Whereas, Retrospective chart review is commonly used by insurers and others to determine their perspective on appropriateness of hospital admission, length of stay in other payment parameters; and

Whereas, Guidelines for hospital admission and length of stay in other clinical parameters are set by the Centers for Medicare and Medicaid Services (core measures, quality metrics, etc.); and

Whereas, These guidelines are constantly changing and being updated by CMS; and

Whereas, Retrospective chart review may occur two years or more after the service has been rendered and paid for; and

Whereas, Insurance companies, peer review organizations and others retrospectively review two-year-old charts using current guidelines, resulting in adverse determinations based on these new guidelines that were not in place at the time that the care was provided; and

Whereas, Unfair judgments are being rendered on payment for services provided in a different regulatory environment than when the service was provided; therefore be it

RESOLVED, That our American Medical Association seek legislation/regulation that requires insurance companies, peer review organizations and the Centers for Medicare and Medicaid Services to use the review criteria that existed at the time that services were provided when making their determinations. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 04/25/18
RELEVANT AMA POLICY

Physicians’ Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans H-320.948
It is the policy of our AMA, 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: (1) the principal reason(s) for the determination; (2) the clinical rationale used in making the determination; and (3) a statement describing the process for appeal.

Physicians’ Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans D-320.995
(1) Our AMA will re-distribute its model legislation that would prevent the retrospective denial of payment for any claim for services for which a physician had previously obtained authorization.
(2) Our AMA will work with private sector accreditation organizations to ensure that their health plan and utilization management accreditation standards adequately address fair and appropriate mechanisms for retrospective review.
(3) AMA’s Private Sector Advocacy unit will work with state medical associations, county medical societies, and national medical specialty societies to (a) develop a survey instrument for use by the Federation to gather information from physicians who experience retrospectively denied and/or down-coded claims, (b) seek information on a regular basis from those associations that collect such information, and (c) respond with appropriate legislation, advocacy, and communication initiatives.

See also: Managed Care H-285.998