mandated by commercial entities.
(3) If, at the discretion of the physician, a mother and newborn are discharged at less than forty-eight (48) hours postnatal the insurers provide suitable coverage for follow-up care within forty-eight (48) hours of discharge; and
(4) prohibit insurers from penalizing, harassing or otherwise providing for financial disincentives to any attending provider who orders care consistent with the above positions.

Editorial Note: Also see Women's Health (290)
Authority Note: R204-96; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

121.04 Eligibility, Benefits & Coverage - Physician Notification of Patients in Health Insurance Exchange Grace Period

It shall be the policy of the LSMS that physicians should have meaningful notice from the health insurance issuer when an insured with a qualified health plan purchased with and advance premium tax credit begins the 90 day grace period for failure to pay premiums. Such notice should be provided by a health insurance issuer at any point in which the physician requests information from the health insurance issuer regarding an insured's eligibility, an insured's coverage or health plan benefits, or the status of a claim or claims for services provided to an insured. The health insurance issuer should provide such notice in the same manner through which the physician sought the information from the health insurance issuer or through the manner that the physician normally receives claim remittance advice information. Further, the information provided by the health insurance issuer to the physician should be binding on the health insurance issuer and in the event the health insurance issuer provides information which indicates the insured is eligible for services and does not inform the physician that the insured is in the 90 day grace period the health insurance issuer should be precluded from recouping payments.

Authority Note: Added R401-14

121.05 Eligibility, Benefits & Coverage - Cancellation of Group, Family or Blanket Health Insurance

The LSMS supports health insurance policy coverage which (1) prohibits cancellation of group, family, or blanket health insurance policies after claims for terminal, incapacitating, or debilitating conditions; (2) requires notified insurers to pay for certain claims for illnesses or conditions occurring prior to cancellation of any health policy; (3) prohibits an increase in rates unless the increase is actuarially justified and is based on community experience and the experience and projections for the appropriate pool; and (4) prohibits a premium increase based solely or primarily on the experience with the group which includes an insured with a terminal, incapacitating, or debilitating condition.

Authority Note: R69-91; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

121.06 Eligibility, Benefits & Coverage - Reimbursement in Managed Care Contracts

The LSMS supports efforts to ensure that patients, or their designee, have disclosed upon their request the dollar amounts of allowed coverage reimbursement, when considering undergoing medical services that may result in an obligation for a copayment based on those coverage amounts.

Authority Note: R208-96; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

121.07 Eligibility, Benefits & Coverage - Reference Pricing

The LSMS policy is to advocate for the inclusion of the concept of a schedule of benefits/provider fee schedule system with balance billing as one option in a pluralistic array of choices regardless of whether it is called Benefit Payment Schedule, Reference Pricing, Fixed Indemnity or some other than current name so long as the plan is free to establish its payments, physicians are free to establish their fees and patients and physicians are free to determine how to resolve any difference between payments and fees.

Authority Note: Added R408-14

121.08 Eligibility, Benefits & Coverage - Usual, Customary, and Reasonable (UCR) Calculations

The Usual, Customary, and Reasonable (UCR) method of determining health insurance reimbursement has been demonstrated to be terribly flawed. The LSMS favors the indemnity method of determining health insurance benefits (a defined schedule of procedures along with a matching schedule of payment benefits). The LSMS holds that fair and equitable treatment of the private patient demands that a schedule of medical procedures and a schedule of matching insurance payments are essential and should be provided to the patient prior to the purchase of health care coverage.

Authority Note: R11-88; reaffirmed 1998; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

121.09 Eligibility, Benefits & Coverage - Coverage for Children and Adolescents

The standard for private insurance in Louisiana should include coverage of medical care needed by infants, children and adolescents, including prenatal consultations, newborn care, preventive care, health supervision and treatment services through age 21 years and that such services should encourage continuity of care by private care physicians.

Authority Note: R69-89; reaffirmed 1999; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

121.10 Eligibility, Benefits & Coverage - Policy on LA Health Exchange Essential Health Benefit Package

The LSMS supports the position that any Louisiana Health Insurance Exchange Essential Health Benefits Package should be required to include mental health and substance abuse disorder services including behavioral health treatment at parity in financial requirements and treatment limitations with benefits for other medical or surgical illness.

Authority Note: R215-12; reaffirmed R103-17

121.11 Eligibility, Benefits & Coverage - Patient Eligibility for Medical Services

The LSMS encourages all managed health care companies in Louisiana to provide reasonable and adequate 24 hour a day access to determine eligibility of patients, names or approved network hospitals and names of approved physicians. The LSMS believes that managed health care companies should be required to pay for any appropriate services rendered to patients when hospitals or physicians have made reasonable efforts to determine eligibility.

Authority Note: R208-97; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

121.12 Eligibility, Benefits & Coverage - Health Savings Accounts

The LSMS strongly supports the utilization of Health Savings Accounts (HSAs) as one option in a pluralistic system for patient health care coverage.

Authority Note: SR211-94; reaffirmed R101-04; reaffirmed R101-10; reaffirmed as amended R101-15

121.13 Eligibility, Benefits & Coverage - Commercial Insurance; Pre-existing Conditions

The LSMS opposes the inclusion of any pre-existing condition clause in a health insurance contract as these clauses generally prevent the acquisition of affordable health care insurance.

Authority Note: R101-15

121.14 Eligibility, Benefits & Coverage – Commercial Insurance; Lifetime Cap on Benefits

The LSMS opposes the inclusion of any lifetime cap on benefits in any health insurance contract.

Authority Note: R101-15

121.15 Eligibility, Benefits & Coverage - Commercial Insurance; Preventative Care

The LSMS supports requiring all third party payers to include as a benefit of the health insurance coverage for appropriate preventive care based on evidence-based guidelines developed by nationally recognized medical specialty societies for patients at various stages of life.

Authority Note: R101-15

121.16 Eligibility, Benefits & Coverage - Commercial Insurance; Prompt Pay

The LSMS supports requiring commercial health insurance issuers to pay physicians in a timely manner and will continue to inform its members of the law and rules regarding prompt pay in its publications and through its website.

Authority Note: R102-15

121.17 Eligibility, Benefits & Coverage - Commercial Insurance; Medical Loss Ratio

The LSMS encourages commercial insurance companies to change the term "medical loss ratio" to "Medical Benefits Ratio" and that insurance companies define the elements comprising the medical benefits ratio. Additionally, in the interest of full transparency, health financing plans, including insurance, prepaid care and value based payment models, be required to publish their Medical Benefits Ratio.

Authority Note: R205-17

Health Care Quality Initiatives (122)

122.01 Health Care Quality Initiatives - Disclosure of Utilization Review Criteria

Third party payors should be required, upon request, to disclose to physicians the utilization review criteria used to determine treatment reimbursement.

Authority Note: R221-99; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

122.02 Health Care Quality Initiatives - Public Reporting of Health Quality Indicators

The LSMS supports public reporting of health quality measures including those by Department of Health and Human Services, Centers Medicare and Medicaid Services, Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, and National Quality Forum.

Authority Note: R303-03; reaffirmed sub R101-08; reaffirmed as amended R102-13; reaffirmed R101-18

122.03 Health Care Quality Initiatives - Health Care Quality Guidelines

The LSMS opposes all government and insurance efforts to take control of quality assurance programs, and supports all appropriate avenues to ensure that LSMS physicians be involved in all stages of development, review, and implementation of quality standards in the Medicaid program.

Authority Note: R206-94; amended R101-04; reaffirmed R101-10; reaffirmed as amended R101-15

122.04 Health Care Quality Initiatives - Physician Clinical Performance Assessments

The LSMS opposes the use of any clinical performance assessments completed by private or government payors from being introduced into evidence during any medical malpractice, state licensure, or hospital peer review proceeding.

Authority Note: R102-15

Managed Care (123)

123.01 Managed Care - Gag Orders

The LSMS opposes managed care companies imposing any form of gag clause that prevents a physician from discussing quality of care issues and treatment options with their patients. The LSMS is opposed to managed care companies terminating physicians without cause and provide physician applicants with all reasons for denial of an application or renewal of a contract. A due process appeal containing the precise mechanism outlined in the Health Care Quality Improvement Act of 1986 must be accorded.

Authority Note: R211-96; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

123.02 Managed Care - Peer Review Mechanisms

The LSMS opposes managed care organizations/plans as acceptable peer review mechanisms so long as they do not have autonomous medical staff sections with separate bylaws and due process rights for physicians.

Authority Note: R404-96; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

123.03 Managed Care - Managed Care Plan's Conditional Approval for Network

The LSMS supports requiring managed care organizations (MCOs) operating in Louisiana to reimburse physicians for all care provided to patients covered by the MCO during the time between when the physician applies for credentialing with the MCO and the time the physician is finally approved for participation in the MCO panel.

Authority Note: R209-04; reaffirmed R101-10; reaffirmed as amended R101-15

123.04 Managed Care - Regulation of Managed Care Companies

All managed care companies in Louisiana should be regulated by the same laws and standards which regulate health insurance companies except for different solvency standards for provider sponsored organizations as established by the state insurance commissioner and/or state law. The LSMS strongly supports the AMA's efforts to change ERISA laws that exempt self-insured plans from state laws or regulations.

Authority Note: R203-97; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

123.05 Managed Care - Managed Care Plan Credentialing and Application Process

The LSMS supports regulations which would require all managed care organizations to develop a uniform platform which would allow physician applicants the ability to immediately assess the status of his/her application for credentialing for an MCO panel. Fines should be implemented following 60 days after all documents are received that the managed care company is delayed in making a final decision on the physician's application. MCOs seeking recredentialing of physicians should require only that physicians note or report any changes from the initial application or prior recertification.

Authority Note: R207-04, reaffirmed R101-10; reaffirmed R101-15

123.06 Managed Care – Commercial Insurance Tying

The LSMS opposes any law, policy, or contractual provision which seeks to require mandatory participation in the Medicaid program if the physician otherwise participates in commercial health insurance plans.

Authority Note: R404-3rd Resolve, reaffirmed R102-15

INDIGENT AND UNINSURED (130)

130.01 Indigent and Uninsured - Support of Healthcare for the Indigent

The LSMS is committed to the delivery and availability of high quality medical care to the indigent population of Louisiana in a cost-effective, efficient manner. The LSMS supports appropriate levels of funding for providers of healthcare to the indigent of Louisiana. The LSMS encourages the legislature to provide for ongoing health care services to the indigent in a fiscally sound and programmatically adequate system.

Authority Note: R42-86; amended 1996; reaffirmed R101-03; amended R306-06; reaffirmed R101-11; reaffirmed R101-16

130.02 Indigent and Uninsured - Health Care for the Indigent, Elderly and Chronically Ill

The LSMS opposes any plan or effort that would establish a two-tiered system of health care, and contravene physician services to the elderly, the poor, and the chronically ill, including replacing these services with nurse-centered programs.

Authority Note: R14-88; reaffirmed 1998; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

130.03 Indigent and Uninsured - Reforming Care for the Uninsured

The LSMS work with the Louisiana Department of Health and Hospitals and the Louisiana Legislature to develop and implement a fiscally sound, quality plan to address the need for access to quality medical care for indigent and uninsured populations in the state.

Editorial Note: All see Health Care Reform (100)
Authority Note: R214-94; reaffirmed R101-04; reaffirmed R101-10; reaffirmed as amended R107-13; reaffirmed R101-18

130.04 Indigent and Uninsured - Reimbursement for Care Provided to Hospitalized Patient

Physicians should be reimbursed for uncompensated care when care is provided in a hospital setting and the hospital is eligible for uncompensated care reimbursement.

Authority Note: R213-98; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

130.05 Indigent and Uninsured - Health Care for the Uninsured

The LSMS supports the creation of a health insurance risk pool to offer coverage for the medically uninsured and those who are above the poverty level and are Medicaid ineligible who cannot afford rates for individual coverage but could buy coverage at a group rate and would include coverage for the mentally ill.

Authority Note: R12-89; reaffirmed 1999; amended R101-06; reaffirmed R101-11; reaffirmed R101-16

130.06 Indigent and Uninsured - Publicly Funded Healthcare Programs : Patient Protections and Rights

The LSMS supports policies and initiatives which would require publicly funded programs providing healthcare services, to provide patients receiving services through these programs a schedule or list of the entitlements, benefits and patient rights including the right to select either a public or private sector physician for their health care.

Authority Note: SR211-94; reaffirmed R101-04; reaffirmed R101-10; reaffirmed as amended R101-15

LSMS: ADMINISTRATION AND ORGANIZATION (140)

140.01 LSMS: Administration and Organization - LSMS Policy Compliance

The LSMS Board of Governors, LSMS Councils and Committees, and LSMS staff shall uphold the policies established by the LSMS House of Delegates.

Authority Note: R122-01; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

140.02 LSMS: Administration and Organization - LSMS Annual Meeting

The Board of Governors establish the dates and location of the annual House of Delegates meeting upon the recommendation of the Speakers of the House of Delegates.

Authority Note: R125-03; reaffirmed sub R101-08; reaffirmed R101-13; reaffirmed R101-18

140.03 LSMS: Administration and Organization - Refund of Dues

No LSMS dues refunds will be made after the beginning of the membership year.

Authority Note: R102-98; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

140.04 LSMS: Administration and Organization - Confidentiality Agreement

The President has the authority to remove any council or committee member appointed by the President for breach of confidentiality imposed on council or committee business. All LSMS councils and committees must follow the same confidentiality standards adopted for the Board of Governors including the signing of a confidentiality agreement.

Authority Note: R130-02; reaffirmed R101-07; reaffirmed R102-12; reaffirmed R102-17

140.05 LSMS: Presidential Communications

The LSMS President will transmit, no less than quarterly, a personal email communication to all members of the society informing them on recent, current and future LSMS activities and providing an opportunity for input and feedback.

Authority Note: R107-16 and R108-16

American Medical Association (141)

141.01 American Medical Association - LSMS AMA Official Family

Any former AMA President from Louisiana may be included as a member of the LSMS Official Family to the AMA in attending interim meetings of the AMA House of Delegates if approved by the Board of Governors.

Authority Note: R104-99; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

141.02 American Medical Association - Member-In-Training as AMA Delegates

The LSMS House of Delegates policy is that at least one alternate delegate position be reserved for members-in-training in the AMA Delegation. If a member-in-training is elected to a delegate position then the number of alternate delegate positions reserved for members-in-training be reduced by one. Such positions, as specifically designated by the House of Delegates, will be filled by election as described in the LSMS bylaws. A member-in-training is a Fellow, Resident, or Medical Student. If no member-in-training is nominated for either position, then that position will be open to any member of the society, the election being conducted by such method as described in the LSMS bylaws.

Authority Note: R120-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

141.03 American Medical Association - Increase or Decrease in AMA Delegation

In the event the LSMS AMA Delegation is either increased or decreased in the number of delegates or alternate delegates when the LSMS House of Delegates is not in session, the LSMS Board of Governors is empowered to adjust the size of the LSMS AMA Delegation in the manner it feels is most equitable.

Authority Note: R134-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

Boards and Commissions (142)

142.01 Boards and Commissions - Procedure for Nominations to State Boards and Commissions

The LSMS establishes the following mechanism for determining nominees to state boards and commissions. The Board of Governors will define the details for implementing the process.
(1) Publish vacancies on boards and commissions to component societies and the Board of Governors when the need to fill a vacancy is imminent. Incumbents eligible for renomination will be contacted as to their willingness to serve.
(2) Receive the names of nominees according to published deadlines with the additional requirement of a curriculum vitae which would be indicated in the notice of the vacancy.
(3) The President has the responsibility to appoint all positions pending advice and consent of the Board of Governors. If an immediate response is necessary on a vacancy the President should consult with the Executive Committee of the Board to determine the appropriate response.
(4) The Board of Governors will select the nominees to the Louisiana State Board of Medical Examiners *and the Patients Compensation Fund Oversight Board.* Candidates for nomination will be invited for interview by the Board of Governors.
(5) Component societies, state specialty societies, the Council on Legislation, LSMS committees and LSMS staff serve as a resource to the Board and the President regarding potential nominees.

Authority Note: R95-112; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

Legislation and Regulation (143)

143.01 Legislation and Regulation - LSMS Legislative Agenda

The Council on Legislation, in consultation with the Executive Committee of the Board of Governors, shall prioritize the LSMS state legislative effort on an ongoing, as needed, basis predicated upon the practical and political realities existing at the time. The Council on Legislation, on occasion, may exercise appropriate

legislative discretion within the LSMS priority system and, in accordance with existing LSMS policy, during unpredictable legislative circumstances calling for immediate action.

Authority Note: R227-99; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

143.02 Legislation and Regulation - Coordination of Legislative Efforts

The LSMS, with input from and in close cooperation with component societies, will develop a formal plan of action for both fiscal and regular sessions of the legislature to most effectively use staff and financial resources on a state and local level to initiate strategies prior to and during each legislative session aimed at communicating Medicine's message to key legislators and other interested organizations. This will include an assessment of the communication efforts and the use of the most appropriate medium and technology to ensure responsiveness to members' questions.

Authority Note: R224-97; reaffirmed R103-06; reaffirmed R101-11; reaffirmed R101-16

143.03 Legislation and Regulation - Medical Malpractice Laws

Authority is conferred to act swiftly and decisively on any legislation introduced that improves or gives stability to the medical malpractice laws of Louisiana to the Council on Legislation and the Department of Governmental Affairs in concert with the LSMS Executive Committee and the LSMS Executive Vice President.

Editorial Note: Also see Medical Malpractice (233)
Authority Note: R211-02; reaffirmed R101-07; reaffirmed R102-12; reaffirmed R105-17

143.04 Legislation and Regulation - Meetings with Area Legislators

The LSMS will promote regular dialogue between individual legislators and LSMS members living in the legislators' districts by encouraging societies to have meetings at least annually with individual legislators and LSMS members living in those districts. When requested by component societies, the LSMS will assist in coordinating the meetings with individual legislators.

Authority Note: R115-99; reaffirmed R103-06; reaffirmed R101-11; reaffirmed R101-16

143.05 Legislation and Regulation - LSMS Presence at Medicaid Budget Hearings

The LSMS Department of Governmental Affairs will be present at any legislative committee hearing at which physician reimbursement will be discussed. The Department of Governmental Affairs will be present when the DHH budget is presented in committee so that reimbursement issues can be addressed. The LSMS Department of Governmental Affairs will work with the specialty societies to coordinate the attendance of physicians to provide testimony where issues related to Medicaid reimbursement are addressed.

Authority Note: R409-98; reaffirmed R103-06; reaffirmed R101-11; reaffirmed R101-16

MEDICAID (150)

150.01 Medicaid - Medicaid Policy

The LSMS supports a Medicaid program which achieves the following:

1. Provides access to quality and robust care to Medicaid recipients.
2. Ensures there are viable and effective mechanisms to provide health insurance coverage to low-income individuals and the disabled.
3. Provides reasonable and timely payments to physicians providing Medicaid services.
4. Supports Medicaid payment parity with Medicare for primary care services.
5. Relies on funding sources which are dedicated and stable thereby allowing the program to remain fiscally sound and sustainable even in times where the state of Louisiana is facing budget deficits.
6. Supports state efforts to expand their Medicaid programs, including increased flexibility through the waiver process and/or block grants.

7. Empowers Medicaid recipients to own their own healthcare and make decisions about their healthcare needs by utilizing co-payments and deductibles which are commensurate with reimbursement allowed under federal and state law.
8. Supports allowing states the option to provide private sector coverage to their non-disabled and non elderly Medicaid beneficiaries, such as refundable and advanceable premium tax credits that can be used to purchase coverage with little to no cost-sharing.
9. Is privatized based on the principles contained in the LSMS Access to Better Care plan (ABC Plan) which calls for the following choices for patients; traditional insurance plans, managed care plans (HMO, PPO, etc) benefit payment schedule plans, and purchasing pools to enable individuals to achieve group rate premiums.
10. Does not discriminate against any physician specialty.
11. Provides incentives such as small business tax breaks, limited malpractice caps, or other non-reimbursement incentives for physicians who accept Medicaid patients.
12. Provides complete financial transparency so that it can easily be determined if taxpayer dollars are being used in a manner which maximizes access to quality and robust care.

Authority Note: R107-13, reaffirmed as amended R204-17

150.02 Medicaid - Physician Freedom to Accept Medicaid

The LSMS opposes any effort to impose a penalty on a physician for declining to accept Medicaid patients.

Authority Note: Added R404-14

150.03 Medicaid - Medicaid Managed Care Financial Incentives

The LSMS encourages the use of monetary incentives provided to enrollees of Medicaid managed care plans to incentivize the Medicaid recipient to make good health choices so the monetary incentives may only be used to purchase healthcare products and services.

Authority Note: Added R410-14

150.04 Medicaid - Medicaid Reimbursement for Multiple Physician Visits

Medicaid reimbursement should be allowed for concurrent care by physicians providing care to a patient on a single day. The LSMS supports DHH rules to allow Medicaid reimbursement to all physicians providing care to patients for all medical services and/or office visits in excess of the 12 visit per calendar year limit.

Authority Note: R214-98; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

150.05 Medicaid - Medicare-Medicaid Crossover Payments

The Louisiana Department of Health and Hospitals alter its existing rules concerning reimbursement of physicians for care of dually eligible (Medicare/Medicaid) beneficiaries to allow for full cost-sharing of co-payments and deductibles, as mandated by federal Medicare and Medicaid laws. The LSMS, together with component societies, join with existing statewide patient advocacy coalitions, to encourage the Louisiana Department of Health & Hospitals to restore funding for Medicare-Medicaid crossover payments.

Editorial Note: Also see Medicare (190)
Authority Note: R408-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

Medicaid Funding (151)

151.01 Medicaid Funding - Funding of LaCHIP

The LSMS supports full matching funds for the state child health insurance program (LaCHIP).

Authority Note: R215-98; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

151.02 Medicaid Funding - SCHIP Legislation

The LSMS opposes the inappropriate use of the SCHIP program as an incremental step toward a single-payer government run health care system.

Authority Note: R115-07; reaffirmed R215-11; reaffirmed R102-12; reaffirmed R105-17

MEDICAL EDUCATION (160)

160.01 Medical Education - Medical Education Policy

The LSMS believes the ultimate purpose of medical education—including basic medical education for medical students and provisionally registered doctors, postgraduate training and continuing medical education (CME)—is to train the very best physicians, which in turn can improve the health and the health care of the population and ensure the vibrant and robust future of the practice of medicine. The LSMS endorses all efforts an d initiatives which further the pursuit of medical education. These efforts include but are not limited to the following:
(1) Ensuring appropriate funding exists and is dedicated to supporting the medical schools located in Louisiana.
(2) Making available sufficient and appropriate financial aid, whether through grant or loan programs, which encourages Louisiana citizens to enter into medical school and begin their journey into the practice of medicine.
(3) Ensuring that residency programs in the state are well supported both from a financial standpoint and an educational standpoint ensuring that Louisiana physicians are educated not only to handle the challenges of real-life medical practice but also to prepare for an ever changing health care system.
(4) Encouraging physicians in Louisiana to continue their medical education and to earn, on a voluntary basis, the AMA's Physician Recognition Award or comparable awards given my medical specialty organizations.
5) Ensuring the appropriate governance and leadership autonomy for the public medical schools in Louisiana by continuing the current governance practice of direct reporting of the chancellors at LSUHSC-New Orleans and LSUHSC-Shreveport to the LSU System President.
6) Ensuring public-private partnerships created with teaching hospitals connected with GME Programs in Louisiana medical schools are structured in a way that supports adequate financial and academic resources with the goal of preserving and improving the GME system in Louisiana.

Authority Note: R108-13; reaffirmed R101-18

160.02 Medical Education - Medical Education and Public Health Services

The LSMS will support measures that mitigate the expense medical students incur for medical education without compromising the quality of education. The LSMS supports maintaining the highest standards for students of medicine and persons in graduate medical education. The LSMS supports including basic public health services as a governmental responsibility in Louisiana; and that these basic services are, as a minimum, health education, control of the spread of communicable diseases, promotion of a clean and healthy environment, and outreach health clinics for the hard-to-reach populations.

Authority Note: R304-93; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed as amended R101-15; reaffirmed as amended R403-17

160.03 Medical Education – Cost Transparency

The LSMS supports transparency and requests that justification be provided for any institutional or legislative action that increases the cost of medical education.

Authority Note: R403-17

160.04 Medical Education – Abolition of USMLE Step 2 Clinical Skills

The LSMS supports the abolition of USMLE Step 2 CS for US medical students.

Authority Note: R404-17

MEDICAL MARIJUANA (170)

170.01 Medical Marijuana - General Policy

The policy of the LSMS is to support the current 1991 law in Louisiana that permits the use of medical marijuana.

Authority Note: Added R205-14

MEDICAL RESEARCH (180)

180.01 Medical Research - Enhanced Health Care Research Initiatives

The policy of the LSMS is the following: (1) to advocate for the establishment of a new social compact for health research that provides government funding, assures evidence-based setting of priorities and engages public support of increased government resources dedicated to healthcare research, (2) to advocate for renewal of a partnership in health research that seeks the public good among government, industry, universities, clinicians and researchers, and (3) to support national efforts to encourage Congress to adopt a five year gradually increasing, annually extending commitment to health research.

Authority Note: Added R405-14

180.02 Medical Research - Biomedical Research

The LSMS supports the concept of humanely performed animal-based biomedical research.

Authority Note: R66-90; amended R101-2000; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

MEDICARE (190)

190.01 Medicare - Louisiana as One Medicare Region

The LSMS endorses designation of the entire state one region for the purpose of reimbursement under Part B of Medicare.

Authority Note: R22-83; reaffirmed 1988; reaffirmed 1998; reaffirmed R101-03; referred to the Board of Governors sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

190.02 Medicare - Restructuring of Medicare Program

The LSMS supports a Medicare program which achieves the following:

1. Supports reforms to the Medicare program to ensure that it is a viable and effective mechanism to provide health insurance coverage to seniors.

2. Supports the restructuring of Medicare's age-eligibility requirements and incentives to match the Social Security schedule of benefits.

3. Supports a Medicare defined contribution program that would enable beneficiaries to purchase coverage of their choice from competing health plans.

4. Supports preserving traditional Medicare as an option.

Editorial Note: Also see Health Care Reform
Authority Note: R17-89; amended R101-99; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16; reaffirmed as amended R204-17

190.03 Medicare - Medicare Payments to New Physicians

The LSMS opposes discriminatory Medicare payment reductions to new physicians.

Authority Note: R55-92, reaffirmed R101-03, reaffirmed sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

190.04 Medicare - Due Process Rights Under Medicare

Physicians' due process rights should be guaranteed in any dealings with the Medicare Part B carrier.

Authority Note: R52-90, reaffirmed R101-2000, reaffirmed R101-06, reaffirmed R101-11; reaffirmed R101-16

190.05 Medicare - Medicare Evaluation & Management Documentation Guidelines

The LSMS opposes the development of Medicare E&M Guidelines that employ quantitative formulas and/or assigns numeric values to elements documented in the medical record to qualify as clinically appropriate medical record keeping.

Authority Note: R402-98, amended R101-06, reaffirmed R101-11; reaffirmed R101-16

190.06 Medicare - Disclosure of Medicare HMO Policies

The LSMS supports regulations which require Medicare HMOs operating in Louisiana to establish truth in selling policies which require full disclosure of the limitations for covered services and incentives under which Medicare HMOs operate.

Authority Note: R216-98; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

MENTAL HEALTH (200)

200.01 Mental Health - Mental Health Care

The LSMS endorses the concept that the state of Louisiana provide mental health treatment and programs for the medically indigent under the supervision of a licensed physician. The LSMS encourages its members to be more aware of the limitations and restrictions on obtaining access to medical treatment for mental illnesses and/or substance abuse disorders and encourage its members to become proactive in resolving these access problems in coordination with civic organizations addressing the problem.

Authority Note: R44-90; reaffirmed R101-2000; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

200.02 Mental Health - Discrimination against Psychiatric Consultation

The LSMS opposes the policy of insurers that treat consultation for patients with psychiatric symptoms in a discriminatory manner. Primary insurers be held fully accountable for the policies and performance of their subcontractors and be held fully responsible for the equitable treatment of all patients and provide timely reimbursement for legitimate services under their plans, whether subcontracted or not. Further, primary insurers be required to cancel contracts with subcontractors no longer financially able to provide contracted services without resorting to discriminatory practices.

Authority Note: R216-03; reaffirmed sub R101-08; reaffirmed R102-13; reaffirmed R101-18

200.03 Mental Health - Parity of Benefits for Mental Illness

The LSMS affirms its support of health system reform which will guarantee parity of benefits for the mentally ill from its inception and opposes any reform which further stigmatizes our mentally ill patients by continuing to deprive them of the necessary access to affordable care.

Authority Note: R309-93 reaffirmed R123-2000; reaffirmed R101-04; reaffirmed R101-10; reaffirmed R101-15

200.04 Mental Health - Mental Health Centers in Louisiana

The LSMS opposes psychologists and inadequately-trained social workers treating psychiatric patients in mental health centers without physician supervision.

Authority Note: 1977; amended R101-97; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

PHYSICIANS (210)

210.01 Physicians - Definition of a Physician

A physician is a person who has been admitted to a medical school or a school of osteopathic medicine, which school is approved by his or her state licensing board, and has successfully completed the prescribed course of studies, has graduated and holds a diploma as a doctor of medicine or osteopathic medicine and has completed the requisite qualifications to be licensed to practice medicine or osteopathic medicine. The LSMS supports limiting the use of the term *physician* to describe only doctors of medicine or osteopathic medicine.

Authority Note: R16-84; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

210.02 Physicians - Physician Freedoms in Delivering Health Care

The LSMS supports the following:
(1) Freedom to decide whom he or she will treat, except in emergencies.
(2) Freedom to determine the method of treatment of his or her patients compatible with good medical practice and the consent of the patient.
(3) Freedom to determine the method of receiving payment for his or her services.
(4) Freedom to practice in the geographical location of his or her choice.
(5) Freedom to admit a patient to a hospital for treatment as being his or her sole prerogative, consistent with official policy of the hospital medical staff.

Authority Note: 1970; amended R101-2000; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

210.03 Physicians - Criminalization of Medical Decisions:

The LSMS opposes the criminalization of medical decisions and actions by physicians and other healthcare providers who in loyalty to their patients and who in proper exercise of their clinical judgment and for appropriate reasons depart from established medical care and resource allocation guidelines or standards.

Editorial Note: Also see Abortion (10)
Authority Note: R307-04; reaffirmed as amended R102-10; reaffirmed as amended R101-15

210.04 Physicians - Guidelines for Rendering a Second Opinion

The LSMS guidelines for physician conduct during the rendering of a second opinion are as follows:
(1) When a physician refers a patient for a second opinion, it is the ethical responsibility of the physician rendering the second opinion to release the patient back to the referring physician.
(2) The physician selected by a patient for the purpose of obtaining a second opinion is not obligated to advise the patient’s primary physician of the finding or recommendations.
(3) It is considered unethical for the physician rendering a second opinion to undermine the relationship between a patient and his or her primary physician for self-serving purposes.

Authority Note:R15-88; reaffirmed 1998; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

210.05 Physicians - Home Health Care Services

The attending physician should provide all initial orders for home health patient care, (to include medication, lab and ancillary services) and all requests/consults for an evaluation of unique home environmental concerns by an appropriately qualified individual.

Authority Note: R409-97; amended R101-06; reaffirmed R101-11; reaffirmed R101-16

Advertising (211)

211.01 Advertising - Advertising by Physicians

The LSMS opposes false, fraudulent, misleading, or deceptive statements of professional credentials by physicians. Advertising or other publicity by individual physicians, medical group practices, or professional medical corporations, including participation in public functions, should not contain self-laudatory statements of claims regarding the quality of their services which cannot be readily measured or accurately defined. A physician, medical group practice, or professional medical corporation should not offer compensation or give anything of value to representatives of the press, radio, television, or other communication mediums in anticipation of or in return for professional recognition in a public news item of any kind. A paid advertisement must be identified as such unless it is apparent from the content that it is a paid advertisement.

Authority Note: R9-84; reaffirmed R101-04; reaffirmed R101-10; reaffirmed R101-15

Licensure and Discipline (212)

212.01 Licensure and Discipline - Separate Physician Licensing Boards

The LSMS opposes the creation of separate physician licensing boards apart from the Louisiana State Board of Medical Examiners.

Authority Note: R508-93; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

212.02 Licensure and Discipline - Due Process Regarding Sanctions

A physician should not be officially sanctioned by any Third-Party Payor or governmental agency until he or she has had the opportunity of a fair hearing and full due process.

Authority Note: R21-88, R101-98; amended R101-06; reaffirmed R101-11; reaffirmed R101-16

212.03 Licensure and Discipline - Licensure Confidentiality

The LSMS is committed to the fundamental principle of confidentiality as a basic tenet of the physician-patient relationship and urges that the type of information available to the State Board of Medical Examiners be limited to information which is reasonably related to the physician's ability to practice medicine.

Authority Note: R54-88; amended R101-98; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

212.04 Licensure and Discipline - Federally Established National Licensing Board

The LSMS opposes all efforts by the federal government to establish a National Licensing Board for medical doctors.

Authority Note: R401-12; reaffirmed R105-17

212.05 Licensure and Discipline - Prevent Linking Medical Licensure to Any Public or Private Health Plan

The LSMS supports legislation and/or regulation to prevent linking a physician's license to practice medicine with mandatory participation in any public or private health care insurance or health care payment product.

Editorial Note: All see Medicare (190) & Medicaid (150)
Authority Note: R209-11; reaffirmed R101-16

212.06 Licensure and Discipline - Multiyear Medical License

The LSMS encourages the Louisiana State Board of Medical Examiners to consider increasing the licensing period for medical licenses from one to multiple years. The fees for a multi-year license should equal to no more than the current one year fee times the number of years the license is valid.

Authority Note: R214-03; reaffirmed sub R101-08; amended R214-11; reaffirmed R101-16

212.07 Licensure and Discipline - Licensure Fee Exemption for Physicians Over the Age of 75

The LSMS endorses the concept of a license fee exempt status for physicians beyond the age of 75 who wish to maintain a practice.

Authority Note: R70-89; reaffirmed 1999; reaffirmed R101-06; reaffirmed R 101-11; reaffirmed R101-16

212.08 Licensure and Discipline - Representation on Louisiana State Board of Medical Examiners (LSBME)

The composition of members selected to serve on the Louisiana State Board of Medical Examiners should include regional representation in the state.

Authority Note: R116-2000; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

212.09 Licensure and Discipline – Maintenance of Licensure

The LSMS is opposed to any effort by the state of Louisiana, including but not limited to the Louisiana State Board of Medical Examiners, to require that a physician complete a "maintenance of licensure (MOL)" program similar to that proposed by the Federation of State Medical Boards (FSMB) as a condition of licensure.

Authority Note: R403-15

212.10 Licensure and Discipline – Maintenance of Certification

The LSMS opposes mandatory maintenance of certification, and encourage physicians to strive constantly to improve their care of patients by the means they find most effective and encourages the continued use of state requirements for CME hours as a means of ensuring physicians remain up-to-date on patient care issues. Additionally, the LSMS opposes any efforts that would require a physician secure a Maintenance of Certification as a condition of licensure, reimbursement, employment, or admitting privileges at a hospital.

Authority Note: R402-15, amended and reaffirmed R202-18

212.11 Federal Compact for Telemedicine

The LSMS opposes the federal compact for the practice of telemedicine as it is currently written and will oppose any legislation introduced to implement the provisions of the compact in Louisiana.

Authority Note: R404-15

212.12 Licensure Should not be Tied to EHR Proficiency

The LSMS opposes the denial of a medical license to any physician based solely on the grounds of failure to use an electronic health record (EHR), or failure to demonstrate proficiency in use of an electronic health record.

Authority Note: R106-18

Physician Contracts & Payment (213)

213.01 Physician Contracts & Payment - Physicians Rights Under Health Coverage Plans

The LSMS believes that all physicians should enjoy the following rights with regard to health coverage plans:

(1) Health coverage plans should be prohibited from terminating contracts with physicians *without cause* and should provide physician applicants with all reasons for denial of an application or nonrenewal of a contract. ~~A~~ Physicians should be accorded a due process appeal which utilizes the procedure for appeal set forth in the Healthcare Quality Improvement Act of 1986. Procedures that ensure confidentiality of provider and individual medical records must also be followed.

(2) Health coverage plans should establish credentialing criteria to allow physicians within the plan's geographic service area to apply for credentials. Credentialing should be based on standards of quality with criteria and profiles available to physicians.

(3) Health coverage plans should establish a mechanism under which physicians can provide input into insurer's medical policies.

(4) Health coverage plans should allow for physician to provide input regarding their participation in health coverage plans which includes, but is not limited to, the following:

a. Permitting physicians to negotiate with insurers on the terms and conditions of their participation on provider panels.

b. Disclosing all participation requirements and selective contracting criteria to physicians interested in entering into a contractual relationship.

c. Establishing self-governing medical staffs similar, if not identical, to those in hospitals that function under the principles of self-governance.

d. Establishing appropriate utilization review criteria which includes but is not limited to:

(i) A model in which a medical director is responsible for all clinical decisions of the plan.

(ii) Screening criteria, weighting elements, and computer algorithms used in the review be based on sound scientific principles, developed with physicians having an essential role~~;~~.

(iii) Only a physician of the same specialty as the practitioner who provided a service should be permitted to recommend denial of coverage or payment.

(iv) Provide to participating physicians the names and credentials of those who conduct medical necessity or appropriateness reviews.

Editorial Note: All see Health Insurance (120)
Authority Note: R211-94; reaffirmed R101-04; reaffirmed R101-10; reaffirmed as amended R101-15

213.02 Physician Contracts & Payment - Right of Physician and Patient to Privately Contract

The LSMS holds inviolate the constitutional right of citizens to enter into private contracts, such as between physician and patient, and the right of the parties to determine the arrangements under which services are rendered. The LSMS unalterably opposes any legislation that (1) interferes with the right of private contract between citizens; (2) prohibits a physician from directly billing a private patient; (3) mandates physician acceptance of patient coverage benefits.

Authority Note: R20-84; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

213.03 Physician Contracts & Payment - Regulation of Physician Fees

Attempts to regulate the fees of physicians who do not accept assignment, but who bill their patients directly, is a violation of the constitutional right of the physician to contract for services with his or her private patients.

Authority Note: R16-86; reaffirmed 1996; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

213.04 Physician Contracts & Payment - Discounting of Cost of Care

The LSMS supports allowing hospitals and physicians and other healthcare providers to discount the cost of care to the uninsured and to those individuals who have purchased high deductible insurance plans as the physician or healthcare provider deems appropriate based on the patient's economic conditions.

Authority Note: R203-04; reaffirmed R101-10; reaffirmed R101-15

213.05 Physician Contracts & Payment - Timely Payment of Claims By Health Insurers

Insurers should make timely payments to physicians, and other health care providers, as well as to the patients (insured) in accordance with laws related to payment of benefits after receiving proof of a clean claim, or be subject to penalties as specified in statutes.

Editorial Note: All see Health Insurance (120)
Authority Note: R52-89; amended R101-99; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

213.06 Physician Contracts & Payment - Fee Schedule Transparency

Insurers should be required to file reimbursement methodologies with the Department of Insurance and place on the insured's benefit card specific information including, but not limited to, co-pay amounts, plan hospitals, and plan differentiation if the company has more than one product in the area. The LSMS position is that insurance companies should disclose physician payment (fee) schedules in contracts and make available upon request of the physician or patient, the contracted discounts for medical providers (i.e. hospitals, imaging lab, medications, etc.)

Authority Note: R206-96; reaffirmed R101-06; reaffirmed R101-11; R212-12, 1st resolve; reaffirmed as amended R103-17

213.07 Physician Contracts & Payment - Pay for Performance versus Quality of Care

The LSMS opposes any pay-for-performance program that does not meet all the principles set forth in the AMA's Initial Principles and Guidelines for Pay-for-Performance and adopted by the LSMS House of Delegates.

The LSMS supports the development of quality review initiatives that respect patient choice, use accurate data and fair reporting to produce evidence based guidelines and provide meaningful information for patients to use in their health care decisions. Quality review programs should not impose financial requirements that interfere with the clinical decisions made between a patient and his or her physician and used to educate and assist physicians in providing the most effective care to their patients.

Editorial Note: All see Health Insurance (120) &Health Care Quality Initiative (122)
Authority Note: R401-07; reaffirmed R102-12; reaffirmed as amended R103-17

213.08 Physician Contracts & Payment - Pay for Performance Guidelines

The LSMS supports the AMA Principles and Guidelines for Pay for Performance Programs and will take all appropriate steps to actively oppose efforts by third party payers to rank, profile or otherwise score physicians purely for corporate cost containment purposes. Additionally, the LSMS will publicize the insurance industry's economic profiling practices and how they impact patient care and access.

Editorial Note: see AMA Policy H-450.947 in Appendix A
Authority Note: R105-06; reaffirmed R 101-11; reaffirmed R101-16; reaffirmed as amended R109-17

213.09 Physician Contracts & Payment - Utilization and Cost of Medical Services

The LSMS supports all actions to encourage and support collaborative specialty development and review of any appropriateness criteria, practice guidelines, technical standards, and accreditation programs, particularly as Congress, federal agencies and third party payers consider their use as a condition of payment.

The LSMS opposes efforts by private payers, hospitals, Congress, state legislatures, and federal and state agencies to impose policies designed to control utilization and costs of medical services unless those policies can be proven to achieve cost savings and improve quality while not curtailing appropriate growth and without compromising patient access.

Authority Note: R216-06; reaffirmed R101-11; reaffirmed R101-16

213.10 Physician Contracts & Payment - Insurer Explanation of Benefit Forms

Insurance carriers should provide an explanation of medical benefits (EOMB) to health care providers whenever the carrier's reimbursement differs from the amount billed by the provider. The EOMB must be provided with the reimbursement check.

(1) The EOMB must contain appropriate identifying information so the provider can relate a specific reimbursement to the applicable claimant, the procedure billed, and the date of service.
(2) The carrier shall use the provider's listed EOMB CPT codes and descriptors to demonstrate how each charge has been reduced or disallowed.
(3) The EOMB shall specify what underlying managed care organization's contractual fee schedule is used for determining reimbursement and/or applicable discounts.
(4) The EOMB shall clearly identify the insured's remaining financial responsibility under the contract.

Editorial Note: Also See Health Insurance (120)
Authority Note: R207-96; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

213.11 Physician Contracts & Payment - Reducing Payment for Previously-Adjudicated Claims

The LSMS supports policies which prohibit third-party payors, including government plans, from reducing or withholding payment on current or future claims to satisfy corrections or alterations to unrelated previously-adjudicated claims. The LSMS supports policies which instead require third-party payors to notify physicians of the need to remit a separate payment for the error which resulted in overpayment.

Editorial Note: Also See Health Insurance (120), Medicare (190) & Medicaid (150)
Authority Note: R210-03; reaffirmed sub R101-08; reaffirmed as amended R103-B-13; reaffirmed R101-18

213.12 Physician Contracts & Payment - Retroactive Claims Denials

There should be a statute of limitations of twelve months for previously approved and paid claims to be reconsidered and request for refund to be made after which time payments are final and cannot be recouped against future claims.

Authority Note: R211-98; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

213.13 Physician Contracts & Payment - Health Plan Charges for Tracing Third-Party Checks

The LSMS opposes any business practice by an insurance company, employer-sponsored plans, or third-party administrators which requires payment of a fee to trace a check which, according to them, has been sent to the physician previously. The LSMS supports policies which require health insurance plans and/or employer-sponsored plans and/or third-party administrators to issue a replacement check or submit for signature by the physician, an acknowledgment of non-receipt of the check and/or request for reissue after 60 days if the original check has not been processed by the physician.

Authority Note: R211-03; reaffirmed sub R101-08; reaffirmed as amended R103-B-13; reaffirmed R101-18

213.14 Physician Contracts & Payment - Physician Reimbursement in Government Programs

The LSMS supports increases in physician reimbursement rates of all existing federal and state medical programs, and opposes all federal and state efforts to establish any new medical reimbursement programs that are supported by provider fees.

Editorial Note: Also see Medicare (190) & Medicaid (150)
Authority Note: R206-02; reaffirmed 101-07; reaffirmed R102-12; reaffirmed R103-17

213.15 Physician Contracts & Payment - Contracts and Ethical Duty

The LSMS opposes agreements or clauses in participating physician contracts which unreasonably restrain the physician from providing information to the patient about policies and decisions of an insurer or other contracting entity. These provisions constitute an unacceptable restriction on the physician's ethical duty to act as the patient's advocate.

Authority Note: R511-93; reaffirmed R101-03; and sub R101-08; reaffirmed R102-13; reaffirmed R101-18

213.16 Physician Contracts & Payment - Physician Negotiating Units

The LSMS supports the right for all physicians to form local and/or regional negotiating units consistent with our medical ethics and professionalism for the purpose of collectively bargaining with managed care plans, insurers, and employers on issues related to health care quality, patient rights, and physician rights, and to oppose the affiliation of physician negotiating units with labor unions and of the negotiating units without the right to strike.

Authority Note: R404-99; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

213.17 Physician Contracts & Payment - Inclusion of Payment Schedule in Contracts

Each third party payor attach a complete payment schedule which is updated whenever the payment schedule is altered but at least yearly to the physician contract.

Authority Note: R218-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

213.18 Physician Contracts & Payment - Non-Compete Clauses in Contracts

The LSMS opposes non-compete and restrictive covenants in employer contracts for physicians.

Authority Note: R409-03; reaffirmed sub R101-08; reaffirmed as amended R208-12; reaffirmed R103-17

213.19 Physician Contracts & Payment - Assignment of Medical Insurance Benefits

Insurance companies providing health care insurance in Louisiana should be required to send payment directly to any health care provider designated by a valid act of assignment of the subscriber; said payments shall be made in a timely fashion, and in accordance with all laws governing health insurance payments.

Authority Note: R17-90; reaffirmed R101-2000; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

213.20 Physician Contracts & Payment - Bundled Payment Systems

The LSMS opposes mandatory bundling of reimbursement for episodes of care to hospitals that precludes independent billings by physicians.

Authority Note: R113-10; reaffirmed R101-15

213.21 Physician Contracts & Payment - National Health Insurance and Physician Payment

The LSMS opposes any provision in any national health insurance legislation which would preclude billing of patients by physicians and encourages the AMA to take the same position.

Authority Note: R705-74; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

213.22 Equitable and Adequate Reimbursement

The LSMS supports equitable and adequate reimbursement to physicians in order to increase access to care.

Authority Note: R105-18

Physician Patient Relationship (214)

214.01 Physician Patient Relationship – General Policy

The LSMS principles of the physician/patient relationship:
(1) Patients should seek a clear understanding of fees with their physician. Neither the patient nor the physician should be hesitant to talk about this important financial consideration.
(2) The patient should make every effort to pay the physician's bill promptly. Because most physicians do not charge interest on unpaid balances, delay in settling a bill translates into an increase in the cost of medical practice which, like all other costs, is passed on to future patients.
(3) The physician should be told if a patient is in a hardship situation. A physician's first obligation is to provide good medical care. One of the most disturbing things about government intrusion is the failure to acknowledge that physicians in this country are traditionally willing to adjust to the needs of their patients on a case by case basis when genuine hardship occurs.
(4) Patients should be able to rely on their physicians as their advocate. Physicians should explain to patients all known costs of medical care (hospitals, tests, therapy, etc.).
(5) Patients should establish a relationship with a primary care physician for their confidential health maintenance and emergency needs.
(6) Physicians should accommodate second opinions for those patients who are uncomfortable with a diagnosis or treatment plan.
(7) Patients should do everything possible to promote and maintain their well-being such as: fastening seat belts and child restraints, abstaining from smoking, maintaining good nutrition, exercise and practicing temperance in alcohol consumption.

Authority Note: R10-85; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R102-13; reaffirmed R101-18

214.02 Physician Patient Relationship – Patient Rights and Responsibilities

The LSMS considers the following patients' rights and responsibilities to be fundamental in fostering the trusting patient-physician relationship which is essential to successful outcomes.
(1) the right to receive complete and easily understood information from a treating physician about his or her medical care and to have his/her questions answered;
(2) the right to appropriate informed consent regarding the benefits, risks, and costs of diagnostic and treatment alternatives, including the physician's counsel as to the optimal course of action;
(3) the right to make decisions regarding the health care recommended by a treating physician. Patients may accept or refuse any recommended medical treatment;
(4) the right to be advised of any potential conflicts of interests their treating physician may have involving care to be provided or recommended;
(5) the right to select the physician of his or her choice (unless the patient has contracted otherwise with a third party), to change physicians as warranted, to request second opinions, and to expect the physician to function as the primary advocate for his or her health and well being;
(6) the right to confidentiality of medical records, communications, and information shared with his or her physicians, which should not be revealed to any third party without current consent of the patient unless otherwise provided for by law or by the need to protect the welfare of the individual or the public interest;
(7) the responsibility to be a partner in his or her health care by maintaining a healthy lifestyle and avoiding behaviors that are detrimental to good health;
(8) the responsibility to establish a relationship with a physician of his or her choice and to provide accurate information regarding personal and health histories essential to his or her care;
(9) the responsibility to actively participate in decisions about his or her health care, to ask questions and seek information about his or her medical condition and the treatment recommended, and to cooperate on mutually accepted courses of treatment;

(10) the responsibility to make arrangements for the payment of his or her medical care to the extent possible. Patients should seek a clear understanding of the costs of their care by talking to their physician, discussing possible financial hardships, and becoming knowledgeable about the terms, coverage provisions, rules and restrictions of their health care plans.

Authority Note: R109-96; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

214.03 Physician Patient Relationship – Home Health Care Referral Influence

The LSMS opposes pressure from hospitals, employers, or other interest groups on physicians to refer patients to a particular home health care agency. The patient's individual physician and patient should determine the choice of agency and the physician should determine the medical necessity of all treatments including the various allied health providers, number of visits, and equipment provided.

Authority Note: R408-97; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

214.04 Physician Patient Relationship – Diagnostic Imaging Services

The LSMS supports patients receiving imaging services at facilities where appropriately trained medical specialists can perform and interpret imaging services regardless of medical specialty. The LSMS opposes any attempts by federal and state legislators, regulatory bodies, hospitals, private and government payers and others to restrict reimbursement for imaging procedures being performed and interpreted by physicians based on the proper indications for the specific imagine technique regardless of their medical specialty. In the interest of transparency, when a patient is referred to an imaging facility outside of the referring physician's office, any financial interest of the referring physician in that imaging facility should be disclosed to the patient.

Authority Note: R216-06; reaffirmed R101-11; reaffirmed R101-16

Physician Referral (215)

215.01 Physician Referral – Incentives

The LSMS opposes business practices whereby payments by or to a physician are made solely for the referral of a patient. A physician should not accept payments for prescribing or referring a patient to said source. Referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed.

Authority Note: R8-85; reaffirmed R101-95; reaffirmed R101-03 and sub R101-08; reaffirmed as amended R103-B-13; reaffirmed R101-18

215.02 Physician Referral - Self-Referral

The LSMS believes that in general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships—including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices—are expected to uphold their responsibilities to patients first. When physicians enter into arrangements that provide opportunities for self-referral they must:

(1) Ensure that referrals are based on objective, medically relevant criteria.

(2) Ensure that the arrangement:

- (a) is structured to enhance access to appropriate, high quality health care services or products; and
- (b) within the constraints of applicable law:
  - (i) Does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;
  - (ii) Does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services, and
  - (iii) Adheres to fair business practices vis-à-vis the medical professional community—for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.

(3) Take steps to mitigate conflicts of interest, including:

(a) ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products;

(b) establishing mechanisms for utilization review to monitor referral practices; and

(c) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.

(4) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral.

Authority Note: R509-93; reaffirmed R101-03; sub R101-08; reaffirmed as amended R103-B-13; reaffirmed R101-18

Quality of Care (216)

216.01 Quality of Care - Third-Party Payor Determinations

LSMS members have an ethical responsibility not only to treat their patients skillfully but also to act as their patients' advocates. A physician may be obliged to object to requests and challenge any PRO or Third-Party Payor determination that is contrary to the patient's medical interest. A decision to discharge a patient from hospitalization based on the recommendation of a PRO or Third-Party Payor should be critically evaluated by the physician. A physician's determination with respect to discharge from hospitalization and a physician's objection to discharge should be made a matter of record in the patient's progress notes.

Authority Note: R4-88; amended R101-98; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

216.02 Quality of Care - Patient Safety

The LSMS supports patient safety initiatives and education in Louisiana of both health care providers and the public by working with Louisiana physicians, Louisiana Hospitals, the Louisiana Department of Health and Hospitals, and the Louisiana Health Care Review (eqHealth Solutions) to work toward an overall reduction in medical errors.

Authority Note: R312-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

Standard of Care (217)

217.01 Standard of Care - The Standard of Care

The LSMS recognizes the term "standard of care" as a term of legal doctrine within the law of negligence to be confined to legal usage and opposes use of the term within the art of medicine. The LSMS finds that standards, guidelines, and statements providing guidance to improve decision-making and promote beneficial outcomes for the practice of medicine shall not be held as establishing a standard of care but may be used by qualified experts in testimony addressed to the standard of care. The LSMS specifically opposes the use of the term "standard of care" as a conclusion or assertion propounded by standards, guidelines, and statements providing guidance to improve decision-making and promote beneficial outcomes for the practice of medicine.

Authority Note: R214-12; reaffirmed R103-17

217.02 Standard of Care - Inappropriate Use of Payment and Coverage Decisions

The LSMS opposes payment and coverage decisions of governmental and commercial health insurance entities to be considered as evidence in determining the standard of care for medical practice.

Authority Note: R402-07; reaffirmed R102-12; reaffirmed as amended R103-17

217.03 Standard of Care - Comparative Effectiveness Research

While the LSMS supports quality research and quality guidelines, we oppose the use of these guidelines as a justification for the rationing of patient care, the calculation of physician reimbursement, or the establishment of a standard of medical care. Additionally, the LSMS supports repeal of the authorization and funding of the Federal Coordinating Council for Comparative Effectiveness Research and the National Coordinator for Health Information Technology based on their violation of LSMS policy 217.03.

Authority Note: R112-10; amended R120-11; reaffirmed R101-16

PRESCRIPTION MEDICATIONS (220)

220.01 Prescription Medications - Atypical Antipsychotic Medications

The LSMS supports efforts to include second or third generation antipsychotic medications on restricted formularies.

Editorial Note: Also see Mental Health (200)
Authority Note: R202-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

Prescribing & Dispensing (221)

221.01 Prescribing & Dispensing - Physician Dispensing

The LSMS supports the physician's right to dispense drugs and devices when it benefits the patient and is consistent with AMA ethical guidelines.

Authority Note: R17-88; reaffirmed 1998; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

221.02 Prescribing & Dispensing – Physician Compounding

The LSMS supports the protection of individualized compounding in a physician's office.

Authority Note: R206-17

221.03 Prescribing & Dispensing - Usage of Brand and Generic Name for Prescription Medications

It is LSMS policy to support pharmacists and pharmaceutical companies provide both the generic and brand name on all prescription bottles.

Authority Note: R124-06; abandoned as directive but reaffirmed as policy Sub R102-11; reaffirmed R101-16

221.04 Prescribing & Dispensing - Internet Prescribing of Treatment Therapies

The LSMS supports the Louisiana State Board of Medical Examiners and the Louisiana State Board of Pharmacy jointly establishing standards for evaluating Internet prescribing of treatment therapies that may be in violation of the Louisiana Medical Practice Act, the Louisiana Pharmacy Act, and existing laws and regulations, and develop if necessary a mechanism to enforce these standards. The LSMS supports the following AMA recommendations on Internet prescribing:

(1) Development of principles describing appropriate use of the Internet in prescribing medications;
(2) Support the use of the Internet as a mechanism to prescribe medications with appropriate safeguards to ensure that the standards for high quality medical care are fulfilled;
(3) Urge state medical boards to ensure high quality medical care by investigating and, when appropriate, taking necessary action against physicians who fail to meet local standards of medical care when issuing prescriptions through Internet web sites that dispense prescription medications;
(4) Work with the Federation of State Medical Boards and others in endorsing or developing model state legislation to establish limitations on Internet prescribing;

(5) Support the National Association of Boards of Pharmacy and support their Verified Internet Pharmacy Practice Sites program so that physicians and patients can easily identify legitimate Internet pharmacy practice sites;
(6) Work with federal and state regulatory bodies to close down Internet web sites of companies that are illegally promoting and distribution (selling) prescription drug products in the United States; and
(7) Keep pace with changes in technology by continually updating standards of practice on the Internet.

Authority Note: R206-99; reaffirmed R101-06; reaffirmed R303-07; reaffirmed R102-12; reaffirmed R103-17

Substitution (222)

222.01 Substitution - Generic Substitution by Pharmacists

The LSMS opposes the practice of generic substitution of drugs by a pharmacist except where the substitution has been authorized by the prescribing physician.

Authority Note: R41-79; amended R101-99; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

222.02 Substitution - Substitution of Biosimilar Medicines

The LSMS position is that physicians retain the authority to select the specific products their patients will receive and that automatic substitution of biosimilar medicines without the consent of the patient's treating physician should be prohibited. Also, the LSMS supports any state legislative proposal that allows physicians to continue to be the primary health care professionals who determine the biologic therapies most appropriate for their patients based on their own review of the clinical data and their own clinical judgment. Additionally, the LSMS opposes reimbursement restrictions that have the effect of forcing patients to switch from their physician-prescribed biologic therapies and supports legislation in Louisiana to clarify that substitution of drugs and biologics without treating physician consent should be prohibited.

Authority Note: R214-11; reaffirmed R101-16

PROFESSIONAL LIABILITY (230)

230.01 Professional Liability - Current Automobile Driver's Licensure

Physicians should be protected from civil liability for reporting, on medical grounds, potentially unsafe automobile drivers to the Louisiana State Department of Public Safety.

Authority Note: R33-88; amended R101-98; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

Duty to Warn (231)

231.01 Duty to Warn - Amendments to the Louisiana Sanitary Code

The LSMS supports the position that it is the responsibility of any individual having a reportable disease or condition diagnosed or reported by an attending, examining or prescribing physician to take reasonable measures to prevent spreading of the disease to others. A physician who has complied with the duty to report a case of a reportable disease or condition to the State Health Officer as specified in the Louisiana Sanitary Code should not be obligated to identify or warn unidentified cases or susceptible contacts of the patient. Additionally, complying with the duties of reporting a reportable disease or condition should not constitute a breach of patient confidentiality.

Authority Note: R205-12, 1st, 2nd and 3rd resolves; reaffirmed R104-17

Medical Expert Testimony (232)

232.01 Medical Expert Testimony - Rendering Opinions For Reports and Testimony to Third Parties

Preamble

The LSMS is dedicated to the highest standards of medical care for the patients of Louisiana. The LSMS recognizes there are appropriate requests made to members of the LSMS to comment to third parties about the cause of a disease process in a patient, the limitations that a disease process imposes on the patient, the care given to a patient by another health care provider, or other appropriate questions duly requested by authorized individuals. In these circumstances, the LSMS believes that the opinions rendered should comply with following The Professional Standards and Guidelines of Conduct and Accountability for Rendering Opinions in Reports and Testimony to Third Parties.

The physician who is called upon to render opinions to third parties has an ethical obligation to proceed with cautious deliberation. It is often difficult to judge the performance of another colleague, health care provider, or health care facility unless the physician approaches the evaluation in an honest and objective manner, and reviews relevant information.

The physician should avoid rendering opinions prior to reviewing relevant information and should not make implied agreements with third parties prior to a full examination of the relevant materials. Whenever possible the physician should require a written request by the third party outlining the scope and purpose of the evaluation and extent of opinions requested.

The physician should be mindful of the inherent bias in reviewing materials only provided by the requesting third party. The physician should request additional relevant information as necessary before rendering an expert opinion.

Advocacy and partisanship should be discouraged. While the physician may advocate a position which is supported by collateral sources of information after reviewing the available medical literature and scientific evidence, the physician should avoid taking on the role of the third party in advocating positions not supported in the medical literature or the available records.

It is ethical for a physician to charge an hourly fee to provide services to third parties. It is considered unethical to render opinions for a fee contingent on the outcome of the matter at issue.

The physician should avoid testifying in areas that are clearly outside of the physicians' area of expertise.

When rendering opinions concerning the standard of care the physician must be mindful that the standard applies to the time of the incident in question. Retrospective application of the present standard of care is not acceptable. The physician should also be mindful of the inherent hindsight bias which is pervasive in retrospective evaluations.

The physician should be mindful that many approaches to the provision of care are acceptable standards of practice. The care provided by a physician should be reasonable under the circumstances of the case under review. That physicians commonly have different but acceptable practice patterns must be taken into consideration when the physician analyzes information for third parties.

The physician must be mindful of the potential conflicts of interest in rendering opinions to third parties. If these conflicts could unduly bias the physician, then an opinion should not be rendered.

The physician should be mindful that purely self-serving, arbitrary and capricious opinions and testimony and failure to adhere to the guidelines set forth above may result in reprimands and/or sanctions by peer review organizations, professional societies, the LSMS, and the Board of Medical Examiners, as applicable. Physicians have an ethical obligation to report such behavior to the appropriate organization or board.

Authority Note: R127-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

232.02 Medical Expert Testimony - Qualifications of a Medical Expert Witness

The LSMS supports a legislative definition of the appropriate qualifications for a medical expert witness in actions for damages involving a claim of negligence against a physician. Such legislation should specify that in any claim of professional negligence against a physician, the court shall admit expert medical testimony as to the standard of care only from physicians who have actually practiced in the appropriate specialty on at least a half-lime basis during the past two years.

Authority Note: R107-92; reaffirmed R101-02; reaffirmed 101-07; reaffirmed R102-12; reaffirmed R105-17

232.03 Medical Expert Testimony - Immunity for Expert Witnesses

Louisiana statutes should provide immunity from civil and criminal liability for all physicians who provide expert testimony according to the ethical guidelines of the American Medical Association and the LSMS.

Authority Note: R215-93; reaffirmed 308-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

232.04 Medical Expert Testimony - Physicians' Testimony in Malpractice Trials

The LSMS opposes any state law which allows attorneys to mandate physicians to testify as to the standard of care in a medical malpractice case.

Authority Note: R216-96; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

Medical Malpractice (233)

233.01 Medical Malpractice - Tort Reform

The LSMS supports the enactment of legislation that will foster needed tort reforms to address the expanding burden of the current tort system, particularly the high transition costs of medical professional liability in Louisiana and across the nation.

Authority Note: R51-86; reaffirmed R101-03; reaffirmed sub R101-08; amended R114-10 last bullet; reaffirmed as amended R101-15

233.02 Medical Malpractice - Establish the Authority to Limit Damages

The LSMS supports appropriate legislative initiatives which seek further solidify the established authority of the legislature to limit damages for medical malpractice awards.

Authority Note: R207-08; reaffirmed as amended R101-15

233.03 Medical Malpractice - Limitations on Malpractice Recovery

The LSMS is committed to preserving a total cap on medical professional liability damage awards paid by or on behalf of health care providers in Louisiana and supports other changes in the medical professional liability statutes that enhance affordability and availability of medical professional liability insurance.

Authority Note: R203-01; amended R102-06; amended R207-08; reaffirmed R201-13; reaffirmed R101-18

233.04 Medical Malpractice - Solidary Liability

The LSMS believes that in matters of tort litigation each tortfeasor shall pay only for the portion of the damage that he/she has caused, and the tortfeasor shall not be solidarily liable with any other person for damages attributable to the fault of that person. The LSMS opposes any attempt to reinstitute solidary liability in Louisiana.

Authority Note: R101-05; reaffirmed R101-15

233.05 Medical Malpractice - Opposition to Safe Harbor Defense in Medical Professional Liability

The LSMS is opposed to the use of safe harbor defenses, wherein guidelines are purported to be accepted as the standard of care, in matters pertaining to medical professional liability.

Authority Note: R112-13; reaffirmed R101-18

233.06 Medical Malpractice - Guidelines for Malpractice Case Review by Physicians

LA. R. S. 40:1299.47 details the procedure physicians must follow during participation in a medical review panel. Appropriate opinions and decisions rendered shall be based upon objective medical information and clinical experience. Physicians must participate in an open minded and conscientious manner.

Authority Note: R74-89; amended R404-2000; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

233.07 Medical Malpractice - Loser Pays Rule in Civil Litigation

The LSMS supports a loser pays rule in civil litigation.

Authority Note: R208-04; reaffirmed R101-10; reaffirmed R101-15; reaffirmed R102-15

233.08 Medical Malpractice - Penalties for Frivolous Malpractice Suits

The LSMS supports the imposition of penalties applied to an individual plaintiff or an attorney and his or her client who files a medical malpractice action without merit against a physician licensed to practice medicine in Louisiana.

Authority Note: R34-86; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

233.09 Medical Malpractice - Contingency Fee System

The LSMS supports revision of the contingency fee system in medical professional liability suits so that a graduated scale of attorney fees, consistent with reforms passed in other states, be applied to any liability settlements or awards.

Authority Note: R31-86; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

PUBLIC HEALTH (240)

240.01 Public Health - Louisiana Poison Control Center

The LSMS endorses funding for a poison control center within the state or contract with a regional national center which allows access to vital public safety information by hospitals, physicians and the public.

Authority Note: R68-89; amended R101-99; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

Children and Youth (241)

241.01 Children and Youth - Child Death Review Panel

The LSMS supports the Child Death Review Panel and mandated funding for and access to the services of Forensic Pathologists where necessary for the death scene investigation and autopsies for unexpected deaths in infants and children. The LSMS supports appropriate and timely exchange of information concerning child deaths between medical, social services and law enforcement agencies, supports the Child Death Review Panel having access to the Office of Community Service files and recommendations, through the amendment of Louisiana's Children's Code, Article 615, if necessary, and supports the establishment of DHH regional Child Death Review Panels in order to expedite the timely investigation of unexpected child deaths.

Editorial Note: Also see Public Health (240)
Authority Note: R210-97; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

241.02 Children and Youth - School-Based Health Programs

The LSMS recognizes the need for and urges the development of comprehensive school based health clinics to address the health needs of our youth including, but not limited to, the prevention of drug abuse, AIDS, sexually transmitted diseases, and unintended pregnancy. The LSMS supports enhanced funding of health clinics in junior/senior high schools specifically to provide resource information upon student request.

Authority Note: R39-90; reaffirmed R101-2000; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

241.03 Children and Youth - Evaluation and Treatment of Handicapped Children

Child and adolescent psychiatrists should be included by the State Department of Education and made part of the Competent Authority Team for program planning, evaluation and treatment of handicapped youngsters under PL 94-142 and PL 99-457.

Authority Note: R42-90; reaffirmed R101-2000; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

241.04 Children and Youth - Exposure of Pornography to Children and Adolescents

The LSMS opposes the exposure to children and teens of pornography in print and visual media and encourages component societies and specialty societies to educate and warn the public of the dangers of exposing children and teens to pornography.

Authority Note: R216-92; Reaffirmed R101-02; reaffirmed R101-07; reaffirmed R101-12; reaffirmed R104-17

241.05 Children and Youth - Standards for Child Care Institutions

The LSMS supports a mandate for child care standards in all child care institutions and the immediate closure of those institutions found to be in violation of these standards.

Authority Note: R54-84; reaffirmed R101-03;and sub R101-08; reaffirmed R102-13; reaffirmed R101-18

241.06 Children and Youth - Regional SIDS Centers

The LSMS supports the development of research, management and support services for apnea/SIDS cases in Louisiana.

Authority Note: R306-96; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

241.07 Children and Youth - Standardization of Child Health Certificate

The LSMS supports the development of a standardized Child Health Certificate for children attending day care centers, elementary, middle or high schools and a process for updating the Certificate. All day care centers, elementary, middle or high schools be required to use the most recent standardized Child Health Certificate, and all previous versions be abandoned.

Authority Note: R207-03; reaffirmed sub R101-08; reaffirmed R102-13; reaffirmed R101-18

Environmental Health (242)

242.01 Environmental Health - UV Tanning

The LSMS supports the FDA warning that UVA tanning booths and sunbeds pose potential significant health risks and should be discouraged. The LSMS endorses an educational campaign regarding the skin health and aging hazards of UVA overexposure, in particular from tanning parlor facilities.

The LSMS opposes the use of indoor tanning devices by minors as devices emit UVA and UVB radiation and because overexposure to UV radiation can lead to the development of skin cancer.

Authority Note: R36-89; reaffirmed 1999; reaffirmed R101-06; reaffirmed R101-11; amended R301-14

242.02 Environmental Health – Recycling

The LSMS supports safe and healthy recycling techniques in the management of municipal and personal waste and encourages component medical societies and individual physicians to become informed and participate in the establishment of community recycling programs.

Authority Note: R35-90; reaffirmed R101-2000; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

242.03 Environmental Health - Disposal of Toxic Waste

The LSMS urges the Louisiana Department of Environmental Quality (DEQ), in evaluating applications for discharge permits, to undertake a full analysis of the health effects of potential toxic discharges and subject it to public review as a part of the decision-making process. The LSMS supports the principle of interagency technical review, information sharing, and negotiation as embodied in the DEQ Gypsum Task Force process.

The LSMS supports the elimination of toxic waste products being disseminated into the environment and, through a system of fines for offenders, begin to reduce unacceptable high levels of pollution and toxic waste which pose a significant health hazard to Louisiana residents.

Authority Note: R53-89; reaffirmed 1999; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

Immunizations (243)

243.01 Immunizations - Childhood Immunizations

The LSMS endorses the continued immunization of all children as recommended by the medically-accepted guidelines of the American Academy of Pediatrics, and/or the Advisory Committee on Immunization Practices and opposes any state or federal legislation which may eliminate and/or alter the schedule of immunization of children as recommended by these guidelines.

Authority Note: R302-99; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

243.02 Immunizations – Annual Vaccinations

The LSMS supports the annual administration of vaccines recommended by the Centers for Disease Control and/or the American Academy of Pediatrics. The Secretary of the Louisiana Department of Health and Hospitals should arrange for adequate funding to administer the vaccine in public health clinics. LSMS supports the requirement for all students entering school to have the required vaccines in accordance with State Health Department approved schedule.

Authority Note: R70-90; reaffirmed R101-04; reaffirmed R101-11, reaffirmed as amended R103-15

243.03 Immunizations - Influenza Vaccine for Health Care Workers

The LSMS supports the annual vaccination of health care providers, per CDC guidelines, as a public health measure to protect patients and reduce the spread of disease.

Authority Note: R308-04; reaffirmed R101-10, reaffirmed as amended R103-15

243.04 Immunizations - Varicella and Hepatitis A Vaccines

The LSMS supports efforts to make the vaccines for varicella and hepatitis A available to the population of the state for whom receipt of the vaccines are medically recommended and indicated.

Authority Note: R304-95; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

243.05 Immunizations - Louisiana Immunization Networks for Kids Statewide (LINKS)

The LSMS supports the Louisiana Immunization Networks for Kids Statewide (LINKS) and supports initiatives which seek to:

(1)Achieve consistency between state and federal guidelines for the appropriate timing of vaccine administration.

(2)Develop methods which are secure and simple to correct errors in patient records.

(3)Expand reporting requirements for the LINK system to include all entities that administer vaccines to children.

Authority Note: R103-15

Obesity (244)

244.01 Obesity - Contending with Obesity

The LSMS supports school-based and community programs targeting control of obesity, such as the use of Body Mass Index (BMI) measurements or the use of other generally medically accepted parameters at appropriate ages, with results of the BMI and/or other generally medically accepted parameter be made known to patients and/or the parents or guardians of children with recommendations for referral to medical specialists when and if appropriate.

Authority Note: R210-10, 1st resolve; reaffirmed R103-15, amended and reaffirmed R302-18

244.02 Obesity - Nutritional Labeling

It is LSMS policy to seek and/or support legislation or regulation to require restaurants with 50 or more locations nationally to provide nutritional and calorie information for their standard menu items offered on a regular or ongoing basis.

Authority Note: R206-11; reaffirmed R101-16

244.03 Obesity – Intervention Funding

The LSMS encourages professional, business and the private sector to assist in the creation of a funding source for the state of Louisiana to pay for medications and other nonsurgical interventions in the management of obesity.

Authority Note: R304-17

Public Health Education (245)

245.01 Public Health Education - Patient Education for Home Disposal of Sharps

The LSMS urges physician education of their patients, who use syringes and needles in their homes for self-treatment of illnesses such as diabetes mellitus, about the proper use of safe, puncture-resistant containers for disposal of used injection devices and the disaffection of those sharps.
Authority Note: R40-90; reaffirmed R101-2000; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

245.02 Public Health Education - Sex Education in the Schools

The LSMS supports age appropriate sex education in schools.

Authority Note: R22-89; amended R101-99; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

245.03 Public Health Education – Distribution of Condoms in Public Schools

The LSMS supports local school boards to have the option as to whether condoms can be distributed in public schools. The LSMS believes that the most reliable ways to avoid STD transmission is to abstain from sexual activity. Furthermore, although condom use cannot provide absolute protection, we agree with the CDC that consistent and correct condom use does reduce the risk of STD and HIV transmission.

Authority Note: R210-94;reaffirmed R101-04; reaffirmed SubR102-10; reaffirmed as amended R103-15

SCOPE OF PRACTICE (250)

250.01 Scope of Practice - Expansion of Scope of Practice

It is the policy of the LSMS that the independent practice of medicine is to be reserved for licensed physicians and that non-physicians should only deliver care under the supervision and leadership of licensed physicians. In accordance with its Mission Statement when matters of treatment, diagnosis, patient safety, and quality of care regarding allied health professionals are introduced in the Louisiana legislature, the Council on Legislation is empowered to negotiate the best possible position for the citizens of Louisiana consistent with the following guidelines:

(1) Physicians licensed to practice medicine in the state of Louisiana should be the director of any health system team or team health approach to patient care and be immediately available for onsite consultation and held accountable for all actions thereof.

(2) Whenever prescriptive authority is involved, physicians licensed to practice medicine in the state of Louisiana are the controlling authority for said prescribing practices.

(3) As long as a bill remains active in a legislative session, the Council on Legislation may alter its initial position on the legislation taking into account the practical and political realities existing at any point in time in the legislative process, in consultation and agreement to an emergency vote of the majority of the Council on Legislation members.

(4) Expansion of the scope of practice by a non-physician practitioner should be regulated and controlled through the Louisiana State Board of Medical Examiners when such expansion of the scope of practice would otherwise constitute the practice of medicine.

Authority Note: R205-04; reaffirmed R101-10; reaffirmed as amended 213-12; reaffirmed as amended R106-13/R202-13; reaffirmed R101-15

250.02 Scope of Practice - Scope of Practice for PhD Nurse Practitioners (Nurse Doctors)

The LSMS opposes the use of the title of “doctor” by people holding a doctoral degree in any nursing related field of nurse practitioners in both an out-patient and in-patient setting as it may be confused by patients to mean or be equivalent of “physician.” It is also the policy of the LSMS to advocate strongly against any proposed legislative or administrative expansion of the scope of practice by people holding a doctoral degree in any nursing related field of nurse practitioners to practice medicine independently that is not approved by the Louisiana State Board of Medical Examiners and not in accordance with LSMS Policy 250.01.

Authority Note: R111-13; reaffirmed R101-18

250.03 Scope of Practice - Physician Assistant Scope of Practice

The LSMS upholds the authority of the Louisiana State Board of Medical Examiners as the official credentialing body for physician assistants in the state of Louisiana.

Authority Note: Approved as Action of the BOG 2011; reaffirmed as policy HOD 2012; reaffirmed as amended R105-17

250.04 Scope of Practice - Unsupervised Non-Health Care Personnel

The LSMS supports the establishment of standards to protect the public against potential harm from the performance of medical procedures in salons, health clubs and spas including but not limited to chemical peels, microdermabrasion and/or laser treatments by unsupervised non-health care personnel.

Authority Note: R224-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

250.05 Scope of Practice - Employing Ancillary Personnel

The LSMS believes it is a right for a physician to employ ancillary personnel that enhance and are a direct extension of physician’s specialty and practice.

Authority Note: R406-04; reaffirmed R101-10; reaffirmed as amended R101-15

250.06 Scope of Practice - Certification/Recertification of Skilled Care or Therapy Services

CMS policy should prohibit any physician, other than the attending physician or consulting physician, from certifying or recertifying either skilled level of care and/or therapy services, except in an emergency.

Authority Note: R225-97; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

250.07 Scope of Practice - Naturopathic Physicians

The LSMS opposes the licensing of Naturopathic Doctors to practice naturopathic medicine in Louisiana. In the event Naturopathic Doctors are authorized to be licensed in Louisiana the LSMS advocates they be licensed and regulated by the Louisiana State Board of Medical Examiners.

Authority Note: R207-06; reaffirmed R101-11; reaffirmed R101-16

250.08 Scope of Practice - Laser Surgery

Laser surgery should be performed only by individuals licensed to practice medicine and surgery.

Authority Note: R72-91; reaffirmed R101-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

250.09 Scope of Practice - Pain Management

Interventional pain management is considered to be the practice of medicine.

Authority Note: R105-06; reaffirmed R101-11; reaffirmed R101-16

250.10 Scope of Practice - Anesthesia Care

Anesthesia care administered to patients by nurse anesthetists in state-accredited hospitals, ambulatory care centers, and other health care facilities should be supervised by anesthesiologists when one is available.

Authority Note: R17-87; reaffirmed R101-97; reaffirmed R101-06; reaffirmed R101-11a; reaffirmed R101-16

SURGERY (260)

260.01 Surgery - Postoperative Care

The surgeon performing the surgery, or another MD with appropriate skills, should provide the surgical postoperative care.

Authority Note: R3-89; amended R101-99; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

TAXES (270)

270.01 Taxes - Sales and Use Tax

No sales and/or use tax should be applied to any materials, including but not limited to prescription drugs and vaccines, that are provided to a patient in a physician's office relating directly to the treatment of a patient.

Authority Note: R130-02; reaffirmed R101-07; reaffirmed R102-12; reaffirmed R102-15

TOBACCO (280)

280.01 Tobacco - Tobacco-Free Society

The LSMS supports the goal of a tobacco-free society.

Authority Note: R41-88; amended R101-98; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

280.02 Tobacco - Statewide Smoking Ban

The LSMS supports a statewide ban on smoking in all restaurants, bars and casinos.

Authority Note: R301-12; reaffirmed R104-17

280.03 Tobacco - No Smoking in Public Places

The LSMS opposes smoking in public places or public meetings except in designated smoking areas. Smoking areas should not be designated in places prohibited by the fire marshal or by other law, ordinance or regulation and smoking be restricted in all Louisiana hospital and state office buildings, including the state Capitol.

Authority Note: R64-89; reaffirmed 1999 and R25-1984; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R102-13; reaffirmed R101-18

280.04 Tobacco - Smoke-Free Work Environment

Employers should be required to provide a work environment reasonably free of recognizable hazards and to protect employees from avoidable perils, specifically with respect to smoking and the work environment.

Authority Note: R42-88; reaffirmed R62-89; R101-99; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

280.05 Tobacco - No Smoking in Health Facilities

There should be no cigarette machines in any health facility in Louisiana and no smoking signs be installed in all health facilities and physicians' offices of the state.

Editorial Note: Also see Health Care Facilities (90)
Authority Note: R20-89; amended R101-99; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

280.06 Tobacco - Smoking Policy for Public Elementary and Secondary Schools

The LSMS supports the prohibition of the use of tobacco products by students in public elementary and secondary schools. Public school officials should allow smoking by teachers and staff in designated smoking areas only. The LSMS urges the Louisiana State Department of Education to adopt a statewide curriculum which would include instruction in the health hazards inherent in smoking as well as the use of smokeless tobacco.

Authority Note: R39-88; reaffirmed 1998; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

280.07 Tobacco - Smoking at LSMS Meetings

Smoking is prohibited at all LSMS meetings.

Authority Note: R25-1984; reaffirmed R101-03; reaffirmed sub R101-08, reaffirmed R103-15

280.08 Tobacco - Opposition to the Tobacco Industry

The LSMS is opposed to the tobacco industry in its production, distribution and advertising of addictive tobacco products. The LSMS condemns the intense efforts of the tobacco industry to thwart any attempt to protect the public from tobacco and its related illnesses.

Authority Note: R403-94; reaffirmed R101-04; reaffirmed R101-10; reaffirmed R103-15

280.09 Tobacco - Sale of Tobacco Products to Minors

The sale of tobacco products to anyone under the age of twenty-one (21) should be prohibited by state law.

Authority Note: R70-91; reaffirmed R101-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16; amended R401-16

280.10 Tobacco - Sale of Tobacco Products on all Charity Hospital Properties

The Department of Health and Hospitals should prohibit the sale of tobacco products on all Louisiana Charity acute care general hospital properties. The LSMS urges each Charity Hospital Administrator and Medical Director and local Louisiana Health Care Authority Board to adopt new agreements with the Randolph Sheppard Vending Program to prohibit the sale of tobacco products on hospital property.

Authority Note: R26-91; reaffirmed R101-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

280.11 Tobacco - Increased Tax on Cigarettes

The LSMS supports an increase in the state excise tax on tobacco products.

Editorial Note: See also Taxes (270)
Authority Note: R23-90; amended R101-2000; reaffirmed R101-06; reaffirmed R101-11; amended by R407-14

280.12 Tobacco - Nicotine Addiction

The LSMS believes that it is imperative to educate its members on the need to appropriately diagnose nicotine addiction and ensure, through appropriate regulatory agencies, that third party payers provide payment for the treatment of nicotine abuse and/or addiction which is on parity with other mental and physical conditions.

Authority Note: R405-94; reaffirmed R101-04; reaffirmed R101-10; reaffirmed as amended R103-15

WOMEN'S HEALTH (290)

290.01 Women's Health - Elective Deliveries Prior to 39 Weeks

The LSMS supports the policy of ending elective non-medically indicated inductions and elective non-medically indicated C-sections prior to 39 weeks in physician practice and community settings.

Authority Note: R301-11; reaffirmed as amended R201-13; reaffirmed R101-18

290.02 Women's Health - Performance Standards for Mammography

No mammogram should be performed without a concurrent history and physical breast examination by a licensed physician.

Authority Note: R9-89; reaffirmed R101-99; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

290.03 Women's Health - Screening Mammography for Indigent Women

The LSMS supports the acquisition of dedicated mammogram machines and sufficient staff for the state hospitals.

Editorial Note: Also see Indigent & Uninsured (130)
Authority Note: R28-91; reaffirmed R101-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

290.04 Women's Health - Insurance Coverage for Screening Mammography

The insurance industry should be required to provide insurance coverage to their individual and group policyholders for routine mammography examination in accordance with the recommendations of the American Cancer Society.

Editorial Note: Also see Health Insurance (120)
Authority Note: R11-91; reaffirmed R101-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16

290.05 Women's Health - Mammography Screening in Asymptomatic Women

The LSMS endorses the position of the AMA and other medical organizations to recommend mammograms and clinical breast examinations at one year intervals in asymptomatic women, age 40 and older. The LSMS encourages quality control efforts to assure high quality, low-dose mammography, evidenced by accreditation of each facility by organizations such as the American College of Radiology or others with comparable programs.

Authority Note: R58-89; amended R303-99; reaffirmed R101-06; reaffirmed R101-11; reaffirmed R101-16

290.06 Women's Health - Safety and Performance Standards for Mammography

All physicians in the state who are performing mammography follow the basic requirements and guidelines as set forth by the American College of Radiology.

Authority Note: R116-92; reaffirmed R101-02; reaffirmed R101-07; reaffirmed R102-12; reaffirmed R104-17

Appendix A

AMA Policy H-450.947

PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.
2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.
3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.
4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.
5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

<u>Quality of Care</u>

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.

- Evidence-based quality of care measures must be the primary measures used in any program.
1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.
2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
4. Performance measures should be scored against both absolute values and relative improvement in those values.
5. Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities.
6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
7. Performance measures must be selected for clinical areas that have significant promise for improvement.

- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.

- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.

- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.

- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.

- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.

- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.

- Programs must not create conditions that limit access to improved care.
1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-

economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.
2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).

- Programs must neither directly nor indirectly encourage patient de-selection.

- Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

Physician Participation

- Physician participation in any PFP program must be completely voluntary.

- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.

- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.

- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.

- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
1. Programs should provide physicians with tools to facilitate participation.
2. Programs should be designed to minimize financial and technological barriers to physician participation.

- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.

- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.

- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.

- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).

- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.
1. Programs should use accurate administrative data and data abstracted from medical records.
2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.

- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.

- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.

- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.
1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.
2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.

- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.

- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards

- Programs must be based on rewards and not on penalties.

- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.

- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.

- Programs must finance bonus payments based on specified performance measures with supplemental funds.

- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.

- Programs must not reward physicians based on ranking compared with other physicians in the program.

- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.

- Programs must not financially penalize physicians based on factors outside of the physician's control.

- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.

- Programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.

2. Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance."

Appendix B