



Principles of health insurer conduct

Sixth edition

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Council on Medical Service

The American Medical Association (AMA) Council on Medical Service is charged with studying and evaluating the social and economic aspects of medical care and the practice of medicine, and suggesting means for the timely development of services in a changing socioeconomic environment on behalf of the public and the profession.

The Council on Medical Service, which has recommended many of the AMA’s policies related to insurer conduct, provided editorial guidance for the development of this document.

Preface

“Principles of health insurer conduct” is a new title for this piece. Previous editions of this document were titled “Principles of managed care.” Today it seems that all health care is managed in some way. Accordingly, the term “managed care” has become imprecise. What concerns patients and physicians today is insurer conduct in general. As the new title indicates, this updated collection of AMA policies reflects this broader concern.

The use of health insurance companies by employers and state and federal programs has strongly influenced the practice of medicine and exerted immense pressure on physicians. In response, the AMA has developed a strong policy base and established various mechanisms to address issues related to working with health insurance companies. The following principles of health insurer conduct represent an important component of these efforts. It is hoped that these principles, which are based entirely on AMA policy, will promote effective health insurance techniques that are fair and equitable to physicians, and help ensure that high quality health care services are delivered to patients.

Employers, state and federal programs, and health insurers are strongly encouraged to use these guidelines in developing their own policies and procedures. In addition, any public or private entity that evaluates health insurance organizations or their contracted entities for the purposes of certification or accreditation is encouraged to use these principles when developing standards.

Physician involvement

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 (H-285.954 [1]):

- 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.

Interference by third parties that cause a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient should be condemned. (H-5.989 [1])

Physicians should not be prevented from freely discussing with or providing information to patients about medical care and procedures. (H-5.989 [2])

Any regulation that proposes restrictions on physician-patient communications should be opposed. (H-5.989 [3])

Physicians participating in managed care plans must be able to comment on and present their positions

regarding the managed care plan policies and procedures without threat of punitive action. (H-165.888 [4])

Physician representatives and leaders must communicate key policies and procedures to the practicing physicians who participate in the health plan and participating physicians must have an identified process to access their physician representatives. (H-285.931 [9])

Health plans that require physicians to bill patients for out-of-pocket payments and do not allow physicians to collect these payments in a more efficient manner should be opposed. (H-165.849)

Third party payers and purchasers should provide cost data in a reasonable and useable manner so that physicians have easy access to the best available data associated with costs at the point of decision-making. (H-450.938 [3])

Physicians must inform their patients of medically appropriate treatment options regardless of their cost or the extent of their coverage. (H-140.978 [2])

All managed care plans and medical delivery systems must include significant physician involvement in their health care delivery policies similar to those of self-governing medical staffs in hospitals that should extend to all sites of care. The principles of self-governance for managed care medical staffs should include, but not be limited to (H-285.931 and H-285.983):

- the development of medical staff bylaws which cannot be unilaterally changed by the governing board of the medical delivery system; (H-285.983 [2,a])
- due process protections for physicians credentialed by the medical delivery system; (H-285.983 [2,c] and H-285.931 [1])
- representation by practicing physicians as the decision-makers in the credentialing and recredentialing process; (H-285.931 [2])
- full indemnification by the managed care entity of physicians who, in good faith, serve as members of credentialing, quality assurance, and utilization review committees of the medical delivery system; (H-285.983 [2,d])
- practicing physician involvement in: (a) the selection and removal of their leaders who are involved in governance, (b) the development of credentialing criteria, utilization management criteria, clinical practice guidelines, medical review criteria, and continuous quality improvement, and their leaders must be involved in the approval of these processes;

and (d) the development of criteria used by the health plan in determining medical necessity and coverage decisions; (H-285.931 [1,a,b,d])

- peer accountability for professional decisions based on accepted standards of care and evidence-based medicine; (H-285.931 [1,c])
- involvement of all specialties participating in clinical processes toward the development of clinical practice guidelines, disease management protocols; (H-285.931 [3])
- appropriate, periodic, and comparative utilization data for all practicing physicians; and (H-285.931 [7])
- the availability of skilled resource people and information management systems to practicing physicians involved in continuous quality improvement activities so that they have access to information on clinical performance, patient satisfaction, and health status. (H-285.931 [8])

The development and use of level of care guidelines is supported when certain criteria are met. level of care guidelines should (H-285.920):

- function as guidelines only, and should not be used as requirements for all instances and cases. That is, level of care guidelines must allow for appropriate physician autonomy in making responsible medical decisions;
- acknowledge the complexity of care for each patient under the particular set of clinical circumstances;
- apply to all facility support systems so that patients are not assigned a level of care that slows or stalls their treatment;
- be developed under the direction of actively practicing physicians;
- be developed based on individual patient severity of illness and intensity of service;
- be validated through standard data quality control checks and professional advisory consensus;
- be reviewed and updated; and
- allow for a timely appeal process.

Medical director qualifications

Utilization review decisions to deny payment for medically necessary care constitute the practice of medicine. Federal and state patient protection legislation should subject medical directors of managed care organizations to state medical licensing requirements, state medical board review, and disciplinary actions. (H-285.939)

To the greatest extent possible, physicians who are employed as medical directors of managed care organizations shall adhere to the following “Guidelines for Qualifications of Medical Directors of Managed Care Organizations” (H-285.987):

- hold an unlimited current license to practice medicine in one of the states served by the managed care organization;
- have a current license in each applicable state where that medical director will be making clinical decisions or be involved in peer review;
- meet credentialing requirements equivalent to those met by plan providers;
- be familiar with local medical practices and standards in the plan’s service area;
- be knowledgeable concerning the applicable accreditation or “program approval” standards for preferred provider organizations and health maintenance organizations;
- possess good interpersonal and communications skills;
- demonstrate knowledge of risk management standards;
- be experienced in and capable of overseeing the commonly used processes and techniques of peer review, quality assurance, and utilization management;
- demonstrate knowledge of due process procedures for resolving issues between the participating physicians and the health plan administration, including those related to medical decision-making and utilization review;
- be able to establish fair and effective grievance resolution mechanisms for enrollees;
- be able to review, advise, and take action on questionable hospital admissions, medically unnecessary days, and all other medical care cost issues; and
- be willing to interact with physicians on denied authorizations.

Insurer responsibility

Accountability and disclosure

Managed health care plans should meet high standards of truth in advertising and legal safeguards to assure high quality medical care is not compromised by deceptive marketing activities, unsubstantiated claims, bogus quality assurance activities, disruptive referral requirements, and unreasonable precertification, and concurrent review practices. (H-270.982)

Self-insured health benefits plans should be legally accountable for harm to patients resulting from negligent utilization management policies or patient treatment decisions through all available means, including proportionate or comparative liability, depending on state liability rules. (H-285.915 [5])

All managed care plans should be required to clearly and understandably communicate to enrollees and prospective enrollees, in a standard disclosure format, those services that they will and will not cover and the extent of that coverage. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements, or other restrictions that may limit services, referral, or treatment options. (H-285.998 [5])

A consistent format should be established for estimating and publicly reporting health care administrative costs, in order to facilitate unbiased comparisons across insurers, and from different sources, including those overhead expenditures that can be defined as either administrative or non-administrative (e.g., profits and retained earnings). Administrative expenditures should be expressed in the following metrics: dollars per-member-per-month, dollars per claim, percentage of total expenditures, and percentage of total claims payments. (H-155.963)

Managed care plans or networks that use criteria to determine the number, geographic distribution, and specialties of physicians needed should report to the public, on a regular basis, the impact that the use of such criteria has on the quality, access, cost, and choice of health care services provided to their patients. (H-285.984 [3])

Health plans should use a standardized uniform disclosure format that has had appropriate input by medical organizations. (H-180.961)

Third party payers and self-insured plans should publish their payment policies, rules, and fee schedules. All payment schedule updates and changes should be published at least 60 days before such changes in payment schedules are enacted, and all participating physicians should be notified of such changes at least 60 days before changes in payment schedules are enacted. (H-185.975 [1, 3])

Managed care organizations should provide enrollees and participating physicians with the opportunity to complete a “report card” at regular intervals for

appropriate dissemination regarding the quality of service rendered. (H-285.981 [1,e])

Health plans should include in marketing and policy documents a bold type front page that explicitly details any limitations in choice of primary care physicians, access to a specialist and method of physician reimbursement. (H-185.973)

Insurance benefit packages should be adjusted to provide balanced coverage of alternative services and settings in the provision of health care. (H-185.996 [1])

Administrative costs

A consistent format should be used by health plans for estimating and publicly reporting health care administrative costs. (H-155.963 [1])

Medical programs administered by all federal government agencies, exclusive of military health care systems, should make publicly available annually, and publish separately, their medical care costs and their administrative costs. (H-155.985 [5,a])

Federal agencies, exclusive of military health care systems, should provide a fiscal impact report on any proposed new program or modifications to present programs, clearly demonstrating how the cost of care will be reduced or the quality improved, and the expected effect of such new or altered programs on the providers of the services. (H-155.985 [5,b])

Physician data and profiling

Physician profiling must be adjusted to recognize case mix, severity of illness, age of patients and other aspects of the physician’s practice that may account for higher or lower than expected costs. Profiles of physicians must be made available to the physicians at regular intervals. (H-225.961 [1,i])

Physicians should be allowed to review and correct inaccuracies in their patient specific data well in advance of any public release, decreased payments, or forfeiture of opportunity for additional compensation. (H-450.941 [7])

The use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians primarily based on cost of care factors should be opposed. (H-450.941 [2])

The AMA opposes physician profiling data being used for economic credentialing purposes. (H-406.993 [4])

Efforts by third party payers to rank, profile or otherwise “score” physicians purely for corporate cost containment purposes should be opposed. (D-406.996)

Entities that profile physicians should provide them with feedback on their performance and access to education to assist them in meeting norms of practice. (H-295.995 [36])

Any managed care plan that compiles information on physician performance should share that information with the practitioners involved prior to public release. (H-285.994 [3])

Every physician should be given a copy of his/her practice performance profile information at least annually by each organization retaining such physician information. (H-375.969)

Physician data should be used in conjunction with program(s) designed to improve or maintain the quality of, and access to, medical care for all patients and should be used to provide accurate physician performance assessments in concert with the following principles:

1. Patient privacy safeguards

- All entities involved in the collection, use and release of claims data should comply with the HIPAA Privacy and Security Rules. (H-315.972, H-315.973, H-315.983, H-315.984, H-315.989 and H-450.947)
- Disclosures made without patient authorization should be 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 and H-315.983)

2. Data accuracy and security safeguards

- Effective safeguards should be established to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data. (H-406.996, H-450.947 and H-450.961)
- Reliable administrative, technical, and physical safeguards should 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 and H-450.961)
- Physician-specific medical practice data, and all analyses, proceedings, records and minutes from quality review activities should not be subject to discovery or admittance into evidence in any judicial or administrative proceeding without the physician's consent. (H-406.996, H-450.947 and H-450.961)

3. Transparency requirements

- When data are collected and analyzed for the purpose of creating physician profiles, the

methodologies used to create the profiles and report the results should be developed in conjunction with relevant physician organizations and practicing physicians and should be disclosed in sufficient detail to allow each physician or medical group to replicate the findings. (H-315.973, H-406.993, H-406.994, H-406.998, H-450.947 and H-450.961)

- The limitations of the data sources used to create physician profiles should be clearly identified and acknowledged in terms understandable to consumers. (H-406.994 and H-450.947)
- The capabilities and limitations of the methodologies and reporting systems applied to the data to profile and rank physicians should be publicly revealed in understandable terms to consumers. (H-315.973, H-406.994, H-406.997, H-450.947 and H-450.961)
- Case-matched, risk-adjusted resource use data should be provided to physicians to assist them in determining their relative utilization of resources in providing care to their patients. (H-285.931)

4. Review and appeal requirements

- Physicians should be 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 and H-450.961)
- When the physician and the rater cannot reach agreement, physician comments should be appended to the report at the physician's request. (H-450.947)

5. Physician profiling requirements

- 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 should 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 and H-450.961)
- Data reporting programs should only use accurate and balanced data sources to create physician profiles and should not use these profiles to create tiered or narrow network programs that are used to steer patients toward certain physicians primarily based on cost of care factors. (H-450.951)
- When a single set of claims data includes a sample of patients that are skewed or not representative of a physician's entire patient population, multiple sources of claims data should be used. (H-406.991)

- Physician efficiency of care ratings should use physician data for services, procedures, tests and prescriptions that are based on physicians' patient utilization of resources, rather than the actual charges by the physician. (H-406.991)
- Physician profiling programs may rank individual physician members of a medical group but should not use those individual rankings for placement in a network or for reimbursement purposes. (H-406.991)

6. Quality measurement requirements

- The data should be 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 should be clearly identified. (H-450.947)
- Data should be 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 and H-450.961)
- Evidence-based measures should be endorsed by the National Quality Forum (NQF) and/or the AQA Alliance and the Hospital Quality Alliance (HQA), when available. When unavailable, scientifically valid measures developed in conjunction with appropriate medical specialty societies and practicing physicians should be used to evaluate the data. (H-406.991)

7. Patient satisfaction measurement requirements

- 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)
- 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. (H-406.991)
- 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. (H-406.991)

Contracts

Disclosures

At a minimum, the information disclosed in managed care contracts should be in clear terms and include the following (H-285.946):

- reimbursement amounts, conversion factors for the RBRVS system or other formulas if applicable, global follow-up times, multiple procedure reimbursement policies, and all other payment policies;
- any proprietary “correct coding” CPT bundling program that is used;
- grievance and appeal mechanisms;
- conditions under which a contract can be terminated by a physician or health plan;
- patient confidentiality protections;
- policies on patient referrals and physician use of consultants; and
- a current listing by name of the physicians (by specialty) and ancillary service providers participating in the plan.

Insurers should make available their complete payment schedules, coding policies and utilization review protocols to physicians prior to signing a contract and at least 60 days prior to any changes being made in these policies. (H-185.975 [4])

Financial incentives

Physicians should consult with legal counsel prior to agreeing to any health plan contract that contains financial incentives, to assure that such incentives will not inappropriately influence their clinical judgment. (H-285.951 [10])

Physicians agreeing to health plan contracts that contain financial incentives should seek the inclusion of provisions allowing for an independent annual audit to assure that the distribution of incentive payments is in keeping with the terms of the contract. (H-285.951 [11])

Physicians should have the right to enter into whatever contractual arrangements with health care systems they deem desirable and necessary, but they should be aware of the potential for some types of systems to create conflicts of interest, due to the use of financial incentives in the management of medical care. (H-285.951 [2])

Due process protection

All managed care contracts should expressly require the managed care plan to provide meaningful due process protections, in order to prevent wrongful and arbitrary contract terminations that leave the physician without means of redress. (H-285.996)

Managed care organizations should provide due process to physicians in all adverse selective contracting decisions. (H-285.981 [1,d])

Managed care companies should be prohibited from automatically terminating providers who have been sanctioned by state medical boards or by information being provided by the National Practitioners Data Bank without providing due process to the provider. Physicians should have guarantees of due process and civil rights safeguards in peer review and in credentialing. (H-375.973)

Physician payment

The practice of negotiating or creating contractual arrangements between third party payers and hospitals limiting reimbursement to physicians should be condemned unless those physicians have been involved in the negotiation process and have been given a good faith opportunity to participate. (H-385.968)

Managed care contract provisions that prohibit physician payment for the provision of administrative services should be opposed. (H-285.943 [1])

Contracts containing “most favored nation” clauses that require physicians to give a third party payer his or her most discounted rate for medical services should be opposed. (H-385.938)

Physicians entering into capitated arrangements with managed care plans should seek the inclusion of a separate capitation rate (per member per month payment) for the provision of administrative services and physicians entering into fee-for-service arrangements with managed care plans should seek a separate case management fee or higher level of payment to account for the provision of administrative services. (H-285.943 [2])

Liability

Physicians should consider consulting with legal counsel prior to contracting with a managed care entity to prevent the imposition of unfair liability upon the physician. (H-285.995 [1])

Hold harmless clauses in managed care contracts that effectively shift plan liability to the physician should be explicitly identified as such and should be opposed. (H-285.995 [1])

Preferred provider organizations

The medical services agreements between physicians and preferred provider organizations (PPOs) should adhere to the following principles (H-415.987 [1]):

- discounts shall be extended only to enrollees of PPOs who have cards identifying them as such;

- all PPO members eligible for discounts shall be subject to mechanisms that will direct patients to the physician’s practice;
- the types of entities that can be added to the network shall be identified in advance, and providers shall receive timely notice when payers or employers are added;
- all members added to the PPO shall be subject to the same mechanisms to direct patients to the physician’s practice;
- any discounts applicable to a PPO enrollee shall be disclosed at the time coverage is verified; and
- the sale or other unauthorized use of contract rate information shall be specifically prohibited.

Procedural safeguards

Participating physicians should be allowed a minimum of 60 days to review amendments to managed care contracts. (H-285.952)

Contracts that tie a physician’s membership in a managed care panel (e.g., a PPO) to that physician’s participation in any other managed care panel (e.g., an HMO) should be opposed. (H-285.989)

When a “sale of covered lives” takes place due to the sale or merging of health plans, the health plan emerging from such transactions should be required to abide by the original health plan contract with the patient, especially those contract provisions that address health benefits coverage and access to physicians. (H-285.935)

Managed care contracts that allow plans to refuse to pay for provision of covered services for the sole reason that required notification of these services was not reported in a timely manner should be opposed. (H-285.940)

The practice of “retroactive or late assignment” of patients by managed care entities should be eliminated. This practice involves the failure of managed care organizations to require enrollees in a capitated plan to select a physician at the time of enrollment, inform the physician of the enrollment of the patient and the assignment of responsibility until the patient has sought care; and pay the responsible physician the capitated rate until after the patient has sought care. (H-285.947 [1])

“Gag clauses” should be banned from physician contracts. (H-285.959)

Selective contracting

Health plans or networks should provide public notice within their geographic service areas when applications for participation are being accepted. (H-285.991 [1,a])

Managed care organizations should disclose to physicians applying to the plan the selection criteria used to select, retain, or exclude a physician from a managed care plan, including the criteria used to determine the number, geographic distribution, and specialties of physicians needed. (H-285.984 [2])

Physicians should have the right to apply to any managed care plan or network in which they desire to participate. (H-285.991 [1,b])

Physician applications should be approved if they meet physician-developed objective criteria that are available to both applicants and enrollees and are based on professional qualifications, competence, and quality of care. Any economic criteria used in such selective contracting should have a demonstrated positive relationship to the quality and appropriateness of care and to professional competency. (H-230.975 [1])

Selective contracting decisions made by any health delivery or financing system should be based on an evaluation of multiple criteria related to professional competency, quality of care, and the appropriateness by which medical services are provided. In general, no single criterion should provide the sole basis for selecting, retaining, or excluding a physician from a health delivery or financing system. (H-285.991 [1,c])

Managed care plans that contract with selected providers should have an established appeals mechanism by which any provider willing to abide by terms of the plan contract could appeal a decision to deny the provider's application for participation in the plan. (H-285.997 [2])

Prior to initiation of actions leading to termination or nonrenewal of a physician's participation contract for any reason, the physician shall be given notice specifying the grounds for termination or nonrenewal, a defined process for appeal, and an opportunity to initiate and complete remedial activities except in cases where harm to patients is imminent or an action by a state medical board or other government agency effectively limits the physician's ability to practice medicine. (H-285.991 [1,d])

Managed care organizations should provide due process to physicians in all adverse selective contracting decisions. (H-285.981 [1,d])

Transparent/fair contracting

Health Maintenance Organizations (HMOs) should provide patients with a brochure describing the HMO, including limitations of coverage, professional qualifications of personnel providing service, and grievance procedures. (H-195.991 [1])

HMOs should provide ample notice to beneficiaries participating in the HMO of any premium changes. (H-195.991 [2])

HMOs should notify enrollees when contracts with participating hospitals or clinics are canceled or interrupted and the alternative health care options that are available. (H-195.991 [3])

The use of adverse event reporting data by health plans for purposes other than quality improvement and learning should be opposed. (H-285.917 [1,a])

Health insurance companies are not the appropriate entity for determining medical mistakes. (H-285.917 [2])

Health plans should not include the name of a physician in their marketing materials and directory of participating physicians without the prior written consent of that physician. (H-285.924 [1])

Health plans should promptly remove the physician's name from marketing materials and directory of participating physicians upon termination of that physician's contract with the plan. (H-285.924 [2])

Health plans should provide patients with their current directory of participating physicians through multiple media including, but not limited to, the Internet. (H-285.924 [3])

Health plans should continue to cover services provided by physicians who involuntarily leave a plan, for reasons other than loss of/restrictions on their medical license/certification or fraud, until a new printed directory is distributed. (H-285.924 [4])

Payers should make available a copy of the executed contract to physicians within three business days of the request. (H-185.975 [6,a])

Health plan explanation of benefits should contain documentation regarding the precise contract used for determining the reimbursement rate. (H-185.975 [6,a])

Health plans should make all contracts available once a year for physician review at no cost. (H-185.975 [6,c])

No health plan contract should be changed without the physician's prior written authorization. (H-185.975 [6,d])

When a health plan contract is terminated pursuant to the terms of the contract, the contract should not be used by any other payer. (H-185.975 [6,e])

Physicians should be permitted to negotiate individually and collectively with managed care organizations on the terms and conditions of physician

participation in a managed care organization's health benefits plans. (H-385.971 and H-285.981 [1,a])

Formal input should be provided by practicing physicians in the development and refinement of the medical policies of a managed care organization, especially those policies related to physician credentialing, performance review, and utilization review. (H-285.981 [1,b])

Managed care organizations should disclose all participation requirements and selective contracting criteria to applying physicians. (H-285.981 [1,c])

Managed care plans and third party payers should disclose to physicians and the public, the selection criteria used to select, retain, or exclude a physician from a managed care or other provider plans. (H-285.985 [1])

Managed care plans and third party payers should refer questions of physician substance abuse to state medical associations and/or county medical societies for review and recommendation as appropriate. (H-285.985 [5])

Self-insured health benefits plans should (H-285.915):

- ensure that plan enrollees have access to all needed health care services;
- clearly disclose to present and prospective enrollees any provisions restricting patient access to or choice of physicians, or imposing financial incentives concerning the provision of services on such physicians;
- be regulated in regard to plan policies and practices regarding utilization management, claims submission and review, and appeals and grievance procedures;
- conduct scientifically based and physician-directed quality assurance programs;
- participate proportionately in state high-risk insurance pools that are financed through participation by carriers in that jurisdiction;
- be prohibited from indemnifying beneficiaries against actions brought by physicians or other providers to recover charges in excess of the amounts allowed by the plan, in the absence of any provider contractual agreement to accept those amounts as full payment;
- inform beneficiaries of any discounted payment arrangements secured by the plan, and base beneficiary coinsurance and deductibles on these discounted amounts when providers have agreed to accept these discounted amounts as full payment;
- be subject to breach of contract actions by providers against their administrators; and

- adopt coordination of benefits provisions applying to enrollees covered under two or more plans.

Physicians should be able to negotiate (individually and as defined groups) fair contracts with private sector and public sector health plans. (H-383.991)

Credentialing and recredentialing

Managed care companies should use uniform application and reapplication forms. (H-285.979 and H-275.977)

Managed care organizations and insurance companies are encouraged to use state and county central credentialing services, where available, for purposes of credentialing plan physician applicants. (H-285.979 [4])

Hospital medical staff privileges should not be required for physician participation in managed care contract panels and managed care entities should have an effective, physician directed peer review mechanism to fairly evaluate their participating physicians. (H-285.953)

Third party payers should not exclude non-board certified physicians as a class from participation in their programs without regard to individual training, experience, and current competence. (H-180.968)

Health plans that require board certification should allow the completing resident to be included in their plans after showing evidence of having completed the required training and of working toward fulfilling the requirements in the time frame established by their respective Board for completion of certification. (H-180.956 [2])

Final acceptance of residents who otherwise are approved by a health plan should be contingent upon the receipt of a letter from their program directors stating that their training has been satisfactorily completed. (H-180.956 [1])

Managed care organizations, including Medicare and Medicaid, should make final physician credentialing determinations within 45 calendar days of receipt of a completed application, grant provisional credentialing pending a final credentialing decision if the credentialing process exceeds 45 calendar days, and retroactively compensate physicians for services rendered from the date of their credentialing. (H-180.956 [3])

Managed care organizations should recredential participating physicians no more frequently than every two years. (H-285.979 [3])

Recredentialing of a physician or physician group by a managed care plan should not be triggered by a change of practice location within the plan’s contractually defined service area, by a change in practice by a currently credentialed physician to a different group that is also currently credentialed, or to solo practice, or by a change in staff size of the physician group. Any significant resulting change in the number, type, quality or costs of services provided in the practice should be addressed first through physician-directed quality assurance and utilization management mechanisms established in the plan. (H-285.934 [1])

Recredentialing or reconsideration of plan participation for a physician or physician group may legitimately be precipitated by a relocation of the practice outside of the plan’s service area. (H-285.934 [3])

Recredentialing of a physician or physician group by a managed care plan should not be required when two or more such plans merge. (H-285.934 [2])

Volume indicators should not be used as the sole criteria for credentialing and reimbursement. When volume indicators are used, allowances should be made for physicians starting practice. (H-180.963)

Economic factors should not be placed above quality of care factors in economic credentialing by third party payers. (H-180.967)

Clinical issues/benefits

Medical care “carve-outs”

The term “carve-out” should be defined as follows:

A financial arrangement for the provision and/or management of a clinically defined subset of a health plan’s benefits, which is separate from the financial arrangement for the provision and/or management of most or all of the plan’s other health benefits. (H-285.919)

Carve-outs should be opposed when used as a tool to deny necessary and appropriate care, reduce the likelihood that care will be sought, to intimidate patients or referring physicians from initiating needed referrals, or to create additional burdens to either patients or physicians. (H-285.922)

In order to protect the large number of patients currently covered by carve-out arrangements, all managed care plans that provide or arrange for behavioral health care should adhere to the following principles, and any public or private entities that evaluate such plans for the purposes of certification or accreditation should utilize these principles in conducting their evaluations (H-285.956):

- plans should assist participating primary care physicians to recognize and diagnose the behavioral disorders commonly seen in primary care practice;
- plans should reimburse qualified participating physicians in primary care and other non-psychiatric physician specialties for the behavioral health services provided to plan enrollees;
- plans should utilize practice guidelines developed by physicians in the appropriate specialties, with local adaptation by plan physicians as appropriate, to identify the clinical circumstances under which treatment by the primary care physician, direct referral to psychiatrists or other addiction medicine physicians, and referral back to the primary care physician for care of behavioral disorders is indicated, and should pay for all physician care provided in conformance with such guidelines. In the absence of such guidelines, direct referral by the primary care physician to the psychiatrist or other addiction medicine physician should be allowed when deemed necessary by the referring physician;
- plans should foster continuing and timely collaboration and communication between primary care physicians and psychiatrists in the care of patients with medical and psychiatric comorbidities;
- plans should encourage a disease management approach to care of behavioral health problems;
- participating health professionals should be able to appeal plan-imposed treatment restrictions on behalf of individual enrollees receiving behavioral health services, and should be afforded full due process in any resulting plan attempts at termination or restriction of contractual arrangements;
- plans using case managers and screeners to authorize access to behavioral health benefits should restrict performance of this function to appropriately trained and supervised health professionals who have the relevant and age group specific psychiatric or addiction medicine training, and not to lay individuals, and in order to protect the patient’s privacy and confidentiality of patient medical records, should elicit only the patient information necessary to confirm the need for behavioral health care;
- plans assuming risk for behavioral health care should consider “soft” capitation or other risk/reward-sharing mechanisms so as to reduce financial incentives for undertreatment; and
- plans should conduct ongoing assessment of patient outcomes and satisfaction, and should utilize findings to both modify and improve plan policies when indicated and improve practitioner performance through educational feedback.

Mental health carve-out programs should adequately provide for the appropriate diagnosis, evaluation, and treatment of medical comorbidities. (H-285.925 [1])

Where a cap on the number of mental health visits is imposed by a health plan, re-certification for additional visits should be granted upon request by the treating psychiatrist, or other health care professional, without additional personal information from the patient. (H-285.925 [2])

Covered benefits

Cost-effectiveness should not be used by payers to preclude or limit the availability of a safe and effective technology by either refusal to reimburse or by the provision of more limited reimbursement for such technology. Decisions as to the cost-effectiveness of technology can best be made by the physician on an individual patient basis, taking into consideration the needs of the individual and the results of cost-effectiveness analyses. (H-480.984 [i])

Payer determinations regarding coverage for health care technologies should be made with the involvement of the medical community and the public. Such determinations should be timely and responsive to the evolving information on safety and effectiveness. (H-480.984 [j])

Payer coverage policies for investigational technologies should be flexible and reviewed frequently so as to assure that the needs of individual patients are met. (H-480.984 [k])

Payers should integrate the concept of risk/benefit analysis into their decision-making and adapt their coverage policy accordingly. In serious and life-threatening illnesses, payers must recognize that patient and physician may agree upon a particular therapy, notwithstanding a lesser degree of certitude about that therapy's safety and effectiveness, if no other alternative therapies are available. (H-480.984 [l])

Health plan coverage policies should be flexible and responsive when investigational technologies are determined to be the most effective therapy for the individual patient by the treating physician. (H-480.982 [5])

Physicians should be supported in routinely providing lifestyle counseling to patients through adequate third party reimbursement. (H-155.960 [3])

Third party payers should use targeted benefit design, whereby patient cost-sharing requirements are reduced for maintenance medications used to treat chronic medical conditions, particularly when non-compliance

poses a high risk of adverse clinical outcome and/or high medical costs. (H-155.960 [7])

In the interest of achieving greater use of the physician's office, private sector insurance companies should provide reimbursement not only for professional services, but also for other costs which are incurred in that setting, such as surgical trays, sterile draping and necessary supplies. (H-385.996)

Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage. (H-165.846 [2])

Health insurance companies and prepayment plans should adopt policy provisions and mechanisms to ensure the coordination of benefits to enable persons covered under two or more group programs to be fully reimbursed for their expenses of insured services without receiving more in total benefits than the amount of such expenses. (H-185.999)

Health insurance companies should recognize that some medical conditions can be resolved or reduced to the extent that they are no longer valid predictors of morbidity and mortality and underwriting decisions should be based only on the presence of conditions that are valid predictors of morbidity and mortality. Insurance providers should accept appropriately amended medical records when underwriting decisions require medical record review. (H-185.947)

Health insurance should cover pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability. (H-165.856[8])

Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage. (H-165.856 [9])

Health insurers should eliminate the lifetime maximums of health insurance benefits. (H-185.952)

Health care coverage policies related to specialty pharmaceuticals, including co-payment or co-insurance levels and how these levels are determined should be completely transparent. (H-185.953)

Health insurers should make available for purchase a wide variety of group and individual health insurance policies that provide coverage for a range of clinical preventive services. (H-185.954 [3])

Health insurers and health plans should cover medically necessary over-the-counter drugs for which no prescription alternative exists. (H-185.956 [2])

Discriminatory benefit limitations, copayments or deductibles for the treatment of psychiatric illness under existing health care plans should be opposed. (H-185.986)

Health insurers and other third party payers should be prohibited from waiving and/or lowering co-payments only for patients that receive services at store-based health clinics. (H-160.921 [3])

New health benefit mandates unrelated to patient protections, which jeopardize coverage to currently insured populations, should be opposed. (H-185.964)

Health insurance policies should explicitly and specifically list exclusions from coverage in order that these are apparent and comparable. (H-185.971)

The practice of basing copayments on a different basis than the third party reimbursement should be condemned. (H-185.983 [1])

Health insurance providers and third party administrators should maintain a toll-free 24 hour-a-day telephone line, or other confidential electronic means, to provide information about specific coverage and benefits available to any patient presenting for medical care and for physicians to discuss questions regarding patient covered services. (H-185.984 [1,2])

Third party payers should make all guidelines related to patient coverage a matter of public information and easily obtainable by both patients and physicians. (H-185.985)

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. 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. (H-285.998 [5])

Formulary and prescription management Limits should be placed on the extent to which managed care plans use incentives or pressures to lower prescription drug costs. Financial incentives are permissible when they promote cost-effectiveness, not when they require withholding medically necessary care. (H-285.965 [3])

Insurance companies should not mandate changes in medications or increase co-pays for at least one year or the term of the contract, whichever is greater. (H-125.983)

Prescriptions should not be changed without physicians having a chance to discuss the change with the patient. (H-285.965 [3])

Managed care plans should develop and implement educational programs on cost-effective prescribing practices. (H-285.965 [4])

During enrollment, the plan must disclose the existence of formularies, the provisions for cases in which the physician prescribes a drug that is not included in the formulary and the incentives or other mechanisms used to encourage physicians to consider costs when prescribing drugs. (H-285.965 [5])

Plans should disclose any relationships with pharmaceutical benefit management companies or pharmaceutical companies that could influence the composition of the formulary. (H-285.965 [5])

Research should be conducted to assess the impact of formulary constraints and other approaches to containing prescription drug costs on patient welfare. (H-285.965 [6])

Pharmacists should contact the prescribing physician if a prescription written by the physician violates the managed care drug formulary under which the patient is covered, so that the physician has an opportunity to prescribe an alternative drug, which may be on the formulary. (H-285.965 [7])

When pharmacists, insurance companies, or pharmaceutical benefit management companies communicate directly with physicians or patients regarding prescriptions, the reason for the intervention should be clearly identified as being either educational or economic in nature. (H-285.965 [8])

Health plans should provide physicians and patients with their medication formularies through multiple media, including Internet posting. In the case where Internet posting of the formulary is not available and the formulary is changed, coverage should be maintained until a new formulary is distributed. For physicians who do not have electronic access, hard copies must be available. (H-285.965 [10–12])

Health plans should identify participating physicians as their “medical staff” and use such staff to oversee and approve plan formularies, as well as to oversee and participate on properly elected Pharmacy & Therapeutics Committees that develop and maintain plan formularies. (H-125.991 [4,a])

Health plans should have well-defined processes for physicians to prescribe non-formulary drugs when medically indicated. This process should impose minimal administrative burdens and include access to a formal

appeals process for physicians and their patients. (H-125.991 [4,b])

Switching of therapeutic alternates in patients with chronic diseases who are stabilized on a drug therapy regimen should be discouraged. (H-125.991 [4,c])

Health plans should consider incentive-based formularies with tiered co-pays to allow greater choice and economic responsibility in drug selection, as long as excessive cost-shifting to patients does not occur. (H-125.991 [5])

When the prescription of a drug or use of a device represents safe and effective therapy, health plans should consider the intervention as reasonable and necessary medical care, irrespective of labeling, and should fulfill their obligation to their beneficiaries by covering such therapy. (H-120.988)

Tricare Management Activity should alter its payment formula for vaccines for routine childhood immunizations, so that payments for vaccines reflect the published CDC retail list price for vaccines. (D-40.991 [5])

Third party payers should not establish a higher cost-sharing requirement exclusively for prescription drugs approved for coverage under a medical exceptions process. (H-185.961)

Cancellation and rescission

All health insurance carriers should establish an external review procedure that allows the policyholder, their representative, or their attending physician to submit grievances involving adverse determinations. (H-320.952 [2])

Our AMA opposes any attempt by health insurers to cancel, reduce, refuse to renew, or increase the individual's premium for coverage under either individual or group policies based on an illness occurring during the time insurance is in force. (H-185.989)

The AMA encourages state medical societies to urge state insurance commissioners to require insurance companies that rate or reject any applicant for a health policy to explain in writing in terms understandable to the patient the reason(s) for rating or rejection; allow the applicants to submit further information and to protest such action. Such rating or rejection shall not be reported until such information is reviewed. Health insurance coverage denials due to pre-existing conditions and all other reasons not related to fraudulent representation should be eliminated. (H-180.981 [1] and H-165.838 [2])

Health insurance should cover pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability. (H-165.856 [8])

Continued health insurance coverage should be ensured for patients with pre-existing medical conditions transitioning between insurance products. (D-185.988)

Management of medical services

Independent and external review

All managed care organizations should contain an external review procedure with the following basic components (H-320.952):

- 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 a) medical necessity determinations, and b) 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; and
- external grievance reviewers shall obtain input from physicians involved in the area of practice being reviewed. If the review involves specialty or sub-specialty issues, the input shall, whenever possible, be obtained from specialists or sub-specialists in that area of medicine.

Utilization management

Appropriate and consistent standards for private third party utilization review should be developed. Such standards should be used at both the state and national level to seek legislative and regulatory approaches to ensure cost effective, consistent, fair and high quality third party utilization review as well as accessibility to third party reviewers. (H-320.974)

The medical protocols and review criteria used by managed care plans in any utilization review or management program must be developed by physicians. (H-285.998 [5])

Managed care plans should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms used in the review process, as well as how they were developed. (H-285.998 [5] and H-320.968 [2,a])

The following principles should be used for the development and application of utilization management guidelines (H-320.949):

- the criteria or guidelines used for utilization management shall be based upon sound clinical evidence and consider, among other factors, the safety and effectiveness of diagnosis or treatment, and must be age appropriate;
- utilization management guidelines and the criteria for their application shall be developed with the participation of practicing physicians;
- appropriate data, clinical evidence, and review criteria shall 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. The guidelines should also include a statement of their limitations and restrictions;
- patients and physicians should be able to appeal decisions based on the application of utilization management guidelines;
- the competence of non-physician reviewers and the availability of same-specialty peer review must be delineated and assured; and
- maintaining the best interests of the patient, the final decision to discharge a patient, or any other patient management decision, remains the prerogative of the physician.

All notifications, precertifications and appeals for medications and imaging studies should be allowed equally by phone, e-mail, fax or letter. (D-320.992)

When a health plan or 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, shall receive written notification in a timely manner that includes (H-320.948):

- the principal reason(s) for the determination;
- the clinical rationale used in making the determination; and
- a statement describing the process for appeal.

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 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. (H-285.998 [5])

A physician of the same specialty must be involved in any decision by a utilization review or management program to deny or reduce coverage for services based on questions of medical necessity. (H-285.998 [5] and H-320.968 [2,b])

Any physician who makes judgments or recommendations regarding the necessity, appropriateness, 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, and should be professionally and individually accountable for his or her decisions. (H-285.998 [5] and H-320.968 [2,d])

It is the responsibility of the utilization review program or managed care plan to credential or certify that its reviewers are appropriately licensed and have the required experience to perform review. (H-320.969 [4])

A physician whose services are being reviewed for medical necessity should be provided the identity and credentials of the reviewing physician on request. (H-285.998 [5])

A written explanation signed by the reviewing physician(s) should be attached to a denial letter issued from a utilization review program. (H-320.962 [3])

It is the role of the utilization review program or managed care plan to credential/certify that its reviewers are appropriately licensed and have the required experience to perform review. (H-320.969 [4])

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 medical staff credentials committee and/or quality assurance/utilization review committee. (H-320.969 [5])

Utilization review for insurers should be conducted by physicians licensed by the state in which they are doing the review. (H-320.973 [1])

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. (H-320.955)

Health benefit plans should disclose the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and 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. (H-285.998 [5])

Health plans should be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions, 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 patient. (H-285.998 [5] and H-320.968 [3])

Federal law should be enacted to prohibit the exemption from liability of managed care organizations, including ERISA plans, for damages resulting from their policies, procedures, or administrative actions taken in relation to patient care. (H-285.945)

Entities that impose barriers between a physician and the best interests of a patient should be liable for any injury that the patient incurs. (H-320.985 [2])

Payers should be liable for harm occurring as a result of any review decision. (H-285.995 [8])

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 have an appropriately staffed office located in the state in which they are doing the review. (H-320.973 [2])

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. (H-320.988)

Third party payer drug utilization review programs that focus only on cost containment and prevent physicians from prescribing the most appropriate drugs for individual patients should be opposed. (H-120.981 [4])

Utilization review procedures that are implemented by primary and secondary health insurance companies for a single case should be coordinated. (H-320.960 [1])

Any utilization review performed solely upon the basis of an admitting diagnosis, without actual hospital record review, is inadequate, incomplete and incapable of accuracy. (H-320.986 [2])

The coverage and utilization management requirements of secondary payers should not be applicable for patients who have Medicare indemnity as primary coverage. (H-320.960 [2])

Individual physicians should not be reprimanded by reviewing bodies for abiding by the wishes of patients when providing appropriate care to individuals who have exercised advance directives. (H-320.956 [2])

Insurance companies should treat patients with psychiatric illness no differently than they treat any other patients with respect to utilization review and precertification policies, and to afford the same degree of authority to psychiatrists as they afford to all other physicians. (H-345.982)

Volume indicators should be applied only to those treatments where outcomes have been shown by valid statistical methods to be significantly influenced by frequency of performance. (H-180.963)

Adverse decisions concerning hospital admissions should be finalized only by physician reviewers and only after the reviewing physician has discussed the case with the attending physician. (H-320.982 [2,c])

Preadmission review programs should provide for immediate hospitalization, without prior authorization, of any patient whose treating physician determines the admission to be of an emergency nature. (H-320.982 [2,d])

No preadmission review program should make a payment denial based solely on the failure to obtain preadmission review or solely on the fact that hospitalization occurred in the face of a denial for such admission. (H-320.982 [2,e])

All utilization review efforts and preauthorization requests should focus on statistical outliers, rather than routine blanket review of whole populations of physicians or all instances of particular services. (H-320.950 [1,2])

Medical necessity

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: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the convenience of the patient, physician, or other health care provider. (H-320.953 [3])

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 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. (H-285.998 [5])

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. (H-320.995 [2,b])

Physicians should carefully review their managed care contracts to ensure that they do not contain definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness. (H-320.953 [5])

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. (H-320.995 [2,b])

Determinations of medical necessity shall be based only on information that is available at the time that health care products or services are provided. (H-320.953 [7])

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 and should be professionally and individually accountable for his or her decisions. (H-285.998 [5] and H-320.968 [2,b])

A physician whose services are being reviewed for medical necessity should be provided the identity and credentials of the reviewing physician on request. (H-285.998 [5])

Legislation should require that any physician who makes judgments or recommendations regarding the

necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed. (H-320.968 [2,d])

Any managed care plan should respond within one business day to other questions regarding medical necessity of services. (H-285.998 [5] and H-320.968 [2,e])

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. (H-320.968 [2,c])

Prior authorization

All health insurers should include web-based prior authorization services among options for granting prior authorization. (H-285.912)

Any managed care plan utilizing a prior authorization program should act within two business days on any patient or physician request for prior authorization. (H-285.998 [5] and H-320.968 [2,e])

Health plans 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. In the absence of consistent and scientifically established evidence that preadmission review is cost-saving or beneficial to patients, the use of this process should be opposed. (H-285.998 [5])

Claimants should have the right to a review by a physician of the same general specialty as the attending physician of any claim or request for prior authorization denied on the basis of medical necessity. (H-320.982 [3])

Case management

With the present specialization of medical services, it is advantageous to have one individual with overall responsibility for coordinating the medical care of the patient. The physician is best suited by professional preparation to assume this leadership role. (H-285.998 [4])

The primary goal of high-cost case management or benefits management programs should be to help to arrange for the services most appropriate to the patient's needs; cost containment is a legitimate but secondary objective. In developing an alternative treatment plan, the benefits manager should work closely with the

patient, attending physician, and other relevant health professionals involved in the patient's care. (H-285.998 [4])

Appropriate payment for physician time and effort in providing case management and supervisory services is warranted for services that include, but are not limited to, coordination of care, telephone consultations, and office staff time spent in complying with third party payer protocols. (H-385.951)

Physicians should be able to charge the payer or the patient for reasonable cost incurred by spending inordinate amounts of time or effort in providing case management services required by a third party payer which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements. "Inordinate" efforts are defined as those "more costly, complex and time-consuming than the completion of standard health insurance claim forms, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage." (H-285.998 [5])

Third party payers that demand case reviews by telephone should provide payment to physicians for their reasonable charges, if any, for these medical services. (H-320.986 [1])

Any managed care plan that makes available a benefits management program for individual patients should not make payment for services contingent upon a patient's participation in the program or upon adherence to treatment recommendations. (H-285.998 [4])

Where case management or coordination might limit access to appropriate medical care, patients should have the freedom to see a physician appropriate for the services they need, regardless of specialty. Above all, the best interests of the patient must be paramount. (H-200.969 [4])

Managed care plans using the preferred provider concept should not use coverage arrangements that impair the continuity of a patient's care across different treatment settings. (H-285.998 [4])

Managed care plans should provide enrollees, on an ongoing basis, with the right to select a new primary physician from the panel of physicians, and to appeal to the plan when the patient is dissatisfied with his or her present primary physician. (H-285.914 [2])

Care management and disease management
The primary goals of disease management should be (H-285.944):

- to improve outcomes by the provision of timely and appropriate preventive, therapeutic and restorative services. Cost savings and care efficiencies resulting from such services are a secondary but legitimate objective; and
- to promote cooperation between primary care and specialty care physicians to provide a continuum of care for specific health care needs.

Managed care organizations that provide disease management should involve the patient's current primary or principal care physician in the disease management process as much as possible, and minimize arrangements that may impair the continuity of a patient's care across different settings. (H-285.944)

Disease management should continue to place major emphasis on educating and empowering patients to more successfully manage their own health and intelligently use care resources. (H-285.944 [2])

The clinical practice guidelines utilized in disease management should be developed by physicians knowledgeable in dealing with the conditions addressed, and should be updated regularly. (H-285.944 [3])

The decision to participate or not participate in a disease management program should always be the prerogative of the patient, who should be fully informed of any plan coverage conditions attendant on such decisions. (H-285.944 [4])

Physicians should be able to deviate from disease management practice guidelines without incurring sanctions or jeopardizing coverage for services, when in their judgment such deviation is indicated by the medical needs or desires of individual patients. (H-285.944 [5])

Attention to the performance of physicians in disease management programs should be triggered by concern with a physician's overall practice patterns rather than by deviation from practice guidelines in a single case. Emphasis in remedial activities should be on helping the practitioner to correct any overall performance problems identified by peer review, rather than on sanctions. (H-285.944 [6])

Non-physicians who function as care coordinators in disease management programs should be certified or licensed as physician assistants or nurse practitioners, or have at least a comparable level of training. (H-285.944 [7])

The overall authority for decisions to use or not use specialized care and ancillary or supportive services or products for patients enrolled in a disease management program should rest with the primary or principal care physician providing care in the program. (H-285.944 [8])

The primary or principal care physician in a disease management program should strive to assure effective collaboration among the different programs and personnel needed for care of patients with comorbidities, and should be routinely informed by such personnel of the services they provide. (H-285.944 [9])

Managed behavioral health organizations (MBHOs) should share their written disease management protocols with primary care and other treating physicians. When a patient is receiving treatment for mental illness and/or chemical dependency through an MBHO, with the patient's permission and in accordance with relevant legal requirements, the primary care physician should be notified immediately; and, if requested, be kept apprised of the patient's treatment (including all medications prescribed) and progress, so that the primary care and other treating physicians can coordinate the patient's health care needs in optimal fashion. (H-285.921)

Physicians who provide care in disease management programs should be fully licensed to practice medicine in the jurisdiction of the program's location, and should be professionally and legally accountable for any adverse patient events resulting from that care. (H-285.944 [10])

In disease management programs conducted by drug manufacturers, the choice of pharmaceuticals used in program formularies and for care of individual patients should not be restricted to those of the sponsoring manufacturer, but should be based on the clinical judgment of participating physicians and validated outcome studies. (H-285.944 [11])

Telephone triage and counseling

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. (H-160.935 [1])

A physician director of telephone counseling services must be responsible for (H-160.935 [2,a–e]):

- 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; and
- maintaining accountability for the patient until a referral has been effected with an accepting physician.

Telephone triage centers should routinely inform primary or principal care physicians of the disposition of all calls received from their patients. (H-285.944 [14])

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. (H-285.944 [15])

Qualified physicians should be readily accessible for consultation and second-level triage to the nurses or other health professionals providing telephone counseling or triage. (H-285.944 [16])

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. (H-285.944 [3])

Telephone counseling and triage centers should routinely compile outcome information on all calls handled, and should modify their operating policies and referral protocols as needed to enhance the effectiveness of the service. (H-285.944 [13])

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. (H-285.944 [19])

Physicians performing second level triage for telephone triage centers should be compensated for such services by the center or sponsoring health plan. (H-285.944 [17])

Compensation for individuals performing telephone counseling and triage should not be based on the number or the disposition of calls handled. (H-285.944 [18])

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. (H-285.944 [12])

Hospitalist programs

Managed care enrollees and prospective enrollees should receive prior notification regarding the implementation and use of “admitting officer” or “hospitalist” programs. (H-285.964 [1])

Participation in “admitting officer” or “hospitalist programs” developed and implemented by managed care organizations should be at the voluntary discretion of the patient and the patient’s physician. (H-285.964 [2] and H-285.960)

No punitive measure should be imposed on physicians or patients who decline participation in “hospitalists programs.” (H-285.964 [4])

Hospitalist systems when initiated by a hospital or managed care organization should be developed consistent with AMA policy on medical staff bylaws and implemented with approval of the organized medical staff to assure that the principles and structure of the autonomous and self-governing medical staff are retained. (H-285.964 [3])

Any hospitalist model that disrupts the patient/physician relationship or the continuity of patient care and jeopardizes the integrity of inpatient privileges of attending physicians and physician consultants should be opposed. (H-285.964 [5])

Financial incentives

Financial incentives should not result in the withholding of appropriate medical services or in the denial of patient access to such services. (H-285.951 [4])

Financial incentives should enhance the provision of high quality, cost-effective medical care. (H-285.951 [3])

Financial incentives generally should be based on the performance of groups of physicians rather than individual physicians. However, within a physician group, individual physician financial incentives may be related to quality of care, productivity, utilization of services, and overall performance of the physician group. (H-285.951 [8])

Appropriateness and structure of a specific financial incentive should take into account a variety of factors such as the use and level of “stop-loss” insurance, and the adequacy of the base payments (not at-risk payments) to physicians and physician groups. The purpose of assessing the appropriateness of financial incentives is to avoid placing a physician or physician group at excessive risk which may induce the rationing of care. (H-285.951 [9])

Financial incentives should not be based on the performance of physicians over short periods of time, nor should they be linked with individual treatment decisions over periods of time insufficient to identify patterns of care. (H-285.951 [7])

Payment issues

Claims submission

To encourage greater use of electronic data interchange (EDI) by physicians and improve the efficiency of electronic claims processing, public and private payers who do not currently do so should cover the processing cost of physician electronic claims and remittance advice. (H-190.978 [1,a])

Vendors, claims clearinghouses, and payers should offer physicians a full complement of EDI transactions (e.g., claims submission; remittance advice; and eligibility, coverage and benefit inquiry). (H-190.978 [1,b])

Vendors, clearinghouses, and payers should adopt American National Standards Institute (ANSI) Accredited Standard’s Committee (ASC) Insurance Subcommittee (X12N) standards for electronic health care transactions and recommendations of the National Uniform Claim Committee (NUCC) on a uniform data set for a physician claim. (H-190.978 [1,c])

All clearinghouses should act as all-payer clearinghouses (i.e., accept claims intended for all public and private payers). (H-190.978 [1,d])

Practice management systems developers should incorporate EDI capabilities, including electronic claims submission; remittance advice; and eligibility, coverage and benefit inquiry into all of their physician office-based products. (H-190.978 [1,e])

Practitioners should have free choice, without penalty, to transmit claims data either by paper claim or electronically. (H-330.954)

Receipt of each electronic claim should be acknowledged within 24 hours, and accepted or rejected within 10 business days. When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within five business days to allow prompt resubmission of a clean claim. (H-190.964 [1,2] and H-190.959 [2])

Heavy penalties should be imposed on health insurance and managed care companies, including their employees, that do not comply with the laws and regulations establishing guidelines for claims payment. (H-190.959 [3])

State and federal agencies are urged to exercise their authority over health plans to ensure that beneficiaries' claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced. (H-190.969 [1])

Private sector health care accreditation organizations are urged to: (a) develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness, and (b) require accredited health plans to provide this information to patients, physicians, and other purchasers of health care services. (H-190.969 [7])

When there is a specified filing deadline for services, this deadline should be reset when insurance companies contend that they have either not received a filed claim or require additional supporting documentation. (H-190.979)

Physician payment

Reasonable payment levels should be assured for mandated benefits in health insurance policies so as to ensure that these services are readily available to those covered by these policies. (D-385.966)

Any new “transparency” programs unveiled by health plans should be monitored to determine the impact on physicians. (D-180.985 [1])

Insurance companies, their agents, or any contractor should be limited from requesting payment back on paid claims to no more than 90 days after payment is made. A defined and acceptable process should be in place for physicians to dispute these maneuvers to get payment back on claims already processed, verified, and paid. The use of re-pricers and re-reviewers by insurance companies should be banned and they should adhere to their own pricing and reviewing guidelines as agreed upon in their contracts with physicians. (D-385.965)

Physicians should receive fair compensation for administrative costs when providing service to managed care patients. (H-385.948)

Actions should be taken to bring an end to the unilateral and unfair payment methods being used by carriers and insurance companies in their efforts to reduce payment. (D-70.988, H-70.937, H-70.949, H-70.962, H-70.980, H-70.985, and H-285.946)

The modification of procedural descriptions or conversions to different terminologies by third party employees without appropriate professional medical consultation should be opposed. (H-70.999 [1])

The practice of unilateral, arbitrary recoding and/or bundling by all payers should be vigorously opposed. (H-70.937)

Physician payment—denials/delays

Prompt payment to physicians should be assured by all third party payers. (H-385.967)

All health insurance and managed care companies should pay for clean claims submitted electronically within fourteen days and for paper claims submitted within 30 days, with interest accruing thereafter. (H-190.959 [1] and H-190.981)

The use of retrospectively denied and down-coded days by managed care organizations should be opposed. (H-285.927 [1])

Health insurers should not deny payment on lost claims discovered beyond the required filing date when the physician has proof that the electronic or paper claim was filed in a timely manner. (H-190.965)

Delayed payments to physicians and hospitals without justification by third party payers should be prohibited by law. (H-190.972)

Excessive and unnecessary requests for additional information and unexplained delays in processing and payment by third party insurance carriers should be opposed where a completed standard claim form for reimbursement has been submitted. (H-190.991 [1])

Third party insurance carriers should provide payment of claims with interest where clean claims are not paid on a timely basis. (H-190.991 [2])

The retrospective denial of payment should be opposed 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. (D-320.995 [1] and H-320.961)

Health plans should implement online appeal processes to reduce the administrative burden and cost to physicians and their patients when claims are denied inappropriately. (D-320.993 [3])

Health plans should streamline, provide transparency, and lessen the administrative burdens and costs that are incurred by physicians through the health plans appeals processes. (D-320.993 [4])

A percentage of the financial penalty and/or accrued interest should be paid directly to the physician in the cases where payers do not make payment within the specified time frame. (H-385.927)

Health plan contracts should contain a provision to permit the direct billing of patients for medical services for which authorization was denied by a health plan, which the rendering physician, based upon reasonable evidence, determines to be essential for the welfare of the patient and for which prior patient consent was obtained. (H-385.958)

Insurers should be banned from denying or reducing payment for services performed by physicians (MD and DO) based solely on their specialty. (D-385.977)

Denials of payment by a third party carrier for medical services due solely to fiscal considerations and which does not have as its primary purpose the health and safety of the patient should be opposed. (H-385.985)

Physician payment—covered benefits/exclusions

Health insurance policies should explicitly and specifically list exclusions from coverage in order that these are apparent and comparable. (H-185.971)

The health insurance industry should develop and utilize explanation of benefits language that is less misleading or inflammatory than the inaccurate and/or misleading use of the terms “usual, customary or reasonable.” (H-190.994 and H-385.989 [1])

Health plans that restrict a patient’s choice of physicians or hospitals or surgical pathology and cytopathology services should offer, at the time of enrollment and at least for a continuous one-month period annually thereafter, an optional and affordable “point-of-service” type feature so that patients who choose such plans may elect to self refer to physicians outside of the plan at additional cost to themselves. (H-285.914 [1])

Physician payment—errors

The problem of erroneous payments to insurance beneficiaries, instead of to physicians to whom they have assigned such payments, should be minimized or eliminated. (H-385.994)

A national health benefits verification system should exist which would include an obligation on the part of the insurer or managed care plan to pay physicians for any services rendered to patients whose eligibility for benefits have been verified erroneously. (H-185.981)

Public payers

Medicare

In keeping with its support for free market competition among all modes of health care delivery and financing, the AMA strongly opposes mandatory enrollment of Medicare and/or Medicaid patients in managed care plans. (H-290.984)

Medicare Advantage organizations should be required to adhere to the following guarantees to assure quality patient care to medical beneficiaries (H-330.916):

- a Medicare Advantage patient shall have the right to see a duly licensed physician of the appropriate training and specialty;
- if a Medicare Advantage plan is decertified, enrollees in that plan who are undergoing a course of treatment by a physician at the time of such termination shall continue to receive care from their treating physician until an appropriate transfer is accomplished; and
- any Medicare Advantage plan deselection of participating physicians may occur only after the physician has been given the opportunity to appeal the deselection decision to an independent review body.

Medicare managed care plans (e.g., Medicare HMOs, Medicare Choice plans, etc.) that use the RBRVS should do so in a manner that maintains the relativity of the RBRVS utilized in the traditional Medicare program. (H-330.928)

Geographic variations in capitation rates from Medicare or Medicaid should reflect only demonstrable variations in practice costs and correctly validated variations in utilization that reflect legitimate and demonstrable differences in health care need. (H-400.955 [1])

Medicare supplement insurers should be required to accept transmissions from Medicare contractors as a claim for benefits without the need for patients or physicians to submit additional claims. (H-190.962)

Medicare should provide physicians with timely Medicare patient eligibility information and change its entire claims processing system from a batch processing system to a real-time processing system. (H-190.968)

An immediate moratorium on the expansion of the Recovery Audit Contractor (RAC) program is supported, as is limiting or excluding physician billings from the authority of RAC audits altogether. (H-335.963)

Medicare postpayment utilization review and requests to recoup payments should be limited to claims that are no more than two years old from date of submission, except in cases of suspected fraud. (H-335.999)

The sharing of information generated through the Medicare utilization process or other institutional review with state licensure bodies should be opposed until hospital quality assurance committees have been notified and given a reasonable time to respond. (H-275.979)

Any patient, regardless of age or health care insurance coverage, has both the right to privately contract with a physician for wanted or needed health services and to personally pay for those services. Federal and state laws should permanently preserve the patient's basic right to privately contract with physicians for wanted or needed health care services. Limitations on patient and physician rights to contract privately that have been imposed by CMS or the private health insurance industry should be reversed. (H-380.989 [1,2,4])

Physicians should be able to negotiate (individually and as defined groups) fair contracts with private sector and public sector health plans. (H-383.991)

CMS should affirm the patient's and the physician's constitutional right to privately contract for medical services. (H-330.932 [3])

The AMA supports the right of physicians to opt out of Medicare and privately contract with patients. (H-390.854 and D-390.974)

Medicaid

The AMA advocates the same policies for the conduct of Medicaid managed care that the AMA advocates for private sector managed care plans. (H-290.985)

The following criteria should be used in federal and/or state oversight and evaluation of managed care plans serving Medicaid beneficiaries, and by physician organizations monitoring the implementation of managed care for Medicaid beneficiaries (H-290.985):

- adequate and timely public disclosure of pending implementation of managed care under a state program, so as to allow meaningful public comment;
- phased implementation to ensure availability of an adequate, sufficiently capitalized managed care infrastructure and an orderly transition for beneficiaries and providers;
- geographic dispersion and accessibility of participating physicians and other clinicians;
- education of beneficiaries regarding appropriate use of services, including the emergency department;

- availability of off-hours, walk-in primary care;
- coverage for clinically effective preventive services;
- responsiveness to cultural, language and transportation barriers to access;
- in programs where more than one plan is available, beneficiary freedom to choose his or her plan, enforcement of standards for marketing and enrollment practices, and clear and comparable disclosure of plan benefits and limitations including financial incentives on providers;
- beneficiary freedom to choose and retain a given primary physician within the plan, and to request a change in physicians when dissatisfied;
- significant participating physician involvement and influence in plan medical policies, including development and conduct of quality assurance, credentialing and utilization review programs;
- ability of plan participating physicians to determine how many beneficiaries and the type of medical problems they will care for under the program;
- adequate identification of plan beneficiaries and plan treatment restrictions to out-of-plan physicians and other providers;
- intensive case management for high utilizers and realistic financial disincentives for beneficiary misuse of services;
- treatment authorization requirements and referral protocols that promote continuity rather than fragment the process of care;
- preservation of private right of action for physicians and other providers and beneficiaries;
- ongoing evaluation and public reporting of patient outcomes, patient satisfaction and service utilization;
- full disclosure of plan physician and other provider selection criteria, and concerted efforts to qualify and enroll traditional community physicians and other existing providers in the plan; and
- realistic payment levels based on costs of care and predicted utilization levels.

State Medicaid agencies with Medicaid managed care programs should disseminate data and other relevant information to the state medical associations in their respective states on a timely and regular basis. (H-290.985 [22])

Better measurement, monitoring, and accountability systems and indices should be developed within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures

should be linked to health outcomes and access to care. (H-290.982 [11])

Medicaid programs and other third party payers should assure the inclusion of risk adjustment mechanisms in capitation rates to physicians providing care to chronically ill children and adults enrolled in managed care plans. (H-285.957)

TRICARE

In order to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan must be at minimum 100% of the RBRVS Medicare allowable. (H-385.921)

TRICARE Management Activity should implement significant increases in physician payment rates to ensure all TRICARE beneficiaries, including service members and their families, have adequate access to and choice of physicians. (D-40.991 [4,5])

Claims and payment data

The release of raw claims 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. 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 (H-406.990 [1-6]):

- 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;
- upon request of physicians [or their practice entities] to the extent the data involve services that they have provided;
- 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;
- 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];

- to other entities only if the data do not identify specific physicians [or their practice entities];
- 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; and

Any legal disclosures of raw physician-specific data must meet the following criteria (H-406.990 [6,a-d]):

- the publication or release of raw physician-specific information is deemed imperative to safeguard the public welfare;
- the raw data regarding physician claims from governmental healthcare programs is: (1) 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 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; and (2) safeguarded to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data;
- any physician profiling that draws upon raw data acknowledges that the data set is not representative of the physicians' entire patient population and uses a methodology that ensures that: (1) 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; (2) 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®; and (3) 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; and

- 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 their use, publication or release.

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