

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 727
(A-22)

Introduced by: Texas

Subject: Utilization Review, Medical Necessity Determination, Prior Authorization Decisions

Referred to: Reference Committee G

1 Whereas, Prior authorization requirements are increasing in number yearly, and this burden is
2 driving administrative costs to an estimated \$68,274 per physician per year, which equates to
3 \$31 billion annually, according to *Health Affairs*; and
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5 Whereas, Prior authorizations delay care and create obstacles to patients receiving optimal
6 care. A recent American Medical Association survey reported 91% of physicians said prior
7 authorization had a significant or somewhat negative impact on their patients' clinical outcome,
8 and 28% said prior authorization intrusion led to a serious adverse event for a patient under
9 their care; and
10

11 Whereas, Decisions made by insurance medical directors, physicians conducting utilization
12 reviews, and physicians providing peer-to-peer reviews on behalf of insurance companies affect
13 patient care and can lead to adverse outcomes; therefore be it
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15 RESOLVED, That the American Medical Association advocate for implementation of a federal
16 version of Texas' "gold card" law (House Bill 3459), which aims to curb onerous prior
17 authorization practices by many state-regulated health insurers and health maintenance
18 organizations (Directive to Take Action); and be it further
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20 RESOLVED, That our AMA House of Delegates adopt a similar policy to Texas's "gold card" law
21 (House Bill 3459) (Directive to Take Action); and be it further
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23 RESOLVED, That the American Medical Association request that the Council on Ethical and
24 Judicial Affairs devise ethical opinions similar to the Texas Medical Association's Board of
25 Councilors' opinions regarding medical necessity determination and utilization review. (Directive
26 to Take Action)

Fiscal Note: Not yet determined

Received: 05/09/22

RELEVANT AMA POLICY

Utilization Review by Physicians H-320.973

1. It is the policy of the AMA to urge its constituent medical associations to (a) seek the enactment of legislation requiring that utilization review for insurers shall be conducted by physicians licensed by the state in which they are doing the review; and (b) seek enactment of legislation that would require all agencies or groups doing utilization review to be registered with the appropriate health regulatory agency of the state in which they are doing review and to have an appropriately staffed office located in the state in which they are doing the review.

2. Our AMA will continue to work with state medical associations to monitor utilization management policy to ensure that hospital admissions are reviewed by appropriately qualified physicians and promote related AMA model legislation.

Citation: Sub. Res. 175, A-90; Reaffirmation A-97; Reaffirmation A-06; Appended: CMS Rep. 1, I-14; Reaffirmation: A-18

Principles of Drug Utilization Review H-120.978

Our AMA adopts the following Principles of Drug Utilization Review.

Principle 1: The primary emphasis of a DUR program must be to enhance quality of care for patients by assuring appropriate drug therapy. Characteristics: (a) While a desired therapeutic outcome should be cost-effective, the cost of drug therapy should be considered only after clinical and patient considerations are addressed; (b) Sufficient professional prerogatives should exist for individualized patient drug therapy.

Principle 2: Criteria and standards for DUR must be clinically relevant. Characteristics: (a) The criteria and standards should be derived through an evaluation of (i) the peer-reviewed clinical and scientific literature and compendia; (ii) relevant guidelines obtained from professional groups through consensus-derived processes; (iii) the experience of practitioners with expertise in drug therapy; (iv) drug therapy information supplied by pharmaceutical manufacturers; and (v) data and experience obtained from DUR program operations. (b) Criteria and standards should identify underutilization as well as overutilization and inappropriate utilization. (c) Criteria and standards should be validated prior to use.

Principle 3: Criteria and standards for DUR must be nonproprietary and must be developed and revised through an open professional consensus process. Characteristics: (a) The criteria and standards development and revision process should allow for and consider public comment in a timely manner before the criteria and standards are adopted. (b) The criteria and standards development and revision process should include broad-based involvement of physicians and pharmacists from a variety of practice settings. (c) The criteria and standards should be reviewed and revised in a timely manner. (d) If a nationally developed set of criteria and standards are to be used, there should be a provision at the state level for appropriate modification.

Principle 4: Interventions must focus on improving therapeutic outcomes. Characteristics: (a) Focused education to change professional or patient behavior should be the primary intervention strategy used to enhance drug therapy. (b) The degree of intervention should match the severity of the problem. (c) All retrospective DUR profiles/reports that are generated via computer screening should be subjected to subsequent review by a committee of peers prior to an intervention. (d) If potential fraud is detected by the DUR system, the primary intervention should be a referral to appropriate bodies (e.g., Surveillance Utilization Review Systems). (e) Online prospective DUR programs should deny services only in cases of patient ineligibility, coverage limitations, or obvious fraud. In other instances, decisions regarding appropriate drug therapy should remain the prerogative of practitioners.

Principle 5: Confidentiality of the relationship between patients and practitioners must be protected.

Characteristic: The DUR program must assure the security of its database.

Principle 6: Principles of DUR must apply to the full range of DUR activities, including prospective, concurrent and retrospective drug use evaluation.

Principle 7: The DUR program operations must be structured to achieve the principles of DUR.

Characteristics: (a) DUR programs should maximize physician and pharmacist involvement in their development, operation and evaluation. (b) DUR programs should have an explicit process for system evaluation (e.g., total program costs, validation). (c) DUR programs should have a positive impact on improving therapeutic outcomes and controlling overall health care costs. (d) DUR programs should minimize administrative burdens to patients and practitioners.

Citation: (BOT Rep. PPP, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 6, A-03; Reaffirmed: CMS Rep. 4, A-13)

Medical Necessity and Utilization Review H-320.942

Our AMA supports efforts to: (1) ensure medical necessity and utilization review decisions are based on established and evidence-based clinical criteria to promote the most clinically appropriate care; and (2) ensure that medical necessity and utilization review decisions are based on assessment of preoperative symptomatology for macromastia without requirements for weight or volume resected during breast reduction surgery.

Citation: Res. 810, I-16; Reaffirmation: A-18