

REPORT 8 OF THE COUNCIL ON MEDICAL SERVICE (A-17)  
Prior Authorization and Utilization Management Reform  
(Resolution 820-I-16)  
(Reference Committee G)

## EXECUTIVE SUMMARY

At the 2016 Annual Meeting, the House of Delegates adopted Council on Medical Service Report 7-A-16, “Prior Authorization Simplification and Standardization,” which established directives (See Policies D-120.938, D-320.987, and D-320.986) for the American Medical Association (AMA) to support state legislation to restrict use of medical step therapy programs; establish a set of best practices regarding utilization management requirements and advocate with health plans, accreditation organizations, and other relevant stakeholders to adopt these principles; and explore and report on potential funding sources and mechanisms to pay for time and expertise expended pursuing prior authorization procedures. Additionally, at the AMA 2016 Interim Meeting, the House of Delegates referred Resolution 820-I-16, “Retrospective Payment Denial of Medically Appropriate Studies, Procedures and Testing.” The Board of Trustees referred this issue to the Council on Medical Service for a report back to the House of Delegates. Resolution 820-I-16 asked the AMA to advocate for legislation to require insurers’ medical policies to reflect current evidence-based medically appropriate studies and a streamlined process for exceptions for rare or uncommon disease states, as well as prohibit insurers’ use of medical coding as the sole justification to deny payment for medical services and testing.

In its study of these issues, the Council highlights the AMA’s work with state medical associations and national medical specialty societies to address utilization management issues, including step therapy, with state legislation. As directed by Policy D-320.987, the AMA, in partnership with a coalition of 16 other organizations representing physicians, hospitals, pharmacists, and patients, released the Prior Authorization and Utilization Management Reform Principles (the “Principles”) in early 2017. The Council believes that the early response to the advocacy and outreach campaign associated with the Principles has been promising and notes that the AMA’s research efforts to quantify prior authorization burdens have provided important support to these efforts. In exploring the potential sources of physician payment for the completion of prior authorization, the Council considers a variety of logistical and practical factors related to pursuing this strategy. The Council also recognizes the importance of health plans’ medical policies and coverage criteria being based on sound clinical evidence and examines the need for intensive health plan clinical review of claims.

The Council recommends that the AMA continue its extensive advocacy campaign based on the Principles and complete ongoing research on prior authorization burdens to further support this work. While recognizing the associated administrative hassles and clinical burdens, the Council proposes that the AMA refrain from actively seeking physician compensation for prior authorizations due to logistical and practical challenges, as well as the risk of undermining the collaborative outreach efforts associated with the Principles. The Council also recommends reaffirmation of existing policy regarding coverage for medically necessary treatment and creation of new policy supporting increased review of appeal determinations (beyond medical coding alone) by health plans. Finally, the Council recognizes that the AMA’s work to reduce prior authorization requirements could lead to the unintended and undesired consequence of increased post-payment reviews and therefore suggests reaffirmation of policy addressing concerns related to retrospective payment denials and review.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-A-17

Subject: Prior Authorization and Utilization Management Reform  
(Resolution 820-I-16)

Presented by: Peter S. Lund, MD, Chair

Referred to: Reference Committee G  
(J. Clay Hays, MD, Chair)

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1 At the 2016 Annual Meeting, the House of Delegates adopted Council on Medical Service Report  
2 7-A-16, “Prior Authorization Simplification and Standardization.” The report established  
3 the following directives:

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5 Policy D-120.938: That our American Medical Association (AMA) address the negative  
6 impact of medication step therapy programs on patient access to needed treatment by  
7 supporting state legislation that places limitations and restrictions around the use of such  
8 programs and their interference with a physician’s best clinical judgment;

9  
10 Policy D-320.987: That our AMA, in collaboration with state medical associations and  
11 national medical specialty societies and relevant patient groups, create a set of best practices  
12 for prior authorization (PA) and possible alternative approaches to utilization control; advocate  
13 that accreditation organizations include these concepts in their program criteria; and urge  
14 health plans to abide by these best practices in their PA programs and to pilot PA alternative  
15 programs; and

16  
17 Policy D-320.986: That our AMA explore and report on potential funding sources and  
18 mechanisms to pay for time and expertise expended pursuing prior authorization procedures.  
19

20 Additionally, at the 2016 Interim Meeting, the House of Delegates referred Resolution 820-I-16,  
21 “Retrospective Payment Denial of Medically Appropriate Studies, Procedures and Testing,” which  
22 was introduced by the Pennsylvania Delegation. The Board of Trustees referred this issue to the  
23 Council on Medical Service for a report back to the House of Delegates. Resolution 820-I-16 asked:

24  
25 That our AMA advocate for legislation to require insurers’ medical policies to reflect current  
26 evidence-based medically appropriate studies and treatments including those for rare and  
27 uncommon diseases;

28  
29 That our AMA advocate for legislation to require insurers to implement a streamlined process  
30 for exceptions for rare or uncommon disease states; and

31  
32 That our AMA advocate for legislation to prohibit insurers from using medical coding as the  
33 sole justification to deny medical services and diagnostic or therapeutic testing.

1 This report addresses the directive policies established with the adoption of the recommendations in  
2 Council on Medical Service Report 7-A-16 and responds to referred Resolution 820-I-16. It provides  
3 an update on current AMA PA-related advocacy efforts, including the Prior Authorization and  
4 Utilization Management Reform Principles and state legislative activities; describes AMA research  
5 activities aimed at quantifying the burden and negative effects of PA and other utilization management  
6 (UM) processes; and discusses the feasibility of physicians obtaining financial compensation for PA.  
7 Additionally, this report reviews existing policy and coding guidelines applicable to payment denials.  
8

## 9 BACKGROUND

10  
11 Health plans employ PA, step therapy, and other forms of UM to control their members' access to  
12 certain treatments and reduce health care expenses. As detailed in CMS Report 7-A-16, UM  
13 requirements often involve very manual, time-consuming processes that can divert valuable and scarce  
14 physician resources away from direct patient care. More importantly, PA and other UM methods  
15 interfere with patients receiving the optimal treatment selected in consultation with their physicians. At  
16 the very least, UM requirements can delay access to needed care; in some cases, the barriers to care  
17 imposed by PA and step therapy may lead to the patient receiving less effective therapy, no treatment  
18 at all, or even potentially harmful therapies.  
19

20 The issues discussed in Council on Medical Service Report 7-A-16 and raised in Resolution 820-I-16  
21 both reflect growing concerns over health plans' interference with physicians' clinical judgment and  
22 patients' access to prescribed treatment. The increasing patient harms and practice burdens associated  
23 with UM requirements necessitate a broad-based, comprehensive advocacy strategy to effect  
24 meaningful change in health plans' programs and policies. Given the challenging and multi-faceted  
25 nature of these issues, careful examination and evaluation of the suggested approaches is needed to  
26 identify the most viable and impactful strategies.  
27

## 28 RELEVANT AMA ADVOCACY

29  
30 PA and other UM programs are a high-priority advocacy target for the AMA. As summarized below,  
31 several current AMA initiatives address the directives established with Council on Medical Service  
32 Report 7-A-16 and strengthen the AMA's ability to effectively advocate on UM issues.  
33

### 34 *State Legislative Activity*

35  
36 In response to the numerous concerns raised by AMA members and the Federation of Medicine, the  
37 AMA's Advocacy Resource Center works closely with state medical associations and national medical  
38 specialty societies to address PA and other UM-related issues through state legislation. The AMA's  
39 model bill on PA, the "Ensuring Transparency in Prior Authorization Act," addresses a variety of  
40 concerns related to UM programs, including response timeliness, clinical qualifications of health  
41 plans' UM staff, duration of authorizations, public reporting of UM program results, and electronic  
42 PA. The bill also places limitations on plans' step therapy requirements, consistent with Policy  
43 D-120.938.  
44

45 Through close collaboration and strong efforts of the AMA and state medical associations, several  
46 PA/step therapy bills that were based largely on the AMA's model legislation were passed by state  
47 legislatures in 2016. Of particular note were comprehensive bills passed by Ohio and Delaware. The  
48 Prior Authorization Reform Act of Ohio, signed into law in June 2016, limits retrospective denials,  
49 requires advance notification of PA policy changes, mandates timely responses to PA requests, and  
50 incorporates several other aspects of the AMA's model bill. Additionally, the Delaware General  
51 Assembly passed legislation establishing mandatory reporting of PA statistics to public databases,

1 advanced notice of new PA requirements, mandatory time limits for responses, limits on retrospective  
2 denials, and a requirement that pharmaceutical PAs be valid for one year. The AMA intends to build  
3 off of these legislative successes and work with the Federation of Medicine to advance additional  
4 UM-related state legislation.

5  
6 *Prior Authorization and Utilization Management Reform Principles*  
7

8 To improve care access and reduce practice burdens, and in accordance with Policy D-320.987, the  
9 AMA convened a 17 member workgroup of state medical associations and national medical specialty  
10 societies, national provider associations, and patient representatives to create a set of best practices  
11 related to PA and other UM requirements. The workgroup identified the most common provider and  
12 patient complaints associated with UM programs and developed 21 Prior Authorization and Utilization  
13 Management Reform Principles (“the Principles”; see [https://www.ama-](https://www.ama-assn.org/sites/default/files/media-browser/principles-with-signatory-page-for-slsc.pdf)  
14 [assn.org/sites/default/files/media-browser/principles-with-signatory-page-for-slsc.pdf](https://www.ama-assn.org/sites/default/files/media-browser/principles-with-signatory-page-for-slsc.pdf)) to address these  
15 priority concerns. The Principles, which are based on AMA policy, seek to improve PA and UM  
16 programs by addressing the following five broad categories of concern:  
17

- 18 1. Clinical validity
- 19 2. Continuity of care
- 20 3. Transparency and fairness
- 21 4. Timely access and administrative efficiency
- 22 5. Alternatives and exemptions

23  
24 These “best practice” principles serve as the foundation for an ongoing, extensive, multi-pronged  
25 advocacy campaign to reform and improve UM programs. As part of the campaign, workgroup  
26 members directly advocate with health plans, benefit managers, and other UM entities to voluntarily  
27 adopt these principles; urge accreditation organizations, such as the National Committee for Quality  
28 Assurance and the Utilization Review Accreditation Commission, to include these concepts in criteria  
29 for utilization review programs; introduce bills based on these principles to state legislatures;  
30 encourage technological standards organizations to support improved UM processes; and promote the  
31 Principles in a variety of media and communication outlets to raise awareness of the requested  
32 reforms. As part of this campaign, the AMA issued a press release publicizing the Principles, which  
33 received significant coverage in various media outlets. Additionally, the AMA sent letters to the major  
34 national health plans, pharmacy benefit managers, and accreditation bodies that urged alignment of  
35 these organizations’ UM programs or accreditation criteria with the Principles.  
36

37 While the campaign was still in its early stages at the time that this report was written, response to  
38 these initial outreach efforts has been promising. Shortly after the release of the Principles, both Blue  
39 Cross Blue Shield of Western New York and BlueShield of Northeastern New York announced that  
40 they were eliminating PA requirements for more than 200 medical services. The AMA outreach letters  
41 have resulted in several meetings to discuss the Principles with national health plans and other key  
42 stakeholders. In addition, more than 80 medical societies and other health care organizations have  
43 signed on as “supporters” of the Principles. The AMA will continue to engage insurers, employer  
44 coalitions, and other relevant organizations in discussions about the Principles and will identify other  
45 impactful opportunities to promote the Principles throughout the industry to achieve PA reform.  
46

47 *PA Research*  
48

49 The lack of alignment between physician and health plan interests on PA and other UM programs  
50 create significant challenges to achieving meaningful reform on this issue. Recognizing the key role  
51 that credible evidence plays in successful advocacy on this topic, the AMA engaged in two research

1 projects to gather data regarding the impact of PA on patients and physician practices. The following  
2 research projects are designed to inform and strengthen the AMA's ongoing efforts to reduce the  
3 practice burdens associated with UM programs.  
4

5 PA physician survey – In conjunction with a market research partner, the AMA fielded a web-  
6 based, 24-question survey to 1000 practicing physicians in December 2016. The national  
7 sample comprised 40 percent primary care and 60 percent specialty physicians and included  
8 only physicians who routinely complete PAs in their practice. The survey provided the  
9 following key takeaways:  
10

- 11 • Seventy-five percent of physicians reported that the burden associated with PA for their  
12 practice is either high or extremely high;
- 13 • Practices complete an average of 37 PAs per physician per week, which take the physician  
14 and his/her staff an average of 16 hours—the equivalent of 2 business days—to process;
- 15 • Ninety percent of physicians reported that PA delays patients' access to necessary care;
- 16 • More than one-third of physicians reported they have staff who work exclusively on  
17 processing PAs;
- 18 • Nearly 60 percent of physicians reported waiting, on average, at least 1 business day for  
19 PA decisions from health plans—and 26 percent of physicians reported waiting at least 3  
20 business days;
- 21 • Seventy-nine percent of PA requests are eventually approved (72 percent approved on  
22 initial request and seven percent on appeal);
- 23 • Eighty percent of physicians reported they are sometimes, often, or always required to  
24 repeat PAs for prescription medications when a patient is stabilized on a treatment for a  
25 chronic condition; and
- 26 • Fax and telephone were the most commonly reported ways for completing both medical  
27 and prescription PAs.  
28

29 The survey results ([https://www.ama-assn.org/sites/default/files/media-  
30 browser/public/government/advocacy/2016-pa-survey-results.pdf](https://www.ama-assn.org/sites/default/files/media-browser/public/government/advocacy/2016-pa-survey-results.pdf)) served as a valuable  
31 framework for the public release of the Prior Authorization and Utilization Management  
32 Reform Principles and have provided a strong evidence base for other AMA advocacy efforts  
33 related to PA.  
34

35 Academic PA research project – The AMA is partnering with the University of Southern  
36 California Schaeffer Center for Health Policy & Economics on an academic research project  
37 to assess the growing impact of PA on physician practices and patients. Through analysis of  
38 both Medicare Part D drug claims and clinical and claims data from a Federally Qualified  
39 Health Center, this project seeks to establish the overall impact of PA on factors such as total  
40 health care costs and patient outcomes. The current project plan includes a broad analysis of  
41 PA trends, as well as a case study examining the impact of PA for a specific class of drugs and  
42 disease state on patient outcomes and overall medical costs. The goal of this project is to  
43 generate multiple manuscripts for submission to peer-reviewed publications. These anticipated  
44 journal articles should make an important contribution to both the scientific literature on UM  
45 programs and future AMA advocacy.  
46

#### 47 PAYMENT FOR PA

48

49 In addition to the state legislative activities and PA Principles described above, Council on Medical  
50 Service Report 7-A-16 established Policy D-320.986, which directed the AMA to explore “potential

1 funding sources and mechanisms to pay for time and expertise expended pursuing prior authorization  
2 procedures” as another potential strategy for addressing PA burdens. Long-standing AMA policy  
3 supports compensating physicians for the time required to complete PAs on behalf of their patients  
4 (e.g., Policies H-320.968 and H-385.951). Furthermore, Current Procedural Terminology (CPT)  
5 code 99080 supports payment for fulfilling health plans’ administrative requirements such as PA.  
6 However, despite the existence of both policy and tools to support payment for PA, the Council  
7 testified in the reference committee against pursuing this strategy, noting that it was unaware of any  
8 major health plans that are currently compensating physicians for PA work using CPT code 99080  
9 and the unlikelihood that health plans would agree to pay for PA.

10  
11 Supportive testimony for pursuing the payment-for-PA approach cited the 2008 *Gibson v. Medco* case  
12 from the Trumbull County District Court in Ohio.<sup>1</sup> In that case, a judge ruled that the defendant, a  
13 pharmacy benefit manager, was required to pay the physician for his time spent completing PA forms  
14 for prescription medications. Although there was no contract controlling the judgment, the judge noted  
15 that Medco required physicians to pay a \$75 fee for any information requests submitted to Medco, and  
16 he concluded that the physician should have the same right to collect fees for information requests that  
17 the company requires as part of PA.

18  
19 While the *Gibson* case may initially seem encouraging to physicians interested in collecting payment  
20 for PA, the facts of the case and the decision’s lack of precedential authority (as only appellate courts  
21 carry such authority) limit its broad applicability. The court assigned particular importance in the  
22 *Gibson* case to the processing fees charged by Medco for physician inquiries and the lack of  
23 contractual relationship between the physician and the UM entity. These characteristics are not  
24 common traits to most of the PA processes burdening physicians today. The information-request  
25 processing fee assigned by Medco is not a standard practice throughout the industry, and terms of  
26 network participation almost uniformly require physicians to meet the UM requirements of the health  
27 plan or any agents/subcontractors, including benefit managers such as Medco.

28  
29 Even if the *Gibson* decision were broadly applicable, physicians would face several logistical  
30 challenges in obtaining payment for PA from health plans and benefit managers. First, assigning a  
31 specific payment amount to CPT code 99080 would be challenging, as time and administrative costs  
32 likely vary greatly by the specific PA request. PA denials pose another problem for this compensation  
33 model, as it is questionable if health plans would pay physicians to complete PAs for treatment that the  
34 patient never actually receives. Technological issues may also hinder payment for drug PAs, as most  
35 physicians are not equipped to create and submit electronic claims to pharmacy benefit managers.  
36 Even if physicians were successful in obtaining compensation for PA, the payment rate assigned by  
37 health plans would likely be unacceptably low from physicians’ perspectives. Indeed, the court  
38 awarded only \$187.50 to the physician in the *Gibson* case.

39  
40 As an alternative to pursuing health plan payment for PAs, physicians could theoretically seek  
41 compensation from the patient. While patients are a potential funding source for PA work, there are  
42 multiple issues with this approach. Most health plan network participation contracts bar physicians  
43 from billing patients for completion of UM processes, and any physician who chose to bill patients for  
44 PA would be violating these terms of participation and putting his/her network status at risk.  
45 Additionally, by shifting the burden of compensation to the patient, physicians would be introducing a  
46 barrier to care for patients who are unwilling or unable to pay the PA rate. Such a scenario also could  
47 significantly harm the patient/physician relationship and negatively impact patients’ satisfaction with  
48 their care.

49  
50 In its Report 7-A-16, the Council noted that actively pursuing compensation for PA could conflict with  
51 the AMA’s other advocacy efforts on this issue. As described above, the AMA is vigorously working

1 to reform and reduce health plans' overall use of PA and other UM programs. If the AMA were to  
2 undertake and achieve widespread compensation for PA, a perverse and unintended consequence  
3 could be an overall increase in PA requirements, as health plans could use payment as justification for  
4 additional utilization review. Furthermore, the patient care barriers and delays associated with UM  
5 requirements form one of the key persuasive arguments in the AMA's advocacy campaign for PA  
6 reform. Pursuing payment for PA suggests that physicians find PA to be an acceptable practice so long  
7 as they receive compensation for this administrative work, which could undercut the central message  
8 of the AMA's current UM reform efforts.

#### 9 10 PAYMENT DENIAL FOR MEDICALLY APPROPRIATE TREATMENT

11  
12 Referred Resolution 820-I-16 underscores many of the previously discussed concerns regarding health  
13 plans' interference with physicians' clinical judgment and patients' access to medically necessary  
14 treatment. Specifically, the resolution references health plans' use of outdated policy, improper  
15 medical coding edits, or overly rigid medical necessity definitions that fail to take into account  
16 complexities caused by comorbidities as causes for payment denials. The resolution cites the example  
17 of health insurers' failure to cover payment for dual-energy x-ray absorptiometry (DEXA) scans for  
18 patients with sickle-cell disease, despite substantial clinical evidence showing the use of such scans to  
19 be medically appropriate for the diagnosis and treatment of these patients. The resolution asks that the  
20 AMA work to ensure that health plans have medically accurate and up-to-date payment policies and  
21 that there is a streamlined process to ensure payment approval for appropriate treatment of rare  
22 diseases. Additionally, the resolution asks that medical coding not be the sole justification for a  
23 medical insurer's denial of payment.

24  
25 AMA policy states that health plans should base coverage decisions on current clinical information  
26 and support exceptions processes so that patients may receive needed care. For example, Policy  
27 H-320.949 states that UM criteria should be based upon sound clinical evidence, permit variation to  
28 account for individual patient differences, and allow physicians to appeal decisions. Policy H-285.998  
29 states that the medical protocols and review criteria used in UM programs must be developed by  
30 physicians. In line with the asks of Resolution 820-I-16, Policy H-320.945 states that preauthorization  
31 should not be required when a treatment is customary, properly indicated, and supported by peer-  
32 reviewed medical publications.

33  
34 In addition to the above-cited policies, the requests of Resolution 820-I-16 parallel concepts included  
35 in the Prior Authorization and Utilization Management Reform Principles created pursuant to Policy  
36 D-320.987. The principles related to clinical validity and administrative efficiency capture the  
37 resolution's concerns regarding health plan policies being based on clinically appropriate criteria, the  
38 availability of an appeal or exception process, and the streamlining of medical necessity determination  
39 methods. State legislative activity is one of the advocacy channels for these Principles; the legislative  
40 ask of the resolution is therefore included in the PA reform workgroup's ongoing advocacy campaign.

41  
42 Resolution 820-I-16 also seeks advocacy to prohibit insurers from using medical coding as the sole  
43 justification to deny payment for medical services and diagnostic or therapeutic testing. As noted in  
44 the I-16 reference committee report, Policy H-70.914 states that the AMA opposes limitations in  
45 coverage for medical services based solely on diagnostic code specificity. The reference committee  
46 also correctly reported that traditionally, when a diagnosis has not been established or when a code  
47 does not exist for a specific rare disease, general coding guidelines allow for the use of codes that  
48 describe signs and symptoms. In addition, prohibiting claim denials based solely on medical coding  
49 could have the unintended consequence of undermining the current electronic claims adjudication  
50 system, which heavily relies upon medical coding to support automated processing. The use of  
51 medical coding in health care payments facilitates machine processing of claims and significantly

1 reduces adjudication and payment time. Elimination of a codified system for payment approval or  
 2 denial would require manual claim review and result in significant administrative efficiency losses.

3 While the requests of Resolution 820-I-16 focus on claims and initial payment determinations and are  
 4 accomplished through existing policy and coding guidelines, these concerns merit further  
 5 consideration in relationship to appeals. After an initial claim denial, it is reasonable to expect health  
 6 plans to perform a more comprehensive review upon a physician's appeal. Manual review of appeals  
 7 by a physician of similar training to the ordering physician can ensure that physicians and patients  
 8 receive appropriate consideration for coverage of proposed treatment. A detailed, specialty-specific  
 9 review of appeals that includes consideration of all pertinent facts of the clinical case protects patients'  
 10 access to medically necessary treatment.

11  
 12 Furthermore, as its title indicates, Resolution 820-I-16 seeks to ensure that physicians are paid for the  
 13 delivery of medically appropriate care and are not subject to improper retrospective denials. It is  
 14 important that our AMA underscore its commitment to ensuring that physicians receive payment for  
 15 services as expected, especially given our proposed changes to UM systems. The AMA's efforts to  
 16 reform PA programs should not be construed as tacit acceptance of increased post-payment audits or  
 17 retrospective claim denials by health plans. Existing policy already addresses a variety of concerns  
 18 regarding post-payment reviews and retrospective denials. For example, Policies H-320.961 and  
 19 H-320.948 oppose claim denials for previously authorized services and support provision of clinical  
 20 justification to physicians and patients for any retrospective claim denials. Policies D-320.991,  
 21 H-330.921, H-335.981, and H-335.999 support transparency, fairness, and limitations in post-payment  
 22 reviews.

23  
 24 **DISCUSSION**

25  
 26 The Council recognizes the value and importance of the AMA's current multi-pronged advocacy  
 27 efforts related to PA. The recent successes in Delaware and Ohio to achieve meaningful reform in  
 28 health plans' UM programs illustrate the effectiveness of a state approach to this issue and lead the  
 29 Council to recommend continued activity in this area. The favorable initial response to and media  
 30 attention from the release of the Prior Authorization and Utilization Management Reform Principles  
 31 bode well for the ability of the AMA and its coalition partners to effect positive change in PA  
 32 programs. The Council recommends that the AMA maintain the intensity of the current campaign,  
 33 continue to follow through with various stakeholders, and reach out to additional potential partners to  
 34 promote adoption of the Principles. All of these advocacy activities require a solid evidence base to  
 35 establish the patient impact and practice burden of UM burdens. The Council therefore also  
 36 recommends that the AMA continue its efforts to promote the results of the Prior Authorization  
 37 Physician Survey and complete the PA research project with the USC Schaeffer Center for Health  
 38 Policy & Economics.

39  
 40 Given the substantial practice time burdens imposed by PA programs reported in the Prior  
 41 Authorization Physician Survey, it is understandable that physicians would desire compensation for  
 42 PA work. However, after a review of potential funding sources for PA compensation, the Council  
 43 believes that diverting advocacy resources to focus on this particular endeavor is not in the best  
 44 interest of physicians. As described in this report, existing policy and CPT coding support payment for  
 45 PA completion; however, logistical and practical challenges make it unlikely that health plans will  
 46 routinely compensate physicians for completing UM requirements. While the 2008 *Gibson v. Medco*  
 47 case may initially seem promising, the Council's close examination of the case specifics reveals a lack  
 48 of broader applicability. Finally, the Council notes that pursuance of payment for PA may undermine  
 49 the AMA's other strong and effective activities to reduce PA burdens. To avoid threatening the  
 50 success of the AMA's current campaign related to the Prior Authorization and Utilization

1 Management Reform Principles and other PA-related activities, the Council believes that the AMA  
2 refrain from efforts to seek physician compensation for PA work.  
3 Ensuring that patients have timely access to medically necessary care forms the key underlying  
4 concept behind all of the AMA's efforts related to UM reform. The Council notes that existing policy  
5 addresses the need for coverage decisions and UM criteria to be based on sound clinical evidence and  
6 allows for individual patient differences, as requested in Resolution 820-I-16. Existing policy and  
7 general coding guidelines also support the flexibility in coding referenced in the resolution. However,  
8 a strict prohibition of claims denials being based on medical coding alone could have the unintended  
9 consequence of interfering with electronic claims processing. As such, the Council recommends  
10 reaffirmation of existing policy regarding coverage for medically necessary treatment while refraining  
11 from an outright prohibition of payment denials based on coding. The Council also notes that the  
12 advocacy campaign associated with the Prior Authorization and Utilization Management Reform  
13 Principles will accomplish many of the objectives, including state legislative activity, mentioned in the  
14 resolution.

15  
16 The Council believes that the increased level of review for initial coverage determinations referenced  
17 in Resolution 820-I-16 would be more effective for health plans' appeals systems. After an initial  
18 coverage denial, health plans should engage in a more detailed level of review for appeals that extends  
19 beyond coding and includes consideration of any clinical documentation submitted by the physician.  
20 As such, the Council recommends adoption of policy establishing that appeal decisions should not be  
21 based solely on medical coding, but rather on the direct review of a physician of the same  
22 specialty/subspecialty as the prescribing/ordering physician.

23  
24 The issues with retrospective denials cited in Resolution 820-I-16 are both long-standing and of  
25 particular current relevance given the AMA's extensive activities related to UM. To ensure that any  
26 reductions in PA requirements do not result in a subsequent increase in health plan post-payment  
27 reviews and audits, the AMA should reiterate its global concern with administrative burdens related to  
28 medical necessity reviews, whether these processes occur prior to or after the claim payment. Health  
29 plans' post-payment reviews impose many of the same administrative burdens on practices as  
30 prepayment UM programs, with the additional potential harm of recoupment of previously paid  
31 claims. The Council therefore recommends reaffirmation of policies addressing concerns related to  
32 retrospective denials and post-payment audits.

33  
34 Finally, the Council recommends rescinding the directive policies established with Council on  
35 Medical Service Report 7-A-16 (D-120.938, D-320.987, and D-320.986), all of which have been  
36 accomplished with AMA advocacy efforts as detailed in this report.

### 37 38 RECOMMENDATIONS

39  
40 The Council on Medical Service recommends that the following be adopted in lieu of Resolution  
41 820-I-16 and that the remainder of the report be filed:

- 42  
43 1. That our American Medical Association (AMA) continue its widespread prior authorization  
44 (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization  
45 and Utilization Management Reform Principles, AMA model legislation, Prior Authorization  
46 Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is  
47 aimed at reducing PA administrative burdens and improving patient access to care. (New  
48 HOD Policy)
- 49  
50 2. That our AMA oppose health plan determinations on physician appeals based solely on  
51 medical coding and advocate for such decisions to be based on the direct review of a physician

1 of the same medical specialty/subspecialty as the prescribing/ordering physician. (New HOD  
2 Policy)

3  
4 3. That our AMA reaffirm Policies H-320.948 and H-320.961, which encourage sufficient  
5 clinical justification for any retrospective payment denial and prohibition of retrospective  
6 payment denial when treatment was previously authorized, and Policies D-320.991,  
7 H-330.921, H-335.981, and H-335.999, which address fairness and limitations in  
8 post-payment reviews. (Reaffirm HOD Policy)

9  
10 4. That our AMA reaffirm Policy H-320.949, which states that utilization management criteria  
11 should be based upon sound clinical evidence, permit variation to account for individual  
12 patient differences, and allow physicians to appeal decisions, and Policies H-285.998 and  
13 H-320.945, which further underscore the importance of a clinical basis for health plans'  
14 coverage decisions and policies. (Reaffirm HOD Policy)

15  
16 5. That our AMA rescind Policies D-120.938, D-320.987, and D-320.986. (Rescind AMA  
17 Policy)

Fiscal Note: Less than \$500.

#### REFERENCES

<sup>1</sup> *Gibson v. Medco Health Solutions*, Trumbull Cnty. C.D. Ct. No. CVF-06-00106 (Mar. 6, 2008).