THE MEDICAL SOCIETY OF VIRGINIA

2019-2020 POLICY COMPENDIUM

THE MEDICAL SOCIETY OF VIRGINIA

UPDATED 2019-2020 POLICY COMPENDIUM

TABLE OF CONTENTS

05 Professionalism 17

Disciplinary Procedure 17

05.1.01- Board of Medicine Sanctions 17

Gifts and Industry Funding 17

05.2.01- Gifts to Physicians 17

05.2.02- Industry Funding and Support 17

Leadership 18

05.3.01- Physician Members 18

Patient Care 19

05.4.01- Access without Discrimination 19

05.4.02- MSV Opinion on Treatment of Family Members 19

05.4.03- Continuity of Care 19

05.4.04- Organ Harvesting Without Consent 19

05.4.05 – Organ Donation as an Opt-Out Program 20

Physician Wellness and Safety 20

05.5.01- Dissemination of Inflammatory Information 20

05.5.02 Non Peaceful Protests 20

05.5.03 - House Staff Depression 21

05.5.04- Burnout and Suicide Prevention 21

05.5.05- Medical Practitioner Drug Addiction Guidelines 21

Professional Title 21

05.6.01- Use of "Physician" 21

05.6.02 - Use of Title “Dr.” 22

10 Insurance 22

Benefits and Coverage 22

10.1.01 - Review Policies of Insurance Companies 22

10.1.02- Information on Health Care Plans to Patients 23
10.1.03- Transfer of Medical Care 23
10.1.04- Post-Delivery Care for Mothers and Newborns 23
10.1.05- Secondary Insurance Pre-Certification and Reimbursement 23
10.1.06- Screening for Breast Cancer 24
10.1.07- Breast Cancer/Insurance Coverage of Screening Mammography 24
10.1.08- Off Label Use of Drugs or Devices 24
10.1.09- Prostate Cancer Screening 25
10.1.10- Newborn Hearing Screenings 25
10.1.11- Mental Health Parity 25
10.1.12 - Coverage of Medical Formulas and Foods for Medicaid Patients Suffering from PKU 25
10.1.13- Insurance Coverage for Surgical and Medical Treatment of Obesity and Morbid Obesity 26
10.1.14- Health Plan Liability 26
10.1.15- Improve Obesity Medicare & Insurance Coverage 26
10.1.16- Medical Necessity Criteria 27
10.1.17- Reimbursement for Emergent Medical Care 27
10.1.18- Insurance Coverage for Medical Conditions 27
Children's Health Insurance 27
10.2.01- Children's Health Insurance Issues 28
Insurance System and Markets 28
10.3.02- Single Payer System 28
10.3.03- Catastrophic Care 28
10.3.04- Fair Market Competition/Systems 28
10.3.05- Federal Regulation of Private System 29
10.3.06- Freedom of Choice - Patients and Physicians 29
10.3.07- Patient Choice of Hospital 29
10.3.08- Free-Market 29
10.3.09- Opposition to Preferential Treatment 30
10.3.10- Same Rules for Competitors 30
10.3.11- Tax Fairness 30

10.3.12- Use of Medicine/Business Coalitions/Reform 30
10.3.13- Point of Service Option 31
10.3.14- Medical Savings Accounts 31
10.3.15- Low Cost Insurance Product 31
10.3.16 - Third Party Payer Fair Business Practice Principles 31
10.3.17- Guidelines for Health Care System Reform 33
10.3.18- Withdrawal of Insurance Providers from the ACA and Individual Marketplace 35
10.3.19 Establishment of a Reinsurance Program 35
10.3.20 Regulate and License Pharmacy Benefit Managers Who Serve Virginians 35
Managed Care 35
10.4.01- Managed Care and Patient Choice 35
10.4.02- Closed Panel HMOs 36
10.5.03- Principles of Managed Care 36
10.5.04- Balance Billing 41
Medicaid 42
10.6.01- Increased Reimbursement; Underserved Areas 42
10.6.02- 60 Day Recertification of Medicaid Patients 42
10.6.03- Increased Reimbursement 43
10.6.04- Medicaid Cuts 43
10.6.05- Funding for Medicaid 43
10.6.06- RBRVS for Medicaid and FAMIS Pediatric Reimbursement in Virginia 43
10.6.07- Expand Medicaid under the ACA 44
10.6.08- Medicaid Reform for Adults Receiving Social Security Disability Income 44
10.6.09 Opposing Work Requirements for Virginia Medicaid Eligibility 44
Medicare 44
10.7.01- Increased Reimbursement; Underserved Areas 44
10.7.02- Extrapolation of Medicare Chart Audits and Post-Audit Refunds 44
10.7.03- Medicare Carrier Advisory Committee 45
10.7.04- Inequitable Reimbursement of Primary Care Physicians under RBRVS 45
10.7.05- Medicare Private Contracting 45

10.7.06- Payment for Physician Surgical Assistants 46
10.7.07- Medicare Fees 46
10.7.08- Medicare Reimbursement for Medication 46
10.7.09- Medicare Surety Bonds 46
10.7.10- Medicare Prescription Drug Benefits 46
Physician Participation in Health Plans 47
10.8.01- The Credentialing of Physicians by Insurance Companies and Other Third Parties and Competition in the Health Care Market Place 47
10.8.02- Removal of Physicians from Insurance Plans "Without Cause" 47
10.8.03- Any Willing Provider 47
10.8.04- Physician Re-Credentialing by Managed Care Plans 48
10.8.05- Plan Expulsion and Licensure Board Discipline 48
10.8.06- Physician Hospital Admitting Privileges and Plan Participation 48
Reimbursement and Claims 48
10.9.01- Equal Reimbursement for Urban and Rural Areas 49
10.9.02- Home Health Agencies 49
10.9.03- Reimbursement of Rural Practitioners 49
10.9.04- Insurance Market Reform 49
10.9.05- Fee Guidelines 50
10.9.06- Timely Insurance Claims Payment 50
10.9.07- Billing for Uncovered Care 51
10.9.08– Capitation 51
10.9.09- Nondiscriminatory Reimbursement 52
10.9.10- Third Party Payer Retroactive Denials 52
10.9.11- Most Favored Nation Clauses 52
10.9.12- Worker’s Compensation Reimbursement 52
10.9.13- Assignment of Benefits 53
10.9.14- Pay for Performance 53
10.9.15- Payment with Remittance Advice 53

10.9.16- Reimbursement of Telemedicine and Disclosure of Ownership Interests in Telemedicine Companies 53
10.9.17- Payment for Surgical Procedures 54
10.9.18- Physician Reimbursement for Electronic Services 54
10.9.19- Reimbursement for Mandated Medical Services 54
10.9.19 Uninsured Payment Protection 55
10.9.20 Investigation into Healthcare Insurance Copay Accumulator Programs 55
10.9.21 Bill Submission Timelines 55
Utilization Management 55
10.10.01- Financial Incentives/Under or Overutilization 55
10.10.02- Medical Utilization Review 56
10.10.03- Improve Step Therapy in Virginia 56
10.10.04- Improve Upon the Current Prior Authorization Law in the State of Virginia 56
10.10.05- Opposing Health Plans Restricting Medically Necessary Care 57
10.10.06 Prior Authorization Retroactive Denials 57
15 Liability 57
Immunity 57
15.1.01 - Expand Immunity Laws Covering Voluntary Physician Services 58
15.1.02- Physician Reporting to DMV; Immunity 58
15.1.03- Revision of "Good Samaritan" Statutes for Team Physicians 58
Legal Proceedings 58
15.2.01- Confidentiality in Legal Proceedings 58
15.2.02- Malpractice Review Panels 59
15.2.03- Strengthen Good Samaritan Laws 59
15.2.04- Physician-Patient Privilege 59
15.2.06- Malpractice Review Panels-Participation 60
15.2.07- Tort Reform 60
Malpractice 61
15.3.01- Solo Practice/Liability/Medical Review 61
15.3.02 - Medical Malpractice Cap on Damages 62

15.3.03- Malpractice Coverage for Operational Medical Directors 62
15.3.04- Availability of Insurance 62
15.3.05- Premium Discounts as Incentive for Panel Service 63
15.3.06- Statute of Limitations 63
15.3.07- Medical Insurance Payment Guidelines and the Standard of Care 63
Peer Review 63
15.4.01- Peer Review of Disputed Physician Fees 64
15.4.02- Peer Review of Utilization 64
15.4.03- Peer Review 64
20 Medical Education Policies 64
Continuing Medical Education 65
20.1.01 - Continuing Medical Education 65
20.1.02- Reducing Medical Errors 65
20.1.03- Opioid Prescribing Education 65
20.1.04– Policy on Continuing Board Certification (MOC) 66
20.1.05- AMA Potential Resolution: I-17 Fees For Taking Maintenance of Certification Examination 72
Graduate Medical Education and Residency Training 73
20.2.01- Graduate Medical Education Funding and Residency Slots 73
20.2.02- Increased Funding for Residency Training 73
20.2.03 Virginia Medical Clerkship Support 73
Medical Education Funding 73
20.3.03- Medical Education Funding 74
Medical School Curriculum 74
20.4.01- Expansion of Primary Care Departments/Medical Schools 74
20.4.02- Teaching of Basics of Dispute Resolution 74
20.4.03- The Hippocratic Oath 75
20.4.04- Evaluating the Effectiveness of the Step 2 Clinical Skills Exam 75
Medical Student Loans and Debt 75
20.5.01- Medical Student Loans and Debt 75

25 Ethics 75

Abortion and Reproductive Decision Making 75

25.1.01 – Opposition to Title X Prohibition on Abortion Counseling or Referral 76

25.1.02- Opposition to Criminalization of Reproductive Decision Making 76

25.1.03- Support of Expansion of Access to Long Acting Reversible Contraception (LARC) 76

25.1.04 – Opposing Legislative Efforts to Restrict the Provision of Reproductive Healthcare 76

End of Life Care 77

25.2.01- Ethics of Refusing to Provide Futile Care 77

25.2.02- Futile Care/Consultation with Ethics Committees 77

25.2.03- Disagreements Regarding Treatment of the Terminally Ill 77

25.2.04- Physician Assisted Suicide and Euthanasia 78

25.2.05- Advocacy for Physician Orders for Scope of Treatment 78

25.2.06- Treatment of Dying Patients 79

25.2.07- Do Not Resuscitate Orders 79

Patient-Physician Relationship 79

25.3.01- Opposition to Restraining Appropriate Use of Services 79

25.3.02- Legislation, Standards of Care and the Patient/Physician Relationship 80

25.3.03- Establishing a Physician-Patient Relationship via Telemedicine 80

25.3.04- Patient-Physician Communication 81

Clinical Research 81

25.4.01- Animal Research 81

Prohibited Practices 81

25.5.01 Prohibiting Conversion Therapy in Those Under Age 18 81

Equity 81

25.6.01 American “Equal Rights Amendment” 81

25.6.02 Advancing Gender Equity in Medicine 82

30 Business 83

Coding, Reimbursement, and Payment 83

30.1.01 - Right of Physicians to Negotiate Medical Cost and Utilization 83

30.1.02- Workers’ Compensation: Collection of Attorneys’ Fees 83

30.1.03- Responsible Party 84
30.1.04- Coding/Reimbursement for Mental Health Services 84
Licensure, Credentialing, and Privileges 84
30.2.01- Economic Credentialing 84
30.2.02- Economic Credentialing Criteria 85
30.2.03- Encouragement of Open Hospital Medical Staffs 85
30.2.04- Medical License Linkage with Medicare/ Medicaid Participants 86
30.2.05- Medical License Linkage to Hospital ER Call 86
30.2.06- Interstate Licensure Compact in Virginia 86
Mandates on Physician Practice 86
30.3.01- Harassment 86
30.3.02- Federal Regulations 87
30.3.03- Hospital Staff Privileges 87
30.3.04- Physician's Freedom of Choice 87
30.3.05- Release Form Information 87
30.3.06- Prohibition of Nondisclosure Clauses 88
Practice Rights and Assistance 88
30.4.01- Assistance with New Practice Expenses 88
30.4.02- Use of Employees; Transmit Orders 88
30.4.03- Physician Determination of Length of Stay 88
30.4.04- MSV COPN Policy 89
30.4.05- Physician & Medical Staff Bill of Rights 89
30.4.06- Remove Restrictive Covenants for Healthcare Providers in Virginia 89
30.4.07 – Stopping Robocalls in Virginia 89
Quality Practice Programs 89
30.5.01- Quality Assurance Bodies 89
30.5.02- Patient Centered Medical Home 90
Taxes and Fees 90
30.6.01- Opposition to Provider Tax 90
30.6.02- Liens for Hospital and Medical Services 90

30.6.03- Administrative Fees in Medical Offices 91
30.6.04- "Not-for-Profit" Tax Status under PPACA 91
30.6.05- Business, Professional and Occupational License (BPOL) Tax 91
Technology, Data, and Information Sharing 91
30.7.01- State Funding for Electronic Health Information Systems 91
30.7.02- Truth in Virginia Health Care Database 92
30.7.03- Physician Profiles and Health Care Data Collection 92
30.7.04- Physician Profiling 93
30.7.05- Electronic Prescribing 94
30.7.06- Electronic Medical Record Mutual Interaction 94
30.7.07- One Web Portal for State Databases 94
30.7.08- Requests for Patient Information 94
30.7.09- De-Identified Aggregate Patient Health Data 94
30.7.10- Physician Participation in Efforts to Control Healthcare Costs 95
30.7.11- Telemedicine Records 95
30.7.12- E-Prescribing Of Schedule II Medications 95
35 Prescription Drug Policies 96
Controlled Substances 96
35.1.01 - Urine Collection 96
35.1.02 - Access to PMP Data for Law Enforcement 96
Dispensing of Prescriptions 96
35.2.01- Questionable Activities of Certain Pharmaceutical Manufacturers 97
35.2.02- Mailing of Controlled Drug Samples 97
35.2.03- Physician Dispensing 97
35.3.04- Listing of Generic and Proprietary Medications when substituted 97
35.3.05- Virginia Inpatient Pharmacies Being Able to Dispense Outpatient Medications 98
35.3.06- Reasonable Price Control for Prescription Medications 98
Guidelines for Prescriptions 98
35.4.01- Therapeutic Substitution-ACP position 98
35.4.02- Guidelines for Prescriptions 99

Marketing of Prescription Drugs 100
35.5.01- Curtail Direct Consumer Advertising of Prescription Drugs 100
40 Public Health 102
Access to Care 102
40.1.01- Cooperation with Local Health Departments 103
40.1.02- Involvement of Local Businesses 103
40.1.03- Local Plans 103
40.1.04- Medically Underserved Areas 103
40.1.05- Rural Health Transportation 104
40.1.06- Tax Credits for Services to the Uninsured 104
40.1.07- Providing Better Access to Primary Care in Federally Designated Health Professional Shortage Areas 104
40.1.08- Improve Physician Placement 104
40.1.09- Programs to Maintain Elderly Patients in Home Environment 105
40.1.10- Community Adult Day Care 105
40.1.11- Free Clinics 105
40.1.12- Improve Access to Prescription Drugs for the Uninsured 106
40.1.13 - Emergency Department On-Call Physicians 106
40.1.14- Support for Project Access Programs 106
Addiction Prevention and Treatment 107
40.2.01- Addiction in Children 107
40.2.02- Sales Tax Increase for Alcohol 107
40.2.03- Reporting/Substance Abuse 107
40.2.04 - “Good Samaritan” Protection for Overdose Witness 108
40.2.05 Expansion of Drug Takeback Programs 108
AEDs 108
40.3.01- AEDs for Police First Responders 108
Antimicrobial Resistance 108
40.4.01- Nonclinical Antibiotic Usage in Livestock 108
Cancer 108

40.5.01- Screening and Detection Programs 109
40.5.02- Virginia Cancer Registry 109
40.5.03- Physician Reporting of Cancer Cases 109
Child Health 109
40.6.01- Anabolic Steroids 109
40.6.02- AMA Program on Child and Adolescent Health 110
40.6.03- Promote Physical Fitness; Schools 110
40.6.04- Prevent Blindness Virginia/Conexus 110
40.6.05- Inclusion of Pediatricians in Development of Family Service Plans 111
40.6.06- School Start Times and Adolescent Sleep 111
40.6.07- Health Education in Schools 111
40.6.08- In-School Health Services 111
40.6.09 Address the Dangers of Head Trauma and Other Potential Injuries in Sports 112
Communicable and Infectious Disease 112
40.7.01- Screening/Follow-up 112
40.7.02 - Regulation of Tattoo Parlors 112
40.7.03- Promoting Awareness of Babesiosis 113
40.7.04- Care of Patients with HIV/AIDS 113
Environmental Health 113
40.8.01- Repeal of EPA Requirements on Medical Waste 113
40.8.02- Uranium Mining in Virginia 113
40.8.03- Protecting Human Health in a Changing Climate 114
40.8.04 – Recognizing the Potential Impact of Natural Gas Infrastructure Projects on Human Health and Environment 114
40.8.05 – Advancing Worker Heat Protection in the Commonwealth of Virginia 114
Firearms 114
40.9.01- Control of Violent Use of Firearms 115
40.9.02- Support for Firearm Laws Promoting Increased Public Safety 115
40.9.03– MSV School Gun Violence Deterrence Initiative 116
40.9.04- Child Firearm Injury Prevention 116

40.9.05- Gun Violence Restraining Orders 116
Food 116
40.10.01- Oppose Sale of Raw Milk in the Commonwealth 117
40.10.02- Eradicating Food Deserts and Food Insecurity 117
40.10.03 Nutrition 117
40.10.04 Strategies to Reduce the Consumption of Beverages with Added Sweeteners 117
Hazardous Activities 118
40.11.01- Indoor Tanning Regulation 118
40.11.02- Ban on Boxing 118
40.11.03- Dangerous Rapid Weight Reduction 119
Health Literacy/Public Education 119
40.12.01- Educational Programs 119
40.12.02- Health Literacy 119
Housing and Building Safety 119
40.13.01- Funding of Lead Poisoning Program 120
40.13.02- Housing Safety 120
Infant Health 120
40.14.01- Virginia Birth-Related Neurological Injury Compensation Program 120
40.14.03- Infant and Child Death Investigation 121
Infrastructure, Government Appointments, and Staffing 121
40.15.01- Medical Examiner System 121
40.15.02- Agency Jurisdiction 121
40.15.03- Public Health 122
40.15.04- Recertification of EMS Personnel 122
40.15.05- Trauma Research/Development of Systems 122
40.15.06- Qualifications for the State Health Commissioner 122
40.15.07- Increase in Staffing of Medical Death Investigators 123
40.15.08- State Emergency Medical Services 123
Maternal Health 123
40.16.01- Access to Obstetrical Care 124

40.16.02- Maternity Care Program 124
Medicinal Cannabis 124
40.17.01- Cannabis for Medicinal Use 124
Mental Health 125
40.18.01- Changes in Commitment Law; Funding 125
40.18.02- Funding; Public Mental Health Facilities 126
40.18.03- Psychiatrists: State Hospital and Clinics 126
40.18.04 – Optimizing Access of Mental Health Services by Veterans 126
40.18.05 – Supporting Standardization of Mental Health Screenings for Virginia Students 127
Patient Safety 127
40.19.01- Radiation Control; Needless Exposure 127
40.19.02- Protocols to Reduce Patient Morbidity and Mortality in Hospital Emergency Departments 127
40.19.03- Ionizing Radiation; Patient Education 127
40.19.04 – Support for Expansion of Epinephrine Access 128
Preventative Care 128
40.20.01- Reallocation from General Fund for Preventive Health 128
40.20.02- High Blood Pressure Screening 128
Tobacco 128
40.20.03- Legislation Restricting Tobacco Use 129
40.20.04- Sales to Children 129
40.20.05- Smoking Education 129
40.20.06- Sales/Smoking in Health Care Facilities 129
40.20.07- Smoking on School Property 130
40.20.08- Electronic Nicotine Delivery Devices 130
40.20.09- Tobacco use in Cars with Minors 130
40.20.10- Secondhand Smoke 130
40.20.11- Tobacco Sales Tax 131
Transportation and Vehicle Safety 131
40.21.01- Passengers in the Beds of Pickup Trucks 131

40.21.02– Safe Driving Education and Licensing Requirements 132
40.21.03- Elderly Drivers 132
40.21.04- Alcohol/Drug Impaired Drivers 132
40.21.05 - High Speed Police Pursuits 132
40.21.06- Small Personal Watercraft Regulation 133
40.21.07- Child Car Safety 133
40.21.08- Helmet Safety 133
40.21.09- School Bus Drivers Screening 134
Vaccines 134
40.22.01- State Funding For Childhood Vaccines 134
40.22.02- Childhood Immunizations 134
40.22.03 – "Mature Minor" Consent to Medical Care and Vaccinations 134
Violence Prevention 135
40.23.01- Anti-Domestic Violence Statement 135
40.23.02- Physicians' Role in Violence Prevention 135
40.23.03- Corporal Punishment of Foster Children by Foster Parents 135
40.23.04- Human Trafficking 136
45 Scope of Practice 136
Practice Authority 136
45.1.01 - Determination of Fitness to Return to Work 136
45.1.02- Diagnosis by Optometrists 136
45.1.03- Referrals from Physicians 137
45.1.04- Supervision of Physical Therapy Assistants 137
45.1.05- Assuring Quality in Allied Health Scope of Practice 137
45.1.06- Regulations of the Board of Hearing Aid Specialists 137
45.1.07- Scope of Practice Position Statement 138
Prescriptive Authority 139
45.2.01- Allied Mental Health Provider Prescription Authority 139
Practice Settings 139
45.3.01- Employment at Secondary School Level 140

45.3.02- Store Based Health Clinics 140
Workforce 141
45.4.01- MSV Support of Resolving Nursing Shortage 141
Licensure and Certification 141
45.5.01- Chiropractic Licensure under the Board of Medicine 141
45.5.02- NATA's Certification Process 142
45.5.03- Licensure of Naturopaths 142
45.5.04- Associate Physician 142
Education 142
45.6.01- Nursing Education 142
Insurance Coverage 143
45.7.01- Office of Emergency Medical Services 143
45.7.02- Legislation Mandating Medically Necessary Services by Allied Health Professions 143
45.7.03- Coverage Limitations on Physician Scope of Practice 143
50 Government Departments 144
50.1.01- Department of Health Professions 144
50.1.02- Physician-specific information 144
55 MSV Affairs 144
External Affairs 144
55.1.01 - Endorsement of the Commission on Office Laboratory Accreditation (COLA) Program 144
55.1.02- AMA Recruitment of Large Groups; Discounts and other Incentives 145
55.1.03- Requests from State Legislators 145
55.1.04- American Association of Medical Assistants 145
55.1.05- Communications with Local Medical Societies 146
55.1.06- MSV-Local Society Collaboration 146
55.1.07- Specialty Society Inclusion in Legislative Policy 146
55.1.08- Virginia Health Quality Center 146
55.1.09- Support of Northern Virginia Societies 147
Policies and Procedures 147
55.2.01- Conflict of Interest Policy 147

55.2.02- MSV Role in Disputes 148
55.2.03- President's Role; Guidelines for Others 148
55.2.04- Financial Reports 149
55.2.05- Physician Involvement in State Legislative Advocacy 149
55.2.06 - Academic Membership Agreement 149
55.2.07- Honorary Membership to Outgoing Past President 150
55.2.08- Statement of Individual Board Member's Responsibility 150
55.2.09- Statement of Responsibilities of the Board of Directors as a Whole 150
55.2.10- Use of the Term Physician 150
Meetings / Programs 150
55.3.01- Procedures of the House of Delegates of MSV 151
55.3.02- Fall Meeting 151
55.3.03- First Year Delegates Instructional Meeting 151
55.3.04- Medical Student Society Reorganization 151
55.3.05 Establish Evidence Based Guidelines for MSV Resolutions 152

05 PROFESSIONALISM

Disciplinary Procedure

05.1.01- Board of Medicine Sanctions

Date: 11/8/1997

The Medical Society of Virginia opposes publication of a sanction recommendation until the entire appeal process has run its course.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

Gifts and Industry Funding

05.2.01- Gifts to Physicians

Date: 10/31/1992

The Medical Society endorses AMA Code of Medical Ethics Opinion 9.6.2 - "Gifts to Physicians from Industry."

Reaffirmed 11/2/2012
Reaffirmed as amended 10/20/2019

05.2.02- Industry Funding and Support

Date: 10/25/2009

1) Physicians and physician organizations, including the Medical Society of Virginia and its affiliates, should thoroughly evaluate the decision to accept or not accept industry funding and its implications on their activities, on case by case basis. Such evaluation should involve an analysis of relevant ethical standards and guidelines pertaining to financial support and gifts from industry, which may include:
   - American Medical Association ethical opinions and reports
   - Standards developed by national physician specialty societies
   - Medical Society of Virginia Foundation Gift Acceptance Policies and Guidelines
   - Accreditation Council for Continuing Medical Education (ACCME) Standards for Commercial Support

- Report of the Association of American Medical Colleges Task Force on Industry Funding of Medical Education
- Pharmaceutical Research and Manufacturers of America (PhRMA) Code on Interactions with Healthcare Professionals

2) If not accepting funding would impair their ability to effectively achieve their goals, including the delivery of high quality CME and other activities, then physicians and physician organizations should adhere to applicable standards regarding the ethical acceptance of industry funding. Such individuals and organizations should adopt standards that are most relevant to them and their existing or prospective financial relationships with industry.

3) The Medical Society of Virginia supports the efforts of academic medical institutions to provide education and guidance regarding conflict of interest issues and encourages students and residents to maintain their awareness of these issues throughout their training and into their careers.

4) Outside funding opportunities will be reviewed prior to submission for potential conflicts and undue influence by the funder, and will be reviewed post hoc to assure the integrity of the process has been maintained

5) Outside funding of the Medical Society of Virginia activities will remain open to the review of its membership. The Medical Society of Virginia is committed to transparency and rigorous review of all outside funding for any potential or real conflicts of interest.

Reaffirmed as amended 10/20/2019

Leadership

05.3.01- Physician Members

Date: 11/5/1994

The Medical Society of Virginia believes that physicians should serve on hospital governing boards and action committees.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

Patient Care

05.4.01- Access without Discrimination

Date: 11/5/1994

The Medical Society of Virginia believes that all citizens of Virginia should have access to medical services without discrimination based on race, religion, age, social status, income, sexual orientation or perceived gender.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

05.4.02- MSV Opinion on Treatment of Family Members

Date: 11/5/1994

The Medical Society of Virginia believes that as a general rule, a physician should not treat themselves or members of their immediate family.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

05.4.03- Continuity of Care

Date: 10/31/1998

The Medical Society of Virginia believes that Virginia physicians performing surgery have an ethical responsibility to continue the care of their individual patients through the post-surgical recovery and healing period.

Reaffirmed 10/12/2008
Reaffirmed 10/21/2018

05.4.04- Organ Harvesting Without Consent

Date: 08/14/2014

The Medical Society of Virginia opposes unethical organ harvesting practices and fully supports prosecution of those found to have committed such offenses or assisted in procurement and transportation of human tissues or organs that were obtained without consent.

05.4.05 – Organ Donation as an Opt-Out Program

Date: 10/20/2019

The Medical Society of Virginia supports establishing an opt-out organ donation system in Virginia that includes effective and accessible opportunities to decline organ donation status and allows an individual's choice to be made on the basis of a meaningful exchange of information.

Furthermore, the Medical Society of Virginia supports maintaining current Virginia practice of requiring an agent, parent, or guardian consent to the organ donation of minors until minors are eligible to apply for a driver's licenses in an organ donation system based on presumed consent or mandated choice.

Physician Wellness and Safety

05.5.01- Dissemination of Inflammatory Information

Date: 10/30/1993

The Medical Society of Virginia supports legislation to amend the Code of Virginia to make it a criminal offense to endanger physicians and other health care providers by disseminating inflammatory information to advance a political agenda.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

05.5.02 Non Peaceful Protests

Date: 11/5/1994

The Medical Society of Virginia abhors the use of non-peaceful protests against physicians.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

05.5.03 - House Staff Depression

Date: 10/25/2015

The Medical Society of Virginia supports the availability of appropriate mental health services for medical students, residents and physicians.

05.5.04- Burnout and Suicide Prevention

Date: 10/16/2016

The Medical Society of Virginia supports efforts to address the mental health of medical students, residents, and physicians.

The Medical Society of Virginia will work cooperatively with state and national stakeholders to develop and promote strategies for comprehensive education, screening and treatment of mental health issues including burnout and suicide prevention.

05.5.05- Medical Practitioner Drug Addiction Guidelines

Date: 10/16/2016

The Medical Society of Virginia will create a study group/subcommittee to study the problem of drug/opioid abuse among physicians and other healthcare providers, and will recommend guidelines for its members and the medical community on how to respond to suspected or known medical practitioner drug addiction and/or impairment.

Professional Title

05.6.01- Use of "Physician"

Date: 11/5/1994

The Medical Society of Virginia supports the concept that the word physician be restricted for use by one who is a graduate of a school of medicine or osteopathy.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

05.6.02 - Use of Title “Dr.”

Date: 11/4/1995

The Medical Society of Virginia supports the enforcement by appropriate state agencies of the statutes requiring the disclosure of degree earned when using prefix “Dr.” for advertising purposes.

Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

10 INSURANCE

Benefits and Coverage

10.1.01 - Review Policies of Insurance Companies

Date: 10/31/1992

The Medical Society of Virginia supports legislation or regulation to impose the following minimum requirements upon insurance companies and managed care groups:

(1) That adequate authorizing or certifying personnel be available so that an immediate response to the physicians' offices can be obtained.

(2) If there is any question of a disagreement between the physician's office and the certifying personnel that a physician advisor be easily available to help resolve the conflict.

(3) In no instance should a letter written by a physician be required to obtain procedure or admission authorization when the treating physician feels that the care requested is emergent or semi-emergent in nature and that the delay would adversely affect the quality of patient care.

Reaffirmed 11/2/2012

10.1.02- Information on Health Care Plans to Patients

Date: 11/5/1994

The Medical Society of Virginia supports increased patient access to information in selecting health care plans.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.1.03- Transfer of Medical Care

Date: 11/5/1994

The Medical Society of Virginia opposes the detrimental effect on covered patients of insurance policies that provide in-patient hospital coverage only if rendered in specified hospitals and require as condition of such coverage that the insured be required to transfer his medical care from his primary physician to a hospital staff physician.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.1.04- Post-Delivery Care for Mothers and Newborns

Date: 11/4/1995

The Medical Society of Virginia believes: a) any insurer that offers maternity benefits shall provide coverage that is consistent with protocols and guidelines developed by national pediatric, obstetric, and nursing professional organizations for these services. b) any decision to shorten the length of inpatient stay to less than that provided under subsection (a) shall be made by the attending physician after conferring with the mother; c) if a mother and newborn are discharged pursuant to subsection (b) prior to the inpatient length of stay provided under subsection (a), coverage shall be provided for a follow-up visit within 48 hours of discharge.

Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

10.1.05- Secondary Insurance Pre-Certification and Reimbursement

Date: 11/4/1995

The Medical Society of Virginia supports legislation requiring secondary insurance to accept the utilization standards, preauthorization guidelines and reimbursement fee schedule of the

primary insurance company when they are acting as a secondary insurer. Their function should be to reimburse for any coinsurance or deductible payments based on the primary insurance fee schedule, and should require no separate preauthorization and have no utilization standards when acting as a secondary insurer.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

10.1.06- Screening for Breast Cancer

Date: 11/2/1996

The Medical Society of Virginia endorses screening consistent with the American College of Radiology, American College of Obstetrics and Gynecology and Society of Breast Imaging guidelines. Imaging of the breast for patients at risk should be interpreted as a medically appropriate service and should be covered by third party payers.

Reaffirmed as amended 10/16/2016

10.1.07- Breast Cancer/Insurance Coverage of Screening Mammography

Date: 11/8/1997

The Medical Society of Virginia encourages third party payers and government to develop financial mechanisms for screening mammography through endorsements, selective procedure contracting, and other means.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

10.1.08- Off Label Use of Drugs or Devices

Date: 11/8/1997

The Medical Society of Virginia opposes the practice by accident and sickness insurers and health care plans of denying coverage for any drug or device solely on the basis that the drug or device is used for a condition other than a use approved by the Food and Drug Administration.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

10.1.09- Prostate Cancer Screening

Date: 11/8/1997

The Medical Society of Virginia supports insurance coverage for scientifically sound methods of screening for prostate cancer.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

10.1.10- Newborn Hearing Screenings

Date: 10/31/1998

The Medical Society of Virginia supports mandatory hearing screenings for all newborns and mandatory reimbursement for newborn hearing screenings and follow up diagnostic testing for those infants referred after the initial screening.

Reaffirmed 10/12/2008
Reaffirmed as amended 10/21/2018

10.1.11- Mental Health Parity

Date: 10/31/1998

The Medical Society of Virginia supports the concept of insurance coverage parity for mental disorders and physical illness.

The Medical Society of Virginia, recognizing the importance of mental health treatment and adequate insurance coverage for the treatment of mental illnesses, supports legislation to require parity insurance and HMO coverage for the treatment of mental illnesses.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

10.1.12 - Coverage of Medical Formulas and Foods for Medicaid Patients Suffering from PKU

Date: 11/4/2002

The Medical Society of Virginia Medicaid coverage of PHE-restricted diets for PKU patients over 18 years of age.

Reaffirmed 11/2/2012
Reaffirmed as amended 10/22/2017

10.1.13- Insurance Coverage for Surgical and Medical Treatment of Obesity and Morbid Obesity

Date: 11/7/2004

The Medical Society of Virginia affirms the need for government and commercial insurance coverage of legitimate medical diagnostic evaluation and treatments for obesity. The Medical Society of Virginia supports mandated insurance coverage for those surgical and medical treatments for morbid obesity that are nationally recognized as effective for the long-term reversal of morbid obesity.

Reaffirmed 11/5/2006

Reaffirmed 10/16/2016

10.1.14- Health Plan Liability

The Medical Society of Virginia supports holding Virginia health insurance plans, including managed care plans, liable for damages for harm to a patient caused by the health care treatment decisions made by its employees.

Further, the Medical Society of Virginia supports holding physicians harmless who, following pursuit of available appeals procedures, are unable to provide care they deem medically appropriate because of a health plan's determination of coverage.

Amended by Substitution 10/22/2017

10.1.15- Improve Obesity Medicare & Insurance Coverage

Date: 10/22/2017

The Medical Society of Virginia through its delegation to the AMA supports coverage for healthcare costs associated with medical, surgical, nutritional and behavioral treatment interventions for patients diagnosed with obesity.

10.1.16- Medical Necessity Criteria

The Medical Society of Virginia supports requiring any person who defines medical necessity criteria, evaluates the medical necessity of physicians' care of patients, or who has authority to issue denials of treatment or services for a health plan operating in Virginia, be licensed to practice medicine in the Commonwealth of Virginia and Board certified in the appropriate specialty when applicable.

Amended by Substitution 10/22/2017

10.1.17- Reimbursement for Emergent Medical Care

The Medical Society of Virginia opposes any health plan requirements, including managed care plans, which may cause a delay in care, such as pre-authorization, for emergent medical services.

Further, the Medical Society of Virginia opposes the denial of provider reimbursement for these services under any circumstances.

Amended by substitution 10/22/2017

10.1.18- Insurance Coverage for Medical Conditions

Date: 10/20/2019

The Medical Society of Virginia affirms the need for government and commercial insurance plans to refer to a nationally recognized-medical association or organization, such as the American Academy of Dermatology, in defining what is a medical condition versus a cosmetic condition, and be it further,

The Medical Society of Virginia affirms the need for government and commercial coverage for diagnostic evaluation and treatment of all conditions which have been recognized by a national medical association or organization as a medical condition.

Children's Health Insurance

10.2.01- Children's Health Insurance Issues

Date: 11/4/2000

The Medical Society of Virginia will work with other health care advocacy groups to promote improvements in Family Access to Medical Insurance Services (FAMIS) including basic eligibility requirements, expedited receipt of benefits and other measures which will enhance delivery of medical care for children in the Commonwealth through these programs.

Reaffirmed 10/24/2010

Insurance System and Markets

10.3.02- Single Payer System

Date: 10/31/1992

The Medical Society of Virginia will support discussion of a national system of providing and financing a Single Payer System of health insurance.

Reaffirmed 11/2/2012
Reaffirmed as amended 4/28/2018

10.3.03- Catastrophic Care

Date: 11/5/1994

The Medical Society of Virginia endorses the concept of health care plans containing catastrophic coverage.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.3.04- Fair Market Competition/Systems

Date: 11/5/1994

The Medical Society of Virginia supports the concept of neutral public policy and fair market competition among all systems of health care delivery. The potential growth of HMOs should not be determined by federal subsidy, preferential federal regulation, or federal advertising promotion, but by the number of consumers who prefer this mode of delivery. Further, public

policy should not exempt HMOs from fair market competition and applicable laws.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.3.05- Federal Regulation of Private System

Date: 11/5/1994

The Medical Society of Virginia opposes any legislation which would increase federal regulation of or control over the private health care system.

Reaffirmed 11/07/2004
Reaffirmed 10/26/2014

10.3.06- Freedom of Choice - Patients and Physicians

Date: 11/5/1994

The Medical Society of Virginia opposes any legislative program which would prevent free choice of physician by patient or patient by physician.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.3.07- Patient Choice of Hospital

Date: 11/8/1997

The Medical Society of Virginia supports that when medically practical, Emergency Medical Services agencies licensed by the Commonwealth of Virginia and their personnel engaging in the treatment and transport of patients to area hospitals, should honor patient, family or physician requests for specific hospital destinations.
Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

10.3.08- Free-Market

Date: 11/5/1994
The Medical Society of Virginia endorses a plurality of health care delivery and financing systems in a free market setting.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.3.09- Opposition to Preferential Treatment

Date: 11/5/1994

The Medical Society of Virginia opposes any program which would create or perpetuate preferential treatment of any one system or plan of health care over another.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.3.10- Same Rules for Competitors

Date: 11/5/1994

The Medical Society of Virginia believes that all providers should be subject to the same rules as their competitors in order to further the development of competition in the health care industry.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.3.11- Tax Fairness

Date: 11/5/1994

The Medical Society of Virginia actively supports the concept that the purchase of health plan coverage whether by employer, group cooperative, or individual be treated with equal federal and state tax consequences.

The Medical Society of Virginia supports legislation in the Virginia legislature which results in equal Virginia tax fairness.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.3.12- Use of Medicine/Business Coalitions/Reform

Date: 11/5/1994

The Medical Society of Virginia endorses the use of medicine/business coalitions to discuss problems of mutual concern and to work together to seek health system reform in the Commonwealth.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.3.13- Point of Service Option

Date: 11/4/1995

The Medical Society of Virginia supports legislation requiring a point-of-service option for every health insurance policy.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

10.3.14- Medical Savings Accounts

Date: 11/4/1995

The Medical Society of Virginia endorses Medical Savings Accounts as a way to improve patient choice and access to health care.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

10.3.15- Low Cost Insurance Product

Date: 11/8/1997

The Medical Society of Virginia supports the concept of a low cost health insurance product and continued efforts in pursuing a low cost insurance product to be available for uninsured Virginians, low income workers, and small businesses.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

10.3.16 - Third Party Payer Fair Business Practice Principles

Date: 10/31/1998

The Medical Society of Virginia supports the following fair business practices:

I. Payment issues:
   A. Place a time limit for full payment of clean claims,
   B. Disclose to the contracted practice the processing procedure for claims approval,

C. Prohibit the arbitrary bundling of unbundled claims,
D. Prohibit automatic or arbitrary downcoding of claims and request the review of such acts by the Virginia Commissioner of Insurance,
E. Prohibit the garnishment of payment on Explanation of Benefits (EOB),
F. Limit the time for retroactive denial of payments when requesting a refund from a physician after the time the service was provided,
G. Publish the contracted prices to be paid for claims 3 months prior to their effective date, and,
H. Publish the contracted adjudication guidelines three months in advance of their effective date.
I. Prohibit health plans from fining physicians or denying/ withholding payment in instances of patient non-compliance with health plan referral requirements.

II. Contract Issues:
A. Require a reasonable time limit for physicians to receive certification in order to be paid by the plan, or require the plan to pay for the services while waiting for certification,
B. Prohibit the "Most Favored Nation" clause from contracts, and,
C. Prohibit retaliation against physicians or groups who do not accept certain contracts offered by insurers.

III. Physician Due Process:
A. Require a reasonable time limit to receive a precertification authorization for treatment,
B. Provide physicians access to their profiling data, and,
C. Provide procedural due process to physicians expelled from a health plan to include adequate notification of removal, explanation of the reasons for the removal, and the ability to contest the proposed removal through an external appeals process.

IV. Patient Issues:
A. Require that precertification by telephone be toll free for physicians and patients,
B. Require a managed care organization (MCO), health plan, dental plan, or pharmacy benefits manager using a formulary to disclose to its members and participating physicians their initial formulary and annually thereafter, the frequency of formulary changes and a description of the process for developing the formulary and evaluating new therapies,
C. Require any carrier using a restrictive formulary for prescription medications to allow patients to obtain, without penalty to the physician and the patient and in a timely manner, specific drugs and medications not included in the formulary when the formulary's equivalent has been clinically ineffective or when the physician treating the patient believes the formulary's medication causes, or is reasonably

expected to cause adverse or harmful reactions in the patient,
D. Eliminate the necessity for approval or referral from the primary care physician in order for patients to be covered for after-hours urgent care or emergency service in accordance with the prudent layperson statute,
E. Require MCOs to educate their members on after-hours medical care,
F. Require insurance companies to log in appeals at the time of their receipt,
G. That health plans not encourage short-term mail order prescriptions and not financially penalize those who have prescriptions filled locally,
H. Create an objective and timely process for considering the authorization of investigational treatments and for evaluating coverage of innovative technologies, drugs, devices, and procedures.

The Medical Society of Virginia believes that any third-party payer should not interfere in the physician patient-relationship and will strongly oppose any business practices that may compromise the care of patients.

Reaffirmed 10/28/2007
Reaffirmed as amended 10/22/2017

10.3.17- Guidelines for Health Care System Reform

Date: 2/5/2011

The Medical Society of Virginia adopts the following guidelines for health care system reform:

1. Every individual should be required to have an insurance policy that meets individual and family needs. The health care system should be structured so as to encourage the individual purchase of insurance, with a blend of public, private and employer-based incentives.

2. All Virginians should be granted access to essential health care through a defined minimum benefit package.

3. Universal health care should be provided through a private sector/public sector partnership that encourages and emphasizes the responsibility of the individual.

4. Government programs should provide assistance to those unable to provide coverage for themselves or their families. Public financial support for the indigent should be provided through appropriate patient vouchers, incentives and tax credits for the purchase of health insurance.

5. All reform should include the absorption of current Medicare, Medicaid and federal employee health benefits programs. The Medicaid program should be reformed and/or replaced with an alternative system designed to provide benefits to persons at or below the poverty level.

6. The health insurance market should be reformed to increase availability of affordable health insurance options. These reforms should include:
• community based rating
• creation of state risk pools
• elimination of waiting periods and pre-existing condition clauses
• approved health benefit insurance options
• greater emphasis on providing coverage for catastrophic, long term and preventive care
• portability of coverage

7. The health care system should place increased emphasis upon the patient's responsibility for his/her health and insurance premiums should be structured to encourage healthy lifestyles and preventive care. Individuals should be encouraged and rewarded for healthy behaviors (e.g., reduced consumption of alcohol and tobacco, use of seat belts, healthy eating habits and body weight, consistent exercise).

8. Costs and quality should be controlled in part by ensuring that appropriate medical procedures are delivered in a cost effective manner. This can be accomplished through:
1. the development and appropriate use of professionally developed practice parameters
2. enactment of meaningful tort reform to reduce costs associated with the defensive practice of medicine
3. providing immunity to physicians who withdraw or withhold care appropriately deemed to be medically futile by an interdisciplinary ethics committee
4. administrative efficiencies
5. regulatory reform

9. Quality of care is paramount in the doctor/patient relationship and should be promoted by:
• appropriate initial and continuing physician education programs
• credentialing of physicians subject to any willing provider provisions
• encouraging the ethical practice of medicine
• eliminating economic disincentives to provide appropriate care
• appropriate quality assurance mechanisms

10. The patient should be encouraged to base health care decisions on value considerations. Value competition in the health care marketplace should be enhanced by:
• creating easily accessible sources (public and/or private) of information regarding the fees and qualifications of physicians and other health care providers
• requiring physicians and other health care providers to release price information upon request prior to treatment
• encouraging the voluntary release of fee information when feasible

11. Administrative costs should be reduced, and the fairness and appropriateness of coverage decisions should be improved by:
• requiring all third-party payers to use a uniform claims form
• requiring professional development and universal use of one set of medical necessity and utilization review screening criteria by all third-party payers
• eliminating unnecessary regulation and/or streamlining cumbersome regulation of physicians and other health care providers

10.3.18- Withdrawal of Insurance Providers from the ACA and Individual Marketplace

Date: 10/22/2017

The Medical Society of Virginia will propose policy changes which will require health plans participating in the Commonwealth of Virginia State Benefits Program to also provide individual coverage for the public at large in the regions in which they participate, and be it further

that these individual policies must be commensurate with what the plans offer to state employees including benefits, premiums and administrative expenses.

10.3.19 Establishment of a Reinsurance Program

Date: 10/21/2018

The Medical Society of Virginia will work to bring additional insurance carriers into the individual and small group marketplace, in addition to creating a more favorable environment for lower premiums and coverage of persons with costly medical issues.

10.3.20 Regulate and License Pharmacy Benefit Managers Who Serve Virginians

Date: 10/21/2018

The Medical Society of Virginia, in concert and collaboration with local and specialty physician organizations, pharmacist organizations, patient organizations and any other interested and affected parties work to ensure that the Virginia Insurance Commissioner has authority to appropriately oversee the actions of PBMs providing services to Virginians and are held accountable for their actions in the pricing, management and dispensing of medications to Virginians.

Reaffirmed 10/20/2019

Managed Care

10.4.01- Managed Care and Patient Choice

Date: 10/30/1993

The Medical Society of Virginia supports legislation that mandates that any insurance company or managed care health delivery system functioning in the Commonwealth of Virginia provide a provision which allows a patient enrollee an option to seek health care outside the managed care network with a reasonable (not punitive) financial voucher.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

10.4.02- Closed Panel HMOs

Date: 11/5/1994

The Medical Society of Virginia opposes the use of tax exempt funds for the establishment of any closed panel HMO and petitions the General Assembly for legislative relief from such unfair competitive practices.

Reaffirmed 11/7/2004

Reaffirmed 10/26/2014

10.5.03- Principles of Managed Care

Date: 11/5/1994

Introduction
In an ideal world the needs of patients might best be served by free market competition and free choice by physicians and patients between alternative delivery and financing systems, with the growth of each system determined not by preferential regulation and subsidy, but by the number of persons who prefer that mode of delivery or financing. Unfortunately, in the real world unfettered capitalism may not adequately protect the health care needs of Virginia's citizens, both sick and healthy, individual and corporate.

As this state's health care market place becomes increasingly dominated by health plans that utilize various managed care techniques that include decisions regarding coverage and the appropriateness of health care, it is a vital state governmental function to protect patients from unfair managed care practices.

Increasingly, it appears that insurance companies and other managed care organizations are aggressively discontinuing physicians from their networks, making inappropriate decisions to refuse, limit, or terminate health care services, and restricting patient's ability to make choices concerning their health care decisions and providers. It is essential to assure fairness in managed plans and to provide mechanisms for delineating necessary protections for both physicians and patients.

Therefore, The Medical Society of Virginia feels strongly that Virginia should adopt legislation which would require that managed care plans assure fairness to patients and providers. This would include state standards for certification of qualified managed care plans and utilization review programs as well as standards to ensure patient protection, physician and provider fairness, utilization review safeguards and coverage options for all patients, including the ability to enroll in a point of service plan. There should be a certification process with periodic reviews and recertification requirements.

Requirements for meeting the standards of certification should include the criteria articulated throughout the rest of this document.

Definitions
"Managed" care is defined as: systems or techniques generally used by third party payers or their agents to control access and payment for health care services.

Managed care techniques include: (a) Prior, concurrent, and retrospective review of the medical necessity and appropriateness of services and/or site of services. (b) Financial incentives or disincentives related to the use of specific providers, services, or service sites. (b2) Limitations on the numbers and types of providers included in the plan and mechanisms to initially exclude or, later, to deselect providers from plans, (c) Controlled access to and coordination of services by a gatekeeper (d) Payer efforts to identify treatment alternatives and modify benefit restrictions for high-cost patients (high cost case management).

A. Utilization Review
The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payers should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed.

A physician of the same branch of medicine (allopathic or osteopathic) and specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician consultant who is of the same specialty and has appropriate expertise and experience in the field.

A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the

practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for his or her decisions. The names and credentials of individuals conducting necessity or appropriateness reviews must be available upon request.

Any health plan or utilization management firm conducting a prior authorization program should act within two business days after receipt of any patient or physician request for prior authorization and respond by phone within one business day after receipt of other questions regarding medical necessity of services. Plans may not require prior authorization for emergency care. Prior approval decisions should be valid unless based on fraud or incorrect information.

All health plans should establish a formal mechanism for participating physicians to have meaningful input into the plans' medical policies, including coverage and utilization review criteria. Health plans must safeguard medical record confidentiality and are responsible for making sure that patients sign the forms consenting to disclosure of medical information if prior authorization is required for any procedures or services.

B. Gatekeepers, Limited Provider Panels, and Financial Disincentives

Health care plans should be required to limit appropriately those arrangements in which the providers have a financial incentive to limit or deny services, including referrals for patients to specialists. Any financial arrangements that may tend to limit the services offered to patients, or contractual provisions that may restrict referral or treatment options, should be required by law to be fully disclosed to patients and prospective enrollees by all plans utilizing such arrangements.

Regulations protecting patients from under-referral for financial gain are just as desirable as regulations to limit physician self-referral because of concern about overutilization for financial gain. Physicians and managed care organizations must disclose to their patients any financial inducements or contractual agreements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or restrict referral or treatment options. Physicians may satisfy their disclosure obligations by assuring that the managed care plan adequate makes full disclosure of all such arrangements to patients enrolled in the plan. Physicians must also inform their patients of medically appropriate treatment options regardless of their cost or the extent of their coverage.

Physicians should have the right to enter into whatever contractual arrangements with health care systems they deem desirable and necessary, but should be aware of the potential for some types of systems to create undesirable conflicts of interest because of financial incentives to withhold medically indicated services.

Physicians must not allow such financial incentives to influence their judgment of appropriate therapeutic alternatives or deny their patients access to appropriate services, including referrals

to specialists, based on such inducements. Physician payments that provide an incentive to limit the utilization of services should not link financial rewards with individual treatment decisions over periods of time insufficient to identify patterns of care nor should they expose the physician to excessive financial risk for services provided by physicians or institutions to whom he or she refers patients for diagnosis or treatment. When risk sharing arrangements are relied upon to deter excess utilization, physician incentive payments should be based on performance of groups of physicians rather than individual physicians, and should not be based on performance over short periods of time.

Alternative private health benefit plans, with different schedules of deductibles, coinsurance and premiums, should be available to enrollees so that they are aware of the financial tradeoffs associated with different plans. Both private and public third party payment systems should use deductibles and coinsurance as financial incentives for health care recipients to use health care resources in an appropriate manner. However, cost-sharing should not result in an undue financial burden for the health care recipient, and should not act to prevent access to needed care.

Physicians, other health professionals, and third party payers through their reimbursement policies, should continue to encourage use of the least expensive care settings in which medical and surgical services can be provided safely and effectively with no detriment to quality. Evaluation of "Quality" should place some value on the continuity of the patient-physician relationship.

With the increased specialization of modern health care, it may be advantageous for each patient to have a single physician to help coordinate the medical care of the patient and to act as the repository for all of the medical information on the patient. The physician is best suited by professional preparation to assume this leadership role. It may be appropriate to utilize appropriate financial mechanisms to encourage patients to take optimum advantage of such a primary care provider. It may not be medically appropriate or cost effective to require that all medical care be provided by, or with permission from, one’s primary care provider. Specialty physicians should have formal and meaningful input into developing each plan's policies on appropriateness of referrals to specialists.

All restrictive plans should notify physicians annually of their opportunity to apply for plan credentials; establish credentialing standards with input from physicians and make them available to applicants and enrollees. Selection criteria must be based on professional competence and quality of care and, in general, no single criterion, including specialty, should provide for the sole basis for selecting, retaining, or excluding a physician from a health delivery or financing system. Profiling must be adjusted for the individual physician's case mix.

Physicians cannot be removed from a plan because their patients have rare, unusual or highly complex conditions which require specialized care and that are expensive to treat. Nor can they

be removed under a contract that allows termination "without cause" or terminated or denied participation without explanation of reasons for the decisions, and an opportunity to appeal.

All plans should demonstrate adequate access to physicians and other providers, including specialists, to ensure timely, high quality service.

C. High Cost Case Management

The primary goal of high-cost case management or benefits management programs should be to help to arrange for the services most appropriate to the patient's needs. Cost containment is a legitimate but secondary objective. In developing an alternative treatment plan, the benefits manager should work closely with the patient, attending physician, and other relevant health professionals involved in the patient's care.

When inordinate amounts of time or effort are involved in providing case management services required by a third-party payer which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements, the physician may charge the payer or the patient for the reasonable cost incurred. "Inordinate" efforts are defined as those more costly, complex and time-consuming than the completion of standard health insurance claim forms, such as obtaining pre admission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage."

D. Disclosure

All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patients. It is the responsibility of the patient and his or her health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan.

E. Liability

All health plans utilizing managed care techniques, the medical director, and any involved reviewers should be subject to legal action for any harm incurred by the patient resulting from application of such techniques. Such plans should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions; review requirements; financial arrangements; or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to his or her

patient.

F. Consumer Choice
Employers, health plans or networks must allow for patients' choice of physician and system of health care delivery.

Any sponsor (e.g., employer, regional alliance, insurance pool) who offers a restrictive health benefit plan must make available a variety of types of plans including HMO's, traditional insurance plans, or a benefit payment schedule, establishing up front a set amount that will be paid for each covered service.

At the time of enrollment in a plan that restricts access, and at least one year thereafter, each patient shall be offered the opportunity to pay an additional premium for a "point of service" plan that will entitle him or her to reimbursement for services obtained outside the network or outside any restrictive referral rules. "Out- of - network" or "point of service" plans include plans that may reimburse for any non-covered service whether it is provided inside or outside the patient's plan.

The additional premium for point of service coverage must reflect the actuarial value of such coverage. A point of service plan may require a reasonable copayment.

Individuals' and employers' rights to pay for services outside of the health plan or benefit package should be expressly preserved.

In order for consumers to make fully informed decisions it is imperative that all plans disclose to prospective enrollees clear and accurate information, in a standardized format, on coverage exclusions; prior authorization or other review requirements that might result in nonpayment for a given procedure or service; financial arrangements that reward hospitals, physicians and other providers for delivering less care, or that limit referrals to other providers; the enrollees own liability for coinsurance or for payments for out-of-plan services; the plan's administrative expenditures as a percentage of total premiums, and enrollee satisfaction statistics.

Miscellaneous
A state agency must periodically review and revise, if necessary, established standards.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.5.04- Balance Billing

Date: 11/4/2000

The Medical Society of Virginia supports physician's ability to accept assignment of benefits and to balance bill patients that have coverage through a managed care organization with whom the physician does not have a contractual relationship.

The Medical Society of Virginia believes that when a patient receives emergency services from an out-of-network physician, the insurer should hold the patient harmless for the health care services provided, with the exception of the patient's co-pay, coinsurance, or deductible. An appropriately determined reimbursement should be paid directly and in a timely manner to the physician by the health insurer.

The Medical Society supports policies that will reduce a patient's risk of receiving a surprise bill. This includes ensuring all emergency services are reimbursed as emergency services, based on the prudent layperson standard; establishing stronger network adequacy requirements; requiring all health plans to contract with any willing provider; and requiring physicians, hospitals and health insurers to provide as much notification as possible for scheduled health care services when a provider is out-of-network.

Reaffirmed 10/24/2010
Reaffirmed 10/26/2014
Amended by addition and reaffirmed10/21/2018

Medicaid

10.6.01- Increased Reimbursement; Underserved Areas

Date: 11/9/1991

The Medical Society of Virginia advocates increased Medicaid reimbursement levels which often are a major part of practice in an underserved area, and stress physician participation in the program.

Reaffirmed 11/4/2001
Reaffirmed 10/26/2014

10.6.02- 60 Day Recertification of Medicaid Patients

Date: 11/5/1994
The Medical Society of Virginia opposes the 60 day mandatory visitation and recertification of Medicaid patients in nursing homes and believes that visits should be based on need as determined by the attending physician.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.6.03- Increased Reimbursement

Date: 11/5/1994

The Medical Society of Virginia requests the adjustment of physician reimbursement rates by the Department of Medical Assistance for Medicaid services to levels that provide reasonable compensation to physicians for their overhead costs and their professional time.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.6.04- Medicaid Cuts

Date: 11/5/1994

The Medical Society of Virginia opposes reductions in the State's Medicaid budget unless it is clear that such reductions will not adversely affect quality of care for the poor.

Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

10.6.05- Funding for Medicaid

Date: 10/31/1998

The Medical Society of Virginia supports full state and federal funding of the Medicaid program and its potential for improving the health of Virginia's most vulnerable populations.

Reaffirmed 10/12/2008
Reaffirmed 10/21/2018

10.6.06- RBRVS for Medicaid and FAMIS Pediatric Reimbursement in Virginia

Date: 11/4/2001

The Medical Society of Virginia supports legislation that will establish 100% Resource Based Relative Value Scale as the basis for reimbursement for Medicaid and FAMIS in the Commonwealth of Virginia.

Reaffirmed: 10/30/2011

10.6.07- Expand Medicaid under the ACA

Date: 11/2/2012

The Medical Society of Virginia supports legislation to fully expand Medicaid under the limits set by the ACA with two conditions: 1) that any expansion be fiscally responsible; and 2) that such expansion reimburse physicians for provision of professional services to Medicaid patients at a rate that assures access to care for Medicaid patients.

Reaffirmed 10/22/2017

10.6.08- Medicaid Reform for Adults Receiving Social Security Disability Income

Date: 10/22/2017

The Medical Society of Virginia supports allowing Virginians on SSDI to meet income eligibility requirements for Medicaid without consideration of their SSDI.

10.6.09 Opposing Work Requirements for Virginia Medicaid Eligibility

Date: 10/21/2018

The Medical Society of Virginia opposes work requirements as a condition of eligibility for Medicaid.

Medicare

10.7.01- Increased Reimbursement; Underserved Areas

Date: 11/9/1991

The Medical Society of Virginia advocates increased Medicare reimbursement levels which often are a major part of practice in an underserved area, and stress physician participation in the program.

Reaffirmed 11/2/2012

10.7.02- Extrapolation of Medicare Chart Audits and Post-Audit Refunds

Date: 10/31/1992

The Medical Society of Virginia supports legislation that limits or prevents extrapolation of denied claims to physicians on all Medicare payments for refunds. The Medical Society of

Virginia urges the American Medical Association to request Federal legislation that prevents the required payment of refunds by physicians before their right of appeal process is completed.

Reaffirmed 11/2/2012

10.7.03- Medicare Carrier Advisory Committee

Date: 10/31/1992
The Medical Society of Virginia requests that the American Medical Association solicit the Centers for Medicare and Medicaid Services to mandate that each state carrier's professional advisory committee be made up of only physician representatives of the various affected specialties in each state that are approved by their respective state specialty societies as being designated as their representative.

Reaffirmed 11/2/2012

10.7.04- Inequitable Reimbursement of Primary Care Physicians under RBRVS

Date: 10/30/1993

The Medical Society of Virginia believes that the application of grossly inaccurate practice overhead RVU's in the calculation of RBRVS payment schedules to primary care medical practice seriously undermines the fiscal viability of such practices and fosters the denial of care to tens of millions of America's elderly and disadvantaged populations and supports recalculation of practice overhead RVU’s based on current available data.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

10.7.05- Medicare Private Contracting

Date: 11/8/1997

The Medical Society of Virginia opposes the requirement that doctors who privately contract with Medicare patients must opt not to bill Medicare for treating Medicare patients for a two-year period.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

10.7.06- Payment for Physician Surgical Assistants

Date: 11/8/1997

The Medical Society of Virginia opposes Medicare reduction of surgeons' reimbursement when physician surgical assistants are used for complex surgical procedures.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

10.7.07- Medicare Fees

Date: 10/31/1998

The Medical Society of Virginia opposes Medicare registration fees, charges for sending paper claims, and levies imposed on physicians whose practice is audited.

Reaffirmed 10/12/2008
Reaffirmed 10/21/2018

10.7.08- Medicare Reimbursement for Medication

Date: 10/31/1998

The Medical Society of Virginia opposes inadequate Medicare reimbursement for physician purchased medications.

Reaffirmed 10/12/2008
Reaffirmed 10/21/2018

10.7.09- Medicare Surety Bonds

Date: 10/31/1998

The Medical Society of Virginia opposes the implementation of any requirement by the Centers for Medicare and Medicaid Services that would require physicians to purchase surety bonds.

Reaffirmed 10/12/2008
Reaffirmed 10/21/2018

10.7.10- Medicare Prescription Drug Benefits

Date: 11/4/2000

The Medical Society of Virginia supports prescription drug coverage for Medicare recipients in the context of overall Medicare reform.

Reaffirmed 10/24/2010

Physician Participation in Health Plans

10.8.01- The Credentialing of Physicians by Insurance Companies and Other Third Parties and Competition in the Health Care Market Place

Date: 10/30/1993

The Medical Society of Virginia shall work with the AMA and appropriate governmental agencies to pass laws that would outlaw the exclusion of physicians from access to the health care market place on the sole basis of lack of board certification or particular hospital affiliation.

Reaffirmed 11/5/2006
Reaffirmed 10/16/2016

10.8.02- Removal of Physicians from Insurance Plans "Without Cause"

Date: 10/30/1993

The Medical Society of Virginia opposes the practice of insurance companies to remove physicians from their plans "without cause."

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014
Reaffirmed as amended 10/22/2017

10.8.03- Any Willing Provider

Date: 11/5/1994

The Medical Society of Virginia reaffirms its support of “any willing provider” provisions.

Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

10.8.04- Physician Re-Credentialing by Managed Care Plans

Date: 11/8/1997

The Medical Society of Virginia supports physicians maintaining their status with all health plans, including managed care plans, and believes a change in practice location or practice arrangement should not prompt re-selection or renewal of the credentialing process.

Reaffirmed 10/28/2007
Reaffirmed as amended 10/22/2017

10.8.05- Plan Expulsion and Licensure Board Discipline

Date: 11/8/1997

The Medical Society of Virginia opposes the practice of physician expulsion from health benefit plans on the basis of licensure board disciplinary action without suspension or revocation of license, specifically censure or reprimand.

The Medical Society of Virginia supports well-defined disciplinary categories that would accurately describe the nature of the disciplinary action.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

10.8.06- Physician Hospital Admitting Privileges and Plan Participation

Date: 10/30/1999

The Medical Society of opposes insurance companies from terminating or accepting physicians based on the hospital at which they have admitting privileges.

Reaffirmed 10/25/2009
Reaffirmed as amended 10/22/2017

Reimbursement and Claims

10.9.01- Equal Reimbursement for Urban and Rural Areas

Date: 11/9/1991

The Medical Society of Virginia advocates equal reimbursement for health care services in rural and urban areas with support for more rapid recovery of costs for equipment and technology in rural areas where volume use is not as great.

Reaffirmed 10/12/2008
Reaffirmed 10/21/2018

10.9.02- Home Health Agencies

Date: 11/9/1991

The Medical Society of Virginia shall work with appropriate governmental agencies in an effort to develop a reimbursement schedule with respect to home health care commensurate with the tasks performed by the physician provider, especially the primary care physician.

Reaffirmed 10/30/2011

10.9.03- Reimbursement of Rural Practitioners

Date: 10/31/1992

The Medical Society of Virginia endorses the placement of family physicians on the advisory panels of all third party payers which are active in rural areas.

Reaffirmed 11/2/2012

10.9.04- Insurance Market Reform

Date: 10/30/1993

The Medical Society of Virginia supports requiring that the actual discount on each hospital claim and the amount actually paid to the hospital for an insurance claim be made available to both the plan member and, in the case of employer-sponsored insurance, the plan member's employer.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014
Reaffirmed as amended 10/22/2017

10.9.05- Fee Guidelines

Date: 11/5/1994

The Medical Society of Virginia recommends use of the following fee guidelines:

1. The fee charged for each service should be based upon the cost of providing that service by the most efficient high-quality method that is available plus a reasonable compensation for the professional skill and time that is required.

2. In applying usual, customary and reasonable guidelines, such factors as providing emergency service at night and on weekends, taking care of indigent patients, and sponsoring educational programs must be considered, but these factors should not be used as an excuse for excessive charges.

3. These sample principles should be applied to all other diagnostic procedures, such as blood counts, electrocardiograms, electroencephalograms, and x-rays. Physicians should not make a profit from selling another physician's opinion.

4. When physicians draw blood and send it out to a commercial laboratory for testing, they should be paid a reasonable fee to cover the costs of drawing the blood, but they should not be paid or expect a fee for interpreting the results of these tests, as this interpretation has already been paid for when the patient pays for the office visit.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.9.06- Timely Insurance Claims Payment

Date: 11/4/1995

The Medical Society of Virginia supports the timely payment of claims and supports efforts to require all health plans to pay interest on claims unpaid thirty days after submission.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015
Reaffirmed as amended 10/22/2017

10.9.07- Billing for Uncovered Care

Date: 11/8/1997

The Medical Society of Virginia supports allowing physicians to bill patients for care deemed by the plan to be "non-covered" if the patient agrees in advance to bear financial responsibility for the services.

Reaffirmed 10/28/2007
Reaffirmed as amended 10/22/2017

10.9.08– Capitation

Date: 11/8/1997

The Medical Society of Virginia supports strong physician involvement and regulatory oversight of health plans using capitation as the basis for reimbursement. Capitated plans must:

- Allow to determine and participate in quality improvement programs.
- Adequately reimburse physicians appropriately to ensure providers are able to absorb risk and provide appropriate patient care.

The Medical Society of Virginia supports strong and continued evaluation of capitated health plans by the State Health Commissioner and Insurance Commissioner and suggests:

- Requiring the plan to disclose to the plan member the exposure to the incentive risks and insurance risks imposed upon the physician.
- Robust evaluation to declare the covered benefits in the plan, the quality improvement program and the actuarially determined funding of the plan are appropriate and adequate to provide a level of care to the plan members.
- Requiring all licensed capitation plans to provide adequate ‘stop loss’ insurance to empower and protect the physician to provide appropriate and necessary medical care to their patients.

Reaffirmed 10/28/2007
Reaffirmed as amended 10/22/2017

10.9.09- Nondiscriminatory Reimbursement

Date: 11/8/1997

The Medical Society of Virginia endorses a nondiscriminatory reimbursement policy in order to preserve adequate psychiatric care in the Commonwealth of Virginia.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

10.9.10- Third Party Payer Retroactive Denials

Date: 11/8/1997

The Medical Society of Virginia opposes retroactive denials of previously authorized and paid physician claims by third-party payers.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

10.9.11- Most Favored Nation Clauses

Date: 10/31/1998

The Medical Society of Virginia opposes the inclusion in physician insurance contracts of "Most Favored Nation Clauses" which obligate physicians to accept from one insurance company the lowest reimbursement rates that have been negotiated with other insurance companies. The Medical Society of Virginia supports passage of legislation within the state of Virginia to prohibit this practice.

Reaffirmed 10/12/2008
Reaffirmed 10/21/2018

10.9.12- Worker's Compensation Reimbursement

Date: 10/31/1998

The Medical Society of Virginia supports legislation to require third party administrators handling worker's compensation to reimburse physicians within 60 days of submitting a claim; to state that legal action on the part of the patient or employer shall have no effect on provider payment; and to abolish deductions from physician reimbursement to pay for attorney fees in covering patient injuries sustained during employment and possibly covered by workers compensation.

Reaffirmed 10/12/2008
Reaffirmed 10/21/2018

10.9.13- Assignment of Benefits

Date: 10/30/1999

The Medical Society of Virginia supports legislation in Virginia that physicians or other health care providers who file insurance claims for their patients and who have appropriately executed Assignment of Benefits directly receive insurance reimbursement for their medical services from the payer, whether or not they are participating providers with the insurance plan. The Medical Society of Virginia will continue to lobby our legislators educationally, and will introduce assignment of benefits legislation when the situation is appropriate.

Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

10.9.14- Pay for Performance

Date: 11/6/2005

The Medical Society of Virginia supports the AMA's "Principles and Guidelines for Pay-for-Performance Programs."

Reaffirmed as amended 10/25/2015

10.9.15- Payment with Remittance Advice

Date: 08/14/2014

The Medical Society of Virginia strongly encourages health plans to include comprehensive remittance advice in a user-friendly format with any payment or payment retraction, and will address any related member complaints accordingly.

10.9.16- Reimbursement of Telemedicine and Disclosure of Ownership Interests in Telemedicine Companies

Date: 10/26/2014

The Medical Society of Virginia supports the following principles and will pursue appropriate strategies to enact these principles, including but not limited to direct negotiation with third party payers, regulation through the Board of Medicine, or, if necessary, through state legislation:

1. Physicians should receive appropriate reimbursement for telemedicine encounters for patients with whom they have an established physician-patient relationship.

2. Any financial or equity arrangements between insurance companies and direct-to-consumer telemedicine companies should be fully disclosed to patients.

10.9.17- Payment for Surgical Procedures

The Medical Society of Virginia supports reasonable fees for medical and surgical services rendered by physicians of the Commonwealth.

Further, the Medical Society of Virginia believes physicians and their patients should jointly decide where surgical procedures should be performed. Health plans should reimburse physicians appropriately should the necessary office infrastructure be in place to safely perform surgery in an office setting. Reimbursements for procedures occurring in office should also include a facility fee.

Amended by Substitution 10/22/2017

10.9.18- Physician Reimbursement for Electronic Services

The Medical Society of Virginia believes physicians should be reimbursed at a fair fee of their choosing for established patients with whom the physician has had previous face-to-face professional contact, whether the current consultation service is rendered by telephone, fax, electronic mail, or other form of communication.

Further, the Medical Society of Virginia believes these services should be reimbursed by health insurance plans.

Amended by Substitution 10/22/2017

10.9.19- Reimbursement for Mandated Medical Services

The Medical Society of Virginia is believes all providers must be adequately reimbursed for all state and federally mandated medical services.

Further, reimbursement for medical services provided subject to Emergency Medical Treatment and Active Labor Act (EMTALA) be made to all providing institutions on an equivalent basis for equivalent services.

Amended by Substitution 10/22/2017

10.9.19 Uninsured Payment Protection

Date: 10/21/2018

The Medical Society of Virginia acknowledges the deleterious financial impact that cost shifting in hospitals can have on uninsured or inadequately insured patients and support the development of a reasonable fee-schedule for uninsured or inadequately insured patients receiving inpatient and outpatient care.

10.9.20 Investigation into Healthcare Insurance Copay Accumulator Programs

Date: 10/21/2018

The Medical Society of Virginia opposes copay accumulator programs or any program that does not apply all payments made by or on behalf of patients toward deductibles and out of pocket maximums.

10.9.21 Bill Submission Timelines

Date: 10/21/2018

The Medical Society of Virginia supports the implementation of a mandatory deadline of no less than twelve months from the date of service for physicians to submit claims.

The Medical Society of Virginia supports a requirement that requires insurers to add a minimum of 30 days to the submission deadline every time they kick a claim back to a physician for any reason.

Utilization Management

10.10.01- Financial Incentives/Under or Overutilization

Date: 11/11/1989

The Medical Society of Virginia supports the concept of appropriate utilization i.e., that any medical professional reimbursement system that rewards underutilization or overutilization with greater profits is contrary in the Commonwealth, to the best interests of patients and detrimental to the professional ethical behavior of physicians.

Reaffirmed 10/24/2010

10.10.02- Medical Utilization Review

Date: 10/30/1993

The Medical Society of Virginia supports legislation to make the Medical Utilization Review statute more effective by deleting the exclusion in the present definition of "private review agent" as found in the Code of Virginia.

The Medical Society of Virginia supports legislation to make certain that all persons performing utilization review be included in the Medical Utilization Review statute.

The Medical Society of Virginia supports amendments that would include utilization review agents operating under ERISA.

Reaffirmed 11/5/2006
Reaffirmed 10/16/2016

10.10.03- Improve Step Therapy in Virginia

Date: 10/22/2017

The Medical Society of Virginia will work with stakeholders to reform step therapy in Virginia to require health plans, pharmacy benefit managers (PBMs) and other entities involved to cite clinical review data as justification for denials, create a uniform and expedited appeals and exception process, and establish a process for patients who transition from one insurance plan to another.

10.10.04- Improve Upon the Current Prior Authorization Law in the State of Virginia

Date: 10/22/2017

The Medical Society of Virginia will continue to work with Insurers and request they be more open and transparent about their approval (and rejection) processes and insist that they release information identifying the common evidence-based parameters for insurers' approval of the 10

most frequently prescribed chronic disease management prescription drugs, as required by the 2015 law § 38.2-3407.15:2., and be it further

that the Medical Society of Virginia, work to require insurance companies, pharmacy benefit managers (PBM's) and other entities involved to upgrade the electronic approval of prescription requests, which has been shown to bring cost savings in other states within a few years of its implementation, and be it further

that the Medical Society of Virginia join the American Medical Association to aid in prior authorization reform with a goal of building a dialogue between providers, health plans and their third parties eliminate needless administrative waste from the system.

10.10.05- Opposing Health Plans Restricting Medically Necessary Care

Date: 10/22/2017

The Medical Society of Virginia opposes any health plan mechanism that interferes in the timely delivery of medically necessary care, therefore be it further

The Medical Society of Virginia supports requiring health plans to provide physicians with real time access to covered benefits, the criteria for "medical necessity" and cost information so that physicians and their patients may work together to choose the most cost-effective medically appropriate treatment for patient care.

10.10.06 Prior Authorization Retroactive Denials

Date: 10/21/2018

The Medical Society of Virginia supports a requirement that enforces coverage for pre-authorized services by insurance companies and prevents later reversal of already granted pre-authorization.

15 LIABILITY

Immunity

15.1.01 - Expand Immunity Laws Covering Voluntary Physician Services

Date: 10/30/1993

The Medical Society of Virginia believes that appropriate state immunity statutes covering physician services should be expanded to include physicians working in emergency medical service settings, hospitals, or other settings during disaster conditions.

Reaffirmed 10/28/2007

Reaffirmed 10/22/2017

15.1.02- Physician Reporting to DMV; Immunity

Date: 11/8/1997

The Medical Society of Virginia supports immunity for physicians who report to the Department of Motor Vehicles patients whose physical condition is not compatible with safe driving.

Reaffirmed 10/22/2017

15.1.03- Revision of "Good Samaritan" Statutes for Team Physicians

Date: 10/22/2017

The Medical Society of Virginia supports including in the Code of Virginia liability protection for simple negligence for volunteer physicians providing both emergent and non-emergent health care at athletic events or in athletic programs in the Commonwealth of Virginia.

Legal Proceedings

15.2.01- Confidentiality in Legal Proceedings

Date: 10/30/1993

The Medical Society of Virginia supports legislation which will amend the Code of Virginia to strengthen features relating to confidentiality in the areas of discovery, admission as evidence, forced testimony, and protection only for suits concerning the pending subject.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

15.2.02- Malpractice Review Panels

Date: 10/30/1993

The Medical Society of Virginia supports enactment of meaningful tort reform by amending the statute relating to medical malpractice review panels to require the full participation by all parties after the panel has been requested.

The Medical Society of Virginia supports the idea that the panel decision alone, and not evidence of testimony and deliberations of the panel, should be admissible at the trial of the negligence action.

The Medical Society of Virginia supports the establishment of a formal, post-panel settlement conference, with adverse financial consequences for the party not following the settlement conference recommendations and later receiving an adverse verdict at trial.

The Medical Society of Virginia supports legislation to restore the notice of claim language to the Code of Virginia relating to proceedings and panels.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

15.2.03- Strengthen Good Samaritan Laws

Date: 10/30/1993

The Medical Society of Virginia supports legislation requiring payment of court and attorney fees to a defendant who is named in a lawsuit and subsequently eliminated from the suit by application of the Virginia Good Samaritan Act.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

15.2.04- Physician-Patient Privilege

Date: 11/5/1994
The Medical Society of Virginia supports legislation which would amend the Code of Virginia to allow defense attorneys the same access to treating physicians, witnesses, and medical records as afforded to the plaintiffs' attorneys.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

15.2.05 - Support of Countersuits

Date: 11/5/1994

The Medical Society of Virginia supports pursuit of justifiable countersuits.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

15.2.06- Malpractice Review Panels-Participation

Date: 11/4/1995

The Medical Society of Virginia supports a legislative initiative requiring that when a malpractice review panel is convened, participation by both plaintiff and defendant be required, and during the proceedings of a malpractice review panel, full disclosure of all known facts be required by plaintiff and defendant.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

15.2.07- Tort Reform

Date: 11/8/1997

The Medical Society of Virginia believes that malpractice issues should be resolved in an efficient, fair and less costly manner. Therefore the Medical Society supports:

1. Alternative dispute resolution proposals such as capped binding arbitration that are designed to divert claims from the civil justice system and resolve them more quickly and more cost effectively;
2. Uniform standards for medical liability claims including:
    a. Mandatory periodic payment of damage awards exceeding $250,000;
    b. Mandatory offsets for collateral sources; and
    c. Limitation of contingency fees based upon a sliding scale
3. Filing an affidavit by an expert witness stating that the standard of care was violated or that malpractice has occurred prior to filing a medical malpractice lawsuit.
4. Equal access to the treating physicians and their records for the plaintiff's and the defendant's attorneys.

5. That evidence with respect to a punitive damage claim be heard separately from the main suit.
6. That Virginia's "I'm Sorry" legislation should allow statements expressing "apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence" so that physicians are not inhibited from communicating with their patients regarding their medical care.
7. Procedural and evidentiary legislation that better enables fairness and equity in the defense of a medical liability case, which may include legislative initiatives from the following:
    a. Amending the "dead man's statutes" to clarify that a treating physician may testify as to the health care and professional services rendered to a deceased patient;
    b. Amending Va. Code §8.01-399 regarding physician communications to eliminate the requirement that documentation must be contemporaneously entered in the patient's chart;
    c. Clarifying that medical malpractice cases have to be filed in the jurisdiction where the care is rendered;
    d. Requiring that medical malpractices cases be served within one year of the date they are filed in Court or else they are dismissed with prejudice;
    e. Limiting the exceptions to the statute requiring expert witness certification so they only apply to retention of foreign bodies and wrong site surgeries;
    f. Amending the "habit and customs statute" to clarify that a defendant physician may rely on this in defense of a wrongful death action;
    g. Requiring a pre-trial scheduling order and in a medical malpractice case requiring a plaintiff to designate expert witnesses soon after serving the motion for judgment as opposed to 90 days prior to trial; and
    h. Amending the "expert witness statute" to give trial court judges the ability to review the expert witness certification obtained by plaintiff's counsel,
8. Pilot programs that allow privileged early disclosure of adverse medical outcomes.

Furthermore, the Medical Society of Virginia opposes adoption of a comparative negligence doctrine, and believes that in a claim for contributory negligence, the negligence of the plaintiff does not have to coincide in time with that of the defendant.

Reaffirmed 10/24/2010

Malpractice

15.3.01- Solo Practice/Liability/Medical Review

Date: 11/9/1991

The Medical Society of Virginia shall make efforts to protect the concept of solo practice in primary care against the prejudices of medical liability insurance companies, and medical review processes which focus on solo practicing physicians as compared to group practices.

Reaffirmed 10/30/2011

15.3.02 - Medical Malpractice Cap on Damages

Date: 11/9/1991

The Medical Society of Virginia supports maintaining the cap on professional medical liability awards at a level consistent with the Code of the Commonwealth § 8.01-581.15 and seeks legislation that would implement a cost effective alternative to address cases involving substantial medical expenses.

Furthermore, the Medical Society of Virginia opposes efforts to extend the cap or attempts to increase, stack, or repeal the cap, including any attempt to add on an inflation factor.

Reaffirmed 10/30/2011

15.3.03- Malpractice Coverage for Operational Medical Directors

Date: 11/5/1994

The Medical Society of Virginia believes that the delegation and supervision of clinical activities performed by qualified emergency medical technicians certified by the Commonwealth of Virginia should be included among the ordinary duties of physicians covered in full by medical liability insurance policies, unless these activities are already legislatively exempted from such liability.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

15.3.04- Availability of Insurance

Date: 11/4/1995

The Medical Society of Virginia shall monitor the availability of malpractice coverage in the Commonwealth and keep the Legislature informed.

Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

15.3.05- Premium Discounts as Incentive for Panel Service

Date: 11/8/1997

The Medical Society of Virginia encourages malpractice companies to provide appropriate premium discounts to physicians who participate in medical malpractice review panels.

Reaffirmed 10/28/2007

Reaffirmed 10/22/2017

15.3.06- Statute of Limitations

Date: 11/8/1997

ADULT PATIENTS – The Medical Society of Virginia supports a two year statute of limitation from the date of injury and in cases of retained foreign bodies, fraud, or failure to diagnose cancer; one year from the date of discovery.

MINOR PATIENTS – The Medical Society of Virginia supports the longer statute of limitations for minors as currently set forth in Virginia law.

Reaffirmed 10/28/2007
Reaffirmed as amended 4/28/2018

15.3.07- Medical Insurance Payment Guidelines and the Standard of Care

Date: 08/14/2014

The Medical Society of Virginia supports legislative efforts to ensure that no payment standard or reimbursement criteria developed or implemented by any public or private payer shall be construed as an appropriate standard of care or legal basis for negligence or duty of care owed by a health care provider to a patient in any civil action for medical malpractice or product liability.

Peer Review

15.4.01- Peer Review of Disputed Physician Fees

Date: 10/31/1992

The Medical Society of Virginia believes that the payer of a workers' compensation claim should submit disputed charges to a peer review committee for determination of the reasonableness of the challenged fee.

Reaffirmed 11/2/2012

15.4.02- Peer Review of Utilization

Date: 11/5/1994

The Medical Society of Virginia endorses local peer review of both inpatient and outpatient medical utilization.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

15.4.03- Peer Review

Date: 10/16/2016

It is the policy of the Medical Society of Virginia that in absence of a court order the proceedings, minutes, records and reports of the committees set forth in Virginia Code Section 8.01-581.17.B are privileged and confidential and shall only be disclosed as necessary for such committees to carry out official duties or as required by state or federal law.

The Medical Society of Virginia will pursue legislation to amend Virginia Code Section 8.01-581.17 consistent with the Medical Society of Virginia policy.

For policies regarding teaching of basics in dispute resolution, please see the *Medical Education Policies section- IV Medical School Curriculum*

20 MEDICAL EDUCATION POLICIES

Continuing Medical Education

20.1.01 - Continuing Medical Education

Date: 11/5/1994

The Medical Society of Virginia: a) recognizes that Continuing Medical Education (CME) is important to
patient care and should emphasize the importance of physicians' self-directed learning, and b) supports CME as a requirement for relicensure, contingent upon regulations being established by the Board of Medicine; and c) believes that CME and Virginia medical school curriculum should not be mandated in the Code of Virginia.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

20.1.02- Reducing Medical Errors

Date: 11/7/2004

The Medical Society of Virginia encourages physicians to pursue continuing education that includes training in patient safety and risk management

Reaffirmed 10/26/2014

20.1.03- Opioid Prescribing Education

Date: 10/25/2015

The Medical Society of Virginia (MSV) continues to support efforts to have educational programs on opioid prescribing, the Prescription Monitoring Program (PMP) and on addiction available, easily accessible and affordable for prescribers.

MSV acknowledges that Virginia's prescriber licensing bodies (the Virginia Board of Medicine, the Virginia Board of Nursing, and the Virginia Board of Dentistry) may consider requiring specific topic-area continuing education of licensees regarding opioid prescribing and/or addiction education. The development of any such requirements should be undertaken in collaboration with public health experts and the relevant professional and specialty organizations, should include provisions for measuring the effect of implementing the requirements as compared to the desired outcome, and should incorporate an appropriate sunset clause.

Further, the licensing bodies should be mindful of current specialty training requirements that may already address the concern. In response to any such requirements, the MSV should strive to make the prescribed programming easily accessible and affordable for its members.

20.1.04– Policy on Continuing Board Certification (MOC)

Date: 10/20/2019

The Medical Society of Virginia acknowledges that the requirements within the Maintenance of Certification process are costly and time intensive, and they result in significant disruptions to the availability of physicians for patient care.

Further, the Medical Society of Virginia reaffirms the value of continuing medical education, while opposing mandatory Maintenance of Certification as a requirement for licensure, hospital privileges, and reimbursement form third party payers.

Lastly, the Medical Society of Virginia communicates our position regarding Maintenance of Certification to the AMA, specialty societies, universities, and physician and industry groups involved with independent continuing medical, clinical, and scientific education.

In addition, MSV supports the following updated 2019 AMA Principles on Maintenance of Certification H-275.924 and D-275.954.

AMA Policy H-275.924 Continuing Board Certification

Continuing Board Certification

AMA Principles on Continuing Board Certification

1. Changes in specialty-board certification requirements for CBC programs should be longitudinally stable in structure, although flexible in content.

2. Implementation of changes in CBC must be reasonable and take into consideration the time needed to develop the proper CBC structures as well as to educate physician diplomates about the requirements for participation.

3. Any changes to the CBC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for CBC.

4. Any changes in the CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).

5. CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.

6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.

7. Careful consideration should be given to the importance of retaining flexibility in pathways for CBC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.

8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of CBC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with CBC participation.

9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for CBC Part II. The content of CME and self-assessment programs receiving credit for CBC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit", American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."

10. In relation to CBC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

11. CBC is but one component to promote patient safety and quality. Health care is a team effort, and changes to CBC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

12. CBC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.

13. The CBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

14. CBC should be used as a tool for continuous improvement.

15. The CBC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.

16. Actively practicing physicians should be well-represented on specialty boards developing CBC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.

18. CBC activities and measurement should be relevant to clinical practice.

19. The CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care.

20. Any assessment should be used to guide physicians' self-directed study.

21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.

22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

23. Physicians with lifetime board certification should not be required to seek recertification.

24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in CBC.

25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in CBC.

27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Continuing Board Certification from their specialty boards. Value in CBC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both CBC content and processes.

AMA Policy D-275.954 Continuing Board Certification

Our AMA will:
1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a yearly report to the House of Delegates regarding the CBC process.

2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review CBC issues.

3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.

5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.

6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.

7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.

8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.

9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.

10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.

11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician's current practice.

12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.

14. Work with the ABMS to study whether CBC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.

15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.

16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.

17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.

18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.

19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.

20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.

21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.

22. Continue to participate in the National Alliance for Physician Competence forums.

23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.

24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's CBC and associated processes.

26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.

27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.

28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.

29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.

30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.

31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.

32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.

33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.

34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.

35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.

36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.

37. Our AMA will, through its Council on Medical Education, continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.

20.1.05- AMA Potential Resolution: I-17 Fees For Taking Maintenance of Certification Examination

Date: 10/22/2017

The Medical Society of Virginia through its delegation to the American Medical Association supports efforts to ensure financial transparency and a fair fee structure in the MOC fee schedule and supports efforts to reduce MOC fees including a reduction in fees for those who complete requirements through alternative but approved pathways.

Graduate Medical Education and Residency Training

20.2.01- Graduate Medical Education Funding and Residency Slots

Date: 5/31/2014

The Medical Society of Virginia (MSV) encourages and advocates for private and alternative sources of funding for Virginia-specific graduate medical education (GME) opportunities.

MSV will support when appropriate and encourage the American Medical Association to advocate for additional sources of funding direct and indirect costs of GME; to explore funding for additional residency slots; and to encourage state and specialty societies to seek private and alternative sources of funding for state-specific GME opportunities.

Further, the MSV supports that revenue generated through the Affordable Care Act's excise tax on indoor tanning services, the annual fee on health insurance providers, and the annual fee on branded prescription pharmaceutical manufacturers and importers be directed toward increasing GME funding with the intention of expanding the number of available residency positions and maintaining the positions offered now.

20.2.02- Increased Funding for Residency Training

The Medical Society of Virginia encourages medical schools, residency programs, as well as state and federal government to work cooperatively to graduate and train physicians in high-need medical specialties. The Society supports state, public, and/or private sector funding allocated to medical residency in areas of physician shortages and high-need specialties such as primary care, emergency medicine, psychiatry, and pediatric psychiatry, as well as underserved areas.

Amended by Substitution 10/22/2017

20.2.03 Virginia Medical Clerkship Support

Date: 4/28/2018

The Medical Society of Virginia supports tax credits for physicians providing uncompensated supervised education during health care clerkships to students and residents matriculating in the Commonwealth of Virginia, District of Columbia or surrounding states.

Medical Education Funding

20.3.03- Medical Education Funding

The Medical Society of Virginia recognizes the importance of academic medical centers and high-quality medical education in the Commonwealth and across the nation.

Academic medical centers are essential to train high-quality health care professionals and to conduct medical research necessary for quality health care.

Virginia's academic medical centers are integral to meeting the current and future needs of all the citizens of the Commonwealth. As such, the Society supports appropriate state and federal funding for undergraduate and graduate medical education, and research that enables Virginia's academic medical centers to meet these needs.

Amended by Substitution 10/22/2017

Medical School Curriculum

20.4.01- Expansion of Primary Care Departments/Medical Schools

Date: 11/9/1991

The Medical Society of Virginia supports the expansion and responsibilities of the primary care departments and services at the five medical schools with scheduled rural health participation periods for all students.

Reaffirmed 10/30/2011

20.4.02- Teaching of Basics of Dispute Resolution

Date: 11/4/1995

The Medical Society of Virginia believes mediation and arbitration are sound alternatives to settling disputes as they are more efficient, fairer and less costly than litigation. Physicians should become knowledgeable about mediation and arbitration procedures and when feasible request they be used as the initial means of resolving tort claims or other health care conflicts. The Medical Society of Virginia advocates that the teaching of conflict resolution be included the medical school curriculum where appropriate, and supports legislation which would cause mediation and arbitration procedures to be the initial mechanism for handling such disputes.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

20.4.03- The Hippocratic Oath

Date: 10/31/1998
The Medical Society of Virginia reaffirms the importance of an oath that defines the essential standards of conduct of honorable behavior for the physician, such as the modern Hippocratic Oath and/or the Osteopathic Oath and asks that such pledge be taken by every medical school graduate at each graduation ceremony in the Commonwealth of Virginia.

Reaffirmed 10/12/2008
Reaffirmed as amended 9/14/2019

20.4.04- Evaluating the Effectiveness of the Step 2 Clinical Skills Exam

Date: 10/16/2016

The Medical Society of Virginia will establish a workgroup to evaluate the USMLE Step 2 Clinical Skills Exam, including relative value, cost and accessibility. The workgroup shall be composed of students from the Medical Student Section, physician members including International Medical Graduates, medical school faculty, and residency directors.

The Medical Society of Virginia will work with the AMA to address issues of cost and accessibility of the USMLE Step 2 Clinical Skills Exam

Medical Student Loans and Debt

20.5.01- Medical Student Loans and Debt

The Medical Society of Virginia supports efforts to reduce medical student debt, including scholarships, lowering interest rates, and other effective loan repayment programs. The Society strongly supports the availability of medical student loans in Virginia and supports efforts, including overdue debt collection, to maintain the availability of these programs.

Amended by Substitution 10/22/2017

25 ETHICS

Abortion and Reproductive Decision Making

25.1.01 – Opposition to Title X Prohibition on Abortion Counseling or Referral

Date: 11/9/1991

The Medical Society of Virginia opposes Title X regulations that prohibit counseling or referral for abortion services and prohibit any discussion of abortion between the physician and the patient. The Medical Society of Virginia urges federal legislation or executive action to overturn or rescind such regulations.

Reaffirmed 10/30/2011

25.1.02- Opposition to Criminalization of Reproductive Decision Making

Date: 11/2/2012

The Medical Society of Virginia will oppose any legislation or ballot measures that could criminalize in vitro fertilization, contraception, or the management of ectopic and molar pregnancies.

25.1.03- Support of Expansion of Access to Long Acting Reversible Contraception (LARC)

Date: 10/20/2019

The Medical Society of Virginia supports efforts to promote and sustain Long Acting Reversible Contraceptives (LARC) initiatives in Virginia, including continued funding.

The Medical Society of Virginia further supports efforts that allow physicians to more efficiently offer LARC services in their practices.

25.1.04 – Opposing Legislative Efforts to Restrict the Provision of Reproductive Healthcare

Date: 10/20/2019

The Medical Society of Virginia opposes any government mandated efforts to restrict the provision of medically appropriate care, as decided by the physician and patient, in the management of reproductive health.

The Medical Society of Virginia further opposes efforts which enforce medically unnecessary standards on providers and clinics that in turn make it economically or physically difficult for doctors and clinics to provide services.

End of Life Care

25.2.01- Ethics of Refusing to Provide Futile Care

Date: 11/9/1991

The Medical Society of Virginia supports the concept that a physician assumes a sound ethical position when he/she refuses to render medical treatment that the physician reasonably believes is futile either in terms of promoting or improving the health of his/her patient or alleviating the patient's suffering.

Reaffirmed 10/30/2011

25.2.02- Futile Care/Consultation with Ethics Committees

Date: 11/9/1991

The Medical Society of Virginia recommends that in instances where physicians find themselves unable to satisfactorily resolve conflicts arising over requests for treatment that the physician reasonably believes is futile either in terms of promoting or improving the health of the patient or alleviating the patient's suffering, that they turn to their hospital ethics committee for assistance. While the hospital may wish to contact it's counsel in such instances, from the physician's perspective, the assistance of the hospital ethics committee may be more helpful, since such committees will be familiar with the realities of clinical decision-making in the context of withholding or withdrawing treatment.

Reaffirmed 10/30/2011

25.2.03- Disagreements Regarding Treatment of the Terminally Ill

Date: 11/4/1995

Medical treatment of the terminally ill remains the responsibility of the physician to apply his best medical judgment in each instance and always suggest what he feels to be the proper course of treatment. Should there be any disagreement, it is the physician's prerogative to withdraw from the case after proper notification and assistance in the obtaining of another physician. Conversely, it is the prerogative of the family, parent, guardian, spouse, or committee to replace the physician as they wish.

Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

25.2.04- Physician Assisted Suicide and Euthanasia

Date: 11/8/1997

In dealing with the terminally ill, suffering patient, physicians may ethically:

1. Withdraw life-prolonging procedures or decline to initiate such treatment in situations in which a patient is terminally ill and has given informed consent for this to be done either personally or through an advance directive, or in instances in which the patient is unable to give such consent it is obtained from an authorized family member or a surrogate.

2. Prescribe medication to a patient even though the potential exists for inappropriate use by the patient that may result in death, provided the physician's intent in prescribing such medication is not to cause death or to assist the patient in committing suicide.

3. In situations where the distinction between relieving suffering and causing a terminally ill patient's death may be blurred, the physician should exercise his/her best medical judgment in caring for the patient.

4. Withhold or withdraw treatment from a terminally ill patient that the physician reasonably believes to be futile either in terms of promoting or improving the health of the patient or alleviating the patient's suffering, provided the physician's purpose in so doing is not actively to cause the patient's death, but rather to allow death to occur with minimal suffering.

In accordance with the above statements (which are consistent with and supplemented by the views of the Council on Ethical and Judicial Affairs of the American Medical Association 2.17, 2.20 and 2.21), the Medical Society of Virginia strongly opposes the practice of physician assisted suicide or euthanasia.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

25.2.05- Advocacy for Physician Orders for Scope of Treatment

Date: 11/2/2012

The Medical Society of Virginia supports the Physician Orders for Scope of Treatment (POST) form as a uniform, portable and legal document in the Commonwealth of Virginia.

25.2.06- Treatment of Dying Patients

Date: 10/16/2016

The Medical Society of Virginia encourages medical schools, post-graduate specialty programs, and all Virginia physicians to advance and promote their 'at end of life' training.

The Medical Society of Virginia encourages universal use of 'Advance Care Plans' such as 'Living Wills' in Virginia so that every patient expresses his or her wishes for care in end of life decisions.

25.2.07- Do Not Resuscitate Orders

The Medical Society of Virginia recommends that every hospital and medical staff have a written policy consistent with the Virginia Healthcare Decisions Act regarding "No Code/Do Not Resuscitate (DNR)" orders, also referred to as "Allow Natural Death" orders, which uses the following guidelines:

a. That the attending physician take measures to ensure that both the decision and the reasons for No Code/DNR are clearly communicated to those who have vital need to know.
b. That the attending physician and hospital staffs familiarize themselves with the requirements of the Virginia Healthcare Decisions Act and the significance of the Living Will so as to be able to take advantage of the immunity from liability it provides in connection with the writing of "No Code/DNR" orders.

The Medical Society of Virginia supports the applicability of Emergency Medical Services Do Not Resuscitate orders to minors with documented "terminally ill" or "incompatible with extended life" conditions when properly executed by the parents and/ or legal guardians and the attending physician.

Amended by Substitution 10/22/2017

Patient-Physician Relationship

25.3.01- Opposition to Restraining Appropriate Use of Services

Date: 11/5/1994

The Medical Society of Virginia opposes any legislation which would restrain the appropriate

use of needed medical services.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

25.3.02- Legislation, Standards of Care and the Patient/Physician Relationship

Date: 11/2/2012

The Medical Society of Virginia will oppose or work to favorably amend legislation, regardless of its primary intent, that interferes with or jeopardizes the sanctity of the patient/physician relationship or is in conflict with or contrary to broadly accepted, evidence-based standards of care identified by credible medical organizations such as the American Medical Association or the specialties and sub-specialties recognized by the American Board of Medical Specialties.

25.3.03- Establishing a Physician-Patient Relationship via Telemedicine

Date 10/26/2014

The Medical Society of Virginia supports the following principles:

1. A physician-patient relationship with prescribing can only be established via telemedicine if the encounter:
    a. Provides information equivalent to an in-person exam,
    b. Conforms to the standard of care expected of in-person care (for example, if a component of a physical examination is generally the considered standard of care in diagnosing and treating a particular condition, then such a physical examination must also be performed), including through the use of peripheral devices appropriate to the patient's condition,
    c. Incorporates diagnostic tests sufficient to provide an accurate diagnosis (for example, if a diagnostic test is required for an accurate diagnosis of strep throat or urinary tract infection, then such diagnostic test should be performed), or
    d. There is a duly licensed practitioner (such as a nurse, NP, PA, or physician) as a telepresenter with the patient.

2. A physician-patient relationship resulting in prescribing cannot be established through an examination by telephone (audio-only) or email, except in cases of public health emergency as determined by the Secretary of Health and the Commissioner of Health.

3. Such regulation outlined above shall not prohibit currently accepted on-call or cross coverage practices.

25.3.04- Patient-Physician Communication

The Medical Society of Virginia strongly condemns any interference by the government or other third parties that may compromise a physician's ability to use their medical judgment as to what information or treatment is in the best interest of the patient. The Medical Society of Virginia supports communication between a patient and his/her physician on how compensation arrangements and other policies relevant to patient care may impact the quality of his/her care.

Further, the Medical Society of Virginia opposes any efforts to limit, interfere, or restrict communications between a patient and their physician.

Amended by Substitution 10/22/2017

Clinical Research

25.4.01- Animal Research

Date: 11/8/1997

The Medical Society of Virginia supports the need for the use of animals in research.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

Prohibited Practices

25.5.01 Prohibiting Conversion Therapy in Those Under Age 18

Date: 10/21/2018

The Medical Society of Virginia opposes the use of conversion therapy or any similar practice, including but not limited to reparative therapy, ex-gay therapy, or sexual orientation change efforts, in those under age 18.

Equity

25.6.01 American "Equal Rights Amendment"

Date: 10/20/2019

The Medical Society of Virginia supports the Equal Rights Amendment (ERA).

25.6.02 Advancing Gender Equity in Medicine

Date: 10/20/2019

The Medical Society of Virginia supports and adopts the AMA Policy H-65.961 – Principles for Advancing Gender Equity in Medicine.

Further, the Medical Society of Virginia support: a) institutional, departmental, and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; b) pay structures based on objective, gender-neutral objective criteria; c) identification of gender disparity in compensation models, metrics, and actual total compensation for all employed physicians; and d) training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.

AMA Policy H-65.961 Principles for Advancing Gender Equity in Medicine

Principles for Advancing Gender Equity in Medicine:
Our AMA:
1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);

2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;

3. endorses the principle of equal opportunity of employment and practice in the medical field;

4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;

5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;

6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;

7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;

8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.

30 BUSINESS

Coding, Reimbursement, and Payment

30.1.01 - Right of Physicians to Negotiate Medical Cost and Utilization

Date: 10/30/1993

The Medical Society of Virginia, in order to advance health care system reform, believes that modification of antitrust regulations is needed to allow appropriate collective negotiations by physicians.
Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

30.1.02- Workers' Compensation: Collection of Attorneys' Fees

Date: 10/30/1993

The Medical Society of Virginia supports changes in Virginia's Workers' Compensation Statute Section 65.2-714 to ensure that physicians receive all compensation due them for services rendered.

The Medical Society of Virginia supports changes in Virginia's Workers' Compensation Statute so that any fee to attorneys retained by the employee be paid by either the employee, and in the case the appeal is unsuccessful by the employer, or by the state Workers' Compensation Fund.

Reaffirmed 10/12/2008
Reaffirmed 10/21/2018

30.1.03- Responsible Party

Date: 11/4/1995

The Medical Society of Virginia believes the patient, his or her family (in the case of a minor), or legal guardian should be responsible for the cost of physician services.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

30.1.04- Coding/Reimbursement for Mental Health Services

Date: 10/31/1998

The Medical Society of Virginia endorses the DSM 5 as the instrument to document and code biopsychosocial data for data collection and for third party payer reimbursement of primary care providers in the Commonwealth of Virginia.

Reaffirmed 10/12/2008
Reaffirmed as amended 10/21/2018

Licensure, Credentialing, and Privileges

30.2.01- Economic Credentialing

Date: 9/16/2000

In Accordance with AMA policy 230.975, the Medical Society of Virginia:

1) Adopts the following definition of economic credentialing: economic credentialing is defined as the use of economic criteria unrelated to the quality of care or professional competency in

determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges;

2) Strongly opposes the practice of economic credentialing;

3) Believes that physicians should continue to work with their hospital boards and administrators to develop appropriate educational uses of physician hospital utilization and related financial data and that any such data collected be reviewed by professional peers and shared with the individual physicians from whom it was collected;

4) Believes that physicians should attempt to assure provision in their hospital medical staff bylaws of an appropriate role for the medical staff in decisions to grant or maintain exclusive contracts or to close medical staff departments;

5) Will communicate its policy and concerns on economic credentialing on a continuous basis to the American Hospital Association, Federation of American Health Systems, and other appropriate organizations.

6) Encourages state medical societies to review their respective state statutes with regard to economic credentialing, and as appropriate, to seek modifications therein;

7) Will explore the development of draft model legislation that would acknowledge the role of the medical staff in the hospital medical staff credentialing process and assure various elements of medical staff self-governance; and

8) Will study and address the issues posed by the use of economic credentialing in other health care settings and delivery systems (CMS Rep. B, I-91)

Reaffirmed 10/24/2010

30.2.02- Economic Credentialing Criteria

Date: 9/16/2000

In accordance with AMA Policy 230.976, the Medical Society of Virginia opposes the use of economic criteria not related to quality to determine an individual physician's qualifications for the granting or renewal of medical staff membership or privileges (Res. 2, A-91).

Reaffirmed 10/24/2010

30.2.03- Encouragement of Open Hospital Medical Staffs

Date: 9/16/2000

In accordance with AMA Policy 230.976, the Medical Society of Virginia affirms its support for the principle of open staff privileges for physicians, based on training, experience, and demonstrated competence.

Reaffirmed 10/24/2010

30.2.04- Medical License Linkage with Medicare/ Medicaid Participants

Date: 11/4/2002

The Medical Society of Virginia opposes any linkage between physician licensure and Medicare/ Medicaid participation.

Reaffirmed 11/2/2012

30.2.05- Medical License Linkage to Hospital ER Call

Date: 11/6/2005

The Medical Society of Virginia opposes any linkage of a physician's medical license to providing hospital emergency department on call coverage.

Reaffirmed 10/25/2015

30.2.06- Interstate Licensure Compact in Virginia

Date: 10/25/2015

The Medical Society of Virginia supports the development and implementation of an Interstate Medical Compact in Virginia and supports the required legislative and regulatory efforts necessary to adopt the Interstate Licensure Compact in Virginia.

Mandates on Physician Practice

30.3.01- Harassment

Date: 11/9/1991

The Medical Society of Virginia supports legislation at every level to soften harassment of physicians under "antitrust," adverse data bank, and peer review organizations.

Reaffirmed 10/30/2011

30.3.02- Federal Regulations

Date: 10/30/1993

The Medical Society of Virginia supports the efforts of the American Medical Association to seek the repeal of CLIA 88 and OSHA rules that are of unproven value and place onerous financial and time burdens on medical
offices and laboratories.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

30.3.03- Hospital Staff Privileges

Date: 11/5/1994

The Medical Society of Virginia opposes any legislation, on both the state and federal levels, which attempts to mandate a connection between participation and payment programs and staff privileges.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

30.3.04- Physician's Freedom of Choice

Date: 11/5/1994

The Medical Society of Virginia supports the right of every physician to choose those persons whom he or she will accept as patients and also to exercise his or her choice by the terms of contractual arrangements with other physicians, medical groups, hospitals, or other institutions.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

30.3.05- Release Form Information

Date: 10/31/1998

The Medical Society of Virginia recommends that medical records release forms should include the patient’s name, address, date of birth, phone numbers, and a statement that there may be a charge from the sending physician for reproduction and mailing of the chart.

Reaffirmed 10/12/2008
Reaffirmed 10/21/2018

30.3.06- Prohibition of Nondisclosure Clauses

Date: 11/4/2001

The Medical Society of Virginia supports the prohibition of nondisclosure clauses in physician contracts.

Reaffirmed 10/25/2015

Practice Rights and Assistance

30.4.01- Assistance with New Practice Expenses

Date: 11/9/1991

The Medical Society of Virginia encourages the establishment of community credit sources or an endorsement authority for a physician's new practice expenses.

Reaffirmed 11/4/2001

Reaffirmed 10/25/2015

30.4.02- Use of Employees; Transmit Orders

Date: 11/5/1994

The Medical Society of Virginia opposes any amendment to the Code of Virginia that would prohibit a physician from using his employees to transmit orders for hospitalized patients.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

30.4.03- Physician Determination of Length of Stay

Date: 11/4/1995

The Medical Society of Virginia reaffirms that physician professional opinion should be the determining factor in establishing the need for continued hospitalization.

The Medical Society of Virginia opposes legislation giving anyone other than the attending physician the authority to determine length of stay.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

30.4.04- MSV COPN Policy

Date: 1/20/2016

The Medical Society of Virginia supports the deregulation of COPN. The Medical Society of Virginia will consider supporting individual COPN legislation on a case-by case-basis, with decision for approval derived from previously adopted principles of patient safety and access to quality, affordable health care. The Medical Society of Virginia continues to support the economic viability of Virginia's academic health centers. Newly deregulated services should be required to meet a charity care commitment as well as recognized standards of accreditation or quality.

Reaffirmed 5/6/2017

30.4.05- Physician & Medical Staff Bill of Rights

Date: 10/21/2018

Our Medical Society of Virginia adopts AMA policy H-225.942 “Physician and Medical Staff Bill of Rights” in the MSV Policy Compendium.

30.4.06- Remove Restrictive Covenants for Healthcare Providers in Virginia

Date: 9/14/2019

The Medical Society of Virginia will publish a study that provides a legal summary of the tests the court uses for covenants and summaries of several decisions so to inform members on how the court has ruled. The study will be made available for members by December 31, 2019.

30.4.07 – Stopping Robocalls in Virginia

Date: 10/20/2019

The Medical Society of Virginia supports a ban on unsolicited robocalls in Virginia due to the adverse effect they have on patient care.

Quality Practice Programs

30.5.01- Quality Assurance Bodies

Date: 11/5/1994

The Medical Society of Virginia opposes any legislative program which would encourage the dismantling of hospital staffs or other quality assurance bodies deemed appropriate by the medical profession.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

30.5.02- Patient Centered Medical Home

Date: 9/26/2009

The Medical Society of Virginia supports the Patient Centered Medical Home as outlined in the Joint Principles of the Patient Centered Medical Home that were adopted by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association.

Reaffirmed as amended 10/20/2019

Taxes and Fees

30.6.01- Opposition to Provider Tax

Date: 10/31/1992

The Medical Society of Virginia opposes the use of a "provider tax," certificate tax, or professional licensure tax.

The Medical Society of Virginia shall make known its alarm that physicians, hospitals, pharmacists, nurses and other health care providers might be targeted for special and unfair taxation to meet the obligations of all the citizens of the Commonwealth.

The Medical Society of Virginia shall continue to explore, with appropriate State authorities, alternative and appropriate means of providing all necessary medical services for all citizens of the Commonwealth other than through provider taxes.

Reaffirmed 10/30/2011

30.6.02- Liens for Hospital and Medical Services

Date: 11/5/1994

The Medical Society of Virginia supports a statutory change in the Code of Virginia regarding liens for hospital and medical services such that the amount of the statutory lien is increased to cover the reasonable and necessary charges; that a formal recording system for such liens be created; and that the payers of personal injury proceeds be liable for satisfaction of hospital/medical liens for up to one year after the date of payment of proceeds.

Reaffirmed 11/07/2004
Reaffirmed 10/26/2014

30.6.03- Administrative Fees in Medical Offices

Date: 11/7/2004

The Medical Society of Virginia supports the concept that in lieu of other contractual arrangements with insurance plans, a charge to the patient of an administrative fee for services rendered in the physician's office by the physician or his/ her administrative staff for administrative time, not associated with the office visit, is both reasonable and ethical.

Reaffirmed 10/26/2014

30.6.04- "Not-for-Profit" Tax Status under PPACA

Date: 10/30/2011

The Medical Society of Virginia will support a legislative study of the "not-for-profit" tax status requirements for hospital and health systems' under the Patient Protection and Affordable Care Act (PPACA).

30.6.05- Business, Professional and Occupational License (BPOL) Tax

Date: 1/21/2012

The Medical Society of Virginia supports reform of the Business, Professional and Occupational License (BPOL) tax.

Technology, Data, and Information Sharing

30.7.01- State Funding for Electronic Health Information Systems

Date: 11/8/1997

The Medical Society of Virginia supports a state funded electronic health information systems that improve access and communication of health information for physicians with protection of patient confidentiality. Physicians should not be required to pay for the ability to use such electronic health information exchange or system.

Reaffirmed 10/28/2007
Reaffirmed as amended 10/22/2017

30.7.02- Truth in Virginia Health Care Database

Date: 11/8/1997
The Medical Society of Virginia opposes the collection of charge data as a substitute for cost data and supports the collection of meaningful cost data.

Reaffirmed 10/28/2007
Reaffirmed as amended 10/22/2017

30.7.03- Physician Profiles and Health Care Data Collection

Date: 10/31/1998

The Medical Society of Virginia:

1) Urges local medical societies, specialty societies, hospital medical staff, and individual physicians to seek active involvement in the development, implementation, and evaluation of physician profiling initiatives;

2) Encourages research to develop improved data sources, methods, and feedback approaches to physician profiling initiatives;

3) Opposes the use of profiling procedures that do not meet AMA principles for the credentialing or termination of physicians by managed care plans;

4) Opposes physician profiling data being used for economic credentialing purposes;

5) Believes that any disclosure or release of physician profiles shall follow strict conformance to the Medical Society of Virginia and AMA policy on the use and release of physician-specific health care data (AMA Policy H-406.996); and

6) Will monitor the use of profiling procedures related to physician profiling.

The Medical Society of Virginia:

1) Continues to advocate that health care data collected by government and third party payers be used
for education of both consumers and providers; and

2) Believes that government, third party payers and self-insured companies should make physician specific utilization information available to medical societies.
Reaffirmed 10/24/2010

30.7.04- Physician Profiling

Date: 10/30/1999

In accordance with AMA Policy H-406.994, the Medical Society of Virginia advocates that managed care organizations, third party payers, government entities, and others that develop physician profiles adhere to the following principles:

1) The active involvement of physician organizations and practicing physicians in all aspects of physician profiling shall be essential.

2) The methods for collecting and analyzing data and developing physician profiles shall be disclosed to relevant physician organizations and physicians under review.

3) Valid data collection and profiling methodologies, including establishment of a statistically significant sample size, shall be developed.

4) The limitations of the data sources used to develop physician profiles shall be clearly identified and acknowledged.

5) Physician profiles shall be based on valid, accurate, and objective data and used primarily for educational purposes.

6) To the greatest extent possible, physician profiling initiatives shall use standards-based norms derived from widely accepted, physician-developed practice parameters.

7) Physician profiles and any other information that have been compiled related to physician performance shall be shared with physicians under review.

8) Comparisons among physician profiles shall adjust for patient case-mix, control for physician specialty, and distinguish between the ordering or referring physician and the physician providing the service or procedure.

9) Effective safeguards to protect against the unauthorized use or disclosure of physician profiles shall be developed.

10) The quality and accuracy of the physician profiles, data sources, and methodologies shall be evaluated regularly. (CMS Rep. J, A-93; CMS Rep. 10, A-96)

Additionally, the Medical Society of Virginia encourages the inclusion of these Principles into any laws, regulations, or policies
governing the use or creation of physician profiles.

Reaffirmed 10/25/2009
Reaffirmed 10/20/2019

30.7.05- Electronic Prescribing

Date: 10/12/2008

The Medical Society of Virginia supports the concept of electronic prescribing, but strongly condemns a funding structure that financially penalizes physicians for not utilizing such technology.

Reaffirmed 10/21/2018

30.7.06- Electronic Medical Record Mutual Interaction

Date: 10/25/2009

The Medical Society of Virginia supports measures to optimize and require interoperability and other ways of communicating essential patient data between electronic medical record systems.

Reaffirmed as amended 10/20/2019

30.7.07- One Web Portal for State Databases

Date: 1/16/2012

The Medical Society of Virginia supports integrating all state-based reporting systems, including the Virginia Immunization Information System (VIIS), in a physician's EMR system or a single-sign on web-based portal.

Reaffirmed as amended 10/22/2017

30.7.08- Requests for Patient Information

Date: 5/31/2014

The Medical Society of Virginia opposes insurance companies' unrestricted gathering of patient information.

Reaffirmed as amended 10/22/2017

30.7.09- De-Identified Aggregate Patient Health Data

Date: 05/02/2015

The Medical Society of Virginia supports the use or development of tools which utilize de-identified aggregate patient health data to improve care methodologies and will advocate for appropriate protections that allow such use and analysis.

30.7.10- Physician Participation in Efforts to Control Healthcare Costs

Date: 10/16/2016

The Medical Society of Virginia supports efforts to increase transparency for charges related to the provision of health care.

30.7.11- Telemedicine Records

Date: 10/16/2016

The Medical Society of Virginia will develop legislation and/or regulations requiring entities providing telemedicine services outside of a patient's primary medical setting to ask the patient to identify a physician or care setting of record and to provide that clinical setting with a full record of the provided telemedicine service.

The Medical Society of Virginia will explore the feasibility of including such legislation and/or regulations in the 2017 legislative agenda.

The Medical Society of Virginia will educate and advocate to the Medical Society of Virginia members on the use and implementation of telemedicine and other related technology in their practices to improve access, convenience, and continuity of care for their patients.

30.7.12- E-Prescribing Of Schedule II Medications

Date: 10/22/2017

The task force will explore and consider the following topics:

- Mandatory e prescribing for schedule 2 medications
- Requiring a patient-physician relationship based upon a face to face clinical encounter as defined by the health regulatory board of Virginia (or, in the case of a covering situation, clinic)
- All electronic prescribing software approved for use in Virginia be connected to the PMP (all electronic prescribing platforms must be interoperable).
- Interoperability with the PMP's of Virginia's bordering states.
- Waivers and/or subsidization for doctors documenting financial hardship, technology challenges and/or no local broadband service, and for those who write few schedule II prescriptions.
- Identifying the costs associated with implementing the process for physicians and physician groups and how to make it affordable.
- Guidelines on the use paper of prescriptions for specified situations and settings.
- Appropriateness of variable prescribing limits for specific meds and/or dosing based upon patient's condition, type (hospice), and physician specialty and, possibly, with opioid/pain med CME requirements
- Design methods for data collection to monitor impact and other research considerations

- Design methods to detect problem patients and physicians and consider methods for prevention and intervention when necessary, and be it further

This taskforce shall make a report to the Medical Society of Virginia Board of Directors with a recommended position on mandatory e-prescribing to inform the ongoing work as established by HB 2165.

35 PRESCRIPTION DRUG POLICIES

Controlled Substances

35.1.01 - Urine Collection

Date: 11/4/1995

When chain of custody is required, the Medical Society of Virginia supports legislation requiring national standardized custody and control process and forms for collection of urine for drug screening.

Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

35.1.02 - Access to PMP Data for Law Enforcement

Date: 1/16/2012

The Medical Society of Virginia supports allowing law enforcement personnel access to Prescription Monitoring Program (PMP) data while involved in an active investigation.

Dispensing of Prescriptions

35.2.01- Questionable Activities of Certain Pharmaceutical Manufacturers

Date: 10/30/1993

The Medical Society of Virginia opposes pharmaceutical manufacturers paying pharmacists incentives that reward pharmacists for substituting their brand preference for the physician's choice in the prescribing of patient medications based solely on personal financial incentives.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

35.2.02- Mailing of Controlled Drug Samples

Date: 11/8/1997

The Medical Society of Virginia condemns solicitations offering narcotic/analgesic chemical substances through the U.S. Postal Service without adequate safeguards and considers that such solicitation is unethical and should be illegal.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

35.2.03- Physician Dispensing

Date: 11/8/1997

The Medical Society of Virginia supports physician dispensing of prepackaged drugs for a fee or charge when it is in the best interest of the patient.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

35.3.04- Listing of Generic and Proprietary Medications when substituted

Date: 10/31/1998

The Medical Society of Virginia supports Code of Virginia § 54.1-3408.03, which requires that pharmacies and other entities which dispense medications to patients list both the generic and the proprietary name for the medication when generic substitution occurs in the Commonwealth of Virginia.

Reaffirmed 10/12/2008

Reaffirmed 10/21/2018

35.3.05- Virginia Inpatient Pharmacies Being Able to Dispense Outpatient Medications

Date: 10/20/2019

The Medical Society of Virginia supports reform to allow Virginia inpatient hospital pharmacies with 24-hour pharmacy services to dispense outpatient medications for patients treated that same-day at the affiliated hospital.

35.3.06- Reasonable Price Control for Prescription Medications

Date: 10/20/2019

The Medical Society of Virginia supports policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.

Guidelines for Prescriptions

35.4.01- Therapeutic Substitution-ACP position

Date: 11/3/1990

The Medical Society of Virginia supports the following positions of the American College of Physicians (ACP) regarding the issue of therapeutic substitution of drugs.

1. Therapeutic substitution is appropriate only in hospitals with an effectively functioning formulary system and Pharmacy and Therapeutics Committee.

2. Therapeutic substitution jeopardizes patient management when immediate prior consent is not obtained from the authorized prescriber and when documentation of substitutions is untimely or improper. Such practices must not be permitted.

3. The practice of therapeutic substitution may be acceptable in ambulatory settings that meet standards comparable to those of institutional settings.

4. Effective therapeutics require physicians to be well educated in therapeutics and to instruct patients about the proper use and effects of prescribed medication.

Reaffirmed 10/30/2011

35.4.02- Guidelines for Prescriptions

The Medical Society of Virginia adopts the following guidelines:

- All prescriptions must be initiated by the prescribing physician, or appropriately licensed prescribers.

- Authority to dispense may be provided by his signature on the prescription or by direct personal communication by the prescribing physician or an assistant under the physician's direct and immediate supervision to the pharmacist.

- When a prescription has been filled or refilled the maximum number of times as initially designated, it is an expired prescription. Authorization to refill an expired prescription must be obtained by the pharmacist by direct personal communication with the prescribing physician or an assistant under the physician's direct and immediate supervision, or by a new prescription.

- When a pharmacist has concern in his own mind about the timeliness of a prescription refill, patient's need, and all other factors that demonstrate the appropriateness of the physician contact, he should contact the physician for the purpose of obtaining authorization to fill or refill the prescription.

- Patient Profiles maintained by the pharmacist which document the patient's drug history are considered important documents that would be available to assist the pharmacist in familiarizing the physician with the patient and concurrent drugs prescribed by other physicians.

- Using the patient as an intermediary in communications between the physician and pharmacist is unacceptable; e.g., the physician should not tell the patient to inform the pharmacist that the physician approves additional refills of a prescription.

- Use of the term "PRN" as a prescription refill authorization is discouraged.

- Physicians should be specific in designating 1) the frequency, 2) a maximum time limit, and 3) a maximum number of refills.

- The use of patient medication instruction forms and other patient education material by physicians is encouraged.

Amended by Substitution 10/22/2017

Marketing of Prescription Drugs

35.5.01- Curtail Direct Consumer Advertising of Prescription Drugs

Date: 10/20/2019

The Medical Society of Virginia supports current AMA policy H-105.988 on banning direct to consumer advertising of prescription drugs.

AMA Policy H-105.988 Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices

1. To support a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices.

2. That until such a ban is in place, our AMA opposes product-claim DTCA that does not satisfy the following guidelines:

(a) The advertisement should be indication-specific and enhance consumer education about the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used.

(b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing.

(c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for non-prescription products.

(d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments,"• is recommended.

(e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable.

(f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers,

without distraction of content, and will help facilitate communication between physician and patient.

(g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.

(h) In general, product-claim DTCA should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTCA, a disclaimer should be prominently displayed.

(i) The use of actual health care professionals, either practicing or retired, in DTCA to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement.

(j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved.

(k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines.

3. That the FDA review and pre-approve all DTCA for prescription drugs or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product.

4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective regulation of DTCA.

5. That DTCA for newly approved prescription drug or implantable medical device products not be run until sufficient post-marketing experience has been obtained to determine product risks in the general population and until physicians have been appropriately educated about the drug or implantable medical device. The time interval for this moratorium on DTCA for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product's sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implantable medical device for physicians who are most likely to prescribe it.

6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with DTCA.

7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of

DTCA, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public.

8. That our AMA supports the concept that when companies engage in DTCA, they assume an increased responsibility for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine.

9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-claim DTCA and with the Council on Ethical and Judicial Affairs Ethical Opinion E-9.6.7 and to adhere to the ethical guidance provided in that Opinion.

10. That the Congress should request the Agency for Healthcare Research and Quality or other appropriate entity to perform periodic evidence-based reviews of DTCA in the United States to determine the impact of DTCA on health outcomes and the public health. If DTCA is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase DTCA regulation or, if necessary, to prohibit DTCA in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution.

11. That our AMA supports eliminating the costs for DTCA of prescription drugs as a deductible business expense for tax purposes.

12. That our AMA continues to monitor DTCA, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTCA, as necessary.

13. That our AMA supports "help-seeking" or "disease awareness"• advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other medical product and are not regulated by the FDA).

14. Our AMA will advocate to the applicable Federal agencies (including the Food and Drug Administration, the Federal Trade Commission, and the Federal Communications Commission) which regulate or influence direct-to-consumer advertising of prescription drugs that such advertising should be required to state the manufacturer’s suggested retail price of those drugs.

40 PUBLIC HEALTH

Also see Insurance Coverage section

Access to Care

40.1.01- Cooperation with Local Health Departments

Date: 11/3/1990

The Medical Society of Virginia encourages its local component societies to work cooperatively with local health departments to provide health care to all levels of the medically indigent in order to prevent the duplication of services and to conserve limited health care resources.

Reaffirmed 11/2/2012

40.1.02- Involvement of Local Businesses

Date: 11/3/1990

The Medical Society of Virginia encourages its local component societies to enlist the support of their local business communities in local plans to provide care to the medically indigent since the efficient delivery of care to this population would lessen cost shifting to insured patients.

Reaffirmed 11/2/2012

40.1.03- Local Plans

Date: 11/3/1990

The Medical Society of Virginia encourages local component societies to work with their local health departments and local hospitals to develop plans to provide medical care for the medically indigent in their localities.

Reaffirmed 11/2/2012

40.1.04- Medically Underserved Areas

Date: 11/3/1990

The Medical Society of Virginia shall continue its current efforts and initiate other appropriate efforts to attract physicians to the medically underserved areas of Virginia.

Reaffirmed 10/30/2011

40.1.05- Rural Health Transportation

Date: 11/9/1991

The Medical Society of Virginia supports the Medical Transport System, particularly in underserved areas.

Reaffirmed 11/4/2001
Reaffirmed 10/25/2015

40.1.06- Tax Credits for Services to the Uninsured

Date: 10/31/1992

The Medical Society of Virginia supports the investigation of the feasibility of a tax credit for physicians who provide medical care to the uninsured indigent.

Reaffirmed 11/2/2012

40.1.07- Providing Better Access to Primary Care in Federally Designated Health Professional Shortage Areas

Date: 10/30/1993

The Medical Society of Virginia supports changing federal legislation to reinstate the private practice repayment option for indebted physician providers by the National Health Service Corps., so that the National Health Service Corps Loan Repayment Program would apply to all primary care physicians wishing to locate in private practice or in not-for-profit primary health care facilities and practice in a health professional shortage area as designated.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

40.1.08- Improve Physician Placement

Date: 11/5/1994

The Medical Society of Virginia supports increasing the number of rural residency positions and improving the retention of residents, in particular those in primary care, in medically underserved rural areas of Virginia.

The Medical Society of Virginia recommends that the Commonwealth of Virginia increase staff, support, and funding for the Office of Rural Health. In addition, the Medical Society of Virginia recommends that the Virginia Department of Health promote opportunities to practice in rural and health professional shortage areas (HPSA).

The Medical Society of Virginia requests that the Office of Health Planning publish information for physicians to help them know what the process is to convert a county, census tract or designated population into a HPSA.

Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014
Reaffirmed as amended 10/20/2019

40.1.09- Programs to Maintain Elderly Patients in Home Environment

Date: 11/5/1994

The Medical Society of Virginia believes that Virginia physicians should assist in the effort to maintain elderly patients in their home environments. Furthermore, the Medical Society believes that state funding must be available for the establishment of community programs designed to meet the needs of the elderly.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

40.1.10- Community Adult Day Care

Date: 11/4/1995

The Medical Society of Virginia promotes the concept of adult day care on the local and statewide level as an integral part of a community's total health services.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

40.1.11- Free Clinics

Date: 11/8/1997

The Medical Society of Virginia emphatically supports voluntarily staffed Free Clinics.

The Medical Society applauds physician involvement in the development of and participation in Free Clinics and encourages local component societies to publicize free clinic activities so that such services are recognized and utilized to their fullest capacity.

The Medical Society supports the existing civil immunity protections for volunteer health professionals and for the free clinics themselves.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

40.1.12- Improve Access to Prescription Drugs for the Uninsured

Date: 11/8/1997

The Medical Society of Virginia requests the AMA to meet with the Pharmaceutical Research and Manufacturers of America to design a universal form for physicians to fill out requesting stock bottles of medications from American pharmaceutical companies for indigent patients.

Reaffirmed 10/12/2008
Reaffirmed 10/21/2018

40.1.13 - Emergency Department On-Call Physicians

Date: 10/25/2009

The Medical Society of Virginia supports and encourages health care organizations and governmental agencies to assure adequate emergency department on-call specialist access.

Reaffirmed 10/20/2019

40.1.14- Support for Project Access Programs

Date: 10/25/2009

The Medical Society of Virginia affirms the value of physician-directed Project Access programs and equivalent initiatives around the Commonwealth that provide pro bono health care services to underinsured and uninsured individuals. The Medical Society of Virginia encourages entities to provide financial resources in the form of grants or other support to such initiatives.

Reaffirmed 10/20/2019

For policies regarding access to maternal health care, please see the *Public Health section- XIV Maternal, Infant, and Child Health*

For policies regarding access to care in medical school curriculums, please see the *Medical Education Policies section- IV Medical School Curriculum*

Addiction Prevention and Treatment

40.2.01- Addiction in Children

Date: 11/11/1989

The Medical Society of Virginia supports measures to prevent addiction in children in the Commonwealth and in the Nation through the resources at its command.

Reaffirmed 10/25/2009
Reaffirmed as amended 10/22/2017

40.2.02- Sales Tax Increase for Alcohol

Date: 10/31/1992

The Medical Society of Virginia supports legislation to raise the state tax on alcohol and to use the monies generated through this increase in tax to promote preventive medicine, public health and primary care.

Reaffirmed 11/2/2012

40.2.03- Reporting/Substance Abuse

Date: 11/5/1994

The Medical Society supports educational programs in Virginia's schools regarding substance abuse prevention. Such educational programs should include curricula specific to opioid addiction, specifically identifying symptoms of overdose, treating overdose, and providing support for persons experiencing opioid misuse/overdose.

Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014
Amended by addition 10/21/2018

40.2.04 - "Good Samaritan" Protection for Overdose Witness

Date: 1/16/2012

The Medical Society of Virginia supports granting "Good Samaritan" protection for those who call 9-1-1 when witnessing a possible drug overdose, including protection from arrest for persons under the influence or with simple possession.

Amended by Addition: 10/21/2018

40.2.05 Expansion of Drug Takeback Programs

Date: 10/21/2018

The Medical Society of Virginia supports the expansion of Drug Take-Back and other such diversion prevention programs, safe disposal options, or disposal sites, as well as increasing public awareness about the availability of such programs statewide.

AEDs

40.3.01- AEDs for Police First Responders

Date: 11/7/2004

The Medical Society of Virginia supports funding for law enforcement agencies to buy AEDs and to equip and train their personnel as first responders to improve cardiac arrest survival.

Reaffirmed 10/26/2014

Antimicrobial Resistance

40.4.01- Nonclinical Antibiotic Usage in Livestock

Date: 5/31/2014

The Medical Society of Virginia (MSV) opposes the routine use of antibiotics in livestock for nonclinical reasons and supports legislative and other measures that phase out the use of antibiotics in livestock for nonclinical use.

Cancer

40.5.01- Screening and Detection Programs

Date: 11/5/1994

The Medical Society of Virginia encourages all physicians to support screening and detection programs designed to promote the diagnosis of cancer at an early stage.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

40.5.02- Virginia Cancer Registry

Date: 11/5/1994

The Medical Society of Virginia endorses accreditation through the Commission on Cancer of the American College of Surgeons and encourages all hospitals to seek approval. In addition, the Medical Society of Virginia supports hospital participation in the Virginia Cancer Registry.

Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

40.5.03- Physician Reporting of Cancer Cases

Date: 10/31/1998

The Medical Society of Virginia strongly believes that all physicians in Virginia should report cases of cancer to the Virginia Cancer Registry unless they can determine that these cases have already been reported by a hospital, clinic, or in-state pathology laboratory.

The Medical Society of Virginia strongly supports the continued collection of basic data on all cancer patients in Virginia by the Department of Health as specifically outlined in Virginia Codes 32.1-70 and 32.1-71B.

Reaffirmed 10/12/2008
Reaffirmed 10/21/2018

Child Health

40.6.01- Anabolic Steroids

Date: 10/30/1993

The Medical Society of Virginia believes that the state department of education should develop and implement a program of drug testing for all Virginia State District Champions in all varsity sports proceeding to that level, and be it further

The Medical Society of Virginia believes that any program should include 1) mandatory urine testing of each individual champion athlete for illicit drugs; 2) suspension from all Virginia State High School varsity competition for the subsequent calendar year if positive, and 3) elimination of the positive member's varsity team from the State Tournament (gymnastics, swimming, tennis, and track teams excepted because of the individual nature of the sports), and be it further

The Medical Society of Virginia believes that an athlete's or team's refusal to comply with mandatory testing serve to eliminate the varsity team from the state tournament; vacate all team titles earned in that varsity sport in that school year; and suspend the non-complying athlete from sports activities during the subsequent calendar year.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

40.6.02- AMA Program on Child and Adolescent Health

Date: 11/2/1996

The Medical Society of Virginia endorses the AMA Program on Child and Adolescent Health.

Reaffirmed 11/5/2006
Reaffirmed 10/16/2016

40.6.03- Promote Physical Fitness; Schools

Date: 11/8/1997

The Medical Society endorses activities and will support legislation which would promote daily physical fitness in the K-12 school environment as well as in other areas.

Reaffirmed 11/5/2006
Reaffirmed 10/16/2016

40.6.04- Prevent Blindness Virginia/Conexus

Date: 10/31/1998

The Medical Society of Virginia acknowledges and endorses Conexus's efforts to develop broad-based support from those agencies involved in children's health and development programs and supports the adoption of statewide screening of Virginia public school children using the Conexus's standardized screening protocol.

Reaffirmed 10/12/2008
Reaffirmed as amended 10/21/2018

40.6.05- Inclusion of Pediatricians in Development of Family Service Plans

Date: 10/31/1998

The Medical Society of Virginia recommends that Early Childhood Intervention Agencies and Health Insurers in the Commonwealth of Virginia promote voluntary inclusion of pediatric trained physicians in the development of the Individualized Family Service Plans, as required by the Individuals with Disabilities Education Act (IDEA), so that medically-necessary and medically-appropriate services are provided to the child and family.

Reaffirmed 10/12/2008
Reaffirmed 10/21/2018

40.6.06- School Start Times and Adolescent Sleep

Date: 5/31/2014

The Medical Society of Virginia supports legislative and other efforts to encourage public school systems in Virginia to implement a strategy to improve student sleep health to include but not be limited to later school start times.

40.6.07- Health Education in Schools

The Medical Society of Virginia supports comprehensive clinical evidence-based health education in Virginia.

Amended by Substitution 10/22/2017

40.6.08- In-School Health Services

The Medical Society of Virginia supports requiring that every school division in the Commonwealth of Virginia employ or contract through the Health Department for registered nurses, at an appropriate staffing level, meeting or exceeding the U.S. Department of Health and Human Services' recommendations for nurse-to-student ratios, and that every school division in the Commonwealth of Virginia be required to have a formal relationship with a

specific physician for supervision of school nursing services and for arranging specialty consultation as necessary.

Amended by Substitution 10/22/2017

40.6.09 Address the Dangers of Head Trauma and Other Potential Injuries in Sports

Date: 10/21/2018

The Medical Society of Virginia supports recommending schools and organized sports programs in the Commonwealth of Virginia educate students and parents on the risks of participating in sports, including but not limited to brain injury, spinal cord injury, internal organ injuries, and musculoskeletal injuries.

For policies regarding Department of Social Services jurisdiction over Day Care Centers, see *Public Health section- XIII. Infrastructure, Government Appointments, and Staffing*

Communicable and Infectious Disease

40.7.01- Screening/Follow-up

Date: 11/4/1995

The Medical Society of Virginia supports the Virginia Department of Health and other legitimate organization's efforts to control communicable disease and to screen for these diseases particularly in high incidence groups.

Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

40.7.02 - Regulation of Tattoo Parlors

Date: 11/4/2001

The Medical Society of Virginia supports legislation and/or regulation to require that all commercial tattoo parlors and those individuals applying the tattoos be registered with an

appropriate state regulatory board and that all methods employed in the application of tattoos be certified as free of potential contamination.

Reaffirmed 10/26/2014

40.7.03- Promoting Awareness of Babesiosis

Date: 10/25/2009

The Medical Society of Virginia supports efforts to enhance health care providers' awareness of Babesiosis.

Reaffirmed as amended 10/20/2019

40.7.04- Care of Patients with HIV/AIDS

The Medical Society of Virginia supports the Centers for Disease Control Guidelines for HIV Counseling, Screening, Testing, Prevention, Care, Reporting, and Surveillance.

Amended by Substitution 10/22/2017

Environmental Health

40.8.01- Repeal of EPA Requirements on Medical Waste

Date: 10/31/1992

The Medical Society of Virginia, in cooperation with the American Medical Association and other national health provider groups, shall work with Congress and the EPA to modify EPA requirements on medical waste, the goal of which would be to eliminate regulations that cannot be shown scientifically to protect the public health.

The Medical Society of Virginia, in cooperation with the American Medical Association and other national health provider groups, shall work with Congress and other governmental regulatory agencies to ensure that all decisions regarding the regulation of medical practices be based upon scientific principles and/or fact.

Reaffirmed 11/2/2012

40.8.02- Uranium Mining in Virginia

Date: 10/12/2008

The Medical Society of Virginia supports continuing the moratorium on uranium mining in Virginia until there is satisfactory evidence that it will not constitute a public health hazard.

Reaffirmed 10/21/2018

40.8.03- Protecting Human Health in a Changing Climate

Date: 10/16/2016

The Medical Society of Virginia notes the findings of leading U.S. and international scientific bodies that the Earth is undergoing adverse changes in the global climate.
The Medical Society of Virginia supports educating the medical community on the adverse effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education and policymaking.

The Medical Society of Virginia encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the health effects of climate change can be anticipated and responded to more effectively.

40.8.04 – Recognizing the Potential Impact of Natural Gas Infrastructure Projects on Human Health and Environment

Date: 10/20/2019

The Medical Society of Virginia recognizes the potential impact of natural gas infrastructure on human health.

The Medical Society of Virginia supports unbiased comprehensive Health Impact Assessments regarding the health risks of existing and proposed new or expanded natural gas infrastructure in Virginia.

40.8.05 – Advancing Worker Heat Protection in the Commonwealth of Virginia

Date: 10/20/2019

The Medical Society of Virginia supports efforts that advance worker heat protections.

Firearms

40.9.01- Control of Violent Use of Firearms

Date: 11/11/1989

The Medical Society of Virginia supports methods to control the misuse and violent use of firearms, including:

1. Prohibiting firearm ownership by:
    a. Those convicted of a felony
    b. Those convicted of a violent misdemeanor
2. Prohibiting firearm possession by those subject to a protective order pursuant to Virginia law.
3. Banning the sale, rental, or transfer of bump stocks and magazines with a capacity of over ten rounds.
4. Supporting universal background checks for all gun sales and transactions.

Reaffirmed 10/25/2009
Reaffirmed 10/26/2014
Reaffirmed 10/22/2017
Adopted as amended 10/21/2018
Adopted as amended 10/20/2019

40.9.02- Support for Firearm Laws Promoting Increased Public Safety

Date: 11/2/2012

The Medical Society of Virginia opposes repeal of existing state or federal laws and regulations that promote safety and responsibility in the purchase, possession or use of firearms and ammunition. The Medical Society of Virginia supports future laws and regulations relating to firearms which would promote trauma control and increased public safety, including:

1. Creating an Extreme Risk Protection Order allowing law enforcement or the courts to temporarily separate firearms from a person who exhibits dangerous behavior that presents an immediate threat to themselves or others.
2. Requiring that any lost or stolen firearm be reported to law enforcement upon discovery.
3. Limiting the number of handguns to be purchased by any person in a 30-day period.

Reaffirmed 10/26/2014
Reaffirmed 10/22/2017
Adopted as amended 10/20/2019

40.9.03– MSV School Gun Violence Deterrence Initiative

Date: 5/6/2017

The Medical Society of Virginia Board of Directors and relevant stakeholders will engage in an exploratory discussion on the enhancement of protective measures for safety and the deterrence of gun violence in the Commonwealth of Virginia. The coalition formed by the Medical Society of Virginia will provide a model for collaborative leadership nationally in our mutual desire to deter gun violence in our nation's schools.

1. The Medical Society of Virginia endorses recommendations to improve school security in building design, preparedness training, threat reporting, systems, and police support.
2. The Medical Society of Virginia supports evidence-based and age-appropriate school safety and readiness including "Stop the Bleeding" training.

Adopted as amended 10/20/2019

40.9.04- Child Firearm Injury Prevention

The Medical Society of Virginia supports public education programs to reduce injuries to children from firearms as well as the dangers and legal liabilities of leaving loaded, unsecured firearms accessible to children. Such programs should use evidence-based, developmentally age appropriate information.

Further, the Society will the Medical Society of Virginia will cooperate and collaborate with interested advocacy groups regarding prevention of injury to children by firearms.

The Medical Society of Virginia supports requiring safety devices to be sold or transferred with each gun sold or transferred in Virginia, either at a regulated gun store or through any other means such as gun shows.

Amended by Substitution 10/22/2017
Adopted as Amended 10/20/2019

40.9.05- Gun Violence Restraining Orders

Date: 10/22/2017

The Medical Society of Virginia supports gun violence restraining orders as a mechanism to decrease gun related suicides and homicides.

Food

40.10.01- Oppose Sale of Raw Milk in the Commonwealth

Date: 11/6/2005

The Medical Society of Virginia supports the requirement for the pasteurization of all milk and cheese products derived from both cows and goats in the Commonwealth of Virginia and opposes any legislation that would allow the direct sale of raw milk products to individual consumers.

Reaffirmed 10/25/2015

40.10.02- Eradicating Food Deserts and Food Insecurity

Date: 10/25/2015

The Medical Society of Virginia (MSV) supports efforts to reduce or eliminate food deserts and food insecurity in Virginia.

40.10.03 Nutrition

Date: 10/21/2018

The MSV shall encourage evidence-based nutritional guidelines for all citizens of the Commonwealth of Virginia and advocate for the availability of nutritionally healthy food and beverages particularly for the young and underserved.

The MSV will serve as an advocate for education and, when able, provide support for efforts to improve nutritional patterns and impact population health.

40.10.04 Strategies to Reduce the Consumption of Beverages with Added Sweeteners

Date: 4/27/2019

The Medical Society of Virginia supports the following AMA Policy H-150.927:

Our AMA:

(1) acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption, and support evidence-based strategies to reduce the consumption of SSBs, including but not limited to, excise taxes on SSBs, removing options to purchase SSBs in

primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption, and the use of plain packaging;

(2) encourages continued research into strategies that may be effective in limiting SSB consumption, such as controlling portion sizes; limiting options to purchase or access SSBs in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs to children; and changes to the agricultural subsidies system;

(3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; and

(4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and replacing SSBs with healthier beverage choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage choices for students.

Hazardous Activities

40.11.01- Indoor Tanning Regulation

Date: 11/4/1995

The Medical Society of Virginia supports efforts to educate the public about the health risks of indoor tanning and endorses legislation that would ban minors from utilizing tanning beds.

Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

40.11.02- Ban on Boxing

Date: 11/8/1997

The Medical Society of Virginia supports legislation to ban boxing in the Commonwealth of Virginia.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

40.11.03- Dangerous Rapid Weight Reduction

Date: 10/31/1998

The Medical Society of Virginia opposes the practice of any process of dangerous, rapid weight reduction.

Reaffirmed 10/12/2008
Reaffirmed as amended 10/21/2018

Health Literacy/Public Education

40.12.01- Educational Programs

Date: 11/5/1994

The Medical Society of Virginia endorses educational programs which would encourage all citizens to retain a primary physician.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

40.12.02- Health Literacy

Date: 11/4/2002

The Medical Society of Virginia supports health literacy programs and projects that increase the awareness of health literacy as well as educate patients and health care professionals on techniques to strengthen the patient/ physician relationship and improve health literacy.

Reaffirmed 11/2/2012

Housing and Building Safety

40.13.01- Funding of Lead Poisoning Program

Date: 11/5/1994

The Medical Society of Virginia requests that the Commonwealth of Virginia continue funding Virginia's lead poisoning program.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

40.13.02- Housing Safety

The Medical Society of Virginia supports installation of smoke detectors in all residential structures built in Virginia.

Amended by Substitution 10/22/2017

Infant Health

40.14.01- Virginia Birth-Related Neurological Injury Compensation Program

Date: 11/8/1997

The Medical Society of Virginia fully supports the Virginia Birth-Related Neurological Injury Compensation Fund and supports that notice describing the program and its benefits be given to all obstetric patients.

The Medical Society of Virginia supports the statutory definition of "birth-related neurological injury" but is willing to consider any change of the program's current definition based on its merit.

The Medical Society continues to monitor the actuarial soundness of the fund and supports the statutory reduction of assessments so long as the fund remains sound.

The Medical Society supports the establishment of a trust fund or other appropriate mechanism designed to ensure prudent investment of the fund's resources for the benefit of the injured patient.

The Medical Society opposes any attempt to redirect the funds from its intended purpose.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

40.14.03- Infant and Child Death Investigation

The Medical Society of Virginia endorses the position of the American Academy of Pediatrics and urges all attending physicians to obtain autopsies on all suspected cases of Sudden Infant Death Syndrome.

Further, the Medical Society of Virginia supports making an inquiry to the Central Registry of the Department of Social Services for child deaths under age seven. The Medical Society of Virginia supports referral to the police and the district medical examiner when an inquiry reveals confirmed or suspected child abuse.

Amended by Substitution 10/22/2017

Infrastructure, Government Appointments, and Staffing

40.15.01- Medical Examiner System

Date: 11/9/1991

The Medical Society of Virginia recognizes and commends the Medical Examiner system in the Commonwealth and will take active steps to promote physician participation in this worthy public service.

Reaffirmed 11/4/2001
Reaffirmed 10/25/2015

40.15.02- Agency Jurisdiction

Date: 11/5/1994

The Medical Society of Virginia believes that the jurisdiction over Day Care Centers lies with the Department of Social Services which should continue to study existing laws and regulations and make them applicable to all Day Care Centers.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

40.15.03- Public Health

Date: 11/5/1994

The Medical Society of Virginia strongly supports legislation to strengthen the infrastructure of the Public Health System in Virginia, and to provide an equitable, stable and adequate source of funding to accomplish this.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

40.15.04- Recertification of EMS Personnel

Date: 11/4/1995

The Medical Society of Virginia maintains it is the primary responsibility of the Operational Medical Director of an EMS agency to assure optimum availability and quality of care to every extent possible.

The Medical Society of Virginia believes the Operational Medical Director must retain the ultimate authority in evaluating the cognitive and practice skills of EMS personnel practicing under his/her medical license.

The Medical Society of Virginia encourages development of a statewide standardized approach to evaluation of EMS personnel by their respective Operational Medical Directors.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

40.15.05- Trauma Research/Development of Systems

Date: 11/4/1995

The Medical Society of Virginia supports a proactive stance in both trauma research and the development of trauma systems across the State.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

40.15.06- Qualifications for the State Health Commissioner

Date: 10/30/1999

The Medical Society of Virginia supports the requirements for the position of State Health Commissioner established in Code of Virginia § 32.1-17 as follows:

- Board certification by either the American Board of Preventative Medicine or a recognized board in a primary care specialty (as approved by the American Board of Medical Specialists or the Bureau of Osteopathic Specialists of the American Osteopathic Association) and experience in public health.

Reaffirmed 10/25/2009
Reaffirmed 10/20/2019

40.15.07- Increase in Staffing of Medical Death Investigators

Date: 11/6/2005

The Medical Society of Virginia supports maintaining full staffing, as defined by the Chief Medical Examiner, of medical death investigators so that the Commonwealth of Virginia can provide a 24/7 death investigation system within the Office of the Chief Medical Examiner.

Reaffirmed 11/5/2006
Reaffirmed 10/25/2015

40.15.08- State Emergency Medical Services

The Medical Society of Virginia reaffirms that the Office of Emergency Medical Services (OEMS) and the authority for the development and promulgation of rules and regulations governing EMS should remain within the purview of the Department of Health.

The Medical Society of Virginia believes there should be adequate physician representation on the Emergency Medical Services Board to include designees of the Medical Society of Virginia, Virginia College of Emergency Physicians, Virginia Chapter of American Academy of Pediatrics and the Virginia Chapter, American College of Surgeons.

Amended by Substitution 10/22/2017

Maternal Health

40.16.01- Access to Obstetrical Care

Date: 11/5/1994

The Medical Society of Virginia encourages the Commonwealth of Virginia:

(1) to study commercial insurance reimbursement policies that may contribute to the maldistribution of obstetrical care in Virginia,

(2) to study the barriers in Virginia that have resulted in the reduced number of family physicians doing obstetrics in Virginia,

(3) to study the feasibility of implementing in Virginia a program similar to the North Carolina Rural Obstetrical Incentive Program for obstetricians, family physicians, and nurse midwives that reduces the cost of obstetrical malpractice insurance in areas of need.

Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

40.16.02- Maternity Care Program

Date: 11/4/1995

The Medical Society of Virginia supports the maternity care programs administered through regional local health departments as appropriate means of protecting women's and children's health.

The Medical Society of Virginia seeks support from state and national legislators to continue financial and staffing support of maternity care programs in regional and local health departments, and supports development of comprehensive maternity care and information programs, based on public and private health provider cooperation where programs are not in existence.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

Medicinal Cannabis

40.17.01- Cannabis for Medicinal Use

Date: 10/16/2016

Expanding Research on Medicinal Cannabis

The Medical Society of Virginia calls for further adequate and well-designed studies of marijuana and related cannabinoids in patients who have serious conditions for which evidence suggests possible efficacy and a reasonable likelihood that application of such research findings would improve the understanding and treatment of specific disease states.

The Medical Society of Virginia supports down-scheduling marijuana's status as a federal Schedule I controlled substance, with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines and alternate delivery methods and minimizing patient barriers to treatment by removing legal and logistical obstacles.

Medicinal Use of Cannabinoids

The Medical Society of Virginia believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions.

The Medical Society of Virginia recognizes that a physician may deem the use of medical cannabinoids to be appropriate for some patients with severely debilitating conditions , such as intractable epilepsy, that have exhausted other available therapies.

In these situations, the Medical Society of Virginia urges collaboration between the medical community, local, state and national authorities to remove undue barriers.

Medical cannabinoids should be manufactured, processed and dispensed in a consistent and regulated fashion to ensure patient safety. When medical cannabinoids are incorporated as part of a patient's care plan, pursuant to applicable state and federal laws, the patient and their care team, including family caregivers, should not be subject to criminal sanctions.

The Medical Society of Virginia recognizes the significant health issues involving nonmedical use of marijuana and emphasizes that these recommendations apply to proven medical use and does not apply to nonmedical use of marijuana.

Nothing in this policy is intended to encourage the violation of existing state or federal law.

Mental Health

40.18.01- Changes in Commitment Law; Funding

Date: 11/5/1994

The Medical Society of Virginia supports the civil commitment of a patient to a private or a public hospital for psychiatric care with a view to the highest quality medical care and adequate funding be provided for the process established by law.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

40.18.02- Funding; Public Mental Health Facilities

Date: 11/5/1994

The Medical Society of Virginia supports public and private efforts to enhance the funding of public mental health treatment facilities and opposes any reduction in funding.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

40.18.03- Psychiatrists: State Hospital and Clinics

Date: 11/5/1994

The Medical Society of Virginia urges the Virginia Department of Behavioral Health and Developmental Services to ensure that physicians trained in psychiatry be available to its hospitals and clinics.

Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

For policies regarding insurance coverage or reimbursement of mental health care, please see the *Insurance* section

40.18.04 – Optimizing Access of Mental Health Services by Veterans

Date: 10/20/2019

The Medical Society of Virginia supports initiatives in the Commonwealth that encourage and increase access to mental health services.

The Medical Society of Virginia further supports targeted initiatives to improve access to mental health care for veterans and other high-risk populations.

40.18.05 – Supporting Standardization of Mental Health Screenings for Virginia Students

Date: 10/20/2019

The Medical Society of Virginia supports efforts by the Commonwealth to implement mental health programs that provide evidence-based mental health screening and treatment services to students in Virginia.

Patient Safety

40.19.01- Radiation Control; Needless Exposure

Date: 11/5/1994

The Medical Society of Virginia supports methods and practices of radiation control that will reduce needless exposure of patients and workers to ionizing radiation.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

40.19.02- Protocols to Reduce Patient Morbidity and Mortality in Hospital Emergency Departments

Date: 10/25/2009

The Medical Society of Virginia supports and encourages hospitals and physicians to develop and implement protocols which ensure patient safety while addressing overcrowding and boarding in the emergency department.

Reaffirmed 10/20/2019

40.19.03- Ionizing Radiation; Patient Education

Date: 10/16/2016

The Medical Society of Virginia encourages and facilitates the voluntary distribution of information from the American College of Radiology on radiation safety concerns to patients in waiting areas of facilities in Virginia where radiologic or nuclear medicine procedures are ordered or performed using educational media.

40.19.04 – Support for Expansion of Epinephrine Access

Date: 10/20/2019

The Medical Society of Virginia supports expanding access to epinephrine auto injectors designed for layperson use for treatment of anaphylaxis.

Preventative Care

40.20.01- Reallocation from General Fund for Preventive Health

Date: 10/31/1992

The Medical Society of Virginia supports treating the promotion of preventive medicine, public health, and primary care as a priority in the allocation of revenues from the General Fund.

Reaffirmed 11/2/2012

40.20.02- High Blood Pressure Screening

Date: 11/4/1995

The Medical Society of Virginia believes in regular screening for high blood pressure.

Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

Tobacco

40.20.03- Legislation Restricting Tobacco Use

Date: 11/11/1989

The Medical Society of Virginia supports legislation in the General Assembly to restrict tobacco use in Virginia.

Reaffirmed 11/2/2012

40.20.04- Sales to Children

Date: 11/11/1989

The Medical Society of Virginia opposes the sale of nicotine products to children under the age of 21 and opposes the use of nicotine products by children under the age of 21 in public places, including schools and school grounds.

Reaffirmed 10/25/2009
Reaffirmed as amended 10/20/2019

40.20.05- Smoking Education

Date: 10/30/1993

The Medical Society of Virginia shall work actively to disseminate relevant medical information about the health hazards and health costs of smoking.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

40.20.06- Sales/Smoking in Health Care Facilities

Date: 11/4/1995

The Medical Society of Virginia recommends that hospitals and health care facilities in the Commonwealth of Virginia prohibit the sale of tobacco products through gift shops, vending machines or other patient and visitor services, and that smoking in hospitals by employees, medical staff, patients, and visitors be prohibited and/or regulated in a manner consistent with the health care mission of the provider.

Reaffirmed 11/06/2005

Reaffirmed 10/25/2015

40.20.07- Smoking on School Property

Date: 11/8/1997

The Medical Society of Virginia urges state and local school boards to prohibit smoking and other forms of tobacco use on school property.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

40.20.08- Electronic Nicotine Delivery Devices

Date: 5/31/2014

The Medical Society of Virginia (MSV) supports legislation and Food and Drug Administration action to tax, label and regulate electronic nicotine delivery devices (ENDS) as tobacco products and drug delivery devices. Further, the MSV supports state and federal legislation that restricts the minimum age, locations of permissible use, advertising, promotion, and sponsorship of ENDS to the same restrictions as that of tobacco products. The MSV supports local, state and national efforts to require transparency and disclosure concerning the design, content and emissions of ENDS; to require secure, child-proof, tamper-proof packaging and design of ENDS; and to require enhanced labelling that warns of the potential consequences of ENDS use, restriction of ENDS marketing as tobacco cessation tools, and restriction of the use of characterizing flavors in ENDS. The MSV encourages basic, clinical, and epidemiological research concerning ENDS.

40.20.09- Tobacco use in Cars with Minors

Date: 10/25/2015

The Medical Society of Virginia supports statewide legislative efforts to make it illegal for anyone to smoke tobacco in a car with a minor inside of the car.

40.20.10- Secondhand Smoke

The Medical Society of Virginia supports access to clean smoke-free air for all citizens in the Commonwealth, especially children.

The Society supports efforts to eliminate tobacco smoke in public places and places of employment in order to protect Virginians from the hazards of passive smoke inhalation. Further, the Medical Society of Virginia supports efforts to make it illegal to smoke in a car with a minor present.

The Medical Society of Virginia opposes efforts to repeal protections for the public from secondhand smoke.

Amended by Substitution 10/22/2017

40.20.11- Tobacco Sales Tax

The Medical Society of Virginia condemns the introduction of new tobacco products and promotions particularly those designed to attract young people, and supports the ban such of products and promotions.

The Medical Society of Virginia strongly supports a significant tobacco tax increase as a measure to reduce tobacco use in our population. Revenue from such a tax should be used to support health related programs for the citizens in the Commonwealth, tobacco education in elementary and middle schools, funding for childhood respiratory and cardiovascular disease prevention and treatment, as well as subsidizing tobacco farmers who choose to harvest non-tobacco crops.

The Medical Society of Virginia strongly supports a tobacco tax equivalent to at least the national average as a measure to reduce tobacco use in our population. The Medical Society of Virginia supports legislation which would require that the funds generated by an increase in the state tobacco tax be used to support health related programs for the citizens of the Commonwealth.

Amended by Substitution 10/22/2017

Transportation and Vehicle Safety

40.21.01- Passengers in the Beds of Pickup Trucks

Date: 10/30/1993

The Medical Society of Virginia supports prohibiting the transportation of passengers in the bed of a pickup truck.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

40.21.02– Safe Driving Education and Licensing Requirements

Date: 11/5/1994

The Medical Society of Virginia strongly supports stringent licensing requirements and increased education and safety training for motorcycle and automobile operators.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

40.21.03- Elderly Drivers

Date: 11/4/1995

The Medical Society of Virginia believes that drivers over seventy-five years of age should be required to
renew their license every two years with an eye examination and road test. This renewal would also require a hearing examination and a physical examination.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

40.21.04- Alcohol/Drug Impaired Drivers

Date: 11/8/1997

The Medical Society of Virginia urges the continued enforcement of administrative driver's license revocation for drivers whose blood alcohol content exceeds the legal limit or who refuse a blood alcohol determination.

The Medical Society of Virginia supports legislation facilitating the prosecution and removal of alcohol and/or drug impaired drivers from the roadways of the Commonwealth.

Reaffirmed 10/12/2008
Reaffirmed 10/21/2018

40.21.05 - High Speed Police Pursuits

Date: 11/8/1997

The Medical Society of Virginia recognizes high speed pursuits as a public health issue. The Medical Society of Virginia recommends that the appropriate governmental agencies in Virginia implement policies concerning high speed chases and provide training in vehicular pursuit to

appropriate personnel. The Medical Society of Virginia recommends that the State Medical Examiner's office compile statistics on, and report to appropriate agencies, fatalities associated with high speed police pursuit.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

40.21.06- Small Personal Watercraft Regulation

Date: 11/8/1997

The Medical Society of Virginia encourages the safe and responsible operation of personal watercraft. Operators and passengers should be educated about the dangers of intoxication with drugs or alcohol while engaged in motor vehicle or watercraft operation. The Medical Society of Virginia supports the enforcement of relevant regulations.

Reaffirmed 10/28/2007
Reaffirmed as amended 10/22/2017

40.21.07- Child Car Safety

The Medical Society of Virginia supports the American Academy of Pediatrics' recommendations on child restraint devices and seat positioning. Further, the Society supports a uniform system of attachment of car safety seats in vehicles.

The Medical Society of Virginia supports public education programs regarding the proper use of car safety seats for children.

Amended by Substitution 10/22/2017

40.21.08- Helmet Safety

The Medical Society of Virginia encourages the use of safety helmets whenever appropriate, such as riding horses, bicycles, mopeds and "off road" vehicles.
Further, the Medical Society of Virginia supports mandatory requirements for helmet use by minors when operating bicycles and by motorcycle operators and passengers. The Medical Society of Virginia is opposed to the repeal of mandatory helmet laws.

Amended by Substitution 10/22/2017

40.21.09- School Bus Drivers Screening

The Medical Society of Virginia recommends that physical examinations of school bus drivers include questions about history of mental illness, diabetes, hypertension, epilepsy, previous alcoholism or drug abuse, and the use of medication, all of which might affect the ability to drive a bus. Further, the Medical Society of Virginia supports random testing for the presence of alcohol or drugs for school bus drivers.

Amended by Substitution 10/22/2017

Vaccines

40.22.01- State Funding For Childhood Vaccines

Date: 10/30/1993

The Medical Society of Virginia supports the State Health Department in seeking funding to purchase vaccines to be administered in physicians' offices to all children.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

40.22.02- Childhood Immunizations

The Medical Society of Virginia supports the immunization recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians and the Centers for Disease Control as the required schedule for the immunization of infants and for school entry, including higher education, in the Commonwealth of Virginia. The Medical Society of Virginia supports the elimination of all non-medical vaccine exemptions in Virginia.

Finally, the Medical Society of Virginia supports efforts by the Commonwealth of Virginia to fund the purchase of necessary vaccines and their provision to all healthcare practitioners.

Amended by Substitution 10/22/2017

40.22.03 – "Mature Minor" Consent to Medical Care and Vaccinations

Date: 10/20/2019

The Medical Society of Virginia supports the concept of "mature minors" consent to

medical care as an exception to the rules requiring parental consent for receiving medical care and defined as being at least 14 years of age and, based upon their clinician's judgement, has the ability to understand the risks and benefits of the proposed treatment at the same level as an adult and actually giving consent, and be it further

The Medical Society of Virginia further supports the application of mature minors' consent to medical care in ways consistent with the Virginia statutes addressing pregnancy, sexually transmitted, diseases, mental health, addiction, and vaccinations.

Violence Prevention

40.23.01- Anti-Domestic Violence Statement

Date: 11/4/1995

The Medical Society of Virginia opposes any type of domestic violence and supports the inclusion of educational material regarding resources, criminal laws, and prevention in government publications related to marriage and families.

Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

40.23.02- Physicians' Role in Violence Prevention

Date: 11/8/1997

The Medical Society of Virginia recognizes violence as a medical problem that should be of active concern to physicians. The Medical Society of Virginia will promote physician education regarding the epidemiology, recognition, and prevention of violence and actively explore other ways to educate patients, the public, and payers.

Reaffirmed 10/28/2007
Reaffirmed 10/26/2014

40.23.03- Corporal Punishment of Foster Children by Foster Parents

Date: 11/4/2000

The Medical Society of Virginia opposes the use of corporal punishment by foster parents.

Reaffirmed 10/24/2010

40.23.04- Human Trafficking

Date: 10/22/2017

The Medical Society of Virginia will develop a policy to assist physicians in the Commonwealth to identify victims of human trafficking and provide guidelines that allow physicians to report their concerns to the appropriate governmental agencies with anonymity.

45 SCOPE OF PRACTICE

Practice Authority

45.1.01 - Determination of Fitness to Return to Work

Date: 11/5/1994

The Medical Society of Virginia opposes the use of persons other than doctors of medicine or osteopathy, or agents under their supervision, to attest to an employee's fitness to return to work.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

45.1.02- Diagnosis by Optometrists

Date: 11/5/1994

The Medical Society of Virginia opposes the use of optometrists and inadequately trained nonmedical personnel for the diagnosis of eye disease and eye injury.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

45.1.03- Referrals from Physicians

Date: 11/5/1994

The Medical Society of Virginia believes that a physician should at all times practice a method of healing founded on a scientific basis. A physician may refer a patient for diagnostic or therapeutic services to another physician, a licensed limited practitioner, or any other provider of health care services permitted by law to furnish such services, whenever the physician believes that this will benefit the patient. As in the case of referrals to physician specialists, referrals to allied health practitioners should be based on their individual competence and ability to perform the services needed by the patient.

Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

45.1.04- Supervision of Physical Therapy Assistants

Date: 10/31/1998

The Medical Society of Virginia supports physician supervision of licensed physical therapy assistants.

Reaffirmed 10/12/2008
Reaffirmed as amended 10/21/2018

45.1.05- Assuring Quality in Allied Health Scope of Practice

Date: 11/4/2001

The Medical Society of Virginia reaffirms support of a proactive stance to assure quality and cost effective healthcare for the medical care of consumers of the Commonwealth by informing and advising legislators and regulatory agencies on the need for physician oversight of care provided to patients.

The Medical Society of Virginia reaffirms the provision of resources and leadership to affiliated physician groups in an ongoing and coordinated action to inform and advise legislators and regulatory agencies on scope of practice issues.

Reaffirmed 10/30/2011

45.1.06- Regulations of the Board of Hearing Aid Specialists

Date: 11/4/2002

The Medical Society of Virginia supports otolaryngologists as the primary caregivers of children with hearing disorders, and vigorously opposes any efforts to remove the requirement in current regulations that a child must see an otolaryngologist prior to sale of a hearing aid by a hearing aid dealer.

Reaffirmed 11/2/2012

45.1.07- Scope of Practice Position Statement

Date: 1/9/2001

The Medical Society of Virginia believes a patient care team offers the highest quality of care to patients in the Commonwealth. To ensure quality of care, maximize continuity and coordination of care and to guarantee patients are diagnosed by or directed to the most appropriate provider of care, independent practice by allied health or mid-level health practitioners would fragment care and must be opposed.

Experience and the literature are clear that the best quality health care is delivered by health care teams that collaborate closely and share responsibilities according to their unique abilities and training. These teams are best led by physicians whose intensive and extensive education and ongoing rigorous regulation qualify them to oversee the many variables inherent in patient care.

A collaborative practice is one where the health care providers work together in complimentary interdependent roles to provide the highest quality care for patients, families, and communities.

Physicians should work closely with many mid-level providers and it is necessary that they should develop guidelines for these types of relationships. This is especially important to ensure that each patient is seeing the most appropriate health care provider for their needs and that care can be coordinated effectively and delivered safely.

Therefore, the Medical Society of Virginia accepts the following position statements on Guidelines for Physicians supervising mid-level and allied health providers:

1. The physician is ultimately responsible for coordinating and managing the care of patients, and with the appropriate input of other health providers, ensuring the quality of health care provided to patients in all settings.
2. Health care services delivered by physicians and mid-level or allied health providers must be within the boundaries of each practitioner's authorized scope of practice, as defined by state law.
3. The role of the mid-level and allied health providers in the delivery of care should be defined through mutually agreed upon collaborative guidelines, protocols and agreements that

reflect the best available information for delivery of care.

4. The extent of involvement by mid-level and allied health providers in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience and preparation of the provider as adjudged by the physician and as outlined in the collaborative agreement.
5. The physician will strive to set the highest standards for the supervision of mid-level and allied health providers in all settings. The physician, when appropriate and in collaboration with allied health providers, should also delineate when collaboration is appropriate. Physicians should not supervise providers with whose abilities they are not familiar.
6. The physician must be available for consultation with mid-level or allied health providers at all times, either in person or through telecommunication systems or reasonably available means.
7. Patients should be made clearly aware at all times whether they are being cared for by a physician or a mid-level or allied health provider
8. The physician and mid-level or allied health provider together should review all delegated patient services on a regular basis, as well as the mutually agreed upon protocols or guidelines for practice.
9. The physician is responsible for clarifying and familiarizing the mid-level or allied health provider with his/her supervising methods and means of delegating patient care.
10. The patient care team should determine how to accept reimbursement for patient care; such methods should support the collaborative work by the patient care team.
11. The Department of Health Professions and the Board of Medicine are the appropriate governmental bodies to be charged with carefully studying and making recommendations regarding issues of licensure.

The Medical Society of Virginia will work collaboratively with physician specialty societies on scope of practice matters to achieve the best outcomes for patients in the Commonwealth.

Reaffirmed 10/28/2007
Reaffirmed as amended 10/22/2017

Prescriptive Authority

45.2.01- Allied Mental Health Provider Prescription Authority

The Medical Society of Virginia opposes any efforts by psychologists, social workers, licensed professional counselors, and pastoral counselors to obtain prescription privileges.

Reaffirmed as substituted 10/22/2017

Practice Settings

45.3.01- Employment at Secondary School Level

Date: 11/5/1994

The Medical Society of Virginia supports employment of athletic trainers on the secondary school level.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

45.3.02- Store Based Health Clinics

Date: 10/25/2009

It is the Medical Society of Virginia's policy that any individual, company, or other entity that establishes and/or operations store-based health clinics should adhere to the following principles:

1. Store-based health clinics must have a well-defined and limited scope of clinical services, consistent with state scope of practice laws.

2. Store-based health clinics must use standardized medical protocols derived from evidence-based practice guidelines to insure patient safety and quality of care.

3. Store-based health clinics must establish arrangements by which their health care practitioners, when consistent with state law, have direct access to and supervision by MD/DOs.

4. Store-based health clinics must establish protocols for ensuring continuity of care with practicing physicians within the local community.

5. Store-based health clinics must establish a referral system with physician practices or other facilities for appropriate treatment if the patient's conditions or symptoms are beyond the scope of services provided by the clinic.

6. Store-based health clinics must clearly inform patients in advance of the qualifications of the health care practitioners who are providing care, as well as the limitation in the types of illnesses that can be diagnosed and treated.

7. Store-based health clinics must establish appropriate sanitation and hygienic guidelines and facilities to insure the safety of patients.

8. Store-based health clinics should be encouraged to use electronic health records as a means of communicating patient information and facilitating continuity of care.

9. Store-based health clinics should encourage patients to establish care with a primary care physician to ensure continuity of care.

If the store-based clinic is staffed by an independent practice nurse practitioner some of the items may not apply.

Reaffirmed as amended 10/20/2019

Workforce

45.4.01- MSV Support of Resolving Nursing Shortage

Date: 11/6/2005

The Medical Society of Virginia recognizes and supports where possible the efforts of the various groups working to resolve the nursing shortage.

Reaffirmed 10/25/2015

Licensure and Certification

45.5.01- Chiropractic Licensure under the Board of Medicine

Date: 10/31/1992

The Medical Society of Virginia supports the principle that chiropractors and the public are best served by the current system of keeping the regulations of several health professions coordinated by a single board.

Reaffirmed 11/02/2012

45.5.02- NATA's Certification Process

Date: 11/5/1994

The Medical Society of Virginia recognizes the National Athletic Trainers' Association (NATA) as the official organization for athletic trainers and supports its certification procedures and certification board.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

45.5.03- Licensure of Naturopaths

Date: 10/25/2009

The Medical Society of Virginia opposes the full or limited licensure of naturopaths.

Reaffirmed 10/20/2019

45.5.04- Associate Physician

Date: 10/16/2016

The Medical Society of Virginia opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education or American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate U.S. medical education.

Education

45.6.01- Nursing Education

Date: 11/4/1995

The Medical Society of Virginia supports the nursing profession and its educational program, including the three-year schools.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

Insurance Coverage

45.7.01- Office of Emergency Medical Services

Date: 11/5/1994

The Medical Society of Virginia opposes any plans that would lessen or in any other way interfere with physician direction of emergency medical care provided by non-physicians in the pre-hospital setting.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

45.7.02- Legislation Mandating Medically Necessary Services by Allied Health Professions

Date: 11/8/1997

The Medical Society of Virginia will advocate that mandated health insurance coverage for services provided by allied health professions must include provisions that will require that physicians determine "medical necessity" and that qualified physicians supervise allied health services to assure assessment and management are cost-effective and consistent with accepted medical standards.

Reaffirmed 10/28/2007
Reaffirmed as amended 10/22/2017

45.7.03- Coverage Limitations on Physician Scope of Practice

Date: 10/31/1998

The Medical Society of Virginia opposes insurance carriers' coverage determinations which serve to limit the scope of a physicians practice.

Reaffirmed 10/12/2008
Reaffirmed 10/21/2018

50 GOVERNMENT DEPARTMENTS

50.1.01- Department of Health Professions

Date: 11/5/1994

The Medical Society of Virginia believes that the Department of Health Professions should not be regulated by or merged with the Department of Health.

Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

50.1.02- Physician-specific information

Date: 10/31/1998

The Medical Society of Virginia will work with the Board of Medicine to ensure that only appropriate, accurate and necessary physician-specific information, that achieves reasonable and economical disclosure, is available to the public.

Reaffirmed 10/12/2008
Reaffirmed 10/21/2018

55 MSV AFFAIRS

External Affairs

55.1.01 - Endorsement of the Commission on Office Laboratory Accreditation (COLA) Program

Date: 10/30/1993

The Medical Society of Virginia endorses the accreditation program for office laboratories of the Commission on Office Laboratory Accreditation.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

55.1.02- AMA Recruitment of Large Groups; Discounts and other Incentives

Date: 11/5/1994

The Medical Society of Virginia invites the AMA to recruit large groups (greater than 100 members) using discounts or other incentives as deemed appropriate. This invitation is extended on the condition that presentations of such initiatives will take place in person and that the Medical Society of Virginia and appropriate component societies will be invited to jointly participate in such presentations.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

55.1.03- Requests from State Legislators

Date: 11/4/1995

Upon request, the Medical Society of Virginia (MSV) Government Affairs staff will provide any member of the Virginia General Assembly a list of physicians with mailing addresses in his or her legislative district. When the list is sent to the legislator, a clear message will be included stating that the list is intended for constituent communications only, not for political purposes. Because the list is provided as a service to legislators to increase constituent communication between legislators and physicians and not for political purposes, there is no in-kind value assigned to the list. Exceptions to the aforementioned policy will be considered and decided by the MSVPAC Chairman.

Reaffirmed 11/06/2005
Reaffirmed as substituted 10/25/2015

55.1.04- American Association of Medical Assistants

Date: 11/8/1997

The Medical Society of Virginia considers that the American Association of Medical Assistants (AAMA) is an important and worthwhile organization and urges physicians to support their medical assistants and encourage their membership in AAMA.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

55.1.05- Communications with Local Medical Societies

Date: 10/31/1998

Each local medical society executive director or secretary, or in cases where there is no staff, society presidents or secretaries, will be listed on the Medical Society of Virginia (MSV) membership roster for purposes of receiving all mailings that go to MSV physician members.

Reaffirmed 10/12/2008
Reaffirmed 10/21/2018

55.1.06- MSV-Local Society Collaboration

Date: 10/31/1998

The Medical Society of Virginia staff will contact and work collaboratively with local societies on issues (especially those relating to managed care and insurance company policies) affecting their particular part of the state.

Reaffirmed 10/12/2008
Reaffirmed 10/21/2018

55.1.07- Specialty Society Inclusion in Legislative Policy

Date: 10/31/1998

The Medical Society of Virginia (MSV) will request inclusion of representatives of the affiliated specialty societies in the MSV's decision process for legislative action whenever the specialty society or its constituency has a public and vested interest in proposed legislation in the General Assembly of the Commonwealth of Virginia.

Reaffirmed 10/12/2008
Reaffirmed 10/21/2018

55.1.08- Virginia Health Quality Center

Date: 4/7/2000

The Medical Society of Virginia supports the Virginia Health Quality Center in its pursuit of health care quality improvement.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

55.1.09- Support of Northern Virginia Societies

Date: 11/4/2002

The Medical Society of Virginia supports the goals of the initiatives of the Northern Virginia medical societies as they relate to participation in the national effort to change the policies of managed care companies.

Reaffirmed 11/2/2012

Policies and Procedures

55.2.01- Conflict of Interest Policy

Date: 11/5/1994

The Officers, Directors, Associate Directors, Vice Speaker and Executive Vice President of the Medical Society of Virginia (MSV) should avoid any conflict of interest regarding MSV and should fully and immediately disclose any conflict of interest that they might have in connection with any transaction with or related to the Medical Society of Virginia.

GUIDELINES:

1. Any person subject to this policy shall exercise the utmost good faith in all transactions touching upon their duties to MSV. In their dealings with and on behalf of MSV, they shall be held to a strict rule of honest and fair dealing.

2. The acts of any person subject to this policy on behalf of MSV shall be in the best interest of MSV.

3. Any person subject to this policy shall not accept any gifts, favors, payments or things of value that might influence their decision-making or actions affecting the MSV.

4. Although a duality of interests may exist from time to time, such duality shall not be permitted to influence adversely the decision-making process of MSV. Any person subject to this policy shall promptly report the possible existence of a conflict of interest for himself/herself or any other person subject to this policy to MSV's President or

Executive Vice President.

5. When a conflict of interest exists, the person with the duality of interest shall remove himself/herself from involvement in any decision-making process, and shall not act on behalf of MSV in connection with such issue or decision.

6. A full disclosure of all facts pertaining to any transaction that is subject to any doubt concerning the possible existence of a conflict of interest shall be made before consummating the transaction.

7. Any person subject to this policy shall adhere to this policy and complete an Annual Disclosure Questionnaire as a condition of board membership or employment.

8. Any disagreement or dispute with regard to the existence of a conflict of interest shall be resolved by MSV's Executive Committee upon the request of any MSV Board Member or the Executive Vice President.

PROCEDURES:

A. Each year the Executive Vice President shall send to each person subject to this policy a copy of this policy and a Disclosure Questionnaire to be completed and returned.

B. An appropriate report shall be submitted to the MSV Board of Directors regarding any interests disclosed in the questionnaire.

Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

55.2.02- MSV Role in Disputes

Date: 11/5/1994

The Medical Society of Virginia believes that it should not intervene in disputes between physicians and hospital medical staff.

Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

55.2.03- President's Role; Guidelines for Others

Date: 11/5/1994

The Medical Society of Virginia believes that in legislative matters:

A. The President is the official spokesman for The Medical Society of Virginia.

B. The Society's lobbyists will keep the President informed and represent the official position when the President is not available.

C. Medical Society members who speak on behalf of the President or the Society will represent only the official position of the Medical Society.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

55.2.04- Financial Reports

Date: 11/4/1995

A full accounting/audit for fiscal year shall be available at each Annual Meeting. A report of year-to-date financial results, as well as the audit report accepted by the Board of Directors for the most recent completed fiscal year, can be made available to any Medical Society of Virginia member upon request.

Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

55.2.05- Physician Involvement in State Legislative Advocacy

Date: 11/4/1995

The Medical Society of Virginia supports physician involvement in state-level legislative advocacy and encourages members to have active ongoing relationships with members of the General Assembly through visits and events during and between sessions and getting to know their representatives' legislative aides.

Reaffirmed 11/06/2005
Reaffirmed as substituted 10/25/2015

55.2.06 - Academic Membership Agreement

Date: 10/31/1998

The Medical Society may offer, with the approval of the Board of Directors, a special dues program with Virginia's academic medical centers for physicians in a full time academic setting.

Reaffirmed: 10/12/2008

Reaffirmed 10/21/2018

55.2.07- Honorary Membership to Outgoing Past President

Date: 1/22/2000

The Medical Society of Virginia will grant honorary Society membership to the outgoing president.

Reaffirmed 10/24/2010

55.2.08- Statement of Individual Board Member's Responsibility

Date: 1/22/2000

Members of the Medical Society of Virginia Board of Directors will uphold the duties and responsibilities outlined in the MSV Board of Directors Handbook and its appendices.

Reaffirmed as amended 10/16/2016

55.2.09- Statement of Responsibilities of the Board of Directors as a Whole

Date: 1/22/2000

The Medical Society of Virginia Board of Directors will uphold the duties and responsibilities outlined in the MSV Board of Directors Handbook and its appendices.

Reaffirmed 10/24/2010
Reaffirmed as amended 10/16/201635.001

55.2.10- Use of the Term Physician

Date: 11/6/2005

The term "physician" shall be referred to as "physician (M.D. or D.O.)" when referencing membership criteria of the Medical Society of Virginia.

Reaffirmed 10/25/2015

Meetings / Programs

55.3.01- Procedures of the House of Delegates of MSV

Date: 11/4/1995

The Medical Society of Virginia (MSV) adopts the "Procedures of the House of Delegates" as the official source for the conduct of the MSV Annual Meeting.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

55.3.02- Fall Meeting

Date: 11/8/1997

The annual meeting of the Medical Society shall continue to be held in the fall.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

55.3.03- First Year Delegates Instructional Meeting

Date: 11/8/1997

An annual instructional meeting with the first year delegates shall be conducted prior to the first session of the House of Delegates.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

55.3.04- Medical Student Society Reorganization

Date: 11/8/1997

The Medical Society of Virginia (MSV) is committed to the inclusion of medical students at all levels of the decision or policy making process affecting all physicians in the State. The MSV Medical Student Section will provide a forum within the MSV for the exchange of information among students and their more senior colleagues.

Reaffirmed 10/28/2007
Reaffirmed 10/22/2017

55.3.05 Establish Evidence Based Guidelines for MSV Resolutions

Date: 10/21/2018

‘Whereas’ clauses shall include where appropriate and available evidence-based guidelines, the strength of recommendations, or level of evidence if applicable with appropriate citations upon the submission of the resolution; and be it further,

The MSV Rules of Procedure will be updated to reflect this requirement.