

AMERICAN MEDICAL ASSOCIATION PRIVATE PRACTICE PHYSICIANS SECTION

Resolution 2
(June 2021)

Introduced by: Alex Shteynshlyuger, MD

Subject: CPT Denials / Service / Preauthorization Denials

Referred to: PPS Reference Committee

- 1 Whereas, Our American Medical Association (AMA) has previously affirmed that physicians and
2 healthcare practices should be fairly compensated for work involved in administrative work; and
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4 Whereas, The AMA CPT® Editorial Panel is authorized by the AMA Board of Trustees to revise,
5 update, or modify Current Procedural Terminology (CPT) codes, descriptors, rules, and
6 guidelines; and
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8 Whereas, Studies have shown that wrongful adverse determinations by health plans are
9 common, including denial of prior authorization, denial of payment for previously provided
10 service; and
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12 Whereas, Good public and economic policy must align costs, benefits and incentives; currently,
13 all costs in appealing wrongful denials are incurred by healthcare providers and all financial
14 savings and benefits from wrongful denials accrue to health insurance plans leading to perverse
15 incentive that disadvantage patients and endanger their health; and
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17 Whereas, Healthcare providers cannot afford to advocate on patients' behalf to reverse
18 wrongfully denied medically necessary services while health plans have a perverse incentive to
19 deny medically necessary services knowing that healthcare providers cannot afford to appeal
20 every wrongful denial of service; and
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22 Whereas, Compensation for work performed by healthcare providers is accomplished via CPT
23 codes; therefore be it
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25 RESOLVED, That our American Medical Association support and create CPT codes to provide
26 adequate compensation for administrative work involved in successfully appealing wrongful
27 denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or
28 post-service denials, that reflect the actual time expended by physicians and healthcare
29 practices to advocate on behalf of patients, appeal wrongful denials, and to comply with insurer
30 and legal requirements and that compensate physicians fully for the time, effort, and legal risks
31 inherent in such work (Directive to Take Action); and be it further
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33 RESOLVED, That our AMA create CPT codes for primary, secondary, and tertiary appeals to
34 independent review organizations (IROs), state and federal regulators, and ERISA plan
35 appeals, including codes for appeals, reconsiderations, and other forms of appeals of adverse
36 determination (Directive to Take Action); and be it further
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38 RESOLVED, That our American Medical Association will include fair compensation based on
39 CPT codes for appeal of wrongfully denied services in any model legislation and as a basis for
40 all advocacy for prior authorization reforms (Directive to Take Action).

Fiscal Note: Not yet determined

Received: 4/20/21

RELEVANT AMA POLICY

Remuneration for Physician Services H-385.951

1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.

Citation: Sub. Res. 814, A-96; Reaffirmed: A-02; Reaffirmed: I-08; Reaffirmed: I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmed: A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19

Prior Authorization Reform D-320.982

Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.

Citation: Res. 704, A-19

CPT Coding H-70.992

The AMA continues to support a national uniform descriptor system including, but not limited to, the following initiatives: (1) accelerate the process followed by the AMA CPT Editorial Panel, as feasible, to effect expeditiously changes by adding or deleting codes and nomenclature in order to keep CPT-4 as the best single source for up-to-date reference; (2) encourage CMS to direct Medicare carriers to refrain from unilateral deletion of CPT descriptors; and (3) work with national medical specialty societies and state medical associations to review the current status of local carrier descriptor systems and work with CMS to develop an oversight mechanism to monitor carrier compliance with CMS directives on the appropriate use of the national coding system.

Citation: Sub. Res. 47, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

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.

Citation: CMS Rep. 5, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Sub. Res. 728, A-10; Reaffirmed: A-18