

AMA-YPS Handbook Review: HOD Reference Committee G (medical practice)

Full text at <http://www.ama-assn.org/ama1/pub/upload/mm/475/refcomg.pdf>. Recommendations are preliminary until ratified by the AMA-YPS Assembly on June 12, 2009. Recommended AMA-YPS Positions: Support, Active Support, Oppose, Active Oppose, Monitor

RESOLUTION/Report	ACTION REQUESTED	YPS POSITION	FINAL HOD ACTION
<p>BOT Report 2: Increasing Transparency of Hospital Contracts for Clinical and Non-Clinical Services (Resolution 723, A-08)</p>	<p>The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 723 (A-08) and the remainder of the report filed:</p> <ol style="list-style-type: none"> 1. That our American Medical Association (AMA) encourage hospitals to publicly disclose the following parameters of their contracts for the delivery of clinical and non-clinical services: <ul style="list-style-type: none"> • The entity with which the hospital has contracted; • The ownership of the entity with which the hospital has contracted; and • What services are being provided in accordance with the contract. (New HOD Policy) 2. That our AMA establish as policy that the organized medical staffs have an opportunity to be involved in the selection of clinical and non-clinical service providers in hospitals with adherence to appropriate conflict of interest policies. (New HOD Policy) <p>Fiscal Note: Staff cost estimated at less than \$500 to implement.</p>	Support	Adopted as amended; see http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-g-annotated.pdf for exact language
<p>BOT Report 3: Privileging Physicians with Low Volume Hospital Activity (Resolution 724, A-08)</p>	<p>The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 724, A-08, and the remainder of the report be filed:</p> <ol style="list-style-type: none"> 1. That American Medical Association policy be that: <ol style="list-style-type: none"> (a) Due to the variation in hospitals across the country, each hospital and medical staff should create its own methodologies and standards for credentialing and privileging physicians with low activity at their hospitals. These methods and standards should be tailored to the individual hospital's needs, such as a monitoring system for low volume doctors in the absence of performance data, or creating a new, separate staff category for physicians and allied health professionals that would limit a practitioner's activities to referring and following patients, to insure continuity of care and patient safety; (b) When data are not used for physician evaluation, there should be stringent qualifications of those who provide peer recommendations/reviews. These physicians should be familiar with the competency and work of the physician and have an understanding of the specialty in question. Recommendations on medical staff membership and privileges should include the applicant's department chair and chief of staff; (c) Hospitals and medical staffs should use data and references, if available, from another hospital at which the applicant physician may be active as an additional method to verify his/her competency within the hospital environment; (d) Ongoing proctoring and evaluation are tools that should be used when recommending privileges for physicians who are classified as low volume only for certain procedures; 	Support	Adopted

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	<p>(e) Ideally medical staffs should credential only when there is adequate clinical data to permit an objective assessment of an applicant's, or medical staff members, clinical skill and ability; and</p> <p>(f) When an organized medical staff determines that there are not adequate data on an applicant physician, or if a physician seeking privileges has limited experience, consideration should be given to require mandatory consultation for admissions and other appropriate indications. (New HOD Policy)</p> <p>2. That the following AMA policies be reaffirmed:</p> <p>H-230.992, "Hospital Admitting Privileges," H-220.988, "Hospital Admitting Privileges," and H-180.963, "Volume Discrimination Against Physicians." (Reaffirm HOD Policy)</p> <p>Fiscal Note: Estimated cost of \$3,500 to develop and mail communication to appropriate groups.</p>		
<p>BOT Report 6: Protection of Medical Staff Members' Personal Proprietary Financial Information (BOT Report 20-A-08)</p>	<p>The Board of Trustees recommends that the following recommendations be adopted and the remainder of the report be filed:</p> <p>1. That our American Medical Association (AMA) policy be that hospitals/health systems should incorporate, as appropriate, the following guidelines in the development and implementation of their corporate conflict of interest programs (i.e., covering the governing body, corporate officers, and employees/contractors of the hospital/health system):</p> <p>(a) Physicians should be required to disclose personal financial information to the hospital/health system only if they are serving or being considered to serve as a member of the governing body, as a corporate officer, or as an employee/contractor of the hospital/health system; and such information should be used so that other individuals understand what conflicts may exist when issues are discussed and when recusal from voting or discussion on an issue may be appropriate.</p> <p>(b) The personal financial information requested and required of medical staff members who currently serve or are being considered for a position on the hospital/health system governing body, should be no greater than that requested and required of the non-physician members of the hospital/health system governing body, corporate officers, employees or contractors of the hospital/health system.</p> <p>(c) Disclosure of personal financial information, by itself, should not be grounds for exclusion from a position on the governing body, as a corporate officer, or as an employee/contractor of the hospital/health system.</p> <p>(d) Disclosure of personal financial information should not be used for economic</p>	Support	Adopted

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	<p>credentialing, as a means of discrimination, or for other unauthorized or inappropriate reasons. (New HOD Policy)</p> <p>2. That our AMA policy be that medical staff members' personal financial information shall remain confidential except for disclosure to those with a bona fide need for access to such information. The security and storage of such information, including electronic and paper-based, should be at the same level as that afforded to other data and files in the hospital, such as patient and peer review information that enjoy confidentiality and privacy protections, including restricted access, password protection and other protective mechanisms. (New HOD Policy)</p> <p>Fiscal Note: Staff cost estimated to be less than \$500 to implement.</p>		
<p>BOT Report 18: Work of the Task Force on the Release of Physician Data</p>	<p>The Board of Trustees recommends that the following be adopted in lieu of Board of Trustees Report 12 (A-08) and the remainder of this report be filed:</p> <p>1. That our American Medical Association adopt the following <i>Principles for the Public Release and Accurate Use of Physician Data</i>. (New HOD Policy)</p> <p style="text-align: center;"><i>Principles for the Public Release and Accurate Use of Physician Data</i></p> <p><i>The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data when it is used in conjunction with program(s) designed to improve or maintain the quality of, and access to, medical care for all patients and is used to provide accurate physician performance assessments in concert with the following Principles:</i></p> <p>1. <u><i>Patient Privacy Safeguards</i></u></p> <ul style="list-style-type: none"> • <i>All entities involved in the collection, use and release of claims data comply with the HIPAA Privacy and Security Rules (H-315.972, H-315.973, H-315.983, H-315.984, H-315.989, H-450.947).</i> • <i>Disclosures made without patient authorization are generally limited to claims data, as that is generally the only information necessary to accomplish the intended purpose of the task (H-315.973, H-315.975, H-315.983).</i> <p>2. <u><i>Data Accuracy and Security Safeguards</i></u></p> <ul style="list-style-type: none"> • <i>Effective safeguards are established to protect against the</i> 	<p>Support</p>	<p>Adopted as amended; see http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-g-annotated.pdf for exact language</p>

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	<p><i>dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data (H-406.996, H-450.947, H-450.961).</i></p> <ul style="list-style-type: none"> • <i>Reliable administrative, technical, and physical safeguards provide security to prevent the unauthorized use or disclosure of patient or physician-specific health care data and physician profiles (H-406.996, H-450.947, H-450.961).</i> • <i>Physician-specific medical practice data, and all analyses, proceedings, records and minutes from quality review activities are not subject to discovery or admittance into evidence in any judicial or administrative proceeding without the physician's consent (H-406.996, H-450.947, H-450.961).</i> <p>3. <u>Transparency Requirements</u></p> <ul style="list-style-type: none"> • <i>When data are collected and analyzed for the purpose of creating physician profiles, the methodologies used to create the profiles and report the results are developed in conjunction with relevant physician organizations and practicing physicians and are disclosed in sufficient detail to allow each physician or medical group to re-analyze the validity of the reported results prior to more general disclosure (H-315.973, H-406.993, H-406.994, H-406.998, H-450.947, H-450.961).</i> • <i>The limitations of the data sources used to create physician profiles are clearly identified and acknowledged in terms understandable to consumers (H-406.994, H-450.947).</i> • <i>The capabilities and limitations of the methodologies and reporting systems applied to the data to profile and rank physicians are publicly revealed in understandable terms to consumers (H-315.973, H-406.994, H-406.997, H-450.947, H-450.961).</i> • <i>Case-matched, risk-adjusted resource use data are provided to physicians to assist them in determining their relative utilization of resources in providing care to their patients (H-285.931).</i> <p>4. <u>Review and Appeal Requirements</u></p> <ul style="list-style-type: none"> • <i>Physicians are provided with an adequate and timely opportunity to review, respond and appeal the results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to their use, publication or release (H-315.973, H-406.996, H-406.998, H-450.941, H-450.947, H-450.961).</i> 		

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	<ul style="list-style-type: none"> • <i>When the physician and the rater cannot reach agreement, physician comments are appended to the report at the physician's request (H-450.947).</i> <p>5. <u>Physician Profiling Requirements</u></p> <ul style="list-style-type: none"> • <i>The data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians (H-406.994, H-406.997, H-450.947, H-450.961).</i> • <i>Data reporting programs only use accurate and balanced data sources to create physician profiles and do not use these profiles to create tiered or narrow network programs that are used to steer patients towards certain physicians primarily on cost of care factors (450.951).</i> • <i>When a single set of claims data includes a sample of patients that are skewed or not representative of the physicians' entire patient population, multiple sources of claims data are used (no current policy exists).</i> • <i>Physician efficiency of care ratings use physician data for services, procedures, tests and prescriptions that are based on physician utilization of resources so that the focus is on comparative physician utilization and not on the actual charges for services (no current policy exists).</i> • <i>Physician-profiling programs may rank individual physician members of a medical group but do not use those individual rankings for placement in a network or for reimbursement purposes (no current policy exists).</i> <p>6. <u>Quality Measurement Requirements</u></p> <ul style="list-style-type: none"> • <i>The data are used to profile physicians based on quality of care provided — never on utilization of resources alone — and the degree to which profiling is based on utilization of resources is clearly identified (H-450.947).</i> • <i>Data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties, such as the Physician Consortium for Performance Improvement. (H-406.994, H-406.998, H-450.947, H-450.961).</i> • <i>These evidence-based measures are endorsed by the National</i> 		

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	<p><i>Quality Forum (NQF) and/or the AQA and HQA, when available. When unavailable, scientifically valid measures developed in conjunction with appropriate medical specialty societies and practicing physicians are used to evaluate the data (no current policy exists).</i></p> <p>7. <u>Patient Satisfaction Measurement Requirements</u></p> <ul style="list-style-type: none"> • <i>Until the relationship between patient satisfaction and other outcomes is better understood, data collected on patient satisfaction is best used by physicians to better meet patient needs particularly as they relate to favorable patient outcomes and other criteria of high quality care (H-450.982).</i> • <i>Because of the difficulty in determining whether responses to patient satisfaction surveys are a result of the performance of a physician or physician office, or the result of the demands or restrictions of health insurers or other factors out of the control of the physician, the use of patient satisfaction data is not appropriate for incentive or tiering mechanisms (no current policy exists).</i> • <i>As in physician profiling programs, it is important that programs that publicly rate physicians on patient satisfaction notify physicians of their rating and provide a chance for the physician to appeal that rating prior to its publication (no current policy exists).</i> <p>2. That our AMA adopt the following policy, <i>Release of Claims and Payment Data from Governmental Programs</i>. (New HOD Policy)</p> <p>Release of Claims and Payment Data from Governmental Programs The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data only when it preserves access to health care and is used to provide accurate physician performance assessments.</p> <p>Raw claims data used in isolation have significant limitations. The release of such data from government programs must be subject to safeguards to ensure that neither false nor misleading conclusions are derived that could undermine the delivery of appropriate and quality care. If not addressed, the limitations of such data are significant. The foregoing limitations may include, but are not limited to, failure to consider factors that impact care such as specialty,</p>		

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	<p>geographic location, patient mix and demographics, plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution.</p> <p>Raw claims and payment data resulting from government health care programs, including, but not limited to, the Medicare and Medicaid programs should only be released:</p> <ol style="list-style-type: none"> 1. when appropriate patient privacy is preserved via de-identified data aggregation or if written authorization for release of individually identifiable patient data has been obtained from such patient in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and applicable regulations; 2. upon request of physicians [or their practice entities] to the extent the data involve services that they have provided; 3. to law enforcement and other regulatory agencies when there is reasonable and credible reason to believe that a specific physician [or practice entity] may have violated a law or regulation, and the data is relevant to the agency's investigation or prosecution of a possible violation; 4. to researchers/policy analysts for bona fide research/policy analysis purposes, provided the data do not identify specific physicians [or their practice entities] unless the researcher or policy analyst has (a) made a specific showing as to why the disclosure of specific identities is essential; and, (b) executed a written agreement to maintain the confidentiality of any data identifying specific physicians [or their practice entities]; 5. to other entities only if the data do not identify specific physicians [or their practice entities]; or 6. if a law is enacted that permits the government to release raw physician-specific Medicare and/or Medicaid claims data, or allows the use of such data to construct profiles of identified physicians or physician practices. Such disclosures must meet the following criteria: <ol style="list-style-type: none"> a) the publication or release of this information is deemed imperative to safeguard the public welfare; b) the raw data regarding physician claims from governmental healthcare programs is: <ul style="list-style-type: none"> • published in conjunction with appropriate disclosures and/or explanatory statements as to the limitations of the data that raise the potential for specific misinterpretation of such data. These statements should include disclosure or explanation of factors 		

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	<p>that influence the provision of care including geographic location, specialty, patient mix and demographics, health plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution, in addition to other relevant factors.</p> <ul style="list-style-type: none"> • safeguarded to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data. <p>c) any physician profiling which draws upon this raw data acknowledges that the data set is not representative of the physicians' entire patient population and uses a methodology that ensures the following:</p> <ul style="list-style-type: none"> • the data are used to profile physicians based on quality of care provided—never on utilization of resources alone—and the degree to which profiling is based on utilization of resources is clearly identified. • data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties, such as the AMA-convened Physician Consortium for Performance Improvement. • the data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians. <p>d) Any governmental healthcare data shall be protected and shared with physicians before it is released or used, to ensure that physicians are provided with an adequate and timely opportunity to review, respond and appeal the accuracy of the raw data (and its attribution to individual physicians) and any physician profiling results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to the their use, publication or release.</p> <p>3. That the Council on Legislation use the <i>Release of Claims and Payment Data from Governmental Programs</i> as a basis for draft model legislation. (Directive to</p>		

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	<p>Take Action)</p> <ol style="list-style-type: none"> 4. That our AMA create additional tools to assist physicians in dealing with the release of physician data. (Directive to Take Action) 5. That our AMA continue to monitor the status of, and take appropriate action on, any legislative or regulatory opportunities regarding the appropriate release and use of physician data and its use in physician profiling programs. (Directive to Take Action) 6. That our AMA monitor new and existing Web sites and programs that collect and use data on patient satisfaction and take appropriate action when safeguards are not in place to ensure the validity of the results. (Directive to Take Action) 7. That our AMA continue and intensify its extensive efforts to educate employers, healthcare coalitions and the public about the potential risks and liabilities of pay-for-performance and public reporting programs that are not consistent with AMA policies, principles, and guidelines. (Directive to Take Action) 8. That our AMA reaffirm the AMA Principles and Guidelines for Pay-for-Performance (H-450.947). (Reaffirm HOD Policy) 9. That our AMA reaffirm policy, Pay-for-Performance, Physician Economic Profiling, and Tiered and Narrow Networks (H-450.941). (Reaffirm HOD Policy) <p>Fiscal Note: Less than \$500</p>		
<p>Resolution 701: Appropriate Designation of Renumbered CPT Codes (AAP)</p>	<p>RESOLVED, That our American Medical Association oppose the practice of payers inappropriately designating renumbered CPT codes as “new” or “revised” CPT codes (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA develop a symbol to allow appropriate designation of renumbered codes within the CPT nomenclature, keeping them distinct from “new” and “revised” CPT codes. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$1,914.</p>	Support	Not adopted
<p>Resolution 702: Radiology Benefits Managers: Practicing Medicine Without the Patient (ACC)</p>	<p>RESOLVED, That our American Medical Association address the intrusion of radiology benefit managers (RBMs) into the doctor-patient interaction (e.g., denying one diagnostic test in favor of another) by a) studying the prevalence of forced test substitution by RBMs contracted by third-party payers; b) advocating against such practices; c) supporting the use of appropriate use criteria (AUC) developed by medical societies and expert physicians as an alternative to RBMs; and d) reporting back progress on this issue at the 2009 Interim Meeting. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$12,000.</p>	Support	Moved to B (Resolution 231)

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Resolution 703: Cardiac Rhythm Management Device Evaluation (ASA)	RESOLVED, That our American Medical Association work with appropriate groups such as the American College of Cardiology, Cardiac Rhythm Management Device (CRMD) manufacturers, and the US Food and Drug Administration to decrease barriers for periprocedural CRMD interrogation to assure the safety of patients. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$6,427.	Monitor/ Support	Referred for decision
Resolution 704: Physician Owned Hospitals (Int'l College of Surgeons – US)	RESOLVED, That the American Medical Association endorse the concept of physician owned hospitals. (New HOD Policy) Fiscal Note: Staff cost estimated at less than \$500 to implement.	RECOMMENDED FOR THE REAFFIRMATION CONSENT CALENDAR Monitor/Support	Reaffirmed
Resolution 705: Office Payment (IL)	RESOLVED, That our American Medical Association seek methods of rapid, efficient payment of office visits, including (1) evaluation and promotion of electronic adjudication and approval of claims and (2) cash or check payment at the time of service with subsequent reimbursement of the patient by the third party payers and refunds to the patient by the physician, if obligated by contract (Directive to Take Action); and be it further RESOLVED, That our AMA support change in the payment mechanism of low cost billing in all Medicare programs. (New HOD Policy) Fiscal Note: Implement accordingly at estimated staff cost of \$12,000.	RECOMMENDED FOR THE REAFFIRMATION CONSENT CALENDAR Monitor	Reaffirmed
Resolution 706: Standardized Medical Insurance Cards (IL)	RESOLVED, That our American Medical Association support the creation of a uniform Workgroup for Electronic Data Interchange (WEDI)-compliant standard to establish a standardized health insurance identification card (New HOD Policy); and be it further RESOLVED, That our AMA encourage all medical insurance providers, including state Medicaid programs and Medicare, to adopt a standardized machine/computer-read insurance card with accurate and timely information for insureds (Directive to Take Action); and be it further RESOLVED, That, if necessary, our AMA support or introduce legislation to compel all medical payers to adopt a standard insurance card. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$14,263.	RECOMMENDED FOR THE REAFFIRMATION CONSENT CALENDAR Support	Reaffirmed
Resolution 707: Price Transparency (IL)	RESOLVED, That our American Medical Association support legislation that requires insurance providers to provide an online resource for patients and physicians to calculate charges and out-of-pocket expenses associated with investigations and therapies in an effort to better educate patients and physicians on health care costs, equip patients to recognize value in health care, empower patients to participate in the spending of their	RECOMMENDED FOR THE REAFFIRMATION CONSENT CALENDAR	Reaffirmed

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	health care dollars, and promote one-time and long-term patient savings in an effort to reduce economic strains on health care systems. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$9,294.	Monitor/Support	
Resolution 708: Health Insurance and Pharmacies Advise Physicians to Take Action (IL)	RESOLVED, That our American Medical Association adopt policy to oppose the unwanted and unwarranted participation of health care insurance companies and pharmacies in patient diagnosis, treatment and health management. (Directive to Take Action) Fiscal Note: Staff cost estimated at less than \$500 to implement.	RECOMMENDED FOR THE REAFFIRMATION CONSENT CALENDAR Support	Reaffirmed
Resolution 709: The Protection of the Patient-Physician Relationship from Infringement by Third Party Payers (KS)	RESOLVED, That our American Medical Association prepare a new report on the health of the patient-physician relationship which should address the likely impact on the patient-physician relationship of new methods of health care financing, third-party judgments of physician quality, and third-party directed use of comparative clinical effectiveness research data, and the report should recommend specific strategies to protect the patient-physician relationship from infringement (Directive to Take Action); and be it further RESOLVED, That an interim report be prepared for discussion at the 2009 Interim Meeting, with the final report for action at the 2010 Annual Meeting. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$6,060.	Support	Adopted as amended with a change in title; see http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-g-annotated.pdf for exact language
Resolution 710: Identifying Abusive, Hostile or Non-Compliant Patients (MI)	RESOLVED: That our American Medical Association ask its CPT Editorial Panel to investigate for data collection and report back at Annual 2010 meeting: 1) developing a modifier for the E&M codes to identify non-compliant patients and/or 2) develop an add-on code to E&M codes to identify non-compliant patients. (Directive to Take Action) Fiscal Note: Staff cost estimated at less than \$500 to implement.	RECOMMENDED FOR THE REAFFIRMATION CONSENT CALENDAR Monitor	Not adopted
Resolution 711: Physician Representation on Hospital Boards (MI)	RESOLVED, That our American Medical Association seek policy from The Joint Commission to mandate that hospitals maintain non hospital-employed, practicing physician membership on their operating boards. (Directive to Take Action) Fiscal Note: Staff cost estimated at less than \$500 to implement.	RECOMMENDED FOR THE REAFFIRMATION CONSENT CALENDAR Support	Referred

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Resolution 712: Development of a Payment Code for Prior Authorization (MI)	RESOLVED, That our American Medical Association pursue establishment of a CPT code that would allow physicians to seek reimbursement for participating in the prior authorization process with third-party payers and managed care entities. (Directive to Take Action) Fiscal Note: Staff cost estimated at less than \$500 to implement.	RECOMMENDED FOR THE REAFFIRMATION CONSENT CALENDAR Support, if extracted from consent calendar	Reaffirmed
Resolution 713: “Advance Directives for All” Campaign (MI)	RESOLVED, That our American Medical Association seek a new CPT code(s) for advance directive counseling. (Directive to Take Action) Fiscal Note: Staff cost estimated at less than \$500 to implement.	RECOMMENDED FOR THE REAFFIRMATION CONSENT CALENDAR Support, if extracted from consent calendar	Reaffirmed
Resolution 714: Co-Pays and Deductibles (MI)	RESOLVED, That our American Medical Association study the possibility to obligate insurance companies to be responsible for obtaining their own self-authorized co-pays and deductibles from patients to help secure good patient-physician relationships, which may be disturbed by pursuing collections of the co-pays and deductibles from patients. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$3,056.	Monitor	Not adopted
Resolution 715: National Master Patient Identifier (MI)	RESOLVED, That our American Medical Association formalize the position of organized medicine to support and initiate the creation of a National Master Patient Identifier. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$4,580.	Monitor	Referred
Resolution 716: Payment for In-House Coverage (MI)	RESOLVED, That our American Medical Association work with the American Hospital Association to require the equitable treatment of all specialties (Directive to Take Action); and be it further RESOLVED, That our AMA work to require that if a hospital pays one specialty for in-house coverage, it be mandated to pay other specialties for in-house house coverage. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$756.	Monitor	Adopted as amended; see http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-g-annotated.pdf for exact language

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RESOLUTION/Report	ACTION REQUESTED	YPS POSITION	FINAL HOD ACTION
Resolution 717: Short Term Physician Volunteer Opportunities Within the United States (MI)	<p>RESOLVED, That our American Medical Association work with the National Practitioner Data Bank (or a similar credentialing data source) and state licensure boards to provide adequate information and ease of access for volunteer organizations to check the veracity of physicians' credentials at no cost or nominal fee (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA initiate and oversee cooperative effort among state licensure boards to allow short-term (fewer than 90 days) licensure and indemnity across state lines for volunteer physicians who wish to assist any organizations providing health care to the uninsured, regardless of the affiliation of the organization. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$10,000.</p>	Support	Not adopted
Resolution 718: Hospital Restrictions on Access to Medical Records (MO)	<p>RESOLVED, That our American Medical Association reiterate its support of patients' rights to review their own medical records and oppose any efforts to restrict those reviews (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA advocate for the right of physicians to review any medical record pursuant to a written or verbal request from the patient, or if a minor, by the authorized guardian (Directive to Take Action); and be it further</p> <p>RESOLVED, That clarification be requested from the Centers for Medicare & Medicaid Services concerning the rights of patients to examine their own medical records under the Health Insurance Portability and Accountability Act (HIPAA). (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$1,900.</p>	<p>RECOMMENDED FOR THE REAFFIRMATION CONSENT CALENDAR</p> <p>Support-</p>	Reaffirmed
Resolution 719: Decreasing Emergency Department Overcrowding (MSS)	<p>RESOLVED, That our American Medical Association work with state and federal governments, including agencies such as the Centers for Medicare and Medicaid Services and the US Office of Preparedness and Emergency Operations, to develop guidelines and increase incentives for hospitals to reduce emergency department overcrowding. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$6,060.</p>	Support	CMS Report 3 adopted in lieu of Resolution 719

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RESOLUTION/Report	ACTION REQUESTED	YPS POSITION	FINAL HOD ACTION
Resolution 720: Hospital Dress Codes for the Reduction of Nosocomial Transmission of Disease (MSS)	RESOLVED, That our American Medical Association advocate for the adoption of hospital guidelines for dress codes that minimize transmission of nosocomial infections, particularly in critical and intensive care units. (Directive to Take Action) Fiscal note: Staff cost estimated at less than \$500 to implement.	Support	Referred
Resolution 721: Uniform Overhead Emergency Codes (NV)	RESOLVED, That our American Medical Association facilitate the adoption of a uniform system of hospital overhead codes (perhaps the one recommended by the American Hospital Association in 2002) (Directive to Take Action); and be it further RESOLVED, That our AMA members suggest to local hospitals that they adopt this uniform system (Directive to Take Action); and be it further RESOLVED, That our members ask their local hospitals to educate doctors and other personnel regarding the new system. (Directive to Take Action) Fiscal Note: Staff cost estimated at less than \$500 to implement.	RECOMMENDED FOR THE REAFFIRMATION CONSENT CALENDAR Support	Reaffirmed
Resolution 722: Reassessment of AMA Policy Regarding the National Practitioner Data Bank (OH)	RESOLVED, That our American Medical Association review and consolidate its existing policy regarding the National Practitioner Data Bank (NPDB), rescinding AMA Policy H-355.991 should that be determined to be appropriate (Directive to Take Action); and be it further RESOLVED, That our AMA report back to its members an assessment of the current practices of the NPDB which would specifically identify who is eligible to be listed on the NPDB and to whom the information on the NPDB is available. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$4,365.	Support	Not adopted
Resolution 723: The Joint Commission Standards for Focused Professional Practice Evaluations and Ongoing Professional Practice Evaluations (OH)	RESOLVED, That our American Medical Association study The Joint Commission's accreditation standards related to the Focused Professional Practice Evaluations and the Ongoing Professional Practice Evaluations within hospital medical staffs with regard to the complexity, the time commitment, the cost and the potential liability for hospital medical staffs to implement these procedures and with regard to the impact of these new standards to improve the safety and the quality of care for our patients. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$4,500 to research and develop report.	Support	Adopted in lieu of Resolution 726

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RESOLUTION/Report	ACTION REQUESTED	YPS POSITION	FINAL HOD ACTION
Resolution 724: Reimbursement for Services (OK)	RESOLVED, That our American Medical Association, Congress and appropriate federal agencies support efforts to ensure that physicians and other providers receive payment from insurance companies in a timely fashion (Directive to Take Action); and be it further RESOLVED, That our AMA ascertain that any legislative or regulatory solution shall ensure that principles of transparency and accountability are applied to the insurance industry. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$9,294.	Support	Reaffirmed
Resolution 725: Web-Based Prior Authorization Process (OR)	RESOLVED, That our American Medical Association support federal legislation requiring all health insurers to include web-based prior authorization services among options for granting prior authorization. (New HOD Policy) Fiscal Note: Implement accordingly at estimated staff cost of \$1,859.	Support	Adopted as amended; see http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-g-annotated.pdf for exact language
Resolution 726: Ongoing Professional Practice Evaluations (TX)	RESOLVED, That our American Medical Association develop materials and other necessary resources to assist physicians and medical staffs in establishing transparent policies to implement and conduct Ongoing Professional Practice Evaluations. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated cost of \$27,732 which includes staff time, publication, printing, production, postage and promotion costs.	Monitor	Resolution 723 adopted in lieu of Resolution 726
Resolution 727: Medical Directors as "Peer" Reviewers When Pre-Adjudicating Prescribed Tests and Procedures (TN)	RESOLVED, That our American Medical Association adopt and promote policy establishing: 1. That medical determinations of pre-certification/pre-authorization requests be conducted by health plan physicians in the same medical specialty as the physician requesting such determinations; 2. That pre-certification/pre-authorization denials or patient treatment decision modifications create physician/patient relationships incumbent with all the ethical and legal responsibilities and consequences; 3. That physicians participating in pre-certification/pre-authorization decisions should have to provide their name, address, specialty and training as well as medical license information to the patient and requesting physician if a medical service is denied or modified as a result of such a review; and 4. That insurance companies, workers' compensation carriers, and the medical directors employed or utilized by them be made aware of these principles. (New HOD Policy) Fiscal Note: Implement accordingly at estimated staff cost of \$1,914.	RECOMMENDED FOR THE REAFFIRMATION CONSENT CALENDAR Monitor	Reaffirmed

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RESOLUTION/Report	ACTION REQUESTED	YPS POSITION	FINAL HOD ACTION
Resolution 728: Physician Profiling / Grading and Report Cards (IL)	RESOLVED, That our American Medical Association reaffirm its “Guidelines for Pay-for-Performance Programs,” which augment the AMA’s “Principles for Pay-for-Performance Programs” (Reaffirm HOD Policy); and be it further RESOLVED, That our AMA further evaluate this issue and create and support legislation as appropriate so that insurance company grading/rating systems do not encourage deselecting of high-risk patients so as to bolster their profiles and thus contribute to inaccessibility to care for these patients, and not encourage deselecting of physicians. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$9,294.	RECOMMENDED FOR THE REAFFIRMATION CONSENT CALENDAR Support	Reaffirmed
Resolution 729: Policies on Physician Rating (MI)	RESOLVED, That our American Medical Association formulate policies on physician rating and urge insurance companies, third-party agencies, private companies, and Web sites to publish the methods of rating and specifically mention how much of such rating is dependent on the cost incurred by a particular doctor (Directive to Take Action) ; and be it further RESOLVED, That our AMA work to ensure transparency to the whole process of rating physicians with proper steps built in to address the grievances of the physicians involved. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$4,969.	Support	Reaffirmed
Resolution 730: Medical Staff Self-Governance (FL)	RESOLVED, That our American Medical Association encourage The Joint Commission to mandate that medical staff officers be elected by majority vote in a confidential ballot (Directive to Take Action); and be it further RESOLVED, That our AMA encourage The Joint Commission to mandate that medical staff bylaws and any alterations, additions or deletions, be approved by a majority vote in a confidential ballot (Directive to Take Action); and be it further RESOLVED, That our AMA encourage The Joint Commission to mandate that voting be conducted by the medical staff, free of interference of the hospital administration, subject to review by a teller’s committee selected by the majority of active medical staff members. (Directive to Take Action) Fiscal Note: Staff cost estimated at less than \$500 to implement.	RECOMMENDED FOR THE REAFFIRMATION CONSENT CALENDAR Support	Reaffirmed
Resolution 731: Transitions of Care for Patients on Infusion Therapies (Infectious Diseases Society of America)	RESOLVED, That our American Medical Association support key transitional care components (as described below) necessary to safely and effectively provide infusion therapies in the outpatient setting (New HOD Policy); and be it further RESOLVED, That our AMA work with the American Hospital Association (AHA), the Society of Hospital Medicine (SHM), and other stakeholders to ensure that hospitalized patients are seen by qualified subspecialists prior to discharge to the outpatient setting or other settings of care for infusion therapies (Directive to Take Action); and be it further	Support	Reaffirmed

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RESOLUTION/Report	ACTION REQUESTED	YPS POSITION	FINAL HOD ACTION
	RESOLVED, That our AMA work with AHA, SHM, and other stakeholders to ensure that, prior to discharge, arrangements will be made and documented in the medical record for outpatient infusion therapy patients to receive oversight and follow-up care by qualified physicians who have familiarity with such treatment modalities. (Directive to Take Action) Fiscal Note: Staff cost estimated at less than \$500 to implement.		
Resolution 732: Condemnation and Reporting of Unilateral Physician Fee Reduction by Oxford (NY)	RESOLVED, That our American Medical Association condemn the unilateral reduction of fees paid to participating physicians by the Oxford Insurance Company. (Directive to Take Action) Fiscal Note: Staff cost estimated at less than \$500 to implement.	Monitor	Adopted
Resolution 733: Medical Smart Cards (NY)	RESOLVED, That our American Medical Association study and develop a “white paper” on the issue of medical smart cards and aligned technology, including the role of organized medicine in smart card development, the emergence of regional health information organizations (RHIOs), the opportunity for state and specialty societies to obtain grants to educate and inform members of opportunities in this and similar emerging technology and to enumerate the implications which these technologies have for physicians, patients and healthcare, in general. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated cost of \$9,825.	RECOMMENDED FOR THE REAFFIRMATION CONSENT CALENDAR Support	Reaffirmed
Resolution 734: National Practitioner Data Bank: Length of Time for Storing Medical Malpractice Data (NY)	RESOLVED, That our American Medical Association work with the National Practitioner Data Bank so that there is a time frame for storing all entries regarding physicians and that the time frame be limited to ten preceding years. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$4,365.	RECOMMENDED FOR THE REAFFIRMATION CONSENT CALENDAR Support	Reaffirmed
Resolution 735: National Government Services (NY)	RESOLVED, That our American Medical Association should continue to be apprised of intolerable denials and delays in physician payments (Directive to Take Action); and be it further RESOLVED, That our AMA urge the Centers for Medicare & Medicaid Services (CMS) to provide fiscal support to National Government Services (NGS) enabling NGS to have staff review paper claims rejected by the optical scanner and make appropriate improvements, to eliminate many of the denied claims (Directive to Take Action); and be it further RESOLVED, That our AMA seek federal legislation to require that interest payment on Medicare physician claims be based upon 100% of the Medicare allowed amount since delays in payment adversely impact the collection of coinsurance (Directive to Take Action); and be it further	Monitor	Referred

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RESOLUTION/Report	ACTION REQUESTED	YPS POSITION	FINAL HOD ACTION
	<p>RESOLVED, That our AMA seek federal legislation which would impose a monetary penalty upon Medicare carriers, in addition to interest payments, for failure to process and pay claims consistent with the current Medicare payment floors (13 days for electronic submission and 29 for paper claims) (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA seek a requirement that NGS provide a service representative that has the authority to adjudicate claims and can be contacted by telephone for every physician that submits claims (either paper or electronically) (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA request that a person, committee or mechanism be set up to oversee the operation of NGS and that the continuation of the NGS contract be reviewed periodically and be predicated upon the quality or effectiveness of NGS operations. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$4,365.</p>		
<p>Resolution 736: Membership in the Medical Staff (WI)</p>	<p>RESOLVED, That our American Medical Association study how hospital medical staffs involve physician assistants and nurse practitioners in the activities of hospital medical staffs—especially concerning patient care, safety, quality and ethical issues. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$15,000.</p>	Monitor	<p>Adopted as amended; see http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-g-annotated.pdf for exact language</p>