AMERICAN MEDICAL ASSOCIATION PRIVATE PRACTICE PHYSICIANS SECTION

Resolution: 7
(I-25)

Introduced by: Alex Shteynshlyuger, MD

Subject: Due Process for Recoupment by CMS Recovery and Audit Contractors (RAC)—SEC v. Jarkesy

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) appeals process is often stacked against physicians with internal CMS legal jurisprudence and case law contrary to due process; and

Whereas, physicians lack the same fair process under the CMS administrative law judge that is accorded to others in the United States; and

Whereas, Medicare recovery and audit contractors (RACs) have unfettered self-interest to impose costs on physicians by illegitimate recoupment determinations for allegations of fraud and abuse but RACs and CMS administrative contractors are exposed to any downsides of weaponizing the system against physicians as they are not exposed to the costs of defending their decisions; and

Whereas, the United State Supreme Court ruled in *Securities and Exchange Commission v. Jarkesy et al* that when the SEC seeks penalties against a defendant for securities fraud, the seventh amendment entitles the defendant to a jury trial and it could be argued that such ruling should be extended to apply to other agencies such as HHS or CMS; and

Whereas, Medicare RAC recoupments are penalties where the services have been provided and RACs assert that the providers are engaged in fraud and abuse; and

Whereas, physicians must have the same right to a jury trial as do other respondents before the Securities and Exchange Commission; therefore be it

RESOLVED, that our American Medical Association conducts a study and report:

1. Problems with the Centers for Medicare & Medicaid Services (CMS) recoupment and reconsideration/redetermination process and the CMS administrative law judge process, as they affect independent physician practices and physician rights and whether these can be better addressed by federal courts;
2. The implications of *Securities and Exchange Commission v. Jarkesy et al* on the legal legitimacy of CMS existing rules governing reopening, determinations, reconsiderations, decisions and reviews that do not allow a trial by jury;
3. Whether a trial in a federal court would provide physicians a greater due process than the CMS administrative law judge process;

(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

Merit-Based Selection of Administrative Law Judges H-265.985

Our American Medical Association supports merit-based processes for the selection of all Medicare/Medicaid Administrative Law Judges.

Citation: Res. 216, A-24

External Grievance Review Procedures H-320.952

Our AMA establishes an External Grievance procedure for all health plans including those under the Affordable Care Act (ACA) with the following basic components:

(1) It should apply to all health carriers and Accountable Care Organizations;

(2) Grievances involving adverse determinations may be submitted by the policyholder, their representative, or their attending physician;

(3) Issues eligible for external grievance review should include, at a minimum, denials for (a) medical necessity determinations; and (b) determinations by carrier that such care was not covered because it was experimental or investigational;

(4) Internal grievance procedures should generally be exhausted before requesting external review;

(5) An expedited review mechanism should be created for urgent medical conditions;

(6) Independent reviewers practicing in the same state should be used whenever possible;

(7) Patient cost sharing requirements should not preclude the ability of a policyholder to access such external review;

(8) The overall results of external review should be available for public scrutiny with procedures established to safeguard the confidentiality of individual medical information;

(9) External grievance reviewers shall obtain input from physicians involved in the area of practice being reviewed. If the review involves specialty or sub-specialty issues the input shall, whenever possible, be obtained from specialists or sub-specialists in that area of medicine.

Citation: Res. 701, I-98; Reaffirmed: I-99; Reaffirmed: A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Res. 709, A-12; Modified: Res. 712, A-13; Reaffirmed in lieu of: Res. 242, A-17; Reaffirmed: I-17