2020 Third Party Insurance Mid-Year Update

NEW YORK COUNTY MEDICAL SOCIETY

JULY 2020

COVID-19 SPECIAL EDITION

Today's session will address updates on the following topics.

- Medicare
- Summary of COVID-19 Telehealth Services

Medicare

Reminder:

Effective March 9, 2020, for both paper and electronic claims, when a service is billed using a global diagnostic service code (for example, a service billed without modifier TC and/or modifier -26), **the address where the TC (technical component) was performed must be reported on the claim.** Global billing does not apply to anti-markup tests. (For individual help with anti-markup questions, contact the NYCMS Third Party Payer Assistance program – email Susan Tucker at stucker@nycms.org.)

To read more on global billing and how this also impacts the PC (professional component) and TC (technical component) themselves, click on the link here:

https://www.cms.gov/files/document/mm10882

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging

For your information: A new program has been established that may possibly be implemented starting January 1, 2021 – or may be delayed, depending on the Public Health Emergency (PHE). It has to do with Appropriate Use Criteria for certain advanced diagnostic imaging tests.

The Protecting Access to Medicare Act (PAMA) of 2014 established a new program to control the number of advanced diagnostic imaging services furnished to Medicare beneficiaries, and make sure that only appropriate services were approved for payment.

Examples of advanced imaging services include:

- Computed tomography
- Positron emission tomography
- Nuclear medicine
- Magnetic resonance imaging

Under this program, when an advanced imaging service is ordered for a Medicare beneficiary, the ordering professional will be required to consult an interactive, electronic tool called a qualified Clinical Decision Support Mechanism (CDSM).

A CDSM is a tool for use by clinicians that communicates AUC (Appropriate Use Criteria) information to the users, and assists them in making the most appropriate treatment decision for a patient's specific clinical condition during the patient's workup.

The CDSM (Clinical Decision Support Mechanism) will tell the ordering professional whether the order does or does not adhere to AUC (Appropriate Use Criteria). Or, it may show that there is no AUC applicable in this situation - for example, if that particular CDSM contains no AUC to address the patient's clinical condition.

Voluntary participation for this program was established from July 1, 2018, through December 31, 2019. An Educational and Operations Testing Period started on January 1, 2020; it is expected to last for one year (until December 31, 2020). Full program implementation is expected to start January 1, 2021 - but, due to the COVID-19 Public Health Emergency (PHE), full implementation may be delayed further.

Medicare's Change Request (CR) 10481 discusses these periods. The related MLN article may be read at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10481.pdf.

To read the full directive, click on the link here.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11268.pdf

The information on the previous slides is provided FYI ONLY!

2019 MIPS & COVID-19

- In response to the COVID-19 health crisis, CMS initially announced that participants in its 2019 Merit-based Incentive Payment System (MIPS) had until April 30 to submit their data. If the data was already submitted or if participants did submit their data by the deadline, MIPS payment adjustments would be based on this information.
- However, MIPS-eligible clinicians who did not submit data by April 30 are not required to take any additional action to qualify for the automatic Extreme and Uncontrollable Circumstances policy. These clinicians will be automatically identified, and will receive a neutral payment adjustment for the 2021 MIPS payment year.

Additional Relief

In addition, and in response to the 2019 Coronavirus (COVID-19) Public Health Emergency (PHE), the Centers for Medicare & Medicaid Services (CMS) is announcing flexibilities for clinicians participating in the Quality Payment Program (QPP) Merit-based Incentive Payment System (MIPS) in 2020.

Clinicians significantly impacted by the PHE may submit an Extreme & Uncontrollable Circumstances Application to reweight any or all of the MIPS performance categories.

Those requesting relief via the application will need to provide a justification of how their practice has been significantly impacted by the PHE. To file, click on the link here.

- https://qpp.cms.gov/mips/exception-applications#extremeCircumstancesException-2020

Medicare Prior Authorization Program

The Centers for Medicare and Medicaid Services (CMS) is implementing a Prior Authorization (PA) program for certain hospital outpatient department services for dates of service on or after 7/1/2020. To read more, click on the link here

Prior Authorization Program Becomes Effective for Dates of Service on/after 7/1/2020

The impacted services include:

- Blepharoplasty, Eyelid Surgery, Brow Lift and Related Services
- Botulinum Toxin Injection
- Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (Including Lipectomy) and related services
- Rhinoplasty and related services
- Vein Ablation and related services

While only the hospital OPD service actually requires prior authorization, CMS wants to remind other providers that perform services in the hospital OPD setting that **claims related to or associated with these services will not be paid if the service requiring prior authorization is not eligible for payment.**

These related services include, but are not limited to, anesthesiology services, physician services, and facility services. Only associated services performed in the OPD setting are affected.

Depending on the timing of claim submission for any related services, claims may be automatically denied or may be denied on a post-payment basis.

For more information, click on the links here:

- Prior Authorization for Certain Hospital OPD Services webpage: https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives/prior-authorization-certain-hospital-outpatient-department-opd-services
- FAQs https://www.cms.gov/files/document/opd-frequently-asked-questions.pdf
- Send questions to OPDPA@cms.hhs.gov

Important: Since medical necessity is typically documented in the physician's medical record, Part B providers will need to work with the hospital outpatient departments to ensure that prior authorization is obtained before surgeries.

It will then be the responsibility of the hospital OPD to submit the PA request. The requestor is the person or entity that submits the PA request, along with the documentation.

FYI and if needed, NGS Medicare has provided a link the hospital can use, to submit Part A Prior Authorization Requests via NGS Connex. So, again, if needed, you may want to alert OPD staff to this system's availability. It can be accessed at the link here:

- NGSConnex: Part A Prior Authorization Requests

COVID-19 Telehealth & Telemedicine

In light of the Coronavirus pandemic, the following guidance and resources may be helpful in planning to provide telehealth/telemedicine services to your patients. For purposes of clarity:

- ***Telehealth*** refers to the real-time interaction with Medicare patients via audio/video communication (E/M, HCPCS codes, etc.).
- ***Telemedicine*** is defined as a more general concept, involving interactions with a patient via other than a face-to-face encounter. (Non-face-to-face interactions may include E-Visits, Virtual Check-Ins, Telephone Calls, and other visit types.)

Medicare – E-Visits

Medicare pays for patients to communicate with their doctors without going to the doctor's office **using online patient portals.** This option should also be part of your Electronic Health Records software under MIPS.

These individual E/M communications via patient portal are called "E-visits." Like the Virtual Check-Ins shown later in this presentation, E-Visits must be initiated by the patient. However, practitioners may educate beneficiaries on the availability of this kind of service, prior to initiation by the patient.

The communications can occur over a 7-day period. The services may be billed using CPT codes 99421-99423, as follows:

Digital Evaluation and Management Services (E-Visits):

- 99421 – Online digital evaluation and management service, for an established patient*, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
- 99422 – Online evaluation and management service, for an established patient*, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
- 99423 – Online digital evaluation and management service, for an established patient*, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

NOTE: For place of service on E-Visits, CMS is instructing physicians and practitioners who bill for Medicare telehealth services to report the POS code that would have been reported had the service been furnished in person (i.e. Office: 11).

Because ALL codes above are time-based, documentation will require:

- Start time of visit
- End time of visit
- Total Time of visit
- The discussion topic includes the medical necessity (e.g., history, action).

Medicare – Virtual Check-Ins – Brief Telephone Calls

For brief telephone calls with established Medicare Part B patients, HCPCS Code G2012 or G2010 may be appropriate. (NOTE: These DO NOT include calls with technicians or medical assistants, or post-op visits in the global period of a procedure.) These brief phone calls are called "Virtual Check-Ins."

- G2012 is for "Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to a new or established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; minimum of 5 minutes of medical discussion."

- G2010 is for "Remote evaluation of recorded video and/or images submitted by a new or established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment."

NOTE: For place of service on Virtual Check-Ins, CMS is instructing physicians and practitioners who bill for Medicare telehealth services to report the POS code that would have been reported had the service been furnished in person (i.e. Office: 11).

Documentation requirements for Virtual Check-Ins:

- Be sure to note the patient's consent to this type of visit. Consent may be obtained during the phone call and should be documented in the record.
- Document the discussion topic to include the medical necessity (e.g., history, action).
- Document that this conversation took place with the provider, what time the call began, and its length (at least 5 minutes).

Other restrictions related to billing G2012:

- The call was not related to an office visit that took place within the past 7 days.
- An office visit related to the call is not anticipated in the next 24 hours (or "next available" appointment).

Medicare – Expanded List of Telephone Calls

In addition to the Virtual-Check-Ins, which are brief, CMS has expanded the list of Telephone Call interactions and will now pay for longer telephone calls with patients, for physicians (99441-99443) and qualified nonphysicians (98966-98968). These codes may now be used for Medicare patients **and are for new and established patients.**

- 99441 - Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
- 99442 - Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

- 99443 - Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion

- The fees for these longer telephone codes (99441 – 99443) have been increased to match those of in-person Office or Outpatient E/M codes.
- For place of service, CMS is instructing physicians and practitioners who bill for these services to report the POS code that would have been reported had the service been furnished in person (i.e. Office: 11).
- Use Modifier 95 (Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system), even though these are technically audio-only codes. (This measure is temporary – as are some other measures during this Public Health Emergency.)

Medicare – Telehealth Visits

In recognition of the COVID-19 pandemic, **CMS has announced expanded Medicare telehealth coverage that will enable beneficiaries to receive a wider range of health care services from their doctors without having to travel to a health care facility**.

- Effective for services starting March 6, 2020, and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to patients in broader circumstances than before.
- These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.

- Starting March 6, 2020, and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings.
- Before the Emergency, patients were generally required to travel to, or be located in, certain types of originating sites (such as a physician's office, skilled nursing facility or hospital) for the visit. But effective for services starting March 6, 2020, and for the duration of the Emergency, Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home.
- The Medicare coinsurance and deductible generally apply to these services. (There are exceptions, having to do with services related to COVID testing - as follows.)

Modifier CS & Cost Sharing

For E/M services that are related to COVID-19 testing, the CS modifier should be applied – regardless of whether the services are furnished in person or via telehealth. **These services should be allowed at 100%. You should NOT charge Medicare patients any co-insurance and/or deductible amounts for these services.**

As reported previously, Medicare has added the audio-only Telephone Calls (99441-99443) to the list of covered Medicare Telehealth Services.

If you are considering using those codes and COVID-19 testing is involved, be aware of Medicare's new rule (above) in connection with the waiving of cost-sharing amounts.

Cost-sharing does not apply to visits that involve the ordering or administering of COVID-19 lab test U0001, U0002, or 87635, by an outpatient provider, physician, or other provider or supplier that bills Medicare for Part B services. The services must be medical visits that:

- Are furnished between 3/18/2020 and the end of the Public Health Emergency;
- Result in an order for or administration of a COVID-19 test;
- Are related to furnishing or administering such a test, or to the evaluation of an individual for purposes of determining the need for such a test;
- and are in any of the following categories of HCPCS E/M codes:

- Office and other outpatient services
- Hospital observation services
- Emergency department services
- Nursing facility services
- Domiciliary, rest home, or custodial care services
- Home services
- Online digital evaluation and management services

- For services furnished on or after 3/18/2020, and through the end of the Public Health Emergency, outpatient providers, physicians, and other providers and suppliers that bill Medicare for Part B services under these payment systems **should use the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing waiver for COVID-19 testing-related services**.
- **Reminder: These services should be allowed at 100%. You should NOT charge Medicare patients any co-insurance and/or deductible amounts for these services.**

- In addition and more importantly, physicians and practitioners who did not initially submit claims with the CS modifier must notify their Medicare Administrative Contractor (MAC) and request to resubmit applicable claims with dates of service on or after 3/18/2020 with the CS modifier - to get 100% payment.

- The best mechanism for resubmitting claims is through the Reopening Unit, which can be accessed via NGS CONNEX, telephone or in writing. Go to the link here - Part B Re-openings - and scroll down to "Request a Reopening."
- If a claim was submitted and processed with the CS modifier but was not adjusted to pay at 100%, NGS suggests that you contact the reopening line again for an adjustment for the E/M , telehealth codes and tests.

Coding/Billing Instructions for Medicare Telehealth Services

- In addition to the E-Visits, Virtual Check-Ins, and Telephone Visits, you have the option of using codes that are on the List of Medicare Telehealth Services codes (E/M Codes, etc.), at the link here: List of Medicare Telehealth Services
- **NOTE:** The Eye Exam codes (920xx) have been added to the list of Medicare Telehealth Services - only for the duration of the Public Health Emergency.
- For place of service, CMS is instructing physicians and practitioners who bill for Medicare telehealth services to report the POS code that would have been reported had the service been furnished in person (i.e. Office: 11).

- Use Modifier 95 - Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system.
- The old policy requiring that a patient be in a rural setting, and the Originating/Distant Practitioner Site policy, have both been waived for the duration of the Public Health Emergency (PHE).

The following Non-HIPAA-compliant communications platforms may be used during the Public Health Emergency:

- Apple FaceTime
- Facebook Messenger video chat
- Google Hangouts video
- WhatsApp video chat, or
- Skype
- Texting applications such as Signal, Jabber, Facebook Messenger, Google Hangouts, WhatsApp, or iMessageEHR Portal are still allowed.

You are not permitted to use Facebook Live, Twitch or TikTok.

Keep in mind, CMS Medicare will now make payment for professional services furnished to beneficiaries in all areas of the country **in all settings for the duration of the COVID-19 Public Health Emergency (PHE).** This change means that these services will be allowed without regard for rural area designations and/or the Originating/Distant Practitioner site policy that was in place prior to this PHE.

Sources:

- Medicare Administrative Contractor (MAC) COVID-19 Test Pricing (PDF) (3/13/20)
- Frequently Asked Questions to Assist Medicare Providers (PDF) (3/6/20)
- COVID-19: New ICD-10-CM Code and Interim Coding Guidance (2/20/20)

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425–G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406–G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 99431 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

Regarding the chart on the previous slide: Virtual Check-In services, or brief check-ins between a patient and their doctor by audio or video device, could previously only be offered to patients who had an established relationship with their doctor.

Now, doctors can provide these services to both new and established patients.

Telehealth & E/M Documentation Changes

CMS has decided to relax the Telehealth E/M Documentation requirements during the COVID-19 Public Health Emergency. (This change had originally been planned for implementation in 2021.)

This is because the COVID-19 pandemic has impacted many facets of coding and billing.

As a result, questions are being posed as to what level of E/M Telehealth service code (99201 – 99215 et al) one can use, now that patient encounters are remote.

Since 1995, the choice of an E/M code has been based on the chart documentation, to reflect History, Exam and level of Medical Decision Making (MDM).

But now that patient encounters are done through Telehealth, the exam component has been particularly affected and, as you will see, temporarily waived.

Examination via telehealth is limited, but it is permissible for a provider to document pertinent observations such as skin color, skin lesions/rashes, quality of respiration, evidence of wheezing or dyspnea, or vital signs (as reported by the patient).

When this is done, these factors may also contribute to the level of coding.

The good news is that the Centers for Medicare and Medicaid Services (CMS) has:

- Temporarily revised the documentation policy, to specify that "the office/outpatient E/M level selection for these services **when furnished via telehealth** can be based on the level of Medical Decision Making (MDM) or Time, with time defined as all of the time associated with the E/M on the day of the encounter."
- CMS has also removed any requirements regarding documentation of history and/or physical exam in the medical record.

If you choose Time (using the time listed in the narrative of the E/M code in the CPT Coding Manual) as your yardstick in choosing a level of telehealth service, you must **extensively document** what you did during this time period - along with the time started, time ended and total time spent.

Medicaid

The New York State Department of Health has issued the following Medicaid Updates that address billing and coding for COVID-19 telehealth/telemedicine services.

Effective March 13, 2020, during the current state of Emergency ONLY, New York State Medicaid will reimburse telephonic evaluation and management services to members in cases where face-to-face visits may not be recommended and it is appropriate for the beneficiary to be evaluated and managed by telephone.

The guidance is to support the policy that patients should be treated through telehealth, including telephonically, wherever possible - to avoid member congregation with potentially sick patients.

Telehealth will be covered for all appropriate services for all patients who can appropriately be treated through this modality. However, telephonic services are only to be rendered for the care of established patients or the legal guardian of an established patient.

Specific codes for Medicaid can be found at the link here:

NYSDOH Medicaid

- 99441 - Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
- 99442 - Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

- 99443 - Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion

Because 99441-99443 are time-based, documentation will require the following:

- Start time of visit
- End time of visit
- Total Time of visit
- Discussion topic to include the medical necessity (e.g., history, action).

Source

- *NYSDOH Medicaid*

Commercial Insurers – Telehealth Services

On certain issues, the commercial payers are falling in line with Medicare's rules for tele-services reimbursement during the COVID emergency. The payers list the same four service categories that Medicare does: E-Visits, Virtual Check-Ins, Telephone E/M (codes 99441-99443) and Telehealth Services. They permit both Virtual Check-Ins and Telephone E/M (codes 99441-99443) to be done by phone (audio only). Their "remote site" rules are the same as Medicare's, as are their rules regarding non-HIPAA-compliant technology. And, providers are reimbursed for telemedicine at the same rate as in-person visits.

However, and more importantly, there are differences due to the unique nature of the commercial payers' claims processing systems. Some payers have requirements regarding the place of service, and the use of modifiers, that are different from present Medicare requirements. In order not to confuse the issue, we recommend that you carefully review the websites of the plans you participate with and code your claims based on those plans' specific directions.

To begin with, you should look closely at each plan's instructions regarding:

- The services covered.
- The Place of Service (POS) code.
- The modifier(s). These may tell the plan that the claim is for a tele-service.
- Whether the patient can be a new patient or can only be an established patient.

The following are websites for:

- United Healthcare

https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19/covid19-telehealth-services.html?cid=em-other-covid-19email5-apr20

- Emblem Health

- https://www.emblemhealth.com/content/emblemhealth/home/providers/clinical-corner/um-and-medical-management/providers-covid19/covid19-update.html

- Aetna

https://www.aetna.com/health-care-professionals/provider-education-manuals/covid-faq.html

- Empire Blue Cross Blue Shield
- https://providernews.empireblue.com/publication/covid-19-information
- CIGNA
- https://static.cigna.com/assets/chcp/resourceLibrary/medicalResourcesList/medicalDoingBusinessWithCigna/medicalDbwcCOVID-19.html

Prior Authorization Changes

The American Medical Association has prepared and posted a chart showing the "relaxation" of Prior Authorization (PA) requirements for a number of commercial insurers as a result of the COVID-19 pandemic.

https://www.ama-assn.org/system/files/2020-04/prior-auth-policy-covid-19.pdf

New York State Workers Compensation Board

The New York State Workers' Compensation Board (NYSWCB) has created a briefing to inform stakeholders about the Board's actions in response to the COVID-19 outbreak.

The briefing provides a summary of the actions the Board has taken to date, with links to more detailed information. To read more, click on the links here.

- NYSWCB COVID-19 Response

http://www.wcb.ny.gov/content/main/TheBoard/WCBcovidresponse4-20.pdf

- NYSWCB Telemedicine Codes

http://www.wcb.ny.gov/content/main/wclaws/Covid-19/text.pdf

NOTE: The NYSWCB's requirements for Place of Service (POS) and modifiers are different from those of Medicare and some commercial insurers - so please review the Telemedicine Code document carefully.

Miscellaneous

The Centers for Medicare & Medicaid Services (CMS) is encouraging clinicians who participate in the Quality Payment Program (QPP), such as physicians, physician assistants, nurse practitioners, and others, to contribute to scientific research and evidence to fight the Coronavirus Disease 2019 (COVID-19) pandemic.

Clinicians may now earn credit in the Merit-based Incentive Payment System (MIPS) - a performance-based track of QPP that incentivizes quality and value - for participation in a clinical trial and reporting clinical information. The clinician attests to the new *COVID-19 Clinical Trials* improvement activity (IA).

To view the specifics on this new IA, click on the link here, click on View All at the bottom and scroll down to "COVID-19 Clinical Trial.

https://qpp.cms.gov/mips/explore-measures/improvement-activities?py=2020#measures

Thank You!

James A. McNally, CPC, heads his own health care consulting firm specializing in third party insurance issues and has over 40 years of experience in the health care field. He served as Ombudsman and as Associate Director of the Division of Socio-Medical Economics at The Medical Society of the State of New York (MSSNY). Prior to his tenure at MSSNY, he held varied positions in Empire Blue Cross Blue Shield's Medicare Division.

He has worked extensively in the health insurance field handling many diverse issues from third party insurer review and audit actions, assisting physicians on coding and billing policy topics, advising on the implementation of electronic data formats for physicians, and other pertinent medical practice concerns.

Mr. McNally works with a number of national county and specialty societies and has developed and handles their third party payer coding assistance and intervention programs. He can be reached via the NYCMS web site at:

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