AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: (Assigned by HOD)
(A-25)

Introduced by: Private Practice Physicians Section

Subject: Payment Recoupment—Let Sanity Prevail

Referred to: Reference Committee (Assigned by HOD)

Whereas, insurance companies not only create barriers to care and payment, but manage to bamboozle physicians into retrospective recovery or claim recoupment with bolder and more outlandish schemes; and

Whereas, insurance companies often claim errors that are not the fault of the physician as the reason for recoupment; and

Whereas, insurance companies often try to cover up their mistakes and errors by imposing the costs on physicians for services legitimately performed for a medically necessary condition; and

Whereas, insurance companies recoup money for payments made “in error” due to a “coordination of benefits” error that is the fault of the insurance company; and

Whereas, medical practices are not debt collectors for insurance companies where debts belong to the patient or another insurance company; and

Whereas, claim recoupment is administratively costly to physician practices, has no meaningful due process, and is not overseen by any third party as claim-related appeals cannot be referred for outside appeals under most health plan provisions; and

Whereas, claim recovery or recoupment has a significant impact on the financial viability of medical practices with billions of dollars recurred in costs and billions unjustly stolen from physicians; and

Whereas, AMA policy D-385.944, “ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers” refers to the US Supreme Court holding in Rutledge v. PCMA, which gives the states the ability to regulate certain administrative aspects of health plans that do not relate to “a particular scheme of substantive coverage” which includes claim recoupment and payment recovery; therefore be it

RESOLVED, that our American Medical Association advocates for legislation and regulations compliant with the Supreme Court holding in *Rutledge v. PCMA* (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates for legislation and regulations that stipulate that if payment recovery or recoupment is due to coordination of benefit failure, the payer seeks recovery from the patient and/or the correct insurance company or primary payer responsible for the claim (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates for legislation and that whenever a health plan seeks recoupment or payment recovery for overpayment or wrong payment from a physician, a detailed and comprehensive explanation for the payment recoupment/recovery must be provided (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates for legislation and regulation that if the reason for claim recovery or recoupment is not due to physician error, the health plan may not seek recovery from the physician and that health plans must seek resolution from the patient on whose behalf the insurance company paid the claim and who has a contract with the insurance company or the third party responsible for the payment involved in claim recovery or recoupment (Directive to Take Action); and be it further

RESOLVED, that our AMA report back at the 2026 Annual Meeting on the progress of the implementation of this resolution (Directive to Take Action).

Fiscal Note: (Assigned by HOD)

Received:

RELEVANT AMA POLICY

ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers D-385.944

Our American Medical Association will study, and create resources for states, on the implication of *Rutledge, Attorney General Of Arkansas v. Pharmaceutical Care Management Association*, and any other relevant legal decisions from the last several years, in reference to potentially allowing more successful challenges to the actions of healthcare plans protected by the Employee Retirement Income Security Act of 1974 (ERISA) when the quality of care or healthcare outcomes are questioned.

Citation: Res. 224, I-23

Insurance Companies Use of Contractors to Recover Payments D-385.965

1. Our AMA will seek legislation to limit insurance companies, their agents, or any contractors from requesting payment back on paid claims to no more than 90 days after payment is made.

(a) Such legislation would require insurance companies, their agents, or any contractors to have a defined and acceptable process for physicians to dispute these maneuvers to get payment back on claims already processed, verified, and paid.

(b) Such legislation would ban insurance companies, their agents or contractors from using re-pricers and re-reviewers and to adhere to their own pricing and reviewing guidelines as agreed upon in their contracts with physicians.

2. Our AMA will pursue legislation to regulate self-insured plans in this regard and apply the same rules to Medicare and other federal plans.

Citation: Res. 215, A-09; Reaffirmed: BOT Rep. 09, A-19

Creating a Fair and Balanced Medicare and Medicaid RAC Program D-320.991

1. Our AMA will continue to monitor Medicare and Medicaid Recovery Audit Contractor (RAC) practices and recovery statistics and continue to encourage the Centers for Medicare and Medicaid Services (CMS) to adopt new regulations which will impose penalties against RACs for abusive practices.
2. Our AMA will continue to encourage CMS to adopt new regulations which require physician review of all medical necessity cases in post-payment audits, as medical necessity is quintessentially a physician determination and judgment.

3. Our AMA will encourage CMS to discontinue the denial of payments or imposition of negative action during an audit due to the absence of specific words in the chief complaint when the note provides adequate documentation of the reason for the visit and services rendered.
4. Our AMA will assist states by providing recommendations regarding state implementation of Medicaid RAC rules and regulations in order to lessen confusion among physicians and to ensure that states properly balance the interest in overpayment and underpayment audit corrections for Recovery Contractors.
5. Our AMA will petition CMS to amend CMS' rules governing the use of extrapolation in the RAC audit process, so that the amended CMS rules conform to Section 1893 of the Social Security Act Subsection (f) (3) - Limitation on Use of Extrapolation; and insists that the amended rules state that when an RAC initially contacts a physician, the RAC is not permitted to use extrapolation to determine overpayment amounts to be recovered from that physician by recoupment, offset, or otherwise, unless (as per Section 1893 of the Social Security Act) the Secretary of Health and Human Services has already determined, before the RAC audit, either that (a) previous, routine pre- or post-payment audits of the physician's claims by the Medicare Administrative Contractor have found a sustained or high level of previous payment errors, or that (b) documented educational intervention has failed to correct those payment errors.
6. Our AMA, in coordination with other stakeholders such as the American Hospital Association, will seek to influence Congress to eliminate the current RAC system and ask CMS to consolidate its audit systems into a more balanced, transparent, and fair system, which does not increase administrative burdens on physicians.
7. Our AMA will: (A) seek to influence CMS and Congress to require that a physician, and not a lower level provider, review and approve any RAC claim against physicians or physician-decision making, (B) seek to influence CMS and Congress to allow physicians to be paid any denied claim if appropriate services are rendered, and (C) seek the enactment of fines, penalties and the recovery of costs incurred in defending against RACs whenever an appeal against them is won in order to discourage inappropriate and illegitimate audit work by RACs.
8. Our AMA will advocate for penalties and interest to be imposed on the auditor and payable to the physician when a RAC audit or appeal for a claim has been found in favor of the physician.

Citation: Res. 215, I-11; Appended: Res. 209, A-13; Appended: Res. 229, A-13; Appended: Res. 216, I-13; Reaffirmed: Res. 223, I-13; Appended: Res. 213, I-16; Reaffirmed: CMS Rep. 08, A-17