REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 01-JUN-21

Subject: Council on Medical Service's Sunset Review of 2011 House Policies

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another ten years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its ten-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

RECOMMENDATION

The Council on Medical Service recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

Policy #	Title	Text	Recommendation
D-125.992	Opposition to Prescription Prior Approval	Our AMA will urge public and private payers who use prior authorization programs for prescription drugs to minimize administrative burdens on prescribing physicians. (Sub. Res. 529, A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 822, I-11)	Retain. Still relevant.
D-165.985	Evolving Internet-Based Health Insurance Marts	Our AMA will continue to monitor the evolution of the Internet-based health benefits industry and report to the House of Delegates on important developments. (CMS Rep. 5, A-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. Superseded by Policy H-165.839, which states: 1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges: A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features. B) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians. C) Physician and patient decisions should drive the treatment of individual patients. D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options.

Policy #	Title	Text	Recommendation
			E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process. F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices. 2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion of physicians based on conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information.
D-385.960	Appropriate Payments for Vaccine Price Increases	Our AMA will work with national specialty societies to educate physicians to include language in their health insurer contracts to provide for regular updating of vaccine prices and payment levels, which should include	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		real-time adjustments in vaccine pricing. (Res. 807, I-11)	
D-390.958	The Impact of National Physician Payment Reductions on the National Unemployment Rate	Our AMA will expand its previous studies on the economic impact on the medical practice for the purpose of developing data on the negative economic impact on physician practice employees and communities of incremental SGR cuts and will include in future communications with the US Congress, other stakeholders, and the American people, data-driven information on the national economic impact, including the impact from potential loss of employment of medical practice employees and others, due to payment decreases for physician practices. (Res. 218, I-11)	Rescind. The SGR was repealed in 2015. Moreover, the AMA regularly conducts economic analyses that inform AMA advocacy on behalf of physician practices, including a COVID-19 Physician Practice Financial Impact Survey and Changes in Medicare Physician Spending During the COVID-19 Pandemic.
D-400.991	CPT Modifiers	(1) Our AMA will continue to actively collect information, through existing processes, including the semi-annual study of non-Medicare use of the Medicare RBRVS conducted by the AMA Department of Physician Payment Policy and Systems and the recently unveiled AMA Private Sector Advocacy (PSA) Health Plan Complaint Form, and solicit input and assistance in this data collection from other interested members of the Federation on the acceptance of CPT modifiers by third party payers. (2) Pertinent information collected by our AMA through existing methods and collected through the AMA PSA Health Plan Complaint Form about acceptance of CPT modifiers by third party payers be shared with applicable state, county and national medical specialty societies in order to promote a greater understanding of third party payer payment policies related to CPT modifiers. (3) Our AMA use the available information to engage in discussions with payers. (4) Aggregate information collected through existing methods and collected through the AMA PSA Health Plan Complaint Form on acceptance for payment of CPT modifiers by third party payers be disseminated to state and federal regulators and legislators. (Sub. Res. 808, I-01; Modified: CMS Rep. 7, A-11)	Rescind. Superseded by Policy D-70.971 which states: (1) Our AMA Private Sector Advocacy Group will continue to collect information on the use and acceptance of CPT modifiers, particularly modifier -25, and that it continue to advocate for the acceptance of modifiers and the appropriate alteration of payment based on CPT modifiers. (2) The CPT Editorial Panel in coordination with the CPT/HCPAC Advisory Committee will continue to monitor the use and acceptance of CPT Modifiers by all payers and work to improve coding methods as appropriate. (3) Our AMA will collect information on the use and acceptance of modifier -25 among state Medicaid plans and use this information to advocate for consistent acceptance and appropriate payment adjustment for modifier -25 across all Medicaid plans. (4) Our AMA will encourage physicians to pursue, in their negotiations with third party payers, contract provisions that will require such payers to adhere to CPT rules concerning modifiers. (5) Our AMA will include in its model managed care contract, provisions that will require

Policy #	Title	Text	Recommendation
			managed care plans to adhere to CPT rules concerning modifiers. (6) Our AMA will continue to educate physicians on the appropriate use of CPT rules concerning modifiers. (7) Our AMA will actively work with third party payers to encourage their disclosure to physician providers any exceptions by those payers to CPT guidelines, rules and conventions. (8) Our AMA will include in CPT educational publications (i.e. CPT Assistant) examples of commonly encountered situations where the -25 modifier would and would not apply.
D-400.994	Conscious Shedation	Our AMA will support the efforts of the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC) as they review the coding and valuation issues related to procedures that are performed using moderate sedation/analgesia (i.e., "conscious sedation"). (Res. 107, A-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. Directive accomplished. New CPT codes for moderate sedation were implemented and RUC recommendations were adopted by CMS in 2017.
D-435.996	Malpractice Insurance Rate Increases and Physician Reimbursement	Our AMA will: (1) call upon the CMS to use current data in calculating the malpractice insurance portion of the Resource-Based Relative Value Scale and that this calculation take into account inter-specialty and geographic variances; and (2) study the calculated malpractice insurance portion of the RBRVS to determine the effect increasing malpractice insurance costs have on physician reimbursement. (Res. 109, A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
D-70.983	Inappropriate Bundling of Medical Services by Third Party Payers	Our AMA will: (1) continue to promote its Private Sector Advocacy activities and initiatives associated with the collection of information on third party payer modifier acceptance and inappropriate bundling practices; (2) use the data collected as part of its Private Sector Advocacy information clearinghouse to work, in a legally appropriate manner, with interested state medical associations and national medical specialty societies to identify and address inappropriate third party payer coding and reimbursement practices, including inappropriate	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		bundling of services, rejection of CPT modifiers, and denial and delay of payment; (3) continue to monitor the class action lawsuits of state medical associations, and provide supportive legal and technical resources, as appropriate; (4) develop model state legislation to prohibit third party payers from bundling services inappropriately by encompassing individually coded services under other separately coded services unless specifically addressed in CPT guidelines, or unless a physician has been specifically advised of such bundling practices at the time of entering into a contractual agreement with the physician; (5) urge state medical associations to advocate the introduction and enactment of AMA model state legislation on claims bundling by their state legislatures; and. (6) highlight its Private Sector Advocacy document on bundling and downcoding, the related section of the AMA Model Managed Care Contract, and its advocacy initiatives on its web site and other communications measures to assure that physicians are aware of the AMA's advocacy on this issue. (CMS Rep. 6, I-01; Reaffirmed: CMS Rep. 7, A-11)	
H-100.964	Drug Issues in Health System Reform	The AMA: (1) consistent with AMA Policy H-165.925, supports coverage of prescription drugs, including insulin, in the AMA standard benefits package. (2) supports consumer choice of at least two options for their pharmaceutical benefits program. This must include a fee-for-service option where restrictions on patient access and physician autonomy to prescribe any FDA-approved medication are prohibited. (3) reaffirms AMA Policy H-110.997, supporting the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourage physicians to supplement medical judgments with cost considerations in making these choices. (4) reaffirms AMA Policies H-120.974 and H-125.992, opposing the	Retain-in-part. The following subsections should be rescinded for the reasons provided below. Policy H-100.964 should otherwise be retained as still relevant. (4) Policies H-120.974 and H-125.992 have since sunsetted. (8) Superseded by Policy H-35.999. (9) Policies H-115.995 and H-115.997 have since sunsetted. (10) Superseded by Policy H-125.989. (15) Superseded by Policy H-120.988. (17) Policy H-120.983 has since sunsetted.

Policy #	Title	Text	Recommendation
		substitution of FDA B-rated generic drug products. (5) supports a managed pharmaceutical benefits option with market-driven mechanisms to control costs, provided cost control strategies satisfy AMA criteria defined in AMA Policy H-110.997 and that drug formulary systems employed are consistent with standards defined in AMA Policy H-125.991. (6) supports prospective and retrospective drug utilization review (DUR) as a quality assurance component of pharmaceutical benefits programs, provided the DUR program is consistent with Principles of Drug Use Review defined in AMA Policy H-120.978. (7a) encourages physicians to counsel their patients about their prescription medicines and when appropriate, to supplement with written information; and supports the physician's role as the "learned intermediary" about prescription drugs. (7b) encourages physicians to incorporate medication reviews, including discussions about drug interactions and side effects, as part of routine office-based practice, which may include the use of medication cards to facilitate this process. Medication cards should be regarded as a supplement, and not a replacement, for other information provided by the physician to the patient via oral counseling and, as appropriate, other written information. (8) recognizes the role of the pharmacist in counseling patients about their medicines in order to reinforce the message of the prescribing physician and improve medication compliance. (9) reaffirms AMA Policies H-115.995 and H-115.997, opposing FDA-mandated patient package inserts for all marketed prescription drugs. (10) opposes payment of pharmacists by third party payers on a per prescription basis when the sole purpose is to convince the prescribing physician to switch to a less expensive "formulary" drug because economic	

Policy #	Title	Text	Recommendation
		incentives can interfere with pharmacist professional judgment. (11) reaffirms AMA Policy H-120.991, supporting the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge, and to oppose legislation or regulation whose intent is to ban drug sampling. (12) supports CEJA's opinion that physicians have an ethical obligation to report adverse drug or device events; supports the FDA's MedWatch voluntary adverse event reporting program; and supports FDA efforts to prevent public disclosure of patient and reporter identities. (13) opposes legislation that would mandate reporting of adverse drug and device events by physicians that would result in public disclosure of patient or reporter identities. (14) reaffirms AMA Policy H-120.988, supporting physician prescribing of FDA-approved drugs for unlabeled indications when such use is based upon sound scientific evidence and sound medical opinion, and supporting third party payer reimbursement for drugs prescribed for medically accepted unlabeled uses. (15) encourages the use of three compendia (AMA's DRUG EVALUATIONS; United States Pharmacopeial-Drug Information, Volume I; and American Hospital Formulary Service-Drug Information) and the peer-reviewed literature for determining the medical acceptability of unlabeled uses. (16) reaffirms AMA Policy H-100.989, supporting the present classification of drugs as either prescription or over-the-counter items and opposing the establishment of a pharmacist-only third (transitional) class of drugs. (17) reaffirms AMA Policy H-120.983, urging the pharmaceutical industry to provide the same economic opportunities to individual pharmacies as given to mail service pharmacies. (BOT Rep. 53, A-94; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed by CSA Rep. 3, A-97; Amended: CSA Rep. 2, I-98; Renumbered: CMS	

Policy #	Title	Text	Recommendation
		Rep. 7, I-05; Reaffirmation A-10; Reaffirmed in lieu of Res. 201, I-11)	
H-130.945	Overcrowding and Hospital EMS Diversion	It is the policy of the AMA: (1) that the overall capacity of the emergency health care system needs to be increased through facility and emergency services expansions that will reduce emergency department overcrowding and ambulance diversions; incentives for recruiting, hiring, and retaining more nurses; and making available additional hospital beds; (2) to advocate for increased public awareness as to the severity of the emergency department crisis, as well as the development and distribution of patient-friendly educational materials and a physician outreach campaign to educate patients as to when it is appropriate to go to the emergency department; (3) to support the establishment of local, multi-organizational task forces, with representation from hospital medical staffs, to devise local solutions to the problem of emergency department overcrowding, ambulance diversion, and physician on-call coverage, and encourage the exchange of information among these groups; (4) that hospitals be encouraged to establish and use appropriate criteria to triage patients arriving at emergency departments so those with simpler medical needs can be redirected to other appropriate ambulatory facilities; (5) that hospitals be encouraged to create nurse-staffed and physician-supervised telephone triage programs to assist patients by guiding them to the appropriate facility; and (6) to work with the American Hospital Association and other appropriate organizations to encourage hospitals and their medical staffs to develop diversion policy that includes the criteria for diversion; monitor the frequency of diversion; identify the reasons for diversion; and develop plans to resolve and/or reduce emergency department overcrowding and the number of diversions. Citation: (CMS Rep. 1, A-02; Reaffirmed: BOT Rep. 3, I-02;	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		Modified: BOT Rep. 15, I-04; Reaffirmation A-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, A-08; Reaffirmed: CMS Rep. 3, A-11	
H-155.974	Excessive Regulatory Costs	Our AMA will: (1) support actively seeking reduction in regulatory requirements such as record review, length-of-stay review, insurance requirements and form completion, and diagnosis coding for physicians and hospitals, (2) vigorously oppose future regulatory requirements for physicians and hospitals that are not compensated; (3) seek through appropriate legislative channels support for an Economic Impact Statement requirement for all legislation and regulation affecting the delivery of medical care and that the increased cost be reflected in the RBRVS value; and (4) advocate that all governmental health care cost containment activities must simultaneously evaluate and report the total costs associated with their activities, and that government, federal, state and local, join the medical profession and hospitals in their efforts to contain the cost of health care, by reducing the number of regulations, reports, and forms. (Res. 125, A-79; Reaffirmed: CLRPD Rep. B, I-89; Res. 54, I-90; Res. 147, I-90; Res. 135, A-92; CMS Rep. 12, A-95; Reaffirmation A-00; Reaffirmed: BOT Rep. 25, I-01; Reaffirmation A-02; Reaffirmed: BOT Rep. 7, A-11)	Retain. Still relevant.
H-165.862	Evolving Internet-Based Health Insurance Marts	Our AMA endorses the concept and use of Internet-based health insurance marts and health benefits systems as mechanisms for employers and individuals to select and purchase health insurance. (CMS Rep. 5, A-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. Superseded by Policy H-165.839, which states: 1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges: A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features. B) Any benefits standards implemented for plans participating in the exchange

Policy #	Title	Text	Recommendation
			and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians. C) Physician and patient decisions should drive the treatment of individual patients. D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options. E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process. F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices. 2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion

Policy #	Title	Text	Recommendation
			of physicians based on conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information.
H-180.948	Opposition to Incentives for Care in Non-Physician Clinics	Our AMA will communicate with large insurance companies that providing incentives to patients toward non-physician clinics outside the primary care physician relationship can lead to decisions made on limited information, duplication of testing and procedures, ultimately higher health care costs and a reduction in the quality of health care for the patients of America. (Res. 708, A-11)	Retain. Still relevant.
H-185.943	Health Insurance Differences Contribute to Health Care Disparities and Poorer Outcomes	Our AMA affirms its support for elimination of health care disparities caused by differential treatment based on insurance status of Americans. (Res. 119, A-11)	Retain. Still relevant.
H-185.985	Internal Guidelines Used by Third Party Payers to Determine Coverage	Our AMA calls upon all third party payers and appropriate federal regulatory agencies to make all guidelines related to patient coverage a matter of public information and easily obtainable by both patients and physicians. (Res. 126, A-91; Modified: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. Superseded by Policy H-185.984, which supports 24-hour-a-day access to patient coverage and benefits information.
H-200.995	Federally Funded Clinic Programs	Our AMA supports the following policy statements regarding federally funded clinics: (1) Physician services should be available in underserved areas and should be provided in a manner which ensures continuity of patient care, integration with the existing health system, and retention of the health providers. (2) Physicians should be sensitive and responsive to indicators of need for additional health personnel or accessibility of health care. Through their component medical society, physicians should seek involvement in the designation process for Health Manpower Shortage Areas and	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		Medically Underserved Areas. The medical community and local residents are in an excellent position to ascertain the need for additional health providers in the community, and to support appropriate decisions in that regard. (3) Where need is clearly identified, through a federal designation process or other means, the local medical community should explore alternatives for responding appropriately to meet the need. (4) Where physicians have responded appropriately to needs identified through the designation process, the component medical society should work with the local planning groups to remove the area's designation, so that federal resources are not called on to duplicate services. (5) Where identified needs cannot be met by the local medical community, and all local public and private financial assistance options are determined to be inadequate, federal assistance should be sought. In such cases, the local medical community should assume the responsibility of working with the agency applying for federal funds to facilitate the placement of health personnel with long range service potential. (6) Where inappropriate designations were made leading to capacity which exceeds the need, the patient volume is likely to be low, and the unit costs excessive. In such situations, constructive consultation between the local medical community and the federally funded clinic program should explore options for a resolution of the problem. (Res. 125, A-81; Reaffirmed: Sunset Report, I-98; Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11)	
H-215.964	Patient Identification Wrist Bands	Our AMA (1) supports the concept of uniform patient identification wrist bands at all hospitals and other health care facilities where wrist bands are used; (2) encourages the adoption of uniquely colored patient identification wrist bands for specific patient information, such as, patient's name, allergies and those with identified greater fall risk; and (3) will actively pursue national standardization of	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		color-coded wristbands in hospital settings. (Res. 727, A-07; Appended: Res. 720, A-11)	
H-215.971	Standardization of Emergency Paging Nomenclature	Our AMA urges the development of standardized emergency paging nomenclature for hospitals. (Sub. Res. 805, A-00; Reaffirmation A-09; Reaffirmation A-11)	Retain. Still relevant.
H-215.984	Duplicate Bureaucratic Regulations	Our AMA encourages the identification of duplicate regulatory activities and inspection in hospitals and nursing homes so that these matters may be brought to the attention of legislators, governors and regulatory agencies. It is AMA policy that such information be made available nationally via the AMA and the AHA in an attempt to eliminate duplicate bureaucratic bodies and unnecessary regulations. (Res. 53, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 7, A-11)	Retain. Still relevant.
H-215.994	Subrogation by Hospitals	Our AMA urges hospitals to insist that contracts for hospital professional liability insurance require that the carrier obtain the consent of the policy holder prior to initiating legal action against a physician in the name of the hospital. (Res. 2, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-215.996	Compensation for Service on Government Mandated and Funded Hospital Committees	Our AMA believes that federal or third party funds provided for reimbursement of physicians serving on mandated hospital review committees should not be diverted by the hospital for other purposes. (CMS Rep. H, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-220.930	Regulatory Standards Should be Evidence-Based	Our AMA will work through its representatives on the Joint Commission and with other deeming authorities and the Centers for Medicare & Medicaid Services to: (1) ensure that clinical standards imposed on health care institutions and providers be evidence-based with significant efficacy and value, as demonstrated by best available evidence; and (2) require that appropriate citations(s) from the peer reviewed scientific literature be	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		appended to the documentation for every clinical standard imposed on health care institutions and providers. (Res. 727, A-10; Reaffirmed: BOT Rep. 7, A-11)	
H-220.950	Medical Staff Involvement in Hospital Compliance With Accrediting Organization Standards Plans of Action to Correct Deficiencies	Our AMA: (1) adopts the policy that a hospital medical staff must be appropriately involved in a surveyed organization's development of a plan of action to correct a deficiency and that such involvement be consistent with existing medical staff bylaws, rules and regulations; (2) encourages hospital medical staffs to amend their bylaws, if necessary, to establish processes to ensure appropriate medical staff input into the development of a plan of action to correct a deficiency; and (3) urges accrediting organizations to work to ensure that these principles are part of their accreditation standards. (Res. 810, I-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)	Retain. Still relevant.
H-220.953	Quality Improvement Requirements for Leadership Structures of Health Care Organizations	Our AMA supports the following concepts for incorporation in The Joint Commission's accreditation programs for health care organizations: (1) establish accreditation programs with greater emphasis on the assessment of the effect that actions and decisions of the administrative and governing bodies of health care organizations have on the quality of patient care; (2) establish the requirement that management efforts must be made in concert with those of physicians, nurses and other health care professionals pursuant to the needs of the patients served by these professionals and the prevailing standards of practice; (3) establish the requirement of assessing major processes in the health care organization with the goal of continuous improvement rather than intensely focusing on individual persons or services; (4) establish the requirement that risk management processes be established that will emphasize prevention of problems rather than policies that call for taking action only after a problem has arisen; (5) establish accountability of the management and governance elements	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		of a health care organization to its professional staff of physicians and nurses; and (6) require that the bylaws of the governing body provide a process through which the medical staff could appeal any decision made by the administration and/or the governing body which has an adverse effect on the quality of care rendered to patients, require that medical staff bylaws provide a process by which the need for such an appeal is identified, and provide a process for making the appeal. (Res. 822, I-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)	
H-220.995	Hospital Guidelines Impact Statement	Our AMA recommends that when guidelines, rules and specific recommendations to hospitals and other medical facilities are originated by accreditation, certification or regulatory agencies, they include a proof of impact statement to include (1) actual or estimated costs of implementation (as a total cost or cost per bed). Included in the costs should be estimates of volunteer medical staff time required to implement the policy; (2) a brief statement of the expected benefit, goal or improvement in health care or reduction in health care costs; (3) a brief outline of the data tending to prove that the guidelines and rules will actually and significantly improve patient care, not have an adverse impact, and will accomplish the intended goal stated in the benefit statement; and (4) cost estimates of implementation and ongoing compliance, for small, medium, and large hospitals, and/or other health care facilities. (Res. 37, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed in lieu of Res. 816, I-93; Amended: Sub. Res. 805, I-01; Modified: CMS Rep. 7, A-11)	Retain. Still relevant.
H-225.952	The Physician's Right to Exercise Independent Judgement in All Organized Medical Staff Affairs	Our AMA supports the unfettered right of a physician to exercise his/her personal and professional judgment in voting, speaking and advocating on any matter regarding: [i] patient care interests; [ii] the profession; [iii] health care in the community; [iv] medical staff matters; [v] the independent	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		exercise of medical judgment as appropriate interests to be incorporated into physician employment and independent contractor agreements; the right [vi] not to be deemed in breach of his/her employment or independent contractor agreement for asserting the foregoing enumerated rights; and [vii] not to be retaliated against by his/her employer in any way, including, but not limited to, termination of his/her employment or independent contractor agreement, commencement of any disciplinary action, or any other adverse action against him/her based on the exercise of the foregoing rights. (BOT Rep. 2, I-11)	
H-225.972	AMA Sponsored Leadership Training for Hospital Medical Staff Officers and Committee Chairs	It is the policy of the AMA (1) to offer, both regionally and locally, extensive training and skill development for emerging medical staff leaders to assure that they can effectively perform the duties and responsibilities associated with medical staff self-governance; and (2) that training and skill development programs for medical staff leaders be as financially self-supporting as feasible. (Res. 808, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-235.974	Autonomy of the Hospital Medical Staff	Our AMA (1) believes strongly in the autonomy of the hospital medical staff and does not support automatic inclusion of the medical staff in hospital personnel policies and programs; (2) believes hospital medical staffs should develop personnel policies and programs for members of the hospital medical staff and incorporate these policies in the medical staff bylaws or rules and regulations; and (3) understands that there are physicians who are not members of the medical staff but who are employees of the hospital and their participation in hospital programs should be dictated by their employment agreements. (Res. 832, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-240.997	Patient Signatures for Medicare Payment	Our AMA endorses a proposal to permit all physicians to use the patient signature on hospital records in completing any claim form accepted by	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		CMS for Medicare payment for inpatient hospital care. (Res. 15, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	
H-25.989	Long-Term Care Prescribing of Atypical Antipsychotic Medications	Our AMA: (1) will collaborate with appropriate national medical specialty societies to create educational tools and programs to promote the broad and appropriate implementation of non-pharmacological techniques to manage behavioral and psychological symptoms of dementia in nursing home residents and the cautious use of medications; (2) supports efforts to provide additional research on other medications and non-drug alternatives to address behavioral problems and other issues with patients with dementia; and (3) opposes the proposed requirement that physicians who prescribe medications with "black box warnings on an off-label basis certify in writing that the drug meets the minimum criteria for coverage and reimbursement by virtue of being listed in at least one of the authorized drug compendia used by Medicare." (Res. 819, I-11)	Retain. Still relevant.
H-285.920	Criteria for Level of Care Status	(1) Our AMA support the development and use of level of care guidelines that meet the following criteria: (a) Level of care guidelines should 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; (b) Level of care guidelines should acknowledge the complexity of care for each patient under the particular set of clinical circumstances; (c) Level of care guidelines should apply to all facility support systems so that patients are not assigned a level of care that slows or stalls their treatment; (d) Level of care guidelines should be developed under the direction of actively practicing physicians; (e) Level of care guidelines should be developed based on individual patient severity of illness and intensity of service;	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		(f) Level of care guidelines should be validated through standard data quality control checks and professional advisory consensus; (g) Level of care guidelines should be reviewed and updated; and (h) Level of care guidelines should allow for a timely appeal process. (2) It is the policy of the AMA that private sector accrediting organizations, where applicable, should adopt standards that are consistent with AMA criteria for the development and use of level of care status guidelines. (CMS Rep. 5, I-01; Reaffirmed: CMS Rep. 7, A-11)	
H-285.921	Managed Behavioral Health Organizations (MBHOs)	It is the policy of our AMA that, when requested, 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. (Res. 702, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-290.981	Out-of-State Medicaid Patients	The AMA encourages the CMS to propose regulations that prohibit state Medicaid programs from requiring physicians and other providers to be credentialed in the patient's state of residency, as long as the physician or provider is credentialed where the care is rendered. (Res. 136, A-98; Reaffirmed: BOT Rep. 23, A-09; Reaffirmation A-11)	Retain. Still relevant.
H-330.891	Payment and Coverage for Voluntary Discussions of End-of-Life Issues	Our AMA encourages the Centers for Medicare & Medicaid Services to designate voluntary discussions of end-of-life issues as covered services as part of the 2012 Medicare Physician Fee Schedule rule. (Res. 225, A-11)	Rescind. Accomplished in 2019 when the Centers for Medicare & Medicaid Services began paying for advanced care planning using CPT codes 99497 and 99498.
H-330.954	Mandatory Transmission of	Our AMA opposes the policy of local Medicare carriers of mandating that physicians choose between electronic	Retain. Still relevant.

Policy #	Title	Text	Recommendation
	Electronic Claims	remittance advice or standard paper remittance report until all secondary insurers accept the electronic remittance advice explanation of benefits in its present format. (Res. 815, A-93; Appended: Res. 107, I-00; Reaffirmation A-01; Modified: CMS Rep. 7, A-11)	
H-340.997	Medicare Preauthorization Review	Our AMA opposes the mandating of blanket hospital preadmission review for all patients or for specific categories of patients by government or hospital edict, and supports the prerogative of physician-directed peer review organizations to implement focused preadmission review on a voluntary basis. (CMS Rep. G, A-84; Reaffirmed by CLRPD Rep. 3-I-94; Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-345.976	Medicaid Coverage of Adults in Psychiatric Hospitals	1. Our AMA will monitor the Medicaid Emergency Psychiatric Demonstration Project established by the Patient Protection and Affordable Care Act for consistency with AMA policy, especially the impact on access to psychiatric care and treatment of substance use disorders. 2. Our AMA supports the evolution of psychiatrist-supervised mental health care homes. 3. Our AMA encourages states that maintain low numbers of inpatient psychiatric beds per capita to strive to offer more comprehensive community based outpatient psychiatric services. (CMS Rep. 3, A-11)	Retain. Still relevant.
H-35.992	Reimbursement for Allied Health Personnel	Our AMA believes that (1) reimbursement systems should pay physicians or their institutions directly for the services of allied health personnel; and (2) such personnel should be under the supervision of practicing physicians. (BOT Rep. A, NCCMC Rec. 41, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: BOT Rep. H, A-93; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11)	Retain. Still relevant.
H-380.995	Insurance Carrier Terminology	Our AMA urges individual physicians to consider including in their patient information materials an explanation as to why the amount billed may in some cases be more than the insurance benefit paid. (CMS Rep. F, I-81; CLRPD Rep. F, I-91; Reaffirmed:	Rescind. Superseded by Policy H-390.865, which calls for a universal EOB to be issued to both the patient and the physician that includes an explanation of billed, covered and patient responsibility amounts.

Policy #	Title	Text	Recommendation
		Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	
H-383.994	Managed Care Plans and the Right to Set Fees	Our AMA opposes any government or hospital requirement that a hospital-based physician must accept the terms of any managed care plan accepted by the hospital. (Sub. Res. 704, A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-385.916	Reimbursement for Office-Based Surgery Facility Fees	Our AMA urges third party payers to include facility fee payments for procedures using more than local anesthesia in accredited office-based surgical facilities. (Res. 716, A-11)	Retain. Still relevant.
H-385.917	Interpreter Services and Payment Responsibilities	Our AMA supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services. (CMS Rep. 5, A-11)	Retain. Still relevant.
H-385.925	Selective Revenue Taxation of Physicians and Other Health Care Providers	Our AMA: (1) strongly opposes the imposition of a selective revenue tax on physicians and other health care providers; (2) will continue to work with state medical societies on issues relating to physician and other provider taxes, providing assistance and information as appropriate; (3) strongly opposes the use of provider taxes or fees to fund health care programs or to accomplish health system reform; and (4) believes that the cost of taxes which apply to medical services should not be borne by physicians, but through adequate broad-based taxes for the appropriate funding of Medicaid and other government health care programs. (Sub. Res. 258, A-92; Reaffirmed: Res. 134, A-93; Res. 207, I-93; Reaffirmation A-99; Reaffirmation A-00; Appended Res. 132, A-01; Reaffirmation A-05; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmed: CMS Rep. 6, I-11)	Retain. Still relevant.
H-385.932	Contact Capitation Contracts	Our AMA strongly encourages all physicians contemplating entering into contact capitation agreements to exercise extreme caution, with attention to business skills and competencies needed to successfully practice under contact capitation arrangements and potentially uncontrollable market forces that may impact upon ones	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		ability to provide quality patient care. (CMS Rep. 1, A-01; Modified: CMS Rep. 7, A-11)	
H-385.940	CPT Codes for Evening and Night Services	Our AMA will continue its efforts to advocate for the fair and equitable payment of services described by CPT codes, including those CPT codes which already exist for off-hour services and unusual travel. (Sub. Res. 821, A-98; Reaffirmed: BOT Rep. 6, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-385.967	Incentives and Penalties to Encourage Third Party Payers to Make Prompt Payment of Health Insurance Claims	It is the policy of our AMA to investigate and document reports of problems with delays in payments by third party payers, including the federal government, and to seek legislation or regulations that assure prompt payment by all third party payers. (Res. 113, I-91; Reaffirmed: Res. 138, A-98; Reaffirmation I-01; Reaffirmation I-04; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmed: Res. 216, A-11)	Retain. Still relevant.
H-385.968	Physician Fee Determination by Contractual Arrangements Between Third Party Payers and Hospital	Our AMA condemns the practice of negotiating or creating contractual arrangements between third party payers and hospitals limiting reimbursement to physicians unless those physicians have been involved in the negotiation process and have been given a good faith opportunity to participate. (Sub. Res. 248, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-385.970	Payment of Physicians' Services for Patients in Observational or Short Stay Units	Our AMA supports seeking reimbursement from all third party payers for physicians' services to patients who are appropriately managed in short stay units. (Res. 182, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-385.995	Manipulative Casting of Congenital Deformities of the Extremities	Our AMA encourages all third party payers to classify manipulative casting of congenital deformities of the extremities as a surgical procedure, whether performed in the office or hospital. (CMS Rep. L, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-390.889	Medicare Reimbursement of Telephone Consultations	It is the policy of the AMA to: (1) support and advocate with all payers the right of physicians to obtain	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		payment for telephone calls not covered by payments for other services; (2) continue to work with CMS and the appropriate medical specialty societies to assure that the relative value units assigned to certain services adequately reflect the actual telephone work now performed incident to those services; (3) continue to work with CMS, other third party payers and appropriate medical specialty societies to establish the criteria by which certain telephone calls would be considered separate services for payment purposes; (4) request the CPT Editorial Panel to identify or consider developing the additional service code modifiers that may be required to certify specific types of telephone calls as separate from other services; and (5) seek enactment of legislation as needed to allow separate Medicare payment for those telephone calls that can be considered discrete and medically necessary services performed for the patient without his/her presence. (CMS Rep. N, A-92; Reaffirmed: Res. 122, I-97; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-01; Reaffirmation A-07; Reaffirmed in lieu of Res. 824, I-11)	
H-390.895	Medicare Patient Surveys	It is the policy of the AMA to negotiate with CMS to rescind rules and regulations that inordinately withhold payment to physicians for services rendered to Medicare beneficiaries until the beneficiary completes a survey or questionnaire. (Res. 102, I-91; Reaffirmation A-01; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-390.901	Medicare Outpatient Service Charge Limit	Our AMA vigorously opposes the Medicare Part B Policy of Outpatient Physician Charge Limit. (Res. 70, A-91; Modified: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-390.906	Medicare Notification of Payment	Our AMA requests CMS to direct Medicare Part B carriers to furnish all physicians with an Explanation of Medicare Benefits on all claims whether assigned or nonassigned. (Res. 62, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-405.980	Caller Identification	Our AMA, based on the concerns of protecting physicians' privacy,	Rescind. No longer relevant.

Policy #	Title	Text	Recommendation
		supports efforts to allow individuals to block caller identification at no cost to the caller. (Sub. Res. 225, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	
H-45.986	Protection of Insurance Coverage for Medical Attendants Aboard Non-Scheduled Aircraft	Our AMA supports seeking appropriate action, including legislation if necessary, which would result in an exemption or exception to the exclusion of benefits clauses of insurance policies for all medical care providers and others when they are participating in medical aircraft flights, even though such flights might otherwise be considered as "non-scheduled." (Sub. Res. 144, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. Superseded by Policy H-45.997, which supports legislation to provide immunity to physicians providing care during an in-flight medical emergency.
H-450.961	Health Plan "Report Cards"	The AMA: (1) supports the development and appropriate use of health plan performance standards; (2) The AMA urges all organizations that are developing, or planning to develop, health plan performance measures to include actively practicing physicians, physician organizations, and consumers in the development, evaluation and refinement of such measures; (3) The AMA urges all organizations that are developing health plan performance measures to work toward greater uniformity both in the content of such measures and in the formulas used for calculating performance results; (4) The AMA encourages national medical specialty societies and state medical associations to participate in the development, evaluation, and refinement of health plan performance measures; (5) The AMA advocates that individual health plans, government entities, private sector accreditation organizations and others that develop performance measures for use in programs to evaluate the performance of health plans adhere to the following principles: (a) Health plan performance measures shall be developed for a variety of users, including health care purchasers, physicians and other health care providers, and the public.	Retain-in-part. The text of the policy remains relevant and should be retained. To better reflect the content of the policy, the title should be amended by addition and deletion as follows: ~~Health Plan "Report Cards"~~ Health Plan Performance Measures

Policy #	Title	Text	Recommendation
		(b) The involvement of actively practicing physicians and physician organizations in the development, evaluation, refinement, and use of health plan performance measures shall be essential. (c) Health plan performance measures shall include an appropriate mix of process-oriented and outcomes-oriented measures. (d) Health plan performance measures shall be representative of the full range of services typically provided by health plans, including preventive services. (e) The limitations of data sources used in health plan performance measures shall be clearly identified and acknowledged. (f) Valid health plan performance data collection and analysis methodologies, including establishment of statistically significant sample sizes for areas being measured, shall be developed. (g) Performance data used to compare performance among health plans shall be adjusted for severity of illness, differences in case-mix, and other variables such as age, sex, and occupation and socioeconomic status. (h) Health plan performance data that are self-reported by health plans shall be verified through external audits. (i) The methods and measures used to evaluate health plan performance shall be disclosed to health plans, physicians and other health care providers, and the public. (j) Health plans being evaluated shall be provided with an adequate opportunity to review and respond to proposed health plan performance data interpretations and disclosures prior to their publication or release. (k) Effective safeguards to protect against the unauthorized use or disclosure of health plan performance data shall be developed. (l) The validity and reliability of health plan performance measures shall be evaluated regularly. (CMS Rep. 10, I-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmation A-11)	
H-450.975	Definition of Quality	Our AMA adopts the following statement defining patient care quality: Quality of care is defined as the degree	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		to which care services influence the probability of optimal patient outcomes. (CMS Rep. E, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	
H-450.976	Corrective Action and Exclusive Contracts	It is the policy of the AMA that exclusive contracts should never be used as a mechanism to solve quality assurance problems in lieu of appropriate peer review processes. (Res. 3, A-91; Modified: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-465.984	Access to Physician Services in Rural Health Clinics	Our AMA strongly encourages CMS and appropriate state departments of health to review the Rural Health Clinic Program eligibility and certification requirements to ensure that independent (e.g., physician) and provider-based (e.g., hospital) facilities are certified as Rural Health Clinics only in those areas that truly do not have appropriate access to physician services. (Sub. Res. 717, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-465.997	Access to and Quality of Rural Health Care	(1) Our AMA believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources. (2) In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued. (CMS Rep. G, A-87; Modified: Sunset Report, I-97;	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11)	
H-478.989	Biometric Technologies Used to Enhance Security	Our AMA encourages the use of biometric technologies where feasible, such as, but not limited to, fingerprint and palm scanners in hospitals and clinics (1) for patient identification to improve patient safety while reducing health insurance fraud and (2) for providers to streamline and secure user authentication processes and better protect patient privacy. (Res. 816, I-11)	Retain. Still relevant
H-478.996	Medical Care Online	It is the policy of the AMA to support efforts to address the economic, literacy, and cultural barriers to patients utilizing information technology. (CMS Rep. 4, A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-70.917	Ensuring CPT Usage of the Term Physician is Consistent with AMA Policy	1. Our AMA will ensure that CPT employ the term "physician" consistent with our AMA's policy in all internal and external communications, publications and products. 2. As a condition for licensure of CPT intellectual property by outside entities, references to the term "physicians" within CPT must remain consistent with our AMA's policy, and the AMA will take appropriate enforcement action against violators. 3. Our AMA will ensure that the CPT code set continues to be applicable and relevant to physicians and qualified healthcare professionals who may report the professional services described therein. (Res. 602, I-11)	Retain. Still relevant.
H-70.974	CPT Coding System	1. The AMA supports the use of CPT by all third-party payers and urges them to implement yearly changes to CPT on a timely basis. 2. Our AMA will work to ensure recognition of and payment for all CPT codes approved by the Centers for Medicare & Medicaid Services (CMS) retroactive to the date of their CMS approval, when the service is covered by a patient's insurance. (Sub. Res. 809, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Appended: Res. 803, I-11)	Retain. Still relevant.