AMERICAN MEDICAL ASSOCIATION PRIVATE PRACTICE PHYSICIANS SECTION

Resolution: 6
(I-25)

Introduced by: Alex Shteynshlyuger, MD

Subject: Recoupment by CMS Recovery and Audit Contractors (RAC)—Due Process

Referred to: PPPS Reference Committee
(xxxx, MD, Chair)

Whereas, the AMA has adopted policies on health plan recoupment but the problems are not decreasing; they are exponentially increasing; and

Whereas, the Centers for Medicare & Medicaid Services (CMS) is asking the industry for ideas to increase opportunities for recoupment using claims data mining to detect fraud and abuse and offering significant finder fees equal to 15 percent of the amount, often more than what physicians make on office-administered medications, but using claims data is an imprecise tool that cannot easily discern legitimate claims from fraud; and

Whereas, requests for medical records by Medicare Recovery and Audit Contractors (RAC) is a costly process, both financially and administratively, which is not fully compensated by the meager payments by Medicare RAC and requires separate processes for records submission from the usual Medicare Administrative Contractor portal and often requires faxing or mailing information, as was the case with Peformant RAC, a contractor of NGS Medicare in New York; and

Whereas, on a recorded call, the Medicare RAC Performant Medical Director stated that Performant is “not looking for fraud or abuse” but is looking for “documentation technicalities;” and

Whereas, this illustrates that Medicare RAC contractors have a conflict of interest in the appeals process as they get 15 percent if they deny; and

Whereas, physicians are often forced through the process illegitimately where there is neither fraud nor abuse and are forced to spend significant amounts of time and money to clear their good name; and

Whereas, physicians who appeal may win after multiple appeals but still lose financially as every minute fighting illegitimate recoupment determinations adds to losses; and

Whereas, while physicians earn 4.3 percent on office-administered drugs with sequestration, RUC contractors are not obligated to appear in administrative law judge proceedings, but may if they choose to, creating one-sided rights and depriving physicians from mounting an adequate defense by not being able to take deposition from and perform discovery on the RAC contractors; therefore be it

RESOLVED, that our American Medical Association conducts a study that may include a survey and other means to determine:

1. How prevalent are recoupment demands by self-interested Medicare recovery and audit contractors (RAC) where there is no fraud and abuse but only inconsequential "documentation technicalities" or other clerical issues;
2. What is the rate of reversals and appeals of recoupment requests by RAC contractors?
3. What are the costs to providers to navigate the highly complex Medicare recoupment appeal process?
4. When and for what reasons providers choose not to appeal or are unable to appeal, with a particular focus on economic costs, complexity, the byzantine process of dealing with another third party, the tight deadline on appeals, and the net effect on independent physician practices?
5. For high-cost office-administered medications where the provider margin is less than the Medicare RAC fee and a loss to the provider is irrecoverable, how does this affect patient access to in-office administered medications under Medicare Part B, and whether the costs will be shifted to Medicare Part D where patients' out-of-pocket financial obligations are significantly greater?

(Directive to Take Action); and be it further

RESOLVED, that our AMA advocates for legislation and regulation that Medicare contractors must be compelled to appear and be cross-examined during administrative law judge hearings if requested by the provider and to reverse one-sided regulation via advocacy or legal action (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates for legislation and regulation that Medicare contractors (recovery and audit contractors and others) must pay "loser" costs to physicians if the recoupment determination is reversed during the appeal process equal to the amount that the Centers for Medicare & Medicaid Services pays to contractors to recoup successfully, 15 percent of the total amount alleged to be an improper or fraudulent payment (Directive to Take Action); and be it further

RESOLVED, that our AMA report at the 2026 Annual Meeting and annually after that until the goal of this resolution is fully achieved on the progress of implementation of this resolution (Directive to Take Action).

Fiscal Note: (Assigned by HOD)

Received: 9/1/2025

RELEVANT AMA POLICY

Reasonable Time Limitations on Post-Payment Audits and Recoupments by Third Party Payers H-70.926

Our AMA policy is that post-payment audits, post-payment downcodes and other similar requests for recoupment by third party payers be made within one year of the date the claim is submitted or within the same amount of time permitted for submission of the claim, whichever is less.

Citation: Res. 815, A-01; Reaffirmed: I-04; Reaffirmed: A-08; Reaffirmed in lieu of: Res. 202, I-13; Reaffirmed: Res. 707, A-16; Reaffirmed: Res. 227, A-25

Payment for Pre-Certified/Preauthorized Procedures H-385.900

1. Our American Medical Association supports the position that the practice of retrospective denial of payment or payment recoupment for care which has been pre-certified by an insurer should be prohibited under federal statute, except when materially false or fraudulent information has knowingly been given to the insurer by the physician, hospital or ancillary service provider to obtain pre-certification.
2. Our AMA will continue to advocate for legislation, regulation, or other appropriate means to ensure that all health plans including those regulated by ERISA, pay for services that are pre-authorized, or pre-certified by such health plan, including services that are deemed pre-authorized or pre-certified because the physician participates in a “Gold Card” program operated by that health plan.
3. Our AMA encourages legal action against health plans that engage in inappropriate post-service payment denials and payment recoupment.

Citation: Res. 818, I-24; Reaffirmed in lieu of: Res. 225, A-25; Reaffirmed: Res. 227, A-25

Medical Office Screens H-335.981

It is the policy of the AMA to take the following actions: (1) seek specific clarification from CMS on the process, procedures, and criteria of physician office postpayment review and recoupment;

(2) lobby for full due process protection for carrier postpayment review and recoupment situation;

(3) oppose the concept and application of extrapolation;

(4) oppose arbitrary, erratic, or inappropriate components of postpayment review and recoupment; and

(5) seek appropriate relief to achieve equitable treatment of physicians in office postpayment review and recoupment situations.

Citation: Sub. Res. 271, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: CMS Rep. 08, A-17; Reaffirmed: Res. 227, A-25