AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1001
(N-21)

Introduced by: Private Practice Physician Section

Subject: Appeals and Denials – CPT Codes for Fair Compensation

Referred to: Reference Committee G

Whereas, Our American Medical Association (AMA) has previously affirmed that physicians and healthcare practices should be fairly compensated for work involved in administrative work; and

Whereas, The AMA CPT® Editorial Panel is authorized by the AMA Board of Trustees to revise, update, or modify Current Procedural Terminology (CPT) codes, descriptors, rules, and guidelines; and

Whereas, Studies have shown that wrongful adverse determinations by health plans are common, including denial of prior authorization, denial of payment for previously provided service; and

Whereas, Good public and economic policy must align costs, benefits and incentives; currently, all costs in appealing wrongful denials are incurred by healthcare professionals and all financial savings and benefits from wrongful denials accrue to health insurance plans leading to perverse incentive that disadvantage patients and endanger their health; and

Whereas, Healthcare professionals cannot afford to advocate on patients' behalf to reverse wrongfully denied medically necessary services while health plans have a perverse incentive to deny medically necessary services knowing that healthcare providers cannot afford to appeal every wrongful denial of service; and

Whereas, Compensation for work performed by healthcare providers is accomplished via CPT codes; therefore be it

RESOLVED, That our American Medical Association support the creation of CPT codes for consideration by the CPT® Editorial Panel to provide adequate compensation for administrative work involved in successfully appealing denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials, that reflect the actual time expended by physicians and healthcare practices to advocate on behalf of patients, appeal denials, and to comply with insurer and legal requirements and that compensate physicians fully for the time, effort, and legal risks inherent in such work (Directive to Take Action); and be it further

RESOLVED, That our AMA support the creation of CPT codes for consideration by the CPT Editorial Panel for primary, secondary, and tertiary appeals to independent review organizations (IROs), state and federal regulators, and ERISA plan appeals, including codes for appeals, reconsiderations, and other forms of appeals of adverse determination (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for fair compensation based on CPT codes for appeal of denied services in any model legislation and as a basis for all advocacy for prior authorization reforms. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 11/10/21

AUTHORS STATEMENT OF PRIORITY

Submitting appeals for denials of services is one of the most time consuming administrative burdens imposed by health insurers that takes away valuable clinical hours from patient care and increases overhead costs, threatening the viability of independent practices already under financial pressures from the COVID-19 pandemic. As the pace of independent practices closing their doors or becoming acquired by health systems or private equity continually increases, It is imperative to obtain relief from this particular administrative burden as soon as possible.

RELEVANT AMA POLICY

Remuneration for Physician Services H-385.951
1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.
Citation: Sub. Res. 814, A-96; Reaffirmed: A-02; Reaffirmed: I-08; Reaffirmed: I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmed: A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19

Prior Authorization Reform D-320.982
Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.
Citation: Res. 704, A-19

CPT Coding H-70.992
The AMA continues to support a national uniform descriptor system including, but not limited to, the following initiatives: (1) accelerate the process followed by the AMA CPT Editorial Panel, as feasible, to effect expeditiously changes by adding or deleting codes and nomenclature in order to keep CPT-4 as the best single source for up-to-date reference;
(2) encourage CMS to direct Medicare carriers to refrain from unilateral deletion of CPT descriptors; and (3) work with national medical specialty societies and state medical

associations to review the current status of local carrier descriptor systems and work with CMS to develop an oversight mechanism to monitor carrier compliance with CMS directives on the appropriate use of the national coding system.
Citation: Sub. Res. 47, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans D-320.995
(1) Our AMA will re-distribute its model legislation that would prevent the retrospective denial of payment for any claim for services for which a physician had previously obtained authorization. (2) Our AMA will work with private sector accreditation organizations to ensure that their health plan and utilization management accreditation standards adequately address fair and appropriate mechanisms for retrospective review. (3) AMA's Private Sector Advocacy unit will work with state medical associations, county medical societies, and national medical specialty societies to (a) develop a survey instrument for use by the Federation to gather information from physicians who experience retrospectively denied and/or down-coded claims, (b) seek information on a regular basis from those associations that collect such information, and (c) respond with appropriate legislation, advocacy, and communication initiatives.
Citation: CMS Rep. 5, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Sub. Res. 728, A-10; Reaffirmed: A-18