Board Discussion and Action
Policy Manual Sunset Review

Background: The BOD in November 2013 as part of its 2013-14 work plan directed the Constitution and Bylaws Committee (Committee) to review the CMS policy manual to determine those policies that are no longer pertinent and to incorporate like policies into one policy; and that such changes will be brought to the BOD for action by the July BOD meeting.

The Committee's policy review is well underway having held three separate meetings thus far. The Committee recommends review by the BOD in two stages, first at the May and again at the July meeting.

To date, the committee has reviewed roughly two-thirds of the manual (through 325 Public Health). With each policy, the committee made one of four recommendations: Reaffirm, Sunset, Sunset and replace, or Refer for expert review.

- **Reaffirm** – The committee felt the policy was still relevant
- **Sunset** – The committee felt the policy was no longer relevant or had been accomplished and should be removed from the manual and archived
- **Sunset and replace** – The committee felt language in the policy was outdated and should be updated, which requires approval from the House of Delegates
- **Refer for expert review** – The committee felt they did not have enough information about the current status of a policy and sent the policy to an outside expert, experts or committee for recommendation

In the interest of the board's time, the committee requests that the BOD in May review and act on the policies recommended for "Sunset" and "Sunset and replace," below. Any policy that is sunset will be archived in order for CMS to maintain a record of its presence.

Respectfully Submitted:

Mike Volz, MD, Chairman, Constitution and Bylaws Committee
Jan Kief, MD, Immediate Past President
Lynn Parry, MD, Member, BOD and Past President
Robert Yakely, MD, HOD Speaker
Brigitta Robinson, MD, HOD Vice-Speaker

Recommended for Sunset—For Action

100 Abortion

100.999 Medical Treatment for Infants Born Alive During Induced Abortion

The Colorado Medical Society (CMS) believes that the proper medical treatment of infants born alive prematurely, whether by abortion or spontaneously, is a matter which must be resolved on the basis of each individual case. The CMS opposes legislation that would have the effect of implying a predetermination of the nature or extent of medical treatment or care that should or should not be furnished to infants born prematurely under whatever circumstances.

(RES-7, IM 1977)

[Action: Sunset]

105 Acquired Immunodeficiency Syndrome (AIDS)

105.996 Testing for AIDS

The Colorado Medical Society (CMS) supports removing barriers to enable physicians more easily to obtain AIDS testing on patients. The CMS supports confidential testing and the use of such testing and partner notification process as an integral part of the control of HIV infection and AIDS. The CMS also recognizes that although there are downsides to anonymous testing (e.g., decreased ability to do partner notification, difficulty in differentiating duplicate HIV and AIDS case reports, difficulty in monitoring epidemiologic trends, difficulty in monitoring infected persons who continue to practice unsafe behaviors, inability of physicians to confirm test results), the availability of an anonymous test site (ATS) fills an unmet need for a part of the population. Therefore, the CMS supports the continuation of the existing ATS. The CMS also recommends that the ATS be allowed to offer the option of confidential testing. The CMS does not recommend expansion of anonymous testing to additional sites.

(Motion of the Board, November 1992)

[Action: Sunset. Note: This no longer meets current medical practice; there are no barriers to AIDS testing]

105.998 School Attendance for Children with AIDS

The Colorado Medical Society believes that children with HIV seropositive or AIDS-related complex should be allowed to attend regular elementary or secondary school classes. The child's physician is the best judge of whether a child with AIDS or AIDS-related complex should attend school based on the medical factors associated with this condition.

(RES-35, AM 1986)

[Action: Sunset. Note: This is no longer an issue]

105.999 Treatment of AIDS Patients

The Colorado Medical Society (CMS) is committed to the concept of treating AIDS patients and the AIDS-virus infected person in a compassionate and professional manner, which is consistent with the most current medical knowledge, and which protects both the public safety and individual civil liberties. The CMS encourages the treatment of AIDS patients, as in any other chronic but progressive disease, to be primarily in the outpatient setting until such time as the progression of the disease requires another treatment setting.

(RES-38, AM 1986)

[Action: Sunset. Note: This is no longer an issue]

115 Alcohol and Alcoholism

115.998 Driving Under the Influence (DUI) Blood Alcohol Level

The Colorado Medical Society supports the definition of Driving Under the Influence (DUI) blood alcohol level as 0.08% or less.

(RES-5, IM 1998)

[Action: Sunset]

120 Children and Youth

120.999 School Children with Herpes

The Colorado Medical Society (CMS) concurs with the American Medical Association that public elementary and secondary schools should not exclude a child from school attendance or otherwise discriminate against a child only because he has been diagnosed as having a herpes simplex virus. The CMS believes that the child's physician continues to be the best judge of whether a child with herpes simplex virus should attend school based on the medical factors associated with this condition.

(RES-36, AM 1986)

[Action: Sunset]

135 Continuing Medical Education

135.999 Tour/Travel Continuing Medical Education

The Colorado Medical Society does not sponsor, endorse, or otherwise become involved with tour/travel continuing medical education programs, whether on a profit or non-profit basis.

(RES-44, AM 1987)

[Action: Sunset]

155 Drugs: Prescribing and Dispensing

155.993 RX Data 2008

The Colorado Medical Society shall work with the Colorado Board of Pharmacy to make changes in the Electronic Monitoring of Prescription Controlled Substances law to extend access of the program to residents and fellows with active Colorado training licenses in good standing and support a funding mechanism to sustain program longevity.

(Late RES-22, AM 2008)

[Action: Sunset. Note: This has been accomplished]

155.999 Administration and Use of Prescription Drugs

The Colorado Medical Society opposes relaxing the restrictions in the laws of the State of Colorado to permit anyone not now licensed to administer or use in any way a prescription drug except under the direction or supervision of one so licensed.

(RES-4, AM 1976)

[Action: Sunset. Note: This is no longer an issue]

160 Drugs: Substitution

160.997 Substitution of Class B Generic Drugs

The Colorado Medical Society (CMS) reminds its membership of the provisions of CRS 12-22-124 (2) which provides "if, in the opinion of the practitioner, it is in the best interest of his patient that an equivalent drug not be substituted", that prescriptions may be ordered "dispense as written" by writing such orders or initialing a preprinted box to that effect.

The CMS encourages its members to become informed of the equivalence problems of drugs listed as Class B in the Federal Food and Drug Administration published list of generic drugs (the Orange Book) and encourages the cooperation of registered pharmacists with respect to filling of prescriptions through a joint committee of the CMS and the Colorado Pharmacology Association.

(RES-38, AM 1990)

[Action: Sunset]

160.998 Generic Drug Substitution

1. In the interest of cost savings, prescriptions should be written by generic name or without prohibition of substitution whenever the physician can be confident that the generic product is theoretically equivalent to the innovator product;
2. The physician should be cautious in permitting generic substitution for any drug, in which bio-equivalence problems have been documented or extensively anecdotally reported. Examples of such problems include generic substitution for dose critical drugs such as anti-convulsants, digoxin, anti-arrhythmics, L thyroxine, oral contraceptives, and certain neuroleptic drugs;
3. The physician should insist that pharmacists consult the Federal Food and Drug List (the Orange Book) before substituting generic equivalents;
4. The physician and pharmacist should take necessary steps to eliminate confusion by the patient when labels of prescriptions are changed from trade name to generic name, and when the physical appearance such as color, shape, and taste of generic substitutes vary from the originally prescribed product;
5. The pharmacist should provide a product that is coded and identifiable; and
6. Pharmacy drug substitution practices should be monitored by the appropriate Colorado State Agency, and the results of the monitor must be shared with physicians.

(Motion of the Board, June 1988)

[Action: Sunset]

165 Emergency Medical Services

165.996 Statewide Trauma System Development and Refinement

The Colorado Medical Society supports the implementation and refinement via physician input of an integrated statewide trauma system that is fair and effective and is consistent with recognized national standards.

(RES-39, AM 1993)

[Action: Sunset]

165.999 Availability of Emergency Transportation at High School Sports Events

The Colorado Medical Society believes that emergency transportation must be available on the scene or within five minutes from any potentially hazardous high school event and that it is necessary to have a working communication system available at the scene of the event.

(Motion of the Board, January 1983)

[Action: Sunset]

180 Health Care Delivery

180.992 Observation Care

The Colorado Medical Society (CMS) will work with third party payers to establish a uniform definition of “observation care” to include the following:

1. The patient should be designated as under “observation care” if the physician’s intent for hospital stay is less than 24 hours. If the physician’s intent and expectation is for a hospital stay of greater than 24 hours, then the stay should be considered inpatient. The use of 24 hours as a threshold for observation is a guideline. It is not unusual for observation to extend a few hours beyond 24 hours or for patients to be admitted to inpatient status before 24 hours.
2. Patients classified as under “observation care” require hospital level-of-care.
3. The patient should be registered as under “observation care” after initial physician evaluation of the patient’s signs and symptoms and appropriate testing. Post day surgical

patients should be registered as under “observation care” if, after a normal recovery period, they continue to require hospital level-of-care as determined by a physician.

The CMS will establish policy on “observation care” and develop model legislation to ensure that:

1. After initial approval of inpatient admission by insurers, there should be no retrospective reassignment to “observation care” status by insurers unless the original information given to insurers is incorrect.
2. Insurers should provide 60 days prior notice to providers of changes to “observation care” criteria or the application of those criteria with opportunity for comment. There should be no implementation of criteria or changes without first following these protocols.
3. Insurers’ “observation care” policies should include an administrative appeal process to deal with all utilization and technical denials within a 60 day time frame for final resolution. An expedited appeal process should be available for patients in the admission process, allowing for a decision within 24 hours.
4. Insurers and HMOs should provide clearly written educational materials on “observation care” to subscribers highlighting differences between inpatient and “observation care” benefits and patient appeal procedures (Res. 808, I-95).

The CMS reaffirms that only the attending physician can change the patient’s status under the Medical Practice Act.

(RES-21, AM 2004)

[Action: Sunset. Note: Accomplished]

180.994 Use of Current Knowledge in Palliative Medicine

The Colorado Medical Society encourages physicians to attain and use knowledge of palliative medicine in patient care.

(RES-10, AM 2000)

[Action: Sunset]

180.996 Transition of Care for Patients with Special Needs and Circumstances

PREAMBLE

In the process of transitioning of care from one health plan to another, at times it becomes necessary for a patient to leave an ongoing doctor-patient relationship during treatment of a chronic or protracted medical condition and establish a relationship with a new physician. There is great value to the care of the patient in developing a process to facilitate such transfer with minimal disruption to all involved parties.

The recommendations presented herein are designed to recognize the special needs of certain patients with chronic or protracted illnesses who are under the care of either a primary care or specialty care physician at the time of transition. They provide a preferred method by which the patient interacts with the two physicians at both ends of the transition and the new health plan. They provide a framework which is simple and flexible, compensates the transferring physician for the time and effort expended, gives highest priority to concern for patient satisfaction, and promotes an effective vehicle for health plans to transition potentially high cost patients into their plan.

Developed through discussions between the Colorado Medical Society and the Colorado Association of Health Plans, these recommendations are presented to health plans and physicians for their voluntary adoption.

RECOMMENDED ELEMENTS OF TRANSITION

1. Early Notification
   Typically a patient who will be changing plans involuntarily will have a time delay between the notice of change and the effective date. The patient should advise the current physician practice as soon as possible. Health plans should make available:
   a. A written description of the process used to facilitate transition of care, (customer service, new member nurses, etc.)
   b. A written description of its review process of requests to continue services with an existing, non-affiliated provider.
2. Identification of Patients with Special Needs and Circumstances
   Current physicians are expected to identify patients with unique needs and initiate a process to facilitate their transition to a new provider.
   a. Health plans should make available to those patients so requesting, names of available participating providers (primary care and specialty practices) and how to contact them to ease referral and selection.
   b. If requested by the patient, it is appropriate for the current physician to suggest a physician to the patient, and then begin communication with that physician.
3. Transition Planning Visit
   The current physician and patient should schedule a visit in the period before effective date of new plan to plan a smooth transition to the accepting physician's practice.
4. Transfer of Patient Information
   The current treating physician should:
   a. Collect and prepare for transfer of adequate medical records to inform accepting physician of patient's past medical history, treatment modes, medication history, pertinent diagnostic measures, current treatment plan, etc.
   b. Create a letter of referral summarizing pertinent historical and biographical data to facilitate accepting physician's development of rapport with the patient and family.
5. Introductory Visit to Accepting Physician
   Should be arranged as soon as practical after effective date of new plan. The current treating physician should make a recommendation to the patient regarding the timeliness of scheduling the first appointment. The purpose is to begin development of relationship, ensure pertinent records are available, prescriptions are transferred if necessary and consideration of ancillary needs (durable medical equipment, etc.).
6. Physician-to-Physician Consultation
   It may be appropriate for former and accepting physicians to formally consult regarding patient's unique needs.
7. Compensation
   Fair and appropriate compensation should be paid promptly for each of these services by the plan in effect at the time of service.

The following recommendations should also apply when a physician is separating from a health plan:

1. Physician Initiated

   When the physician is voluntarily leaving the plan, the physician should initiate the transition process.

2. Plan Initiated

   When the plan initiated disaffiliation; the health plan should initiate the transition process.

(Motion of the Board, July 1996)

[Action: Sunset. Note: No longer current standard]

180.998 Encouragement of Physician Participation in Project USA

The Colorado Medical Society encourages physician participation in Project USA, administered by the American Medical Association, which recruits physicians and other health care providers for short-term service at National Health Service Corps and Indian Health Service hospitals and clinics.

(RES-67, AM 1994)

[Action: Sunset. Program no longer exists]

185 Health Care System Reform

185.995 A Matrix Based Reform Plan Using A Non-Profit Approach

The Colorado Medical Society, through the Physicians' Congress for Health Care Reform, shall explore and consider advocating for reform legislation using the Matrix as a template with one important addition which represents a compromise between the market based advocates and the single payer advocates – that the proposal be based on a private non-profit payer system.

(Late RES-23, 2008)

[Action: Sunset]

185.997 Individually Selected and Individually Owned Health Insurance

As was originally envisioned by the Colorado Medical Society (CMS) (see original concept paper approved September 1996), the CMS supports the following American Medical Association (AMA) policies on individual health insurance (AMA H-165.920, excerpted portions). The CMS supports the principle of the individual's right to select his/her health insurance plan and actively supports the concept of individually selected and individually owned health insurance. The CMS supports individually selected and individually owned health insurance as the preferred method of people to obtain health insurance coverage. The CMS advocates a system where individually purchased and owned health expense coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it. The CMS supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage; equal tax treatment for the costs of health insurance is necessary, whether that coverage is purchased fully by individuals, partially by employers or fully by employers. The CMS supports and promotes efforts to establish and use medical savings accounts (MSAs). The tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, are an integral component of CMS efforts to achieve universal coverage and universal access. The CMS continues to place a high priority on enactment of federal legislation to expand opportunities for employees and others to individually own health insurance through vehicles such as medical savings accounts.

Additional Information: Individually Selected and Individually Owned Health Insurance System

(Motion of the Board, September 1996 • Amended March 2004)

[Action: Sunset. Note: The Affordable Care Act makes this policy out of date]

190 Health Education

190.998 Journal Exchange

The Colorado Medical Society (CMS) will keep the journal exchange, with journals mailed to CMS and then reposited with Denver Medical Library.

(Motion of the Board, April 1982)

[Action: Sunset]

190.999 Medical Library

The Colorado Medical Society (CMS) will use the Denver Medical Library as now structured and not establish a CMS library.

(Motion of the Board, April 1982)

[Action: Sunset]

195 Health Insurance

195.999 Informed Consent for Insurance Subscribers

The Colorado Medical Society supports the requirement that insurance companies and agents obtain informed consent from each subscriber detailing how their insurance plan is likely to impact or restrict their health care needs.

(RES-22, IM 2004)

[Action: Sunset]

200 Health Insurance Benefits and Coverage

200.997 Consumer Comparative Data

The Colorado Medical Society supports the development of state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on:

1. Coverage provisions, benefits and exclusions.
2. Prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services.
3. Plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient.
4. Medical expense ratios.
5. Cost of health insurance policy premiums.

(RES-62, AM 1996)

[Action: Sunset]

200.998 Insurance Aspects of Comprehensive Pediatric Care

The Colorado Medical Society believes that all third party plans for delivery of medical services to infants and children should be comprehensive in nature.

(RES-39, AM 1987)

[Action: Sunset. Note: This is too broad]

200.999 Reimbursement for Voluntary Home Treatment of Terminally Ill

The Colorado Medical Society believes that all medical charges and costs incurred by individuals electing to remain at home for the period of medical treatment required in the case of a terminal illness be designated as reimbursable by third party insurers, including Medicare, to encourage alternative, less costly treatment settings.

(RES-15, AM 1980)

[Action: Sunset. Note: This is out of date and too vague]

205 Health Planning

205.995 Physician Signature on Cardiopulmonary Resuscitation (CPR) Directives

Colorado Medical Society supports informed patient autonomy and supports the removal of the statutory mandate of the physician's signature on the CPR directive;

- CMS supports using an appropriate document that is properly and legally executed by the patient in order to carry out patient CPR Directives.

(RES-7-A, AM 2007)

[Action: Sunset. Note: This is obsolete; the laws have changed]

205.998 Nursing Home Resident Destination Issues

The Colorado Medical Society believes that nursing home residents' rights and autonomy regarding transport to their designated hospital ought to be honored as often as possible, when specified as part of an advanced medical directive.

(RES-40, AM 1993)

[Action: Sunset. Note: This has no force; likely superseded by contractual agreements]

215 Hospitals

215.999 Status and Disbursement of Profits

The Colorado Medical Society supports the concept that all health plans and hospitals be required to be not-for-profit and provide adequate and sensible remuneration to their administrative personnel and their capital requirements. All assets over and above the mentioned monetary requirements be actuarially returned to the patients (payers of premiums) and providers both in lower or sensible premiums and adequate and sensible provider reimbursements. Monetary consideration should always be secondary to excellent and sensible patient care.

(RES-22, AM 1999)

[Action: Sunset. Note: Nonsensical policy]

225 Licensure and Discipline

225.996 Voluntary License for Retired Physicians

In recognition of volunteer services provided by retired physicians and to encourage further volunteer participation in the area of indigent medical care, the Colorado Medical Society will work with the Colorado State Board of Medical Examiners, and if necessary develop legislation, to waive the fee for renewal of license of retired Colorado physicians who can provide confirmation that their only professional practice involves volunteer medical services for recognized charitable 501(c)(3) organizations or government agencies. If the aforementioned is unsuccessful, an alternative source of funding shall be explored.

(RES-29, AM 1997)

[Action: Sunset. Note: Has not happened and likely never will]

230 Long-Term Care

230.998 Case Management

The Colorado Medical Society (CMS) endorses the utilization of qualified geriatric case managers for the coordination of screening and assessment of long-term care applicants, and for the subsequent development, implementation, monitoring and reassessment of a plan of care. The CMS support legislation to assure the qualification of case managers, to include licensure by an appropriate regulatory agency.

(RES-41, AM 1989)

[Action: Sunset]

235 Managed Care

235.976 Prior Authorization

CMS accepted the report of the CMS-CAHP Work Group on Prior Authorization (PA) and will continue the process of working with Colorado Association of Health Plans (CAHP).

Action steps

1. Develop improved, ongoing PA communications between physicians and the health plans, with emphasis on secure electronic communications where feasible.
    a. Design a Portal/web page to be hosted by CAHP to allow a single point of entry for physicians, with links to all plans' websites, and "drop-downs" to protocol-driven criteria for approval;
    b. Convene "expert" committee made up from physician and staff representatives and health plan staff, including medical directors, IT, legal, and utilization management staff, to develop detailed plan, format, content;
    c. Explore standardized "format" for PA entry pages;
    d. Ensure that all needed PA information is readily available on plans' websites – list of medications requiring PA, patient data required, understandable criteria for approval, appeal process, correct form to be submitted, etc. Goal is to make sure physicians and their staff have clear knowledge of what information is required for approval before the first submission.
2. Improve timeliness of PA consideration, submission of needed patient data, and approval/denial of requests. There is consensus that the principal reason for delay in decisions is the lack of complete patient data [given there is no existing incentive for plans to delay a determination once they have complete information] and the inefficient back-and-forth between prescribing physicians and health plans.
    a. Explore better systems to speed communication directly between health plans and physicians when more information is needed. Focus on asynchronous forms of communication to avoid wait times in both directions.
    b. Review current federal mandates and NCQA and URAC guidelines for timing of urgent and non-urgent PA requests; consider applying the Medicare Part D standards, i.e. 24 hours for urgent requests and 72 hours for non-urgent requests [timeframes run from receipt of complete information].
    c. Monitor timing of PA actions as the improved system for communications outlined above is implemented.
3. Confirm that ordering physicians receive timely, direct notice when a PA is rejected or requires additional patient data/information. Work toward expanding secure electronic notices and option to transmit the data electronically [in addition to the notice to the patient, which is an accreditation and regulatory requirement]. See 2.a above.
4. Contact PBM's to bring them up to date on progress of the Work Group and include them in future meetings. Consider adding other organizations/stakeholders.

SECOND PHASE ACTION STEPS

5. CMS and CAHP will develop an ongoing education program to enhance the knowledge of prescribing physicians and their staff on the PA process, content of plans' websites, criteria for approval, drugs that require PA, etc.
6. CMS and CAHP should stay informed on the work being done nationally to develop a standardized electronic transaction set for prior authorization. If agreement is reached at the national level, this group should evaluate how the electronic transaction can be

utilized to facilitate better electronic communication and more timely processing of requests.

7. After solving the prescriptive PA problems, consider expanding the scope of the Work Group to include the other procedures requiring PA's.

(BOD-1, AM 2012)
[Action: Sunset]

235.978 National Care Project Physician Input

The Colorado delegation to the American Medical Association (AMA) shall direct the AMA to provide education via established means to providers at acute and post acute levels in the Post Acute CARE (Continuity Assessment Record and Evaluation) demonstration project currently underway.

The Colorado delegation to the AMA shall direct the AMA to urge the Centers for Medicare and Medicaid Services (CMMS) to solicit local, state, and national physician input during the CMMS CARE demonstration period (2008-2011).

(RES-10, AM 2008)

[Action: Sunset]

235.980 Request for Ongoing Reporting from the UnitedHealthcare Physician Advisory Committee (PAC)

The Colorado Medical Society (CMS) continue to provide detailed updates on PAC meetings in *Colorado Medicine* and in written reports with minutes to the Council on Practice Environment (COPE) and CMS Board of Directors. The lack of progression on physicians' concerns raised at the merger hearing be brought to the attention of both UnitedHealthcare and the Commissioner of Insurance and/or the American Medical Association.

(RES-15, AM 2006)

[Action: Sunset. Note: This has been accomplished and incorporated into committee responsibilities]

235.982 Admitting Officer and Hospitalist Programs

1. Managed care plan enrollees and prospective enrollees should receive prior notification regarding the implementation and use of "admitting officer" or "hospitalist" programs;
2. Participation in "admitting officer" or "hospitalist programs" developed and implemented by managed care or other health care organizations should be at the voluntary discretion of the patient and the patient's physician;
3. Hospitalists systems when initiated by a hospital or managed care organization should be developed consistent with American Medical Association policy on medical staff bylaws and implemented with approval of the organized medical staff to assure that the principles and structure of the autonomous and self-governing medical staff are retained;
4. Hospitals and other health care organizations should not compel physicians by contractual obligation to assign their patients to "Hospitalists" and that no punitive measure should be imposed on physicians or patients who decline participation in "hospitalist programs."
5. Colorado Medical Society opposes any hospitalist model that disrupts the patient/physician relationship or the continuity of patient care and jeopardizes the integrity of inpatient privileges of attending physicians and physician consultants.

(RES-7, AM 2002)

[Action: Sunset. Note: CMS has no power to implement this]

235.985 Managed Care Contract Participation Listing Deadline

The Colorado Medical Society shall pursue legislation stating that health plans cannot market physicians as members of their network without the written consent of the physician unless the physician is under signed contract 120 days prior to the effective date of the contract year of the health benefit plan.

(RES-8, AM 2000)

[Action: Sunset]

235.989 Position Paper: Prior Authorizations

The Colorado Medical Society (CMS) objects to any prior authorization process that is implemented solely for the purpose of creating a barrier to care. Prior authorization mechanisms created as barriers to care increase overall health care expenses by adding an unnecessary administrative burden.

The CMS encourages all managed care organizations with a prior authorization process, to have the process contain at least the following elements:

- Authorization of enough visits to complete a course of treatment for the specified condition;
- There are circumstances when a health plan wants to know of the existence of a clinical condition. In these circumstances, notification is preferred to prior authorization unless there is a valid clinical rationale for prior authorization;
- The criteria used for adjudication of prior authorization should be available to physicians in advance, and the process should be as streamlined as possible. Aids for the physician's office such as worksheets are desired;
- Admissions, referrals, and procedures that meet nationally or regionally accepted guidelines should be exempt from prior authorization; and
- Compliance with time limit and written notification standards set forth in Colorado Regulation 4-2-17 "Prompt Investigation of Health Plan claims Involving Utilization Review".

(RES-24, IM 1997)

[Action: Sunset. Note: Accomplished with prior authorization law]

235.991 Managed Care Network Adequacy

The Colorado Medical Society (CMS) shall encourage managed care plans to have provider networks sufficient to not require patients to travel more than 25 miles to receive appropriate primary care services and consulting specialty services. Managed care plans shall be restricted from marketing or enrolling patients who reside in areas poorly served by such plans. The CMS shall support such requirements through legislation or regulation as may be appropriate.

(RES-52, AM 1996)

[Action: Sunset. Note: This is law now]

235.992 Access to Care (Gatekeeper Systems)

The Colorado Medical Society believes that managed care organizations should provide patients, as well as physicians, with a clear and concise explanation of the type of gatekeeper model their plan utilizes. This explanation should be written in easily understood language and include the procedures for referrals, as well as any physician reimbursement mechanism that may be construed to limit access to care.

(RES-56, AM 1996)

[Action: Sunset. Note: Does not happen]

235.998 Punitive Protections for Physicians Participating in Health Care Plans

All managed care plans and medical delivery systems must include significant physician involvement in their health care delivery policies similar to those of self-governing medical staffs in hospitals Any physicians participating in these plans must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.

(RES-16, IM 1994)

[Action: Sunset]

235.999 Point of Service Option for Managed Care Enrollees

The Colorado Medical Society encourages all health plans that restrict access by enrollees or members to health care providers to offer coverage for health care services provided by out-of-network providers through an alternative "Point of Service Option". The benefit level of such plans shall not be set so low as to act as a prohibitive deterrent to patient utilization of this option.

(RES-30, IM 1994)

[Action: Sunset. Note: Out of date]

245 Medical Education

245.997 Topics and Responsibility for the Annual Meeting Educational Program

Contemporary issues affecting medicine should be the main thrust of the Education Program at the Colorado Medical Society Annual Meeting.

(RES-1, AM 1991)

[Action: Sunset]

260 Medicare

260.996 Correction of Medicare Under-reimbursement to Colorado Physicians

The Colorado Medical Society (CMS) continues to encourage our congressional delegation to introduce and support legislation that would remedy the Medicare's Geographic Practice Cost Indices (GPCI) adjustment for Colorado, so that Medicare reimbursement to Colorado physicians becomes comparable to the reimbursement in regions with similar costs of living. The CMS shall continue to work with the Governor and other state officials to document the impact of low Medicare reimbursement on Colorado and encourage the Centers for Medicare and Medicaid Services to support legislation to remedy the current inequities.

(Revised Late RES-28, AM 2002)

[Action: Sunset. Note: This is an AMA issue]

260.997 Terminating Participation in Medicare - Managed Care Plans' Responsibility to Patients

While the Colorado Medical Society (CMS) recognizes the managed care plan's right to make business decisions, they are responsible for assuring their enrollees receive the health care needed with a minimal amount of disruption. It is ultimately the responsibility of the HMO to help minimize the financial impact to the patient and to assist in the transition of care.

The CMS encourages any managed care organization terminating a particular line of business or terminating a particular group of insureds to:

- Establish education sessions for enrollees outlining options available to them and steps to be taken to review those options;

- Develop a list of resources available to assist patients, such as government agencies, consultants etc.; and
- Implement the CMS/Colorado Association of Health Plan's "Recommended Elements of Transition of Care".

Additional Information: Recommendations for Transition of Care

(RES-15, AM 1999)

[Action: Sunset. Note: This is no longer an issue]

270 Non-Physician Providers

270.995 Physical Examinations

The Colorado Medical Society will seek legislation defining the physical examination of athletes for sports participation, or of driver candidates for operation of commercial vehicles within the State of Colorado, as being the practice of medicine legally restricted to either a person possessing a license to practice medicine or a person performing a delegated medical function.

(RES-14, AM 2003)

[Action: Sunset. Note: Not current practice]

270.997 Non-Physician Providers

The Colorado Medical Society (CMS) defines non-physician providers (NPPs) as physician assistants (PAs) and advanced practice nurses (APNs). The CMS defines APNs as professional nurses with additional education and clinical experience beyond traditional nursing education. APNs include clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, and nurse practitioners.

The CMS encourages the profession of medicine to study the roles, education, scope of practice, potential for autonomy and accountability, and quality issues regarding NPPs to create a basis for informed recommendations and ongoing dialogue with public policy makers and other health professionals.

1. Role

   The CMS supports incentives to facilitate the education and practice of NPPs that focus on the need for (medical) primary care skills.

2. Education

   The CMS supports minimum education requirements and minimum clinical experience requirements for all NPPs. The CMS supports the requirement for a master's level of education in order to be eligible for the title of APN. The CMS supports the definition of APN in Colorado statute to assure title protection and appropriate educational preparation. In addition to specific education requirements the CMS supports a clinical experience criterion, such as a formal internship. The CMS believes that the PA programs, which include minimum education requirements, clinical experience and certification, provide an excellent model for NPP licensure. The CMS recommends that physicians have input into the education and clinical requirements of NPPs in Colorado, specifically with regard to that content which is in the domain of medicine.

3. Scope of Practice

   The CMS supports the development and implementation of uniform regulations for both APNs and PAs. Any functions that are traditional to the practice of medicine must be accompanied by specific education, certification, clinical experience, and require physician review and approval.

   a. Independent Medical Functions: The CMS believes that independent medical functions should be limited to those practitioners who are licensed to practice

medicine as defined in the Medical Practice Act. NPPs do not have the minimum education, clinical experience and certification tests required by the Medical Practice Act.

b. Collaborative Practice: The CMS supports the concept of collaborative practice between physicians and NPPs. Collaborative practice includes those medical functions that relate to self-limited and stable chronic conditions, as well as preventive services, provided by an NPP, which do not require the physical presence of the participating physician. The CMS supports mechanisms to facilitate collaborative practice plans.

c. NPP Practice with Delegated Medical Functions: The CMS recognizes that currently NPPs perform delegated medical functions under existing statutes. The CMS recommends no modifications of this practice with the following exceptions:

I. On-site physician supervision shall not be limited to a specific number of NPPs, provided the physician supervisor can document adequate supervision.

II. Specific protocols are not required with on-site supervision.

III. Physician sign off on charts is required weekly.

4. Representation of NPPs in the CMS

The CMS supports dialogue between organized medicine and NPPs in order to promote the role of NPPs as members of the health care team.

Additional Information: Collaborative Practice Plan Guidelines

(RES-44, AM 1994)

[Action: Sunset. Note: Outdated]

280 Occupational Health

280.994 Workers' Compensation-Level 1 Accreditation

The Colorado Medical Society opposes mandatory Level 1 accreditation for physicians treating Workers' Compensation injuries.

(Motion of the Board, January 1996)

[Action: Sunset. Note: This is no longer an issue]

280.995 Independent Medical Examination

Colorado Medical Society supports the integrity of the "Independent Medical Examination" by assuring that a physician can determine who will be present during examination. If the physician's integrity is abridged by judicial action, the physician has the right to refuse to perform the examination.

(RES-14, IM 1993)

[Action: Sunset. Note: The law has changed so all IMEs must be audio-taped]

285 Peer Review

285.999 Peer Review Organization (PRO) Data Dissemination

The Colorado Medical Society (CMS) discourages the use of any peer review organization (PRO) data by any hospital, medical staff, or other body for credentialing purposes. The CMS strongly urges PROs to discontinue (or refrain from initiating) dissemination of any such utilization review or quality data collected from their work under their scope of practice for credentialing or any other similar purpose.

(RES-66, AM 1991)

[Action: Sunset]

290 Physician Fees

290.999 Medicare Fees

The Colorado Medical Society supports all efforts to minimize all government controls on physicians' fees.

(Substitute Resolution in lieu of RES-15 and RES-25, IM 1987)

[Action: Sunset. Note: As stated, it could interfere with mechanisms to increase fees]

295 Physician Payment

295.987 Budget Neutrality Factor

The Colorado Delegation to the American Medical Association (AMA) shall encourage the AMA to oppose the commercial plans' use of adverse adjustment factors designed for use by government plans.

The Colorado Delegation to the AMA shall encourage the AMA to support federal legislation requiring transparent and separate identification of the use of all adjustment factors, including the Budget Neutrality Factor, by commercial plans.

(RES-19, AM 2008)

[Action: Sunset. Note: Accomplished]

295.988 Delivery of Multiple Services to Patients at a Single Encounter

The Colorado Medical Society supports the reform of payment rules amongst all payers that penalize the delivery of more than one service to patients at single encounter or on a single day. The Colorado Delegation to the American Medical Association (AMA) shall bring a similar resolution to the AMA.

(RES-13, AM 2008)

[Action: Sunset]

295.989 Medical Directors' Responsibility in Denial of Procedures

The Colorado Medical Society take appropriate actions through its quarterly payers meetings and in discussions with the Colorado Insurance Commissioner and the legislature to require insurance companies to have their medical director call the ordering physician during regular office hours if a test or procedure is denied and not just send a denial.

(RES-12, AM 2005)

[Action: Sunset]

295.994 Reimbursement for Paperwork Completion

The Colorado Medical Society believes physicians should receive reimbursement for completion of mandated forms.

(RES-36, AM 1993)

[Action: Sunset]

295.997 Reimbursement of Expenses Incurred with Office Procedures

Overhead expenses incurred by physicians when rendering office procedures should be reimbursed at actual cost when appropriate documentation is supplied to the third party payer. Actual cost should be inclusive of invoice cost, personnel costs, and all associated costs appropriately applied. This policy applies to all third party payers including Medicare and Medicaid.

(RES-34, AM 1991)

[Action: Sunset]

310 Pregnancy and Child Birth

310.999 Length of Hospital Stay Following Obstetric Delivery

The Colorado Medical Society believes post-partum stays shall in the opinion of the attending physician be sufficient for the adequate recovery and instructional guidance for mothers and newborns and that appropriate ambulatory services should be provided in the early post-partum period.

(RES-18, IM 1996)

[Action: Sunset. Note: This is no longer an issue]

320 Professional Liability

320.996 Reporting on Applications

The Colorado Medical Society opposes the need for reporting on medical staff and other non-licensing board applications, including insurance company credentialing applications, (except for professional liability insurance applications) any threatened, pending, or closed professional liability claims where the claim did not result in payment on behalf of that physician. Credentialing applications should not contain questions that are subjective and accusatory in nature such as: "Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?" or "Have you ever had any malpractice actions (pending, settled, dropped, dismissed, arbitrated, mediated or litigated)? If yes, provide information for each case." A limitation of not more than five years should be placed on the centralized credentialing collection services to implement this policy.

(RES-28, AM 2004)

[Action: Sunset. Note: We supported the Skolnik law and support transparency.]

320.998 Governmental Immunity

The Colorado Medical Society supports the expansion of the Colorado Governmental Immunity Act to cover all state licensed physicians while engaged in the care of the indigent patient.

(RES-40, AM 1996)

[Action: Sunset]

Recommended for Sunset and replace-For Action

100 Abortion

100.998 Termination of Pregnancy

The Colorado Medical Society (CMS) supports early health education and the distribution of safe, ~~more~~ effective methods of family planning for males and females as primary methods of birth control. The termination of pregnancy by a licensed physician in an approved medical setting is a safe medical procedure surrounded by moral and ethical implications. Neither the State nor the Federal government should interfere with the physician/patient relationship and the ability of physicians to counsel their patients on all options for the management of unwanted pregnancy unless there is compelling state interest in which case the regulations must be limited to those reasonably related to those interests. The CMS encourages the development of comprehensive programs including more contraceptive research, mandatory health education for school children, and sex education and family life programs for school children~~, and thorough counseling of~~

~~persons with unintended pregnancies regarding the pros and cons of all options available as well as prevention of future unintended pregnancies~~.

(RES-53, AM 1989)

[Action: Sunset and replace]

135 Continuing Medical Education

135.986 Mission Statements

The Colorado Medical Society adopts the mission statement contained in the ~~Program of Accreditation for Continuing Medical Education Policies and Procedures revised April 2003 and~~ CPEA Handbook for CME Educators, Accreditation Policies and Procedures, revised 8/2011 and approved by the Committee on Professional Education and Accreditation. The CMS adopts the CMS CME mission statement revised 12/2012 and approved by the CME Committee.

(RES-70, AM 2003)

[Action: Sunset and replace. Note: Replace with recommendation by CPEA]

135.987 Program Accreditation Program of Recognized Intrastate CME Accreditor and CME Accredited Provider

~~The Colorado Medical Society (CMS) is committed to providing value to its membership by accrediting quality continuing medical education (CME) programs that are accessible. The CMS is currently recognized by the Accreditation Council for Continuing Medical Education (ACCME) as an accreditor of intrastate providers of CME. The Committee on Professional Education and Accreditation has the responsibility of maintaining and improving the program for accreditation on behalf of the CMS and in accordance with the standards established by the ACCME.~~ The Colorado Medical Society (CMS) is committed to ensuring high-quality accredited continuing medical education (CME) for physicians. The CMS is recognized by the Accreditation Council For Continuing Medical Education (ACCME) as an accreditor of intrastate providers of CME. And, the CMS is accredited by the ACCME to provide CME for physicians. The Committee on Professional Education and Accreditation (CPEA) has the responsibility of maintaining and improving the recognized accreditor program on behalf of the CMS and in accordance with national standards established by the ACCME. The CME committee (separate from the CPEA) has responsibility for maintaining and improving the CMS CME program.

(RES-30, AM 1996)

[Action: Sunset and replace. Note: Replace with recommendation by CPEA]

135.988 Financial Support of Accreditation Program

The Colorado Medical Society retains the responsibility for the ~~Accreditation~~ CME programs and seeks to make ~~it~~ them financially ~~a~~ self-supporting ~~program~~.

(RES-46, AM 1993)

[Action: Sunset and replace. Note: Replace with recommendation by CPEA]

135.989 Policies and Procedures

The Colorado Medical Society (CMS), ~~and the Committee on Professional Education and Accreditation~~ the CPEA, and the CME Committee have adopted the ~~American Council for Continuing Medical Education~~ ACCME national standards and policies. ~~and procedures for standards of commercial support and disclosure.~~ All providers accredited by the CMS must comply with the current standards and policies ~~the current standards for commercial support found in the Program for Accreditation of Continuing Medical Education Policies and Procedures.~~ found in the CPEA Handbook for CME Educators, Accreditation Policies and Procedures, and all CME activities approved by the CMS must comply with ACCME national standards and policies.

(Motion of the Board, October 1991)

[Action: Sunset and replace. Note: Replace with recommendation by CPEA]

135.990 Educational Programs of Other Organizations

The Colorado Medical Society (CMS) frequently receives requests from other organizations/institutions to ~~co-sponsor or~~ joint sponsor educational ~~events~~ activities directly or indirectly related to the broad field of medicine and health care. ~~The CMS is no longer accredited by the American Council for Continuing Medical Education to co-sponsor or joint sponsor educational activities. All such requests will be declined.~~ The CMS will consider joint sponsor requests on an individual activity basis subject to the review process of the CME office and CME committee.

(RES-1, AM 1991, Motion of the Board, July 2001)

[Action: Sunset and replace. Note: Replace with recommendation by CPEA]

135.991 Endorsement of Outside Educational Programs

Any outside organization/institution desiring endorsement of its program by use of the Colorado Medical Society (CMS) name must submit its request to the ~~Manager~~ Director for Continuing Medical Education for preliminary investigation after which the request shall be directed, as efficiently as possible, to the appropriate CMS committee or council for further recommendation, then to the Board of Directors for final approval/disapproval.

(RES-1, AM 1991)

[Action: Sunset and replace. Note: Replace with recommendation by CPEA]

135.992 Committee on Professional Education and Accreditation

The Colorado Medical Society is the final authority for the accreditation of Colorado intrastate organizations/institutions that provide continuing medical education (CME). The Committee on Professional Education and Accreditation (CPEA) is responsible for the operation of the accreditation program. Each application for accreditation will be reviewed by the CPEA and actions of the CPEA are final, subject to appeal. The accreditation process and available types and duration of accreditation are described in the ~~Program of Accreditation of Continuing Medical Education Policies and Procedures~~ CPEA Handbook for CME Educators, Accreditation Policies and Procedures that ~~are~~ is available, upon request, from the Department of Health Care Policy.

(RES-1, AM 1991)

[Action: Sunset and replace. Note: Replace with recommendation by CPEA]

135.994 Liaisons With Other Organizations

The Colorado Medical Society (CMS) maintains liaison on educational matters with organizations local, state and national that are concerned with continuing medical education. The CMS participates, when appropriate, in the educational activities of such national organizations as the American Medical Association, the Accreditation Council for Continuing Medical Education, the American Hospital Association, the Association for Hospital Medical Education, the Association of American Medical Colleges, ~~the Alliance for Continuing Medical Education~~ Alliance for Continuing Education in the Health Professions. The CMS also maintains similar relationships with such Colorado organizations as the Colorado Alliance for Continuing Medical Education, the Colorado Hospital Association, the State Departments of Education and Health, and the medical specialty societies; keeps informed concerning the medical education activities of community hospitals, component medical societies, medical groups and individuals; and works with and supports them when appropriate.

(RES-1, AM 1991)

[Action: Sunset and replace. Note: Replace with recommendation by CPEA]

135.995 Issuance of Credit

In the state of Colorado, only organizations accredited by the Colorado Medical Society and the ~~American~~ Accreditation Council for Continuing Medical Education are accredited to extend Category 1 Continuing Medical Education credit toward the American Medical Association

Physicians Recognition Award to physicians. These organizations are responsible for maintaining records regarding physician attendance and credits earned.

(RES-1, AM 1991)

[Action: Sunset and replace. Note: Replace with recommendation by CPEA]

155.998 Use of Anabolic Steroids

The Colorado Medical Society (CMS) considers the prescription, recommendation, or use of anabolic steroids for the purpose of the hormonal manipulation of athletes that is intended as a performance aid for athletes to increase muscle mass, strength, or weight manipulation without a medical necessity to do so to be unethical and reason for immediate investigation by the Council on Ethical and Judicial Affairs of the CMS and prompt reporting to the Colorado ~~Board of Medical Examiners~~ Medical Board.

(RES-40, AM 1987)

[Action: Sunset and replace. Note/Task for staff: Move under Drug Abuse, Misuse and Inappropriate Use. (Move doesn't require HOD approval.)]

180 Health Care Delivery

180.987 Patient Safety

The Colorado Medical Society considers patient safety ~~The Ad Hoc Workgroup on Patient Safety and Professional Accountability, comprising physicians from numerous specialties and across the state, reiterates its endorsement of Banner Goal 5:~~

- ~~To pursue as~~ a high priority and ~~as~~ an important component of health care reform~~, the re-design of patient safety systems through approaches that unify all stakeholders in health care delivery and~~ to make Colorado the safest state in the nation in which to receive medical care.

~~Using this focus on~~ CMS considers patient safety ~~as~~ the foundation of our liability reform efforts in order to make ~~the Workgroup outlined a five-year approach for making~~ Colorado the safest state in the country for patients in which to receive medical care. ~~that includes several initiatives. Click here to view the work plan.~~

(LATE ADHOC-1, AM 2010)

[Action: Sunset and replace]

180.989 Store Based Clinics

Colorado Medical Society supports various options for the delivery of medical care so long as they meet the quality standards of effectiveness, equity, timeliness, efficiency, patient centeredness and safety as well as increase patient access to care.

~~Colorado Medical Society remains diligent in its opposition to delivery systems that erode the "medical home" and/or do not meet the quality standards outlined above.~~

(RES-9, AM 2007)

[Action: Sunset and replace]

185 Health Care System Reform

185.989 Practice Evolution Recommendations

Rapid health care system evolution continues to pressure physicians as they face a myriad of connected and often conflicting issues that affect their ability to care for patients and transform their practices. Some of the more important issues include payment reform, HIT/HIE and performance assessment data reporting programs by public and private payers. The Committee on Physician Practice Evolution (CPPE) has focused efforts over the last year on:

- Ensuring that physicians thrive personally and professionally throughout their careers in an evolving health care system;

- Driving health care system innovation that results in access to high quality, cost-effective care for patients and their communities; and
- Improving care and demonstrating value through physician ownership, use and sharing of data.

The following report of the Committee on Physician Practice Evolution (CPPE) reviews outcomes from work to date and makes the following recommendations for action:

- Payment reform and performance measures/transparency programs
  Many physicians are struggling to care for their patients, their practices and themselves as the health care system continues to rapidly evolve. Demands to demonstrate value and control health care costs are challenging the status quo, straining relationships and opening new opportunities.

  Payers are increasingly utilizing physician designation programs to ascertain provider quality and efficiency. Programs are not always aligned, lack a high degree of transparency and are difficult for physicians and other stakeholders to interpret and take action. Moreover, health plans are using these programs to tier out their networks and/or experiment with alternative payment methodologies. Physicians are not well equipped to respond to these programs and position their practices for alternative and/or enhanced payments and new delivery models.

  Continue to execute a broad-based, outreach and education campaign that emphasizes core competencies and capabilities necessary for physician practices to survive and thrive under new payment models, delivery systems, transparency initiatives and administrative simplification. Help doctors to understand what they can expect from the health care system in the future and provide practical tools and advice to concentrate their preparation and transformation efforts.

  Aggressively advocate for transparency of payment and performance measure program methodologies and processes. Advocate for standardization of methodologies and measures across payer programs.

- Reporting of physician data
  Public and private payers utilize physicians' claims data in their profiling and transparency programs, which, as noted above, can have a direct impact on their continued participation with the payer or how they will be reimbursed. Currently physicians are prevented from effectively using the data in these reports as they are complex, difficult to understand and the format and analytic methodologies used to create them vary from one payer to the next. Additionally, the usefulness of the data contained in these reports is also limited by the lack of aggregated claims data from all sources, including Medicare and Medicaid.

  CMS recognizes the importance of providing performance information to physicians so that they can verify the accuracy of profiling results, especially given how the payers are utilizing this data. If there were greater standardization of the reporting format and increased transparency of the methodology used to create them, then reports could be valuable sources of information to support physicians in their decision-making.

  Continue to work with CIVHC to ensure that the reports developed from the All Payer Claims Database (APCD) are methodologically sound, easy to understand and use, and are data-driven tools for quality and practice improvement. CMS should also continue to work with health plans and CIVHC to determine the feasibility of using the

APCD to merge the claims history used by each of the payers and health plans into a single all-payer report, rather than the limited payer-specific data currently in use.

- ~~New Medicare Part B Contractor~~

  ~~Many physicians experienced extensive delays in payment for Medicare claims during the last transition of Medicare Administrative Contractors (MAC). Such a disruption in cash flow can be a significant hardship on some practices. Any number of factors can contribute to processing delays when delaying with such a large conversion, Colorado is just one of the seven new states that will be under the new MAC. It is important to establish direct, open communication channels with the contractor well in advance of the effective date, and maintain an ongoing working relationship on behalf of CMS members.~~

  ~~Monitor the transition of the Medicare Administrative Contractor for Colorado from TrailBlazer Health Enterprises to Novitas Solutions (which becomes effective November 19, 2012) and advocate for members as needed.~~

(CPPE-1, AM 2012)

[Action: Sunset and replace]

190 Health Education

190.997 Character-based Sex Education in Schools

The Colorado Medical Society supports the current Colorado Statute on comprehensive health education, which states that "any curriculum and materials developed and used in teaching sexuality and human reproduction shall include values and responsibility and shall emphasize abstinence to school aged children," as well as teaching "safe sex."

(Substitute RES-28, IM 1996)

[Action: Sunset and replace. Note: Dr. Parry will send to the pediatricians to check on national policy.]

225 Licensure and Discipline

225.998 Support of Colorado Physician Health Program

The Colorado Medical Society (CMS) reaffirms its support for the goals of the Colorado Physician Health Program and conveys to the Colorado ~~Board of Medical Examiners~~ Medical Board CMS' concerns with regard to the possibility of taking funding from the Colorado Physician Health Program.

(RES-69, AM 1990)

[Action: Sunset and replace]

225.999 Support of Colorado ~~Board of Medical Examiners~~ Medical Board

The Colorado ~~Board of Medical Examiners~~ Medical Board will be encouraged to enlist the resources of the Colorado Physician Health Program when physicians can reasonably benefit from the program's resources.

(RES-76, AM 1987)

[Action: Sunset and replace]

245 Medical Education

245.993 Medical Student Tuition and Debt

~~Medical student tuition and debt be a legislative priority of CMS.~~ The Colorado Medical Society (CMS) supports legislation that would decrease medical school tuition debt.

(RES-8, AM 2006)

[Action: Sunset and replace; Note: Ask medical students for feedback]

270 Non-Physician Providers

270.999 Regulation of Allied Health Professionals

The Colorado Medical Society supports the following position on regulation of allied health professionals:

1. Regulation should be imposed upon a profession only for purposes of protecting the public.
2. If regulation is needed, the form of regulation should be that which is least restrictive necessary to protect the public interest.
3. If regulation is imposed, the regulation should be subject to periodic review by the legislature to insure its continuing necessity and appropriateness.
4. Definitions: *Certification* (also called Title Protection): granted to an individual who has met certain prerequisite qualifications. Includes the right to use the "title" of the profession or occupation or to assume of use the term "certified" in conjunction with the title. *Licensure*: a process by which a statutory regulatory entity grants to an individual who has met certain prerequisite qualifications, the right to perform prescribed professional and occupational tasks and to use the title of the profession or occupation. *Registration*: a process which requires that, prior to rendering services, all practitioners formally notify a regulatory entity of their intent to engage in the profession or occupation.
5. Standards: *A profession or occupation shall be regulated by the state only when*:
   - It can be demonstrated that the unregulated practice of the profession or occupation can clearly harm or endanger the health, safety, or welfare of the public, and the potential for the harm is recognizable and not remote or speculative;
   - The public can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
   - The public cannot be effectively protected by other means in a cost effective manner. *The least restrictive method of regulation shall be imposed, consistent with the public interest*:
     a. If existing common law and statutory civil remedies and criminal sanctions are insufficient to reduce or eliminate existing harm, regulation should occur through enactment of stronger civil or criminal sanctions;
     b. If a professional or occupational service is performed primarily through business entities that are not regulated, the business entity or facility should be regulated rather than the employee practitioners;
     c. If the threat to public health, safety, or welfare is relatively small, regulation should be through a system of registration;
     d. If the consumer may have a substantial interest in relying on the qualifications of the practitioner, regulation should be through a system of certification; or
     e. If it is apparent that the public cannot be adequately protected by any other means, a system of licensure should be imposed.
6. Criteria for consideration (Regulation):
   - How does the profession or occupation relate to the practice of medicine?
   - What is the nature of the potential harm to the public?
   - Are there specific examples of such harm?
   - How will the practice of quality medicine be affected?

- ~~Extent to which consumers will benefit from a method of regulation for this profession or occupation?~~
- ~~Extent to which physician practice will be affected?~~
- ~~Extent to which practitioners are autonomous, as indicated by:~~
  - ~~a. Degree to which practice requires independent judgment~~
  - ~~b. Degree to which practitioners are supervised~~
  - ~~c. Efforts previously made to address the concerns giving rise to the current need for regulation~~
  - ~~d. Why alternatives to regulation would not be adequate to protect the public interest~~
  - ~~e. Benefit to the public if regulation is granted~~
  - ~~f. Extent to which the public interest might be harmed by regulation of the profession or occupation, including the effect that the registration, certification, or licensure will have on the costs of the services to the public~~
  - ~~g. How the standards of the profession or occupation will be maintained~~
  - ~~h. Profile of the Practitioners in the state, including a list of associations representing the practitioners, and an estimate of the number of such practitioners in each association.~~

~~(RES-21, IM 1990)~~

1. Regulation should be imposed upon a profession for the primary purpose of protecting the public. Secondarily, regulation should be imposed to protect the allied health professional practice in a safe manner.
2. If regulation is needed, the form of regulation should be that which is the minimum necessary to protect the public and ensure that the allied health professional can practice in a safe manner.
3. All regulation of allied health professionals must be subject to periodic review by the legislature to insure its continuing necessity and appropriateness. This ensures that the regulations are current and most effective in protecting the public.
4. Definitions: *Certification* (also called Title Protection): granted to an individual who has met certain prerequisite qualifications. Includes the right to use the "title" of the profession or occupation or to assume of use the term "certified" in conjunction with the title. *Licensure*: a process by which a statutory regulatory entity grants to an individual who has met certain prerequisite qualifications, the right to perform prescribed professional and occupational tasks and to use the title of the profession or occupation. *Registration*: a process which requires that, prior to rendering services, all practitioners formally notify a regulatory entity of their intent to engage in the profession or occupation.

[Action: Sunset and replace. Note: Rewritten by Marschall Smith, former Director of the CMB; will get a new citation pending approval by the 2014 HOD]

285 Peer Review

285.995 Support of Physician Peer Review

The Colorado Medical Society (CMS) supports the concept of physician peer review and the direct involvement and participation of Colorado physicians in the peer review process. ~~The CMS believes that the Colorado Foundation for Medical Care is the appropriate body to conduct peer review in the state.~~

(Motion of the Board, March 2004)

[Action: Sunset and replace. Note: CFMC no longer exists]