

American Medical Association

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Principles of Medical Review

Second Edition

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Preface

As government, business, and third party payers continue to search for ways to lower their health care costs, a wide variety of medical review methodologies continue to be in demand. By and large, these methodologies attempt to evaluate the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities on a preadmission, concurrent, or retrospective basis. These “quality of care” reviews typically do not involve billing concerns, administrative problems, or any other non-medical complaint. To an extent, selected medical review programs tend to infringe upon the clinical decision-making process of individual physicians. Nonetheless, medical review is recognized and accepted by third party payers and the general public as a means of balancing the rights of physicians to exercise medical judgement freely with the obligation to do so in a cost-effective manner.

The American Medical Association (AMA) has long emphasized the need for physician accountability and has been an advocate of physician-directed peer review to ensure quality of care. Yet, in acknowledging that medical review programs play an important role in promoting an efficient distribution of health care resources, the AMA strongly believes that the decision as to what medical treatment an individual patient should receive remains that of the physician and his or her patient or their representative. Furthermore, many of the costs and administrative hassles brought about by many medical review programs act as restrictions in the practice of medicine and are counterproductive to the provision of needed care to patients. Medical review needs to promote collaborative efforts with physicians through cooperative projects that are aimed at improving cost effective, quality health care.

Over the years, the AMA has worked to more explicitly identify and quantify problems associated with medical review; and to closely monitor and seek to change signifi-

cantly the area of medical review. The AMA has developed jointly with major third party payer and medical review trade associations important guidelines on prior authorization, claims submission and review, concurrent review, and general administrative procedures. In addition, the AMA is an active participant in the standards development of the American Accreditation HealthCare Commission/URAC, the national leader in accreditation of the utilization review industry and a creator of quality benchmarks for managed care. The AMA has been a corporate member of AAHCC/URAC since 1991 and currently holds a seat on the Commission's Board of Directors. Much of the AMA policy success has involved the key areas of protecting the patient/ physician relationship; assuring clinical expertise of review staff; protection of confidential health information; internal quality management, complaint and grievance handling, and oversight of delegated functions. The AMA is committed to continuing to develop a strong policy base and establish various mechanisms to address issues related to medical review.

The following "Principles of Medical Review," represents a further extension of these efforts. It is hoped that these principles, which are based entirely on existing AMA policy, will help promote effective medical review practices that are of value to physicians in ensuring that high quality health care services are delivered to patients, and will help eliminate ineffective and onerous medical review practices that inappropriately interfere with physicians' clinical autonomy. The AMA strongly encourages all medical review agencies and health plans to use these guidelines in developing their own policies and procedures. In addition, any organizations that certify or accredit entities in the medical review industry are encouraged to use these principles in conducting their evaluations.

Purpose

- Quality of patient care should be the emphasis of any medical review process or outcome.
- To the degree possible, quality assurance and medical review systems should be structured to recognize high quality care and to correct instances of deficient practice.
- The initial focus of any medical review or quality assurance activity should be to help the practitioner correct deficiencies in knowledge, skills, or technique.
- Utilization management programs should be non-intrusive, have reduced administrative burdens, and allow for adequate input by the medical profession.
- Physician-directed peer review mechanisms must take the lead in fostering appropriate utilization of services and encouraging less hospital-intensive patterns of care where indicated.

Coverage Limitations

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

- A health plan has the right to make coverage decisions, but practicing physicians participating in the health plan must be able to discuss treatment alternatives with their patients to enable them to make informed decisions. The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's managed care plan.

Medical Necessity and Screening

- Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient.
- Utilization review entities, when rendering determinations of appropriateness and necessity, should maintain focus and emphasis on quality, and not cost, and take into consideration the entire system of alternative facilities and services, with close attention as to their availability and accessibility.
- Screening is defined as health care services or products provided to an individual without apparent signs or symptoms of an illness, injury or disease for the purpose of identifying or excluding an undiagnosed illness, disease, or condition.
- Medical necessity is defined as health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:
 - in accordance with generally accepted standards of medical practice
 - clinically appropriate in terms of type, frequency, extent, site, and duration; and

- not primarily for the convenience of the patient, physician, or other health care provider.
- Determinations of medical necessity should be based only on information that is available at the time that health care products or services are provided.
- Insurers should develop formal protocols as to their methodology for determining “medical necessity,” including distinctions between those instances where in-house medical expertise is considered sufficient and those where outside consultation is considered necessary;
- Third party methodologies for determining “medical necessity” should be made available to medical societies and to individual physicians, as well as listings of those specific situations (such as the ordering of either experimental or outdated procedures or questionable hospital admissions) where additional data may be required.
- In “medical necessity” decisions where the determination may be modified by additional medical evidence, there should be an opportunity for the treating physician to provide such evidence before a final decision not to pay is made.

■ Pre-certifications/Pre-authorizations

- In the absence of consistent and scientifically established evidence that preadmission review is cost-saving or beneficial to patients, the process should not be used.
- Any health plan or utilization management firm conducting a prior authorization program should act within two business days on any patient or physician request for prior authorization and respond within one business day to other questions regarding medical necessity of services.

- Any health plan requiring prior authorization for covered services should provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring prior authorization are recommended by the physicians.
- High quality medical care should not be compromised by unreasonable pre-certification and concurrent review practices.
- Managed care plans should restrict their pre-authorization requests to physicians whose claims have shown to be statistical outliers
- Blanket hospital pre-admission review for all patients or for specific categories of patients by government or hospital edict should not be mandated.
- Any preadmission/prior authorization should allow immediate hospitalization in an emergency. Failure to obtain prior authorization for emergency care should never constitute a basis for denial of reimbursement by any third party payer.
- There should be direct and continuing communications to physicians and insureds regarding prior authorization requirements.

■ Physician Decision-Making

- Certain professional decisions critical to high quality patient care should always be the ultimate responsibility of the physician practicing in a health plan, whether in primary care or another specialty, either unilaterally or with consultation from the plan, including but not limited to the following:
 - what diagnostic tests are appropriate
 - when and to whom in-plan physician referral is indicated

- when and to whom out-of-plan physician referral is indicated
 - when and with whom consultation is indicated
 - when non-emergency hospitalization is indicated
 - when hospitalization from the emergency department is indicated
 - choice of in-plan service sites for specific services (office, outpatient department, home care, etc.)
 - hospital length of stay
 - frequency/length of office/outpatient visits or care
 - use of out-of formulary medications
 - when and what surgery is indicated
 - when termination of extraordinary/heroic care is indicated
 - recommendations to patients for other treatment options, including non-covered care
 - scheduling on-call coverage
 - terminating a patient-physician relationship
 - whether to work with, and what responsibilities should be delegated to, a mid-level practitioner, and
 - determination of the most appropriate treatment methodology.
- Guidelines for the extent of practicing physician involvement in plan medical decisions and policies should be developed and widely disseminated. Such guidelines should be relevant to their jurisdiction, allow for variation in plan sponsorship and structure, and optimize patient care.
 - Organizational structures that may lead to nonphysician control of medical decision-making should be strongly opposed.

- Practicing physician involvement should take place in the development of selection criteria, utilization management criteria, clinical practice guidelines, medical review criteria, and continuous quality improvement, and physician leaders must be involved in the approval of these processes.
- Maintaining the best interests of the patient uppermost, the final decision to discharge a patient, or any other patient management decision, remains the prerogative of the physician.
- Clinical decision-making and financial management should reside within the community health network whenever feasible with physicians retaining responsibility for a network's medical, quality and utilization management.

Clinical Practice Guidelines

- Practice parameters developed by or in conjunction with physician organizations should be promoted as a basis for review criteria.
- Physicians subject to using specific guidelines in managed care settings should insist on using AMA-recognized guidelines.
- To maximize the opportunity for clinical integration and improvement in patient care, all of the specialties participating in a clinical process must be involved in the development of clinical practice guidelines.
- Variations from medical practice guidelines and parameters are not, except in very limited circumstances, per se indicators of quality or medical necessity problems. Only where a variation involves provision of a service or procedure deemed by the preponderance of medical opinion to be inappropriate in any clinical situation should it be used as a per se indicator for judgments regarding quality or payment denials. Otherwise, variations from the guidelines

and parameters should constitute only a signal for further peer-to-peer considerations relative to quality or payment issues.

- The following criteria should be used for evaluating the process of development of clinical practice guidelines:
 - Documentation. Clinical practice guideline sponsors have provided sufficient documentation to enable an assessment of the process of development of the guideline.
 - Involvement of Physicians/Physician Organizations. The guideline was developed with representation from practicing physicians and/or physician organizations.
 - Literature Review. A literature search performed; the inclusion/exclusion criteria for the literature search were specified; and the evidence derived from the literature search was rated.
 - Experts' Credentials. If expert opinion was used in the development of the guideline, credentials of the experts were described.
 - Appropriateness. The guideline addresses the appropriateness of its recommendations to specific clinical conditions and settings.
 - Generalizability. The guideline includes disclaimers and/or a discussion of the limitations and/or degree of generalizability of the recommendations specific to clinical conditions.
 - Currentness. The guideline has been developed, reviewed, or updated within the last 5 years.
 - Update Mechanism. There is a mechanism in place to update the guideline.
 - Wide Dissemination. There is a mechanism in place to ensure that the guideline is readily available to all physicians who may be affected by its recommendations.

- Any decision by third party payers requiring physician use of specific practice parameters should include the rationales used to select such practice parameters. Also, any decision by third party payers to require physician use of specific practice parameters should be followed by an evaluation of the impact of implementing such practice parameters.
- Physicians must retain autonomy to vary from practice parameters without retribution in order to provide the quality of care that meets the individual needs of their patients.

Medical Review Criteria

- The medical protocols and review criteria used in any utilization review or utilization management program must be developed by practicing physicians. Utilization review under managed care programs should be based on open and consistent review criteria that are acceptable to and have been developed in concert with the medical profession.
- Public and private payers should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed.
- The criteria or guidelines used for utilization management should be based upon sound clinical evidence and consider, among other factors, the safety and effectiveness of diagnosis or treatment, and must be age appropriate.
- Appropriate data, clinical evidence, and review criteria should be available on request. When used by health plans or health care organizations, such criteria must allow variation and take into account individual patient differences and the resources available in the particular health care system or setting to provide recommended care.

- Review criteria used in utilization review systems should be publicly available to facilitate effective input during their development, implementation, evaluation and modification.

■ Reviewer Qualifications

- Medical review should be performed by physicians or under the close supervision of physicians.
- A physician of the same specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. Any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review
- Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service. In addition, the physician should be professionally and individually accountable for his or her decisions.
- Utilization review organizations should make every effort to avoid potential conflicts of interest for physician reviewers by not assigning cases to a physician reviewer who
 - is an associate or competitor of the physician under review,
 - actively practices in the same hospital as the physician under review when feasible,
 - participated in the development or execution of the patient's treatment plan, or
 - is a member of the patient's family.
- The competence of non-physician reviewers and the availability of same-specialty peer review must be delineated and assured.

- It is the role of the utilization review program to credential/certify that its reviewers are appropriately licensed and have the required experience to perform review.
- Prior to the on-site review, the utilization review program or managed care plan should provide upon request the name(s), credentials and background of their reviewers to the utilization review committee.
- Medical staff should have established protocol for reviewers entry into the hospital and a process for monitoring the reviewer's activities and the confidentiality of the records they review.
- All agencies or groups doing utilization review should be registered with the appropriate health regulatory agency of the state in which they are doing review and to have an appropriately staffed office located in the state in which they are doing the review.
- Hospital medical staffs, prior to approving the written plan for utilization review, should ensure the inclusion of provisions that require the hospital to seek formal review and recommendations from the medical staff concerning "any qualified outside organization" that is going to contract with the hospital to perform review activities specified in the plan, prior to entering into the contract.

■ Review Procedures

- Requests for copies of medical records should be limited to information needed to support claims review.
- Review standards should be based on total consecutive hours from the time the appeal was requested, rather than standards based on the "normal business day." Also, a maximum 72-consecutive-hour managed care expedited appeals should be the standard.

- If a denial letter is given, then a written explanation signed by the reviewing physician(s) should be attached to the denial letter.
- All utilization review efforts should focus on statistical outliers, rather than routine blanket review of whole populations of physicians or all instances of particular services.
- Blanket review of all medical care provided is neither practical nor needed to assure high quality of care. Review can be conducted on a targeted basis, a sampling basis, or a combination of both, depending on the goals of the review process. However, judgment as to performance of specific practitioners should be based on assessment of overall practice patterns, rather than solely on examination of single or isolated cases.
- A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request.
- Utilization review entities should disclose to physicians upon request documentation of employees' qualifications to perform utilization review; and, when review entities determine an admission, service, or procedure is unnecessary, should provide a written basis for that decision, including the process for appealing the decision.
- Utilization review performed solely upon the basis of an admitting diagnosis, without actual hospital record review, is inadequate, incomplete and incapable of accuracy.
- The indication for a diagnostic test is based on the suspected diagnosis of a clinical disorder. Accordingly, a test with normal results should not be deemed de facto unnecessary.

Reconsideration and Appeals

- Patients and physicians should be able to appeal decisions based on the application of utilization management guidelines.
- All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has appropriate expertise and experience in the field. This appeals process should be timely and expeditious.
- Adequate appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients.
- Physicians should be provided with a right to appeal adverse reconsideration decisions just as beneficiaries have rights in this regard.
- The appeals process should be smooth for patients, physicians and hospital staff without disincentives or punishment for appealing.

Retroactive Denials

- Retroactive denials of payment by third party payers for appropriately rendered services for necessary preoperative evaluations and procedures contractually covered by the payers are inappropriate and should not be allowed.

- Retrospective denial of payment should not be allowed for any claim for services for which a physician had previously obtained authorization, unless fraud was committed or incorrect information provided at the time such prior approval was obtained.
- Time limits on retroactive denials of claims should be established under applicable federal laws.
- When a utilization review organization makes a determination to retrospectively deny payment for a medical service, or down-code such a service, the physician rendering the service, as well as the patient who received the service, should receive written notification in a timely manner that includes:
 - the principal reason(s) for the determination;
 - the clinical rationale used in making the determination; and
 - a statement describing the process for appeal.
- Hearing rights should be provided for physicians and beneficiaries in cases of retrospective denial.
- Post-payment downcodes and other similar requests for recoupment by third party payors should be made within one year of the date the claim is submitted or within the same amount of time permitted for submission of the claim, whichever is less.

External Review

- All health plans should contain an external review procedure with the following basic components:
 - It should apply to all health carriers;
 - Grievances involving adverse determinations may be submitted by the policyholder, their representative, or their attending physician;

- Issues eligible for external grievance review should include, at a minimum, denials for medical necessity determinations; and determinations by carrier that such care was not covered because it was experimental or investigational;
- Internal grievance procedures should generally be exhausted before requesting external review;
- An expedited review mechanism should be created for urgent medical conditions;
- Independent reviewers practicing in the same state should be used whenever possible;
- Patient cost sharing requirements should not preclude the ability of a policyholder to access such external review;
- The overall results of external review should be available for public scrutiny with procedures established to safeguard the confidentiality of individual medical information;
- External grievance reviewers should obtain input from physicians involved in the area of practice being reviewed. If the review involves specialty or sub-specialty issues the input should, whenever possible, be obtained from specialists or sub-specialists in that area of medicine.
- If an internal appeal is denied, a plan member should be able to appeal the medical necessity determination or coverage decision to an independent review organization.
- Every organization that reviews or contracts for review of the medical necessity of services should establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review.

- The overall results of external review should be available for public scrutiny with procedures established to safeguard the confidentiality of individual medical information.

Telephone Triage Programs

- Organizations that provide telephone triage services should provide such services 24 hours a day on a year-round basis and calls should be handled as expeditiously as possible.
- Telephone counseling and triage should be performed by health professionals with a level of knowledge and training no less than that of a registered nurse.
- Qualified physicians should be readily accessible for consultation and second-level triage to the nurses or other health professionals providing telephone counseling or triage.
- Telephone counseling services must appoint a physician director. Such services are not absolved of that responsibility by a disclaimer to the callers. A physician director must be ultimately responsible for the telephone triaging of patients in a given system.
- A physician director of telephone counseling services must be responsible for:
 - Providing and updating protocols and algorithms for phone counseling by non-physicians.
 - Identifying high-risk patients who must be directly and immediately referred to physicians at all times.
 - Supervision and review of second-level triage provided by advanced nurse practitioners and physician assistants.
 - Ensuring permanent records of all calls received.
 - Maintaining accountability for the patient until a referral has been effected with an accepting physician.

- Telephone counseling and triage centers should routinely compile outcome information on all calls handled, and should modify their operative policies and referral protocols as needed to enhance the effectiveness of the service.
- Telephone triage centers should routinely inform primary or principal care physicians of the disposition of all calls received from their patients.
- Physicians performing second level triage for telephone triage centers should be compensated for such services by the center or sponsoring health plan. Compensation for individuals performing telephone counseling and triage should not be based on the number or the disposition of calls handled.
- Payment for emergency or other covered services by a health plan should not be conditioned on prior use of the plan's telephone triage center by an enrollee seeking such services, or on adherence by the enrollee to triage center recommendations. Enrollees eligible to use or accessing the triage center should be informed of this policy, and of their right to have immediate access to a physician if desired.
- Quality assurance programs should be developed by national accrediting agencies that address issues raised by telephone counseling centers.
- Both the clinical practice guidelines utilized in disease management and the referral algorithms or protocols used in telephone triage should be developed by physicians knowledgeable in dealing with the conditions addressed, and should be updated regularly.

Confidentiality

- Legislation should govern confidentiality of medical information requested by review entities.

- Patients' privacy should be honored in the context of quality improvement activities, and any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data should be strictly controlled. Any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure.
- Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review. Payers may access and use medical records and individually identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.
- Physicians have an ethical responsibility to protect patient confidentiality. The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law or the need to protect the welfare of the individual or the public interest.
- The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication.
- History, diagnosis, prognosis, and the like acquired during the physician-patient relationship may be disclosed to an insurance company representative only if the patient or a

lawful representative has consented to the disclosure. A physician's responsibilities to patients are not limited to the actual practice of medicine. They also include the performance of some services ancillary to the practice of medicine. These services might include certification that the patient was under the physician's care and comment on the diagnosis and therapy in the particular case.

- Conflicts between a patient's right to privacy and a third party's need to know should be resolved in favor of patient privacy.
- Third party payers that are granted access to patient health care information should be held responsible for reasonable security measures and should be subject to sanctions when confidentiality is breached.
- The utmost effort and care must be taken to protect the confidentiality of all medical records, including computerized medical records. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.
- Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information.

Conflicts of Interest

- Patients are entitled to be advised of potential conflicts of interest that their physicians might have.

- Under no circumstances may physicians place their own financial interests above the welfare of their patients. For a physician unnecessarily to hospitalize a patient, prescribe a drug, or conduct diagnostic tests for the physician's financial benefit is unethical. If a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit.
- Physicians may decide not to treat the patient in order to avoid any perceived conflict of interest or loss of objectivity in rendering the requested second opinion. However, the concern about conflicts of interest does not require physicians to decline to treat second-opinion patients. This inherent conflict in the practice of medicine is resolved by the responsible exercise of professional judgment.
- Monetary incentives may be judged in part on the basis of their size. Large incentives may create conflicts of interest that can in turn compromise clinical objectivity. The proximity of large financial incentives to individual treatment decisions should be limited in order to prevent physicians' personal financial concerns from creating a conflict with their role as individual patient advocates.
- Utilization review organizations should make every effort to avoid potential conflicts of interest for physician reviewers.

Accountability

- Individual physicians should report persistent problems concerning review entities to their state insurance commissioner or other appropriate regulatory authorities.
- Physicians who, in good faith, serve as members of quality assurance, or utilization review committees of a managed care entity should be fully indemnified by that entity.

- Any entity that imposes barriers between a physician and the best interests of a patient should be liable for any injury that the patient incurs.
- Payers should provide their insureds with information enabling them to make informed decisions about choice of plan, and payers should take responsibility when patients are harmed due to the administrative requirements of the plan. Legislative initiatives should provide for disclosure requirements, the conduct of review, and payor accountability.
- Liability should be imposed on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on coverage provisions, benefits, and exclusions; prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; 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; medical expense ratios; and cost of health insurance policy premiums.
- Third party payers who institute preadmission review requirements as a condition for receipt of health benefit plans should be subject to legal action for any harm incurred by the patient resulting from application of such requirements.
- Third party payers should be assigned liability arising from requiring participating physicians to adhere to a specific set of practice parameters.
- Self-insured, employee health benefits plans should be held accountable for negligent utilization review decisions. Meaningful remedies and fair compensation should exist for patients who are injured as a result of such a decision.

The principles contained in this publication have been abstracted and summarized from the following: AMA Policy Compendium, House of Delegates Policies 160.935, 285.944, 320.976, 385.937, 140.989, 285.998, 270.982, 320.950, 320.961, 285.954, 140.990, 285.988, 465.980, 320.952, 320.955, 155.998, 320.953, 320.995, 335.996, 335.977, 335.979, 315.983, 320.986, 320.972, 320.985, 320.968, 320.982, 320.948, 320.949, 320.991, 320.969, 320.988, 315.975, 340.997, 70.926, 335.997, 335.982, 335.968, 375.966, 285.931, 320.949, 320.989, 320.962, 160.966.