AMA
AMERICAN MEDICAL ASSOCIATION
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ORGANIZED MEDICAL STAFF SECTION
Governing Council Report A
Interim 2026 Meeting

Access full text of resolutions/reports in the HOD meeting handbook.

Recommendations key
Instructions for the delegate and alternate delegate are designated as follows:

- *Strongly support* – the delegate/alternate delegate shall support the resolution as written and actively speak in favor of the resolution
- *Support* – the delegate/alternate delegate shall support the resolution as written
- *Monitor* – the delegate/alternate delegate is not instructed to take any action, however, may if they believe it is in the best interest of the OMSS
- *Refer* – the delegate/alternate delegate shall move to refer (the item goes to a Council) or refer for decision (item goes to the Board)
- *Amend* – the delegate/alternate delegate shall move to amend the resolution in the manner prescribed in Report A
- *Oppose* – the delegate/alternate delegate shall oppose the resolution as written
- *Strongly oppose* – the delegate/alternate delegate shall oppose the resolution as written and actively speak in opposition of the resolution

Some items may contain specific instructions not included among those listed above. In such cases, instructions to the delegate/alternate delegate are described in detail alongside the item of business.

Note: Items highlighted in blue have been recommended for reaffirmation.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
1	E&B	BOT 14 - Patient Options to Restrict Secondary Use of Their Healthcare Data	The Board of Trustees recommends that Resolution 004-I-25 be adopted as amended by addition and deletion and the remainder of the report be filed. That our American Medical Association continue to support healthcare data privacy practices that provide patients with options to withdraw or restrict secondary uses of their data, including to retroactively withdrawal of their data from de-identified data sets. (New HOD Policy)	Delegate instructed to support amendment from the informatics caucus.
2	E&B	BOT 18 – Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients	The Board of Trustees recommends that Policy D-65.968 be amended by deletion as accomplished by this report, and that the remainder of the report be filed: Our AMA continue to support efforts by EHR vendors, health systems, and physician practices, and work with relevant collaborators (e.g., the ASTP/ONC, LGBTQIA+ advocacy groups, and minors' privacy experts), to improve EHR usability for transgender and gender-diverse patients, with attention to strong	Delegate instructed to support.

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			privacy protections~~, and report back on this progress by I-26.~~ (Modify Current HOD Policy)	
3	E&B	CCB 02 – Amendments to the Bylaws Governing the AMA Sections	*Refer to report CCB 02 for recommendations.*	Delegate instructed to support changes proposed to Section 7.4.3
4	E&B	CEJA 01 - Preserving Autonomy in the Patient-Physician Relationship	The Council on Ethical and Judicial affairs recommends that Policy D-140.944 be rescinded as having been accomplished by this report.	Delegate instructed to support.
5	E&B	CEJA 03 – Guidelines on Chaperones for Sensitive Exams	The Council on Ethical and Judicial Affairs recommends the following be adopted and the remainder of the report be filed: 1. Opinion 1.2.4, "Use of Chaperones," be amended by deletion and addition as follows: Chaperones should be authorized members of the healthcare team. All chaperones should understand the responsibilities of the role and be aware of mechanisms for reporting unprofessional conduct in keeping with ethics guidance and without fear of retaliation. Physicians should establish clear expectations that chaperones will uphold professional and legal standards of privacy and confidentiality. Respecting patient boundaries and promoting patient dignity requires providing a safe and therapeutic clinical encounter during sensitive examinations and procedures while also empowering patients. ~~Efforts to provide a comfortable and considerate atmosphere for the patient and the physician are part of respecting patients' dignity.~~ Such ~~These~~ efforts ~~may~~ include measures that promote patient privacy, such as providing appropriate gowns, private facilities for undressing, sensitive use of draping, clear~~ly explaining~~ explanations of various components of the physical examination, and the use of ~~having~~ a chaperone ~~available~~. While a sensitive exam is typically understood as one involving any examination of, or procedure involving, the genitalia, breasts,	Delegate instructed to support.

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			perianal region, or the rectum, physicians should be aware that a patient's personal history, beliefs, or identity may broaden their definition of what constitutes a sensitive examination or procedure. Having a chaperone~~s~~ present ~~also~~ during a sensitive exam helps protect the integrity of the patient-physician relationship ~~prevent misunderstandings between patient and physician~~. Physicians should, as always, be mindful of any applicable legal or regulatory requirements regarding the use of chaperones. Additionally, ~~P~~physicians should: (a) Make every reasonable effort to provide a chaperone for all sensitive exams, regardless of patient capacity, unless a delay in obtaining a chaperone would result in significant harm to the patient. (b) Allow patients to decline the presence of a chaperone, unless the physician deems a chaperone necessary for the exam: i. if the patient and physician cannot come to an agreement, then the physician may defer non-emergent examinations or procedures and refer the patient to another clinician; ii. in emergency situations, the physician may proceed in providing care with the presence of a chaperone and document the rationale. ~~(c) Have an authorized member of the health care team serve as a chaperone. Physicians should establish clear expectations that chaperones will uphold professional standards of privacy and confidentiality.~~ ~~(d) In general, use a chaperone even when a patient's trusted companion is present.~~ ~~(e)~~(c) Minimize inquiries or history taking of a sensitive nature while a chaperone is present. (d) Make a reasonable effort to accommodate the expressed preferences of the patient regarding the characteristics of their chaperone, consistent with the interests of patients, physicians, and the maintenance of professional boundaries. (e) Allow a parent or guardian to act as the chaperone for young pediatric patients. If a parent or guardian is unavailable, or if their presence may interfere with the examination, another chaperone should be present. For adolescent	

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			patients, it is appropriate to use a chaperone either in addition to, or instead of, a family member or guardian as determined during shared decision-making between patient and physician. All outpatient practices and inpatient services should have a policy regarding sensitive examinations and procedures that includes the use of chaperones to protect patients and minimize risk. For nonsensitive examinations and procedures, patients may request a chaperone, and reasonable efforts should be made to make one available upon request. (Modify HOD/CEJA Policy) 2. Policy D-140.950 be rescinded, as it has been accomplished by this report. (Rescind HOD Policy)	
6	E&B	CEJA 04 - Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization	The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of the report be filed: 1. That Opinion 1.2.10 be amended by addition and deletion with a change in title to read as follows: Advocacy and Collective Actions by Physicians ~~Political Action by Physicians~~ Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law, ~~or~~ policy, or practice are contrary to the best interests of patients. However, advocacy actions should not put the well-being of patients in jeopardy. Collective action is one means by which physicians can advocate for patients, the health of communities, the profession, and their own health. Physicians have a responsibility to avoid disruption to patient care when engaging in any	Delegate instructed to listen.

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			collective action. When considering collective actions that have the potential to be disruptive, whether aimed at changing the policies of government, the private sector, or their own institutions, there are additional considerations that should be addressed. These include avoiding harm to patients, minimizing the impact of actions on patient access to care, maintaining trust in the patient-physician relationship, fulfilling the responsibility to improve patient care, avoiding mental and physical harms to physicians, promoting physician well-being, upholding the values and integrity of the profession, and considering alternative measures that could reasonably be expected to achieve similar results with less potential effect on patient and physician well-being. When considering participation ~~Physicians who participate~~ in advocacy activities, including collective actions: (a) ~~Ensure that the health of patients is not jeopardized, and that patient care is not compromised.~~ Physicians should recognize that, in pursuing their primary commitment to patients, physicians can, and at times may have an obligation to, engage in collective political action to advocate for changes in law and institutional policy aimed at promoting patient care and well-being. (b) ~~Avoid using disruptive means to press for reform. Strikes and other collective actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.~~ Physicians may also engage in collective action to advocate for changes within their institutions, including changes in patient care practices, physician work conditions, health and well-being, and/or institutional culture that negatively affect patient care: (i) physicians should refrain from collective action that would likely jeopardize the health of patients or compromise patient care; (ii) physicians may, if non-disruptive actions fail, consider engaging in disruptive forms of collective action that do not compromise patient care, with the primary	

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			objective to improve patient care and outcomes by calling attention to and/or making needed changes in practices, protocols, incentives, expectations, structures, and/or institutional culture; and (iii) physicians should avoid disruptive collective actions that would predictably and directly compromise patient care, including strikes, due to their potential to undermine physicians' primary duty to patient welfare, and should not use such actions primarily for physician self-interest. (c) Physicians should avoid forming workplace or other alliances, such as unions, with ~~workers~~ colleagues and others who do not share physicians' primary and overriding commitment to patients. (d) Physicians should refrain from using ~~undue influence or pressure colleagues~~ punitive or coercive means to force others to participate in advocacy activities or collective actions, or to penalize others ~~and should not punish colleagues, overtly or covertly,~~ for deciding not to participate in such activities. (Modify AMA Policy) 2. That Policy H-405.946(2) be rescinded as having been accomplished by this report. (Rescind AMA Policy)	
7	E&B	CEJA 05 – Care of Patients in Legal Custody	The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed: 1. Patients in legal custody possess the same inherent human dignity and right to healthcare as all other patients. Regardless of custodial status, the formation of a patient-physician relationship obligates the physician to work to advance the good of the patient and to uphold respect for patients as persons. Physicians must approach patients in legal custody with a nonjudgmental regard and not allow invidious discrimination or assumptions about criminality to undermine their clinical judgment or the quality of care provided. Patients in legal custody face unique circumstances that render them especially susceptible to harm and healthcare inequities. Understanding the historical, structural, institutional, and legal factors that contribute to their vulnerability provides essential insights that can assist physicians in upholding their ethical responsibilities and optimizing patient care. Confinement, surveillance,	Delegate instructed to listen, consider CEJA 05 alongside Resolution 010.

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			dependence on custodial officials, and loss of legal rights can disrupt access to healthcare services and challenge physicians' ability to uphold their ethical obligations to privacy, confidentiality, and the provision of safe, equitable care. Physicians must ensure the primacy of patient welfare and professional independence despite real or perceived conflicting loyalties to custodial authorities. When caring for patients in legal custody, physicians should: (a) Provide care according to the same professional standards that apply to all patients, and work to identify and eliminate individual and systemic biases that threaten their care. (b) Mitigate real or perceived conflicts of interest and divided loyalties that may interfere with the delivery of equitable, high-quality care. (c) Respect their right to make their own medical treatment decisions and optimize the ability of patients to provide informed consent, including for treatments at the end of life. For patients lacking medical decision-making capacity, utilize a legally authorized surrogate decision-maker who is free from conflicting loyalties to custodial authorities and who will make medical treatment decisions based on ethically appropriate standards unless otherwise legally compelled. (d) Uphold patient privacy and confidentiality to the greatest extent possible. Limit disclosures of patient health information to custodial staff to the minimum amount necessary and obtain patient consent to disclose when possible. (e) Attempt to mitigate the harms of shackling or other custodial restraints when imposed by custodial staff, and advocate for the least restrictive use of custodial restraints safely possible, especially when they interfere with care delivery, with special attention to those most vulnerable to harm. (f) Strive to ensure safe disposition and continuity of care when patients are discharged or return to custody. (g) Support efforts within healthcare institutions to identify and improve policies and procedures that create barriers to optimal care, establish mechanisms for documenting and reporting abuse and neglect, and mitigate conflicts of interest and conflicting loyalties that may threaten the physician's obligation to the primacy of patient welfare.	

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			(h) Advocate with custodial staff and legal authorities to optimize patient access to high-quality, equitable medical care, and advocate for change when patient care or the ethical obligations of physicians are compromised by institutional policies and practices or custodial staff actions that are beyond the physician's control. (New HOD/CEJA Policy) 2. That the third directive of Policy D-345.970 be rescinded as it has been accomplished by this report (Rescind AMA Policy)	
8	E&B	CEJA 07 – Physicians are Not Providers	The Council on Ethical and Judicial Affairs recommends that the fourth item of Policy H-405.942, "Physicians are not Providers," be rescinded as having been accomplished by this report.	Delegate instructed to support.
9	E&B	Res. 002 – Surgical Consent (Ohio)	RESOLVED, that our American Medical Association re-evaluate its CEJA guidelines regarding initial decision for surgery and informed consent - as practice patterns have changed and more team-based care is being utilized - in order to prioritize and strengthen the physician-patient relationship prior to all medical procedures and interventions (Directive to Take Action); and be it further RESOLVED, that our AMA facilitate the creation of specialty-specific guidelines, inclusive of the entire house of medicine, defining meaningful supervision and informed consent processes for physician-led care. (Directive to Take Action)	Delegate instructed to support.
10	E&B	Res. 008 - Recognition of Moral Injury in the Physician Workforce (Resident and Fellow Section)	RESOLVED, that our American Medical Association defines moral injury as the harm that occurs when healthcare professionals are compelled by systemic constraints to act in ways that transgress their moral beliefs and professional obligations, including the inability to deliver evidence-based, equitable, and patient-centered care due to institutional, financial, or administrative barriers (New HOD Policy); and be it further RESOLVED, that our AMA recognizes moral injury as a distinct and significant threat to the wellbeing of medical students, residents, and physicians (New HOD Policy); and be it further	Delegate instructed to support.

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			RESOLVED, that our AMA study the prevalence, drivers, and impact of moral injury across the continuum of medical training and practice, including medical students, residents, and practicing physicians, and report back with recommendations for systemic interventions. (Directive to Take Action)	
11	E&B	Res. 010 - Preserving Human Dignity and Safety by Limiting Unnecessary Restraints and Monitoring (New Jersey)	RESOLVED, that our American Medical Association advocate against the routine use of shackles, ankle monitors, or other restrictive or stigmatizing devices unless an individualized assessment by a qualified professional establishes a substantial safety need that cannot be addressed by less restrictive means (Directive to Take Action); and be it further RESOLVED, that our AMA support policies requiring such measures to be the least restrictive necessary, regularly reassessed, and promptly discontinued when no longer needed, consistent with Code of Medical Ethics Opinion 1.2.7. (New HOD Policy)	Delegate instructed to listen, consider Resolution 010 alongside CEJA Rep. 05.
12	B	BOT 16 – Ensuring Medical Liability Insurance Transparency and Continuity	The Board of Trustees recommends that the second resolve of Resolution 235-1-25 be adopted and that the remainder of the report be filed.	Delegate instructed to support.
13	B	BOT 17 - Addressing and Reducing Patients Boarding in the Emergency/Reducing Emergency Department Boarding through Payment Reform	The Board of Trustees recommends the following be adopted and the remainder of the report be filed: 1. That our AMA continue to support federal legislative efforts to address ED boarding. 2. That our AMA continue to comment on CMS quality measure development efforts related to ED boarding while ensuring emergency physicians are not penalized for factors beyond their control. 3. That our AMA continue to seek out opportunities to advance our policy and reduce ED boarding at the federal and state levels as appropriate. 4. That our AMA continue our advocacy on the myriad, system-wide causes of ED boarding, including but not limited to misaligned financial incentives for hospitals, workforce constraints, prior authorization reform, and strengthening	Delegate instructed to support proposed amendment from Dr. Woody Jenkins.

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			federal coverage for care and physician reimbursement. 5. That our AMA continue our advocacy to address the negative impacts of ED boarding on physicians, health systems, and patients. 6. That our AMA continue to support initiatives led by state and specialty medical associations to advance action on ED boarding at the federal and state levels as appropriate. 7. That our AMA communicate updates on the AMA's ED boarding advocacy efforts through organizational communications channels such as the weekly Advocacy Update. (Directive to Take Action)	
14	B	Res. 201 - Artificial Intelligence Having Prescriptive Authority (American Association of Clinical Urologists)	RESOLVED, that our American Medical Association oppose the use of Artificial Intelligence (AI) without a physician or other health care professional's direct supervision to prescribe either new or refill prescriptions (New HOD Policy); and be it further RESOLVED, that our AMA develops model state legislation regulating AI prescriptive authority so that both new and refill prescriptions are under the direct supervision and control of a physician or other licensed healthcare professional. (Directive to Take Action)	Delegate instructed to support.
15	B	Res. 204 - Federal Framework for Social Media Access by Minors Under Age 16 (Organized Medical Staff Section)	RESOLVED, that our American Medical Association will call upon Congress and the President to enact federal legislation establishing a minimum age of 16 for independent social media account creation with limited supervised access permitted for younger minors only through verifiable parental consent and platform-implemented safeguards (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for legislation requiring social media platforms to deploy privacy-preserving, minimally intrusive age assurance technologies consistent with applicable law, subject to Federal Trade Commission oversight and meaningful penalties for non-compliance (Directive to Take Action); and be it further RESOLVED, that our AMA encourage platforms to (a) disable addictive design features (infinite scroll, autoplay) by default for minors, (b) limit daily usage, and (c) conduct transparent health impact assessments prior to algorithmic changes	Delegate instructed to strongly support.

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			affecting youth (New HOD Policy); and be it further RESOLVED, that our AMA advocate for robust federal funding for longitudinal research into the effects of social media, including equity impacts on rural and underserved youth, to be administered through the National Institutes of Health and the Centers for Diseases Control and Prevention (Directive to Take Action); and be it further RESOLVED, that our AMA support the development of clinical screening guidelines for harmful social media use and public education campaigns (New HOD Policy); and be it further RESOLVED, that our AMA communicate its positions to the U.S. Congress, the White House Office of Science and Technology Policy, the Federal Trade Commission, the Federal Communications Commission, and all relevant state medical associations with policy reassessment required after five years based on outcomes data. (Directive to take Action)	
16	B	Res. 205 - Ensuring Accuracy and Physician Protections for Patient Attribution in Health Plan Quality Measurement and Value-Based Programs (Organized Medical Staff Section)	RESOLVED, that our AMA adopt as policy the following Universal Standards for Patient Attribution: 1. Clinical Relationship: Attribution must be based on a documented clinical relationship, defined by recent clinical encounter(s) within an appropriate timeframe or a verified patient designation of the physician as their primary care provider (PCP); 2. Prospective Notification: Payers must provide physicians with an option for retrospective or prospective attribution methodology and, if opting for prospective attribution, they should provide physicians with a list of attributed patients at least 30 days before the start of a measurement period; 3. Transparency: Payers must disclose the attribution algorithms, claims thresholds, and patient designation processes used to assign patients to physicians; 4. Mandatory Exclusion: Patients subject to an active attribution dispute must be excluded from all quality scoring and financial performance calculations until the dispute is resolved;	Delegate instructed to strongly support.

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			5. Dispute Resolution: Payers must provide a standardized, timely mechanism for physicians to correct or suppress inaccurate attributions, with a determination required within 30 days of submission; (New HOD Policy); and be it further RESOLVED, that our AMA Board of Trustees report back at the 2027 Annual Meeting with recommendations to align and consolidate existing AMA policies related to patient attribution to ensure a streamlined advocacy strategy. (Directive to take Action)	
17	B	Res. 210 - Requiring Physician Oversight for Artificial Intelligence Tools (Indiana)	RESOLVED, that our American Medical Association support federal and state policies requiring that any artificial intelligence-generated diagnostic or treatment recommendations be reviewed, interpreted, and communicated by a licensed physician. (New HOD Policy)	Delegate instructed to support.
18	B	Res. 212 - Medical Staff Approval of Quality-of-Care Issues Prior to Exclusive Contract (American Academy of Emergency Medicine)	RESOLVED, that our American Medical Association amend current policy H-225.985 by addition and deletion to read: Our American Medical Association believes that the medical staff should review, ~~and~~ make recommendations to the governing body, and ultimately approve arrangements related to exclusive contract ~~arrangements~~, prior to any decision being made, in the following situations: 1. ~~the~~ any decision to execute an exclusive contract in a previously open department or service; 2. ~~the~~ any decision to renew or otherwise modify an exclusive contract in a particular department or service; 3. ~~the~~ any decision to terminate an exclusive contract in a particular department or service; and 4. ~~prior to termination of the contract the medical staff should hold a hearing, as defined by the medical staff and hospital to permit interested parties to express their views on the hospital's proposed action.~~ (Modify Current HOD Policy); and be it further	Delegate instructed to strongly support the intent of maintaining openness and autonomy for the medical staff, however the Section remains concerned about how to practically implement the resolution's prescribed changes.

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			RESOLVED, that our AMA advocate to the Centers for Medicare & Medicaid Services and hospital accrediting organizations including Joint Commission to require the above recommendations (Directive to Take Action); and be it further RESOLVED, that our AMA seek federal legislation requiring organized medical staff approval in the above listed situations, and develop model state legislation incorporating the same protections. (Directive to Take Action)	
19	B	Res. 213 - Clear Identification and Differentiation of Physicians and Nonphysicians in Clinical Rosters, Signage, and Listings (American Academy of Emergency Medicine)	RESOLVED, that our American Medical Association amend Policy H-405.951, Definition and Use of the Term Physician, by addition to read as follows: Our AMA will advocate that, in all printed and electronic materials, signage, directories, and listings in clinical departments, hospitals, health care facilities, and similar settings, physicians be listed separately from nonphysicians and that this distinction be clear and unambiguous. (Modify Current HOD Policy)	Delegate instructed to support.
20	B	Res. 226 - Physician-Led Governance of the Use of Augmented Intelligence in Hospital Credentialing, Privileging, and Peer Review (Organized Medical Staff Section, Oklahoma)	RESOLVED, that our American Medical Association advocate that any use of augmented intelligence in credentialing, privileging, peer review, quality review, or corrective action requires physician-led oversight and this be codified in medical staff bylaws (Directive to Take Action); and be it further RESOLVED, that our AMA encourage the requirement of hospital and health systems to fully disclose the data sources, validation, limitations, governance, and intended use of any augmented intelligence tool used in medical staff processes (New HOD Policy); and be it further RESOLVED, that our AMA will communicate its policy on requiring physician-led oversight of augmented intelligence when used in credentialing, privileging, peer review and quality review on a continuing basis to the American Hospital Association, Federation of American Health System, and other appropriate organizations (Directive to Take Action); and be it further	Delegate instructed to strongly support.

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			RESOLVED, that our AMA reaffirm policy H-225.942, Physician and Medical Staff Member Bill of Rights, that opposes any retaliatory peer review privileging action, corrective action, or employment action taken against a physician for good-faith safety reporting advocacy, or participation in organized medical staff governance. (Reaffirmed HOD Policy)	
21	F	CLRPD 02 - Underrepresented in Medicine Advocacy Section Five-Year Review	The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Underrepresented in Medicine Advocacy Section through 2031 with the next review no later than the 2031 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)	Delegate instructed to support.
22	F	CLRPD 03 - Integrated Physician Practice Section Five-Year Review	The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Integrated Physician Practice Section through 2031 with the next review no later than the 2031 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)	Delegate instructed to support.
23	F	Res. 604 - Increasing Time Between Handbook Release and Opening of Online Reference Committees (Texas)	RESOLVED, that our American Medical Association ensure that the House of Delegates handbook is released at least five business days before the opening of the Online Reference Committees to allow adequate time to read and evaluate handbook materials and formulate testimony, while also maintaining the current 21-day window of ORC comment period. (Directive to Take Action)	Delegate instructed to listen.
24	J	CMS 01 - Transparency with the Term “Emergency Department”	The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed: 1. That our American Medical Association (AMA) support the development of standardized emergency department (ED) descriptors that reflect a facility’s level of on-site physician coverage and available services, easily discernible by the prudent layperson. (New HOD Policy) 2. That our AMA recommend that emergency care facilities without a dedicated on-site physician utilize these standardized ED descriptors to promote truth and transparency for patients. (New HOD Policy)	Delegate instructed to listen.

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			3. That our AMA support limiting the designations “emergency department” and “emergency room” to facilities that meet Emergency Medical Treatment and Labor Act (EMTALA) requirements and allowing any EMTALA-covered facility that meets those requirements to be classified as an emergency place of service for billing purposes, regardless of its level of on-site physician coverage. (New HOD Policy) 4. That our AMA support requiring facilities without continuous on-site physician staffing to prominently disclose, through physical and online signage, that physicians are not continuously on duty and on-site; and that our AMA support requiring advertisements for such facilities to include the same disclosure, consistent with Federal Trade Commission guidelines. (New HOD Policy) 5. That our AMA support community engagement to improve the education of patients and allow other healthcare team members to promote efficient and site appropriate care. (New HOD Policy) 6. That our AMA reaffirm Policy H-130.929, which recognizes that the AMA’s preferred model of emergency care is the on-site presence of a physician in the ED whose primary duty is to provide care in that ED and supports state medical associations in developing limited appropriate rural exceptions. (Reaffirm HOD Policy) 7. That our AMA reaffirm Policy D-35.976, which advocates for the establishment and enforcement of legislation and/or regulations that ensure only physicians supervise the provision of emergency care services in an ED. (Reaffirm HOD Policy) 8. That our AMA reaffirm Policy H-160.949, which opposes legislation allowing non-physician groups to engage in the practice of medicine without physician training or appropriate physician supervision, encourages state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician training or appropriate physician supervision, vigorously supports and advocates for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine, and states that the AMA will continue to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician healthcare workers. (Reaffirm HOD Policy)	

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			9. That our AMA reaffirm Policy D-130.958, which seeks federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the ED and supports all EDs be staffed 24 hours per day/7days per week by a qualified physician. (Reaffirm HOD Policy) 10. That our AMA reaffirm Policy H-240.958, which advocates to prohibit insurers from denying or reducing payment for a procedure based solely on the site of service in which it was performed, provided that the procedure is medically necessary and can safely be performed in that location. (Reaffirm HOD Policy)	
25	J	CMS 04 - Determining Fair Market Value when Contracting with Physician Practices	The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed: 1. That our American Medical Association (AMA) support modernization of federal regulatory frameworks, including the Stark law and Anti-Kickback Statute, to reduce unnecessary administrative burden, mitigate penalties for technical or non-substantive violations, and better enable value-based, patient-centered care while maintaining appropriate safeguards against fraud and abuse and protecting patients from conflicts of interest and inappropriate utilization. (New HOD Policy) 2. That our AMA support the Centers for Medicare & Medicaid Services (CMS) explicitly defining factors that can be utilized to calculate “fair market value” (FMV) as it relates to physician compensation including, but not limited to, the following factors: • Physician specialty, subspecialty, or physician services to be provided; • Geographic location; • Supervision of non-physician providers or trainees; • Whether a restrictive covenant is in place and its level of restrictiveness; • Additional roles and responsibilities (e.g., education, quality improvement duties, alternative payment model or value-based care participation, serving as licensed directors of hospital departments or laboratories); • Restrictions on outside activities or income opportunities (e.g. work at a Veterans Affairs facility, work at an academic institution, moonlighting, consulting, development of intellectual property owned by the physician, or	Delegate instructed to support.

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			other outside professional activities); • Specialty or subspecialty shortages, either locally or nationally; and/or • Other factors that impact value to the health system. (New HOD Policy) 3. That our AMA support CMS providing additional guidance on exceptions and/or safe harbors that physicians and employers can rely upon to adjust physician compensation, either through direct compensation, or through value-sharing of other payments that are based on the physician's contribution to the institution. (New HOD Policy) 4. That our AMA encourage physicians to ask for transparency when negotiating an employment contract and ask for employers to disclose and provide the methodology, data sources, and calculations used in determining FMV as it relates to the compensation of independent physicians contracting with the hospital whenever FMV is cited as a reason for the selected compensation level. (New HOD Policy) 5. That our AMA support transparency of ongoing and future proposed physician financial relationships, compensation models, and ownership structures between physicians, hospitals, and other healthcare entities during any negotiation to provide healthcare or administrative services between all parties. (New HOD Policy) 6. That our AMA encourage physicians, particularly those in independent practice that are entering contracting arrangements, to seek independent valuation, legal counsel, and third-party review when negotiating compensation and contractual agreements where FMV is an issue. (New HOD Policy) 7. That our AMA support policies that ensure fair and transparent integrity in physician-health system contractual relationships, including written, transparent, and time-limited agreements, appropriate limitations on restrictive covenants to protect patient access and continuity of care, and preservation of physician advocacy on behalf of patients. (New HOD Policy) 8. That our AMA reaffirm Policy D-405.988, which states that the AMA supports preserving the value of the private practice of medicine and its benefit to patients. (Reaffirm HOD Policy) 9. That our AMA reaffirm Policy D-385.940, which states that the AMA recognizes the substantial impact of Stark law's unequal restrictions on independent physicians, contributing to the growing trend of hospital	

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			consolidation, which has led to negative consequences of restricted access to care and inflated costs, supports comprehensive Stark law reform aimed at rectifying the disparities that disadvantage independent physician practices while preserving the intent of AMA Code of Ethics Policy 9.6.9, "Physician Self-Referral," and supports equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care. (Reaffirm HOD Policy) 10. That our AMA reaffirm Policy H-385.914, which states that the AMA opposes and continues to advocate against the misuse of the Stark law and regulations to cap or control physician compensation. (Reaffirm HOD Policy)	
26	J	Res. 805 - Meaningful Enforcement of Prohibitions on the Corporate Practice of Medicine (American College of Emergency Physicians)	RESOLVED, that our American Medical Association amend Policy H-215.981, "Corporate Practice of Medicine," by modification to read as follows: 1. Our American Medical Association vigorously opposes any effort to pass legislation or regulation that removes or weakens state or federal laws prohibiting the corporate practice of medicine. 2. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups. 3. Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations. 4. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues. 5. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the health care sector such that physician clinical autonomy and operational authority are preserved and protected. 6. Our AMA will create a state corporate practice of medicine template to assist state medical associations and ~~national medical~~ specialty societies as they	Delegate instructed to support.

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			navigate the intricacies of corporate investment in physician practices and health care ~~generally at the state level~~ and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices, including meaningful enforcement mechanisms, remedies, and protections against retaliation and provisions rendering unenforceable contractual restrictions that interfere with physicians' independent professional judgment, patient advocacy, or good-faith reporting] 7. Our AMA supports meaningful enforcement of existing regulations and legislation pertaining to corporate control of practices in the health care sector to ensure that physician clinical autonomy and operational authority ~~is~~ are preserved and protected, including appropriate enforcement authority and meaningful remedies for violations. 8. Our AMA supports capital reserve requirements and leverage standards that preserve access to care for patients and fulfillment of contractual obligations to physicians and trainees by providing stable financing for hospitals, clinics, and other health care facilities. (Modify Current HOD Policy)	
27	J	Res. 808 - Increasing Payment for Patient Portal Messages (Women Physicians Section, Organized Medical Staff Section, Private Practice Physicians Section)	RESOLVED, that our American Medical Association amend Policy H-385.919, "Payment for Electronic Communication," by addition and deletion to read as followed: 1. Our American Medical Association will advocate that ~~pilot projects of innovative~~ physician payment models be structured to include ~~incentive~~ fair market payment for the use of electronic communications such as Web portals, remote patient monitoring, real-time virtual office visits, patient portal messages, and email and telephone communications. 2. Our AMA will continue to update its guidance on communication and information technology to help physicians meet the needs of their patients and practices. 3. Our AMA will educate physicians on how to effectively and fairly bill for electronic communications between patients and their physicians. (Update current policy); and be it further	Delegate instructed to strongly support.

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			RESOLVED, that our AMA advocate for employers to a.) educate physicians on how to effectively and fairly bill for electronic communications b.) create workflows and templates which make such billing easy to implement, and c.) incorporate protected time into a physician's schedule in order to adequately address patient portal messages (Directive to take Action); and be it further RESOLVED, that our AMA prioritize the promotion of already available toolkits and member education resources pertaining to how to more effectively manage inbasket work and bill for patient portal messages. (Directive to Take Action)	
28	J	Res. 809 - Joint Commission Standards for Medical Staff Self-Governance (Organized Medical Staff Section)	RESOLVED, that our American Medical Association, through its appointees to the Joint Commission Board of Commissioners and other appropriate channels, advocate for restoring clear accreditation standards affirming medical staff self-governance and physician-led oversight of credentialing, privileging, peer review, professional competence, quality improvement, patient safety, and other matters involving the professional practice of medicine. (Directive to Take Action)	Delegate instructed to strongly support.
29	J	Res. 810 - Strengthening Medicare and Accreditation Standards for Organized Medical Staff Independence (Organized Medical Staff Section)	RESOLVED, that our American Medical Association advocate that the Centers for Medicare & Medicaid Services (CMS) establish standards requiring, as a Condition of Participation for hospitals participating in Medicare, that Medical Staff Office personnel performing functions on behalf of organized medical staff have clearly defined functional accountability to the organized medical staff, through the Medical Executive Committee or its designee for credentialing, privileging, peer review, corrective action, medical staff governance, quality oversight, and other organized medical staff functions (Directive to Take Action); and be it further RESOLVED, that our AMA advocate that CMS require hospital medical staff bylaws or related governing documents approved through the medical staff bylaw process to define the Medical Staff Office reporting structure, authority over medical-staff work assignments and performance evaluation, safeguards against administrative interference or retaliation, and standards governing access to, use of, and disclosure of confidential medical staff information	Delegate instructed to strongly support.

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			(Directive to Take Action); and be it further RESOLVED, that our AMA advocate that CMS-approved hospital accrediting organizations adopt uniform standards concerning Medical Staff Office functional accountability, protected medical staff resources, access to independent legal counsel when appropriate, and confidentiality of credentialing, privileging, peer review, quality-improvement, corrective-action, and disciplinary information (Directive to Take Action); and be it further RESOLVED, that our AMA advocate that Joint Commission standards explicitly protect the organized medical staff's access to timely, transparent, and interpretable information, adequate resources, and independent authority necessary to meaningfully fulfill its self-governance responsibilities, regardless of how supporting personnel, technology, or administrative infrastructure are organized. (Directive to Take Action)	
30	J	Res. 812 - Protect Patient Choice and Physician Privileges in Hospitals Merger and Acquisitions (New York)	RESOLVED, that our American Medical Association advocate to protect the full admitting and surgical privileges of private practice physicians as a necessary condition of any hospital merger or acquisition and will advocate to protect the employment benefit for physicians, residents and fellows including preservation of salary and benefit levels and Public Service Loan Forgiveness (PSLF) eligibility as a necessary condition of any hospital merger or acquisition. (Directive to Take Action)	Delegate instructed to strongly support.
31	J	Res. 815 - Improving Technology to Combat Automated and Artificial Intelligence-Directed Downcoding of Evaluation and Management Services by Health Insurance Companies (Florida)	RESOLVED, that our American Medical Association advocate with urgency, including through EHR certification criteria and standard billing and clearinghouse functionality, for electronic health record, billing, and practice management systems to automatically detect from the electronic remittance advice when a payer has adjudicated or reimbursed a claim at an E/M service level lower than the level submitted — whether by code reassignment or payment reduction — and to alert physicians or their billing staff, with the original and adjudicated codes, the payer's stated reason, and the applicable appeal deadline, within the time needed to appeal (Directive to Take Action); and be it further	Delegate instructed to support combining Resolutions 815 and 816 and support alternate language offered by the Council on Medical Services.

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			RESOLVED, that our AMA increase awareness of automated, algorithmic, and artificial intelligence-directed E/M downcoding among physicians, medical societies, policymakers, regulators, and other stakeholders; develop, provide, and update resources — including downcoding-specific appeal templates, model contract language, and documentation guidance — to help physicians identify, document, and appeal inappropriate downcoding; and collect and periodically report data on the prevalence and payer-level patterns of such downcoding. (New HOD Policy)	
32	J	Res. 816 - Enhancing Advocacy to Combat Automated Insurance Downcoding of EM Services (Florida)	RESOLVED, that our American Medical Association uses its legal and advocacy resources, when appropriate, to support litigation, including class action suits, challenging automated, algorithmic, or artificial intelligence-directed downcoding of properly documented E/M services without appropriate medical record review (New HOD Policy); and be it further RESOLVED, that our AMA advocates and requests CMS to enforce and strengthen its 2024 Final Rule requirements applicable to Medicare Advantage plans regarding automated coverage and coding criteria, restricts downcoding without clear separate notification of each incident with the explanation of benefits, and establishes minimum transparency standards for all algorithmic claims adjudication policies including public disclosure of the criteria and methodologies used. (Directive to Take Action)	Delegate instructed to support combining Resolutions 815 and 816 and support alternate language offered by the Council on Medical Services.
33	J	Res. 817 - Proposed revised H-450.982, Patient Satisfaction, Patient Experience, and Quality of Care (American College of Emergency Physicians)	RESOLVED, that our American Medical Association recognizes patient feedback and appropriately designed patient-experience and patient-satisfaction measures as valuable tools for improving communication, patient-centered care, health care delivery, quality improvement, formative feedback, and professional development (New HOD Policy); and be it further RESOLVED, that our AMA supports continued efforts to improve the measurement of patient experience and patient satisfaction, including ensuring that such measures are valid, reliable, and used for the purposes for which they were developed (New HOD Policy); and be it further	Delegate instructed to support.

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			RESOLVED, that our AMA opposes tying individual physician compensation, bonuses, hiring, employment retention or termination, promotion, credentialing, contracting, or network participation to patient-experience or patient-satisfaction survey scores (New HOD Policy); and be it further RESOLVED, that our AMA opposes policies or incentives based on patient-experience or patient-satisfaction survey scores that may interfere with independent clinical judgment or incentivize medically unnecessary, inappropriate, or unsafe care (New HOD Policy); and be it further RESOLVED, that our AMA rescind policy H-450.982. (Rescind Current HOD Policy)	
34	J	Res. 820 - Strengthening Emergency Interfacility Transfer Infrastructure (American Academy of Emergency Medicine)	RESOLVED, that our American Medical Association advocate for federally supported regional emergency transfer coordination systems providing a single point of access to real-time receiving-hospital capabilities and medical transport availability for time-sensitive interfacility transfers, with participation by Medicare-participating hospitals with relevant emergency or specialized capabilities (Directive to Take Action); and be it further RESOLVED, that our AMA advocate to Congress and the Centers for Medicare & Medicaid Services for payment models that support emergency interfacility transport readiness, including dedicated or regionally shared advanced and critical-care transport capacity without compromising 911 response. (Directive to Take Action)	Delegate instructed to listen.
35	K	Res. 912 - Reducing Medical Waste Through Electronic Instructions for Use (e-IFU) for Surgical and Medical Device Products	RESOLVED, that our American Medical Association encourage manufacturers of surgical and medical device products across all surgical specialties to replace paper Instructions for Use (IFU) with electronic Instructions for Use (e-IFU) when feasible, consistent with patient safety and applicable regulatory requirements (New HOD Policy); and be it further RESOLVED, that our AMA advocate to the U.S. Food and Drug Administration and relevant federal agencies to clarify and expand the regulatory pathway	Delegate instructed to support.

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		(American Academy of Ophthalmology)	under the Federal Food, Drug, and Cosmetic Act permitting e-IFU for surgical and medical device products, and to reduce inconsistent international IFU requirements that impede manufacturer adoption of e-IFU (Directive to Take Action); and be it further RESOLVED, that our AMA share findings from published multisociety research on e-IFU with all AMA specialty sections and encourage interprofessional dialogue on sustainable device packaging practices, with the goal of developing a unified, cross-specialty position supporting e-IFU adoption across medicine. (Directive to Take Action)	
36	K	Res. 920 - Improving Protection for Patient Medical Records and Health Care (LGBTQ+ Section)	RESOLVED, that our American Medical Association oppose governmental efforts to compel the disclosure of identifiable patient medical records from physicians or health care institutions when such efforts are primarily directed at investigating or deterring the provision of otherwise ethical, evidence-based medical care and lack a compelling patient safety or public health justification (New HOD Policy); and be it further RESOLVED, that our AMA advocate that governmental requests for identifiable patient medical records in connection with investigations of clinical care be narrowly tailored, supported by an individualized legal basis, and implemented in a manner that minimizes unnecessary intrusion into patient privacy and the patient-physician relationship (New HOD Policy); and be it further RESOLVED, that our American Medical Association amend Policy D-315.966, "Improving Protection for Reproductive Health Information," by addition to read as follows: 1. Our American Medical Association supports legislation and regulations prohibiting the use or disclosure of protected health information (PHI) to conduct a criminal, civil, or administrative investigation into or to impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health and gender-affirming care.	Delegate instructed to support resolves 1 and 2, listen on resolve 3.

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			2. Our AMA advocates to ensure that the release of protected health information of a decedent to forensic pathologists be unimpeded by unnecessary administrative burdens. (Modify Current HOD Policy)	
37	K	Res. 925 - Opposition to Mandatory Testosterone Testing for Active Duty Servicemembers (Organized Medical Staff Section, Oklahoma)	RESOLVED, that our American Medical Association oppose mandatory, non-indication-based federal hormone screening programs, including policies requiring annual testosterone testing and affirms that hormone testing should be guided by individualized clinical judgment and evidence-based medical indications, rather than imposed through categorical or population-based mandates (New HOD Policy); and be it further RESOLVED, that our AMA urge that proposals for federal testing of hormone levels (such as requiring annual testosterone testing of male active duty servicemembers aged 30 or older) should be evaluated for cost-effectiveness and resource stewardship, relative to indication-based clinical testing, including the downstream costs of confirmatory testing, specialty referral, and longitudinal monitoring, prior to implementation (New HOD Policy); and be it further RESOLVED, that our AMA reaffirm policy H-260.963 and call for those principles to be applied to any federal hormone screening program, including the use of standardized, validated testosterone assays and clinician education on assay variability. (Reaffirm HOD Policy)	Delegate instructed to strongly support.
38	K	Res. 928 - Electric Bike and Scooter Safety, Regulation, and Enforcement (California)	RESOLVED, that our American Medical Association amend AMA policy D-10.989 by addition and deletion to read as follows: 1. Our American Medical Association recognizes electric bikes and scooters or micromobility injuries and deaths as a public health issue that would benefit from focused safety and injury prevention strategies. ~~1.~~ 2. Our American Medical Association better defines and expands AMA policy to help improve safety for micromobility (e-bikes and e-scooters) usage by endorsing the following positions: a. Helmets, certified by the US Consumer Safety Product Commission and rated for speed, should be worn for all and be mandatory for Class 3 e-bikes and all scooters;	Delegate instructed to strongly support.

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			b. Additional gear should include elbow pads, knee pads, wrist guards, closed-toe footwear and high-visibility or reflective gear for use at nighttime; c. Headphones should be avoided during use; d. E-scooters and Class 3 e-bikes should have a minimum age of 16 to operate; e. Require education and training for Class 3 e-bikes; f. Define where e-bikes can be ridden both on and off-road, including speed limits on shared paths and no operation allowed on sidewalks; g. No distractions while operating; h. No passengers while operating; i. Regulate out-of-class products and anti-tampering; and j. Training required to operate devices, including smooth and consistent braking at high speeds and basic traffic rules. ~~2.~~ 3. Our AMA advocates for standardized injury surveillance and reporting of micromobility-related injuries at the state and national level, including integration into existing trauma registries and public health reporting systems. ~~3.~~ 4. Our AMA encourages and advocates for accelerated research into the root causes of e-bike and e-scooter related injuries in the United States, with the goal of defining actionable best practices to prevent and/or minimize serious injury associated with operation of various classes of such vehicles, as well as the relevant demographics of the operators thereof (Modify Current HOD Policy); and be it further RESOLVED, that our AMA advocate for Congress to establish a task force to develop recommendations on how states should regulate e-bikes and e-scooters including: • classification and labeling of electric bikes and scooters, • licensing and registration requirements, • age restrictions, • universal helmet use, • required rider safety education and public education • motor power limits and maximum assistance-speed capabilities, • night visibility requirements including lighting and reflectors • braking performance; • battery and electrical safety;	

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			• safeguards against tampering or modification that allows a device to exceed its permitted class, power, or performance limits This task force shall recommend minimum federal standards while allowing states to establish more stringent standards (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for roadway and transportation infrastructure improvements demonstrated to improve the safety of electric bike and scooter users, motorists, and pedestrians (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for parity of enforcement of safety regulations for electric bikes and scooters including citations and other enforcement actions. (Directive to Take Action)	

CONTINUED…

Additional Items of Interest

These items are potentially related to OMSS interests; however the OMSS Governing Council does not recommend any specific action for the Delegate and Alternate Delegate.

Item #	Ref Com	Title	Proposed Policy
1	E&B	CCB 02 - Amendments to Bylaws Governing the AMA Sections	*Refer to report CCB 02 for recommendations.*
2	B	Res. 225 - Supporting a Common Legal Framework for Medical Capacity Holds (Resident and Fellow Section)	RESOLVED, that the American Medical Association study existing laws, institutional practices, and ethical frameworks related to the use of medical holds for patients who lack medical decision-making capacity, with the goal of identifying best practices and informing potential model legislation. (Directive to Take Action)
3	F	CLRPD 01 - Evaluation of the Size and Structure of the AMA House of Delegates	The Council on Long Range Planning and Development recommends that the following recommendations be adopted and the remainder of the report be filed: 1. That delegate apportionment will be capped at its current level (793 delegates) for 2027 apportionment. Constituent association allocation will remain 351 with a corresponding number of 351 specialty society delegates to be apportioned according to established procedures. All other delegations will continue at their A-26 apportionment. 2028 apportionment will be based on year-end 2027 membership figures and so forth moving forward. 2. That, for 2027 apportionment and onward, the bylaws be amended to delete all apportionment language which includes "or fraction thereof" when apportioning any additional delegates beyond the first, so that additional delegates will not be added for a fraction of the recommended apportionment ratio. 3. That specialty society membership numbers will be obtained every three years as opposed to every five years for increased accuracy. 4. That there is a review of current apportionment rules and procedures with a report back to the HOD at the 2027 Interim Meeting, including assessing the ability to and costs associated with obtaining specialty society membership figures on an annual basis.
4	J	Res. 801 - Improving the External Appeals	RESOLVED, that AMA Policy H-320.952, External Grievance Review Procedures, be amended by addition and deletion to read as follows:

Item #	Ref Com	Title	Proposed Policy
		Process for Denied Claims (Medical Student Section)	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;~~ Issues eligible for external grievance review should include, at a minimum, adverse benefit determinations that materially affect an enrollee's coverage of, access to, or financial responsibility for health care items or services, including, but not limited to: determinations based on medical necessity or other medical judgment, experimental or investigational status, plan terms or benefit classification, network status, coding or other administrative grounds, surprise billing protections, or rescission of coverage; provided that external review need not encompass disputes solely concerning practitioner payment that do not affect the enrollee's coverage, access, or financial responsibility; (4) ~~Internal grievance procedures should generally be exhausted before requesting external review;~~ Internal grievance procedures should remain available, but an enrollee, the enrollee's authorized representative, or treating physician should be permitted to seek independent external review of an adverse benefit determination without first exhausting internal grievance procedures. A health plan may conduct internal review concurrently, provided that independent external review is not delayed; (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. (Modify Current HOD Policy)

END