ILLINOIS STATE MEDICAL SOCIETY

Resolution 12.2020-29
(A-21)

Introduced by: Tariq Issa and Divya Meher Surabhi, ISMS Members

Subject: Advocating for All Payer Coverage of Cosmetic Treatment for Survivors of Domestic Abuse and Intimate Partner Violence

Referred to: Council on Economics

Whereas, the CDC reports that 1 in 4 women and 1 in 10 men 18 years of age or older experience intimate partner violence (IPV)[1,2]; and

Whereas, domestic violence accounts for over 20% of all violent victimizations[3]; and

Whereas, nearly half of all domestic and IPV cases result in injury, the most common of which are physical burns and cuts[3]; and

Whereas, international organizations have reported a significant increase in reports of IPV since the onset of the COVID-19 pandemic[4–7]; and

Whereas, acquired facial trauma is associated with a higher likelihood of negative social and functional outcomes including lower self-esteem and higher rates of depression, post-traumatic stress disorder, anxiety disorders, alcohol use disorder, and unemployment[8,9]; and

Whereas, women were more likely to use self-pay to cover IPV-related medical care than to use private insurance prior to the implementation of the Affordable Care Act[11]; and

Whereas, private insurer claims data have shown a rise in the use of private health insurance to cover IPV-related emergency department visits[11]; and

Whereas, many private insurers do not cover medical expenses for cosmetic treatments to injuries that are not considered to provide a gain in functional outcomes; and

Whereas, cosmetic procedures may reduce the incidence of re-lived experiences of psychological trauma by eliminating physical reminders of the acquired disfigurement; therefore, be it

RESOLVED, our ISMS acknowledge that cosmetic treatments may have significant benefits for patient outcomes; and be it further

RESOLVED, our ISMS work with relevant stakeholders such as the American Medical Association and Centers for Medicare and Medicare Services to encourage payers to cover costs associated with cosmetic treatments for survivors; and be it further

RESOLVED, our ISMS introduce state legislation encouraging all payers, including the Centers for Medicare and Medicare Services, cover cosmetic treatments for survivors of domestic abuse.

References:

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Relevant AMA and ISMS Policy:

Definitions of "Cosmetic" and "Reconstructive" Surgery H-475.992

(1) Our AMA supports the following definitions of "cosmetic" and "reconstructive" surgery: Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. (2) Our AMA encourages third party payers to use these definitions in determining services eligible for coverage under the plans they offer or administer.
CMS Rep. F, A-89, Reaffirmed: Sunset Report, A-00, Reaffirmed, A-03, Reaffirmed: CMS Rep. 4, A-13

Insurance Discrimination Against Victims of Domestic Volence H-185.976

Our AMA: (1) opposes the denial of insurance coverage to victims of domestic violence and abuse and seeks federal legislation to prohibit such discrimination; and (2) advocates for equitable coverage and appropriate reimbursement for all health care, including mental health care, related to family and intimate partner violence.
Res. 814, I-94, Appended: Res. 419, I-00, Reaffirmation A-09, Reaffirmed: CMS Rep. 01, A-19

Family and Intimate Partner Violence H-515.965

(1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To suppor physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society. (2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on

violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests. (3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level. (4) Within the larger community, our AMA: (a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters. (b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence. (c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities. (5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where

such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states. (6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that: (a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use. (b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence. (c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems. (d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior. (e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.
(CSA Rep. 7, I-00, Reaffirmed: CSAPH Rep. 2, I-09, Modified: CSAPH Rep. 01, A-19)

ISMS Policy:

It is the policy of ISMS to support and cause to be introduced legislative solutions and other remedies to assure widely available and adequately funded treatment for victims of domestic violence. (HOD 2018)

Fiscal Note:

n/a

Existing ISMS policy related to this issue:

It is the policy of ISMS to support and cause to be introduced legislative solutions and other remedies to assure widely available and adequately funded treatment for victims of domestic violence. (HOD 2018)

ISMS: (1) condemns the senseless violence in families; (2) strongly encourages all physicians to be aware of the potential for signs of abuse in all patients; (3) reminds all physicians of their obligation to participate in any reporting requirements for such abuse; and (4) urges physicians to become active in local programs designed to address the issues of domestic violence. (HOD 1992)