

11.3.1 Fees for Medical Services

Physicians are expected to conduct themselves as honest, responsible professionals. They should be knowledgeable about and conform to relevant laws and should adhere to professional ethical standards and sound business practice. Physicians should not recommend, provide, or charge for unnecessary medical services. Nor should they make intentional misrepresentations to increase the level of payment they receive or to secure noncovered health benefits for their patients.

With regard to fees for medical services, physicians should:

- (a) Charge reasonable fees based on the:
 - (i) kind of service(s);
 - (ii) difficulty or uniqueness of the service(s) performed;
 - (iii) time required to perform the service(s);
 - (iv) skill required to perform the service(s);
 - (v) experience of the physician;
 - (vi) quality of the physician's performance.
- (b) Charge only for the service(s) that are personally rendered or for services performed under the physician's direct personal observation, direction, or supervision. If possible, when services are provided by more than one physician, each physician should submit his or her own bill to the patient and be compensated separately. When physicians have professional colleagues assist in the performance of a service, the physician may pay a reasonable amount for such assistance and recoup that amount through fees charged to the patient, provided the patient is notified in advance of the financial arrangement.
- (c) Itemize separately charges for diagnostic, laboratory, or clinical services provided by other health care professionals and indicate who provided the service when fees for others' services cannot be billed directly to the patient, in addition to charges for the physician's own professional services.
- (d) Not charge excessive fees, contingent fees, or fees solely to facilitate hospital admission. Physicians must not charge a markup or commission, or profit on services rendered by other health care professionals.
- (e) Extend professional courtesy at their discretion, recognizing that it is not an ethical requirement and is prohibited in many jurisdictions.

AMA Principles of Medical Ethics: II,VI

Opinion 11.3.1 Fees for Medical Services reorganizes guidance from opinions originally issued without background reports and the following:

CEJA Report 3-A-16 Modernized *Code of Medical Ethics*

CEJA Report 2-A-04 Professional courtesy to physicians and their families

CEJA Opinion 9-I-03 Costs, *Amendment*

CEJA Report 7-A-94 Professional courtesy

Report of the Judicial Council B-A-80 Laboratory services

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AMA Principles of Medical Ethics: II,VI

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2 - A-04

Subject: Professional Courtesy to Physicians and Their Families,
(Resolution 1, A-03)

Presented by: Michael S. Goldrich, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Mary W. Geda, MD, Chair)

1 Resolution 1 (A-03), “ Professional Courtesy to Physicians and Their Families” was presented by
2 the New Jersey delegation at the 2003 Annual Meeting. It directed the AMA to establish guidelines
3 for professional courtesy for physicians’ offices and hospitals, to disseminate those guidelines to
4 hospital medical staffs and all elements of the Federation, and to advocate for the repeal of the
5 current federal anti-kickback statute.

6
7 The resolution was referred in part on the basis that there already exists AMA policy that addresses
8 professional courtesy. It also was noted that any extension of such policy raises legal concerns.
9 This report addresses primarily existing policy related to professional courtesy. Upon consulting
10 with the AMA’s Advocacy Group, it does not appear feasible for the AMA to advocate a repeal of
11 the federal anti-kickback statute, which addresses practices beyond professional courtesy. Moreover,
12 repeal of the entire federal anti-kickback statute is an overly broad proposal to resolve concerns that
13 result from the application of a limited and specific portion of the statute.

14 15 AMA POLICY

16
17 Opinion E-6.13 (AMA Policy Database), “Professional Courtesy,” issued in 1994, refers to
18 professional courtesy as a long-standing tradition in the medical profession. However, it is not an
19 ethical requirement. Physicians may decide to waive or reduce fees when treating fellow colleagues
20 (including medical students) or their families according to their own judgment.

21
22 However, Opinion E-6.13 does not stand alone. Rather, it cautions that accepting insurance
23 payments while waiving co-payments may violate Opinion E-6.12, “Forgiveness or Waiver of
24 Insurance Co-payments.” This latter Opinion explains that many health insurance policies are
25 designed to make patients more conscious of the cost of their medical care through co-payments. It
26 further warns that a waiver of the co-payment may violate such policies, or may constitute fraud
27 under the law.

* Reports of the Council on Ethical and Judicial Affairs are assigned to the reference committee on Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 Legal issues were reviewed in detail in BOT Report 18 - A-98, "Professional Courtesy," including
2 the legal risks of extending professional courtesy to a physician-patient who is in a position to make
3 referrals. A summary of these issues is available online at [http://www.ama-
5](http://www.ama-
4 assn.org/ama/pub/category/4615.html)

6 As a distinct but related matter, it is important to recognize that the AMA's Code of Medical Ethics
7 calls upon physicians to provide medical care to those in need, irrespective of their ability to pay or
8 their insurance status. Therefore, professional courtesy extended on the basis of financial need is
9 ethically justifiable on the basis of altruism.

10 11 CONCLUSION

12
13 Guidelines for professional courtesy are already included in the AMA's Code of Medical Ethics;
14 they acknowledge that the practice is long-standing, but warn physicians to respect laws that may
15 affect professional courtesy as well as health insurance policies that prohibit waivers of co-
16 payments. Similar caution was urged in a previous report from the Board of Trustees. Therefore,
17 the AMA already has adequate guidance for physicians who wish to extend professional courtesy in
18 the current healthcare environment.

19 20 RECOMMENDATION

21
22 The Council on Ethical and Judicial Affairs recommends the following be adopted and the
23 remainder of this report be filed:

24
25 That Policies H-140.938, D-140.997, D-140.999 and E-6.13 be reaffirmed in lieu of Resolution
26 1, A-03. (Reaffirm HOD/CEJA Policy)

Fiscal Note: Less than \$500.00

Appendix

H-140.938 Professional Courtesy

The AMA reaffirms a physician's right (consistent with Council on Ethical and Judicial Affairs Opinion E-6.13) to provide professional courtesy. (Sub. Res. 4, I-97; Reaffirmation I-98; Reaffirmed: Res. 5, I-02)

D-140.997 Professional Courtesy

Our AMA will disseminate the AMA's and CMS's current positions regarding professional courtesy to the physicians in this country. (Res. 6, A-99)

D-140.999 Preservation of Professional Courtesy

Our AMA will petition CMS, the U.S. Attorney General and the U.S. Congress to reverse the unreasonable and intrusive policy of considering professional courtesy among physicians fraud. (Res. 6, I-98)

E-6.13 Professional Courtesy

Professional courtesy refers to the provision of medical care to physician colleagues or their families free of charge or at a reduced rate. While professional courtesy is a long-standing tradition in the medical profession, it is not an ethical requirement. Physicians should use their own judgment in deciding whether to waive or reduce their fees when treating fellow physicians or their families. Physicians should be aware that accepting insurance payments while waiving patient co-payments may violate Opinion 6.12. (II, IV) Issued June 1994.

8. DISCLOSURE OF FAMILIAL RISK IN GENETIC TESTING

HOUSE ACTION: FILED

At the 2002 Annual Meeting, the AMA House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-A-02, "Disclosure of Familial Risk in Genetic Testing" (see Policy H-140.899, AMA Policy Database).

However, in response to concerns that were raised, the Council carefully reconsidered the standard of disclosure that should apply to familial risk in genetic testing. At the 2003 Annual Meeting, the AMA House of Delegates adopted the recommendations of CEJA Report 9-A-03, "Disclosure of Familial Risk in Genetic Testing," which amends H-140.899. The Council issues this Opinion, which is based on CEJA Report 9-A-03. It will appear in the next version of *PolicyFinder* and the next print edition of the *Code of Medical Ethics*.

E-2.131 Disclosure of Familial Risk in Genetic Testing

1. Physicians have a professional duty to protect the confidentiality of their patients' information, including genetic information.
2. Pre- and post-test counseling must include implications of genetic information for patients' biological relatives. At the time patients are considering undergoing genetic testing, physicians should discuss with them whether to invite family members to participate in the testing process. Physicians also should identify circumstances under which they would expect patients to notify biological relatives of the availability of information related to risk of disease. In this regard, physicians should make themselves available to assist patients in communicating with relatives to discuss opportunities for counseling and testing, as appropriate.
3. Physicians who order genetic tests should have adequate knowledge to interpret information for patients. In the absence of adequate expertise in pre-test and post-test counseling, a physician should refer the patient to an appropriate specialist.
4. Physicians should encourage genetic education throughout a medical career. (I, IV, V, VIII)

Issued December 2003 based on the report "Disclosure of Familial Risk in Genetic Testing," adopted June 2003.

9. COSTS, AMENDMENT

HOUSE ACTION: FILED

The Council on Ethical and Judicial Affairs offers a minor editorial change to clarify the scope of Opinion E-2.09, "Costs." CEJA presents this amended Opinion, which will appear in the next version of *PolicyFinder* and the next print edition of the *Code of Medical Ethics*.

E-2.09 Costs.

While physicians should be conscious of costs and not provide or prescribe unnecessary medical services, concern for the quality of care the patient receives should be the physician's first consideration. This does not preclude the physician, individually or through medical or other organizations, from participating in policy-making with respect to social and economic issues affecting health care. (I, VII)

Issued March 1981; Updated June 1994 and June 1998; Updated December 2003.

information, patients must give their permission after being fully informed about the purpose of such disclosures. If permission is not obtained, physicians violate patient confidentiality by sharing specific and intimate information from patients' records with commercial interests.

Arrangements of this kind may also violate Opinion 8.061 on gifts to physicians from industry.

Finally, these arrangements may harm the integrity of the patient-physician relationship. The trust that is fundamental to this relationship is based on the principle that the physicians are the agents first and foremost of their patients.

(The Disclosure of Records to Data Collection Companies Opinion will appear in the next edition of Current Opinions with Annotations as Opinion 5.075 and is derived from Principles I, II and IV of the Principles of Medical Ethics.)

7. PROFESSIONAL COURTESY*

HOUSE ACTION: FILED

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(The Professional Courtesy Opinion will appear in the next edition of Current Opinions with Annotations as Opinion 6.13 and is derived from Principles II and IV of the Principles of Medical Ethics.)

8. RETENTION OF MEDICAL RECORDS*

HOUSE ACTION: FILED

Physicians have an obligation to retain patient records which may reasonably be of value to a patient. The following guidelines are offered to assist physicians in meeting their ethical and legal obligations:

1. Medical considerations are the primary basis for deciding how long to retain medical records. For example, operative notes and chemotherapy records should always be part of the patient's chart. In deciding whether to keep certain parts of the record, an appropriate criterion is whether a physician would want the information if he or she were seeing the patient for the first time.
2. If a particular record no longer needs to be kept for medical reasons, the physician should check state laws to see if there is a requirement that records be kept for a minimum length of time. Most states will not have such a provision. If they do, it will be part of the statutory code or state licensing board.
3. In all cases, medical records should be kept for at least as long as the length of time of the statute of limitations for medical malpractice claims. The statute of limitations may be three or more years, depending on the state law. State medical associations and insurance carriers are the best resources for this information.

**B. LABORATORY SERVICES
(RESOLUTION 76, I-79)**

(Reference Committee on Amendments to Constitution and Bylaws, page 257)

HOUSE ACTION: ADOPTED IN LIEU OF RESOLUTION 76 (I-79)

Resolution 76 (I-79), which was referred to the Board of Trustees, asks the Judicial Council to review item 4.40 of "Opinions and Reports" on laboratory services. Representatives of the two organizations expressing an interest in the subject, the Medical Society of the District of Columbia and the College of American Pathologists, were contacted for their views.

The College representatives recommended no change in item 4.40. The Society representative also expressed approval of item 4.40, but indicated that there was a concern limited to the use of the word "mark-up" in the penultimate sentence of the final paragraph of item 4.40. The Council's report will, therefore, focus on what is meant by the use of the word "mark-up."

The word "mark-up" has traditionally been used in this context to describe the commercial exploitation of patients by charging for services that are not provided. A "mark-up" is an excessive charge that exploits patients if it is nothing more than a tacked on amount for a service already provided and accounted for by the laboratory.

As item 4.40 also indicates, this professional concern for patients does not prohibit a physician from recovering expenses for acquisition or processing of specimens. If there are acquisition or processing charges, the Council recommends that the patient be adequately notified of such charges.

The Council's review of voluminous material on Medicare/Medicaid, HEW Health Care Financing Administration, Blue Cross/Blue Shield, and proposed federal legislation also uncovered a question of which components of physician services, following receipt of the laboratory results, should be reimbursed. Questions of description of services typically are and should be determined by reference to the most recent edition of "Current Procedural Terminology" (CPT-4). If a change is desired or desirable in reimbursement standards, this would appear to be an issue within the purview of the Council on Medical Service. The ethical concern here is that the patient not be exploited by charges for services not provided.

CONCLUSION

Subpart (2) of item 4.40 is changed to read as follows:

- (2) If a laboratory is owned, operated, and supervised by a non-physician in accordance with state law and performs tests exclusively for physicians who receive the results and make their own medical interpretations, the following considerations would be applicable.

The physician's ethical responsibility is to provide his patients with high quality services. This includes services which he performs personally and those which he delegates to others. A physician should not utilize the services of any laboratory, irrespective of whether it is operated by a physician or non-physician, unless he has the utmost confidence in the quality of its services. He must always assume personal responsibility for the best interests of his patients. Medical judgment based upon inferior laboratory work is likewise inferior. Medical considerations, not cost, must be paramount when the physician chooses a laboratory. The physician who disregards quality as the primary criterion or who chooses a laboratory solely because it provides him with low cost laboratory services on which he charges the patient a profit, is derelict in not acting in the best interests of his patient. However, if reliable quality laboratory services are available at lower cost, the patient should have the benefit of the savings. As a professional man, the physician is entitled to fair compensation for services. He is not engaged in a commercial enterprise and he should not make a markup, commission, or profit on the services rendered by others. A physician should not charge for services that are not provided. A markup is an excessive charge that exploits patients if it is nothing more than a tacked on amount for a service already provided and accounted for by the laboratory. This does not prohibit a physician's acquisition charge or processing charge, if any, and the patient should be notified of any such charge.