REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-A-25

Subject: Council on Medical Service Sunset Review of 2015 House Policies

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee G

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

1. As the House of Delegates adopts policies, a maximum 10-year time horizon shall exist. A policy will typically sunset after 10 years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

RECOMMENDATION

The Council on Medical Service recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

APPENDIX – Recommended Actions

POLICY #	Title	Text	Recommendation
D-120.977	Medicare Patient Access to Implantable Morphine Pumps	Our AMA, in collaboration with appropriate medical societies, will continue to work to address the need for appropriate treatment of patients requiring long-term pain management.	Rescind. Numerous AMA policies address pain management, including H-185.931, D-120.976, and H-120.960. **Workforce and Coverage for Pain Management H-185.931** 1. Our AMA supports efforts to improve the quality of care for patients with pain, ensuring access to multiple analgesic strategies, including non-opioid options and interventional approaches when appropriate, with a focus on achieving improvement in function and activities of daily living. 2. Our AMA supports guidance on pain management for different clinical indications developed by the specialties who manage those conditions and disseminated the same way other clinical guidelines are promoted, such as through medical journals, medical societies, and other appropriate outlets. 3. Our AMA will advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain. 4. Our AMA supports health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits. 5. Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, as well as an expanded behavioral health workforce to improve the availability of services to address the psychological, behavioral, and social aspects of pain and pain management within

POLICY #	Title	Text	Recommendation
			multidisciplinary pain clinics. Patients and their caregivers should be involved in the decision-making process. 6. Our AMA supports an expanded availability of comprehensive multidisciplinary pain medicine clinics for patients in both urban and rural areas, and an improvement in payment models for comprehensive multidisciplinary pain clinics services such that such services can become more financially viable. **Pain Management D-120.976** Our AMA will: (1) support more effective promotion and dissemination of educational materials for physicians on prescribing for pain management; (2) take a leadership role in resolving conflicting state and federal agencies' expectations in regard to physician responsibility in pain management; (3) coordinate its initiatives with those state medical associations and national medical specialty societies that already have already established pain management guidelines; and (4) disseminate Council on Science and Public Health Report 5 (A-06),"Neuropathic Pain," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain); and (5) disseminate Council on Science and Public Health Report 5 (A-10), "Maldynia: Pathophysiology and Nonpharmacologic Approaches," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain). **Protection for Physicians Who Prescribe Pain Medication H-120.960** Our AMA supports the following: (1) the position that physicians who appropriately prescribe and/or

POLICY #	Title	Text	Recommendation
			administer controlled substances to relieve intractable pain should not be subject to the burdens of excessive regulatory scrutiny, inappropriate disciplinary action, or criminal prosecution. It is the policy of the AMA that state medical societies and boards of medicine develop or adopt mutually acceptable guidelines protecting physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain before seeking the implementation of legislation to provide that protection; (2) education of medical students and physicians to recognize addictive disorders in patients, minimize diversion of opioid preparations, and appropriately treat or refer patients with such disorders; and (3) the prevention and treatment of pain disorders through aggressive and appropriate means, including the continued education of doctors in the use of opioid preparations. Our AMA opposes harassment of physicians by agents of the Drug Enforcement Administration in response to the appropriate prescribing of controlled substances for pain management.
D-160.933	Payment Mechanisms for Physician-Led Team-Based Health Care	Our AMA will develop educational programs to assist members wishing to develop and implement physician-led team based care payment methodologies at the individual team, practice, accountable care organization, hospital and health system levels.	Rescind. Accomplished by several *Advocacy Issue Briefs* and other resources on the AMA website: 1) Physician-Led Team-Based Care 2) AMA Advocacy Resource Center – Physician-Led Health Care Teams 3) Models of Physician-Led Team-Based Care 4) Summary of physician payment & delivery models 5) Ed Hub Module – Physician Payment Models Guide 6) Ed Hub Module – Physician-Led Models to Achieve the Quadruple Aim 7) AMA/AHIP/NAACOS Playbook of Voluntary Best Practices for VBC Payment Arrangements
D-165.954	Update on HSAs, HRAs, and Other Consumer-	Our AMA will: (1) educate physicians about health insurance plan practices that may impact physician billing and collection	Retain.

POLICY #	Title	Text	Recommendation
	Driven Health Care Plans	of payment from patients with health savings accounts (HSAs), health reimbursement arrangements (HRAs), and other forms of consumer-driven health care; and (2) monitor and support rigorous research on the impact of HSAs and HRAs on physician practices, and on levels and appropriateness of utilization, including preventive care, costs, and account savings.	
D-280.988	Observation Status and Medicare Part A Qualification	Our AMA will advocate for Medicare Part A coverage for a patient's direct admission to a skilled facility if directed by their physician and if the patient's condition meets skilled nursing criteria.	Rescind. Superseded by Policy H-280.947. **Three Day Stay Rule H-280.947** 1. Our American Medical Association will continue to advocate that Congress eliminate the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services, and educate Congress on the impact of this requirement on patients. 2. Our AMA will continue to advocate, as long as the three-day stay requirement remains in effect, that patient time spent in the hospital, observation care or in the emergency department count toward the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services. 3. Our AMA will actively work with the Centers for Medicare and Medicaid Services (CMS) to eliminate any regulations requiring inpatient hospitalization as a prerequisite before a Medicare beneficiary is eligible for skilled (SNF) or long-term care (LTC) placement. 4. Our AMA advocates that the Medicare three-day hospital inpatient requirement for skilled nursing facility admissions be immediately rescinded for uniformity and safety for all Medicare recipients.
D-290.987	Early and Periodic Screening, Diagnosis, and Treatment	Our AMA recognizes the importance of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and will advocate for EPSDT to remain intact as critical to the health and well-being of children.	Retain.

POLICY #	Title	Text	Recommendation
D-375.996	Peer Review Immunity	Our AMA: (1) recommends that medical staffs adopt bylaws that provide for a peer review process that is consistent with HCQIA criteria and AMA policy; (2) recommends medical staffs include bylaw provisions that provide an option or alternative for external and impartial review when there is an allegation by a reviewed physician; (3) recommends that if physicians believe that negligent or misdirected peer review is a problem, legislative action be considered at the state level to assure a fair due process proceeding for physicians subject to review; and (4) shall continue to monitor the legal and regulatory challenges to peer review immunity and non-discoverability of peer review records and proceedings, as well as consider legislative remedies, including the feasibility and impact of amending HCQIA to provide the option for external peer review for hospital medical staff physicians.	Rescind: Superseded by Policy D-375.997. **Peer Review Immunity D-375.997** 1. Our American Medical Association will recommend medical staffs adopt/implement staff by laws that are consistent with HCQIA and AMA policy by communicating the guidelines from AMA policy H-375.983 widely through appropriate media to the relevant organizations and institutions, including a direct mailing to all medical staff presidents in the United States, indicating that compliance is required to conform to HCQIA and related court decisions. 2. Our AMA will monitor legal and regulatory challenges to peer review immunity and non discoverability of peer review records/proceedings and continue to advocate for adherence to AMA policy, reporting challenges to peer review protections to the House of Delegates and produce an additional report with recommendations that will protect patients and physicians in the event of misdirected or negligent peer review at the local level while retaining peer review immunity for the process. 3. Our AMA will continue to work to provide peer review protection under federal law.
D-450.958	Pain Medicine	Our AMA: (1) continues to advocate that the Centers for Medicare & Medicaid Services (CMS) remove the pain survey questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS); (2) continues to advocate that CMS not incorporate items linked to pain scores as part of the CAHPS Clinician and Group Surveys (CG-CAHPS) scores in future surveys; and (3) encourages hospitals, clinics, health plans, health systems, and academic medical centers not to link	Retain.

POLICY #	Title	Text	Recommendation
		physician compensation, employment retention or promotion, faculty retention or promotion, and provider network participation to patient satisfaction scores relating to the evaluation and management of pain.	
D-450.962	Pain Management and the Hospital Value-Based Purchasing Program	1. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) to: (a) evaluate the relationship and apparent disparity between patient satisfaction, using the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) and Emergency Department Patient Experience of Care (ED-PEC) survey, and hospital performance on clinical process and outcome measures used in the hospital value based purchasing program; and (b) reexamine the validity of questions used on the HCAHPS and ED-PEC surveys related to pain management as reliable and accurate measures of the quality of care in this domain. 2. Our AMA urges CMS to suspend the use of HCAHPS and ED-PEC measures addressing pain management until their validity as reliable and accurate measures of quality of care in this domain has been determined.	Retain.
D-510.991	Requiring The Joint Commission to Conduct Root-Cause Analysis to Determine How its Surveys Allowed Veterans Administration Hospitals to Cause Delay in Treatment and Harm Veterans	Our AMA supports The Joint Commission making public its findings following its resurveying of Veterans Health Administration (VHA) facilities to ensure quality of care and patient safety.	Rescind: This has been completed.
D-70.945	ICD-10 Implementation	1. If a delay of ICD-10 implementation is not feasible, our American Medical	Rescind: ICD-10-CM was implemented on 10/1/15.

POLICY #	Title	Text	Recommendation
		Association will ask the Centers for Medicare & Medicaid Services (CMS) and other payers to allow a two-year grace period for ICD-10 transition, during which physicians will not be penalized for errors, mistakes, and/or malfunctions of the system. Physician payments will also not be withheld based on ICD-10 coding mistakes, providing for a true transition where physicians and their offices can work with ICD-10 over a period of time and not be penalized. 2. Our AMA will educate physicians of their contractual obligations under Medicare and insurance company contracts should they decide to not implement ICD-10 and opt to transition to cash-only practices which do not accept insurance. 3, Our AMA will aggressively promote this new implementation compromise to Congress and CMS since it will allow implementation of ICD-10 as planned, and at the same time protect patients' access to care and physicians' practices. 4. Our AMA will provide the needed resources to accomplish this new compromise ICD-10 implementation and make it a priority. 5. Our AMA will seek data on how ICD-10 implementation has affected patients and changed physician practice patterns, such as physician retirement, leaving private practice for academic settings, and moving to all-cash practices and that, if appropriate, our will AMA release this information to the public.	
D-70.946	Physician Participation as the 5th	1. Our American Medical Association will advocate for a group with strong physician	Retain; still relevant, as it references "future ICD systems" (e.g., ICD-11).

POLICY #	Title	Text	Recommendation
	Cooperating Party in the International Classification of Diseases System in the United States	participation to be the 5th Cooperating Party for ICD-9-CM and ICD-10-CM with equal power of the current four Cooperating Parties in the planning, interpretation and deployment of ICD-9-CM, ICD-10-CM and future ICD systems. 2. Our AMA will seek to be invited by the United States Department of Health and Human Services to submit nominee[s] for physician group[s] or a group with strong physician participation to be designated as the 5th Cooperating Party for ICD-9-CM, ICD-10-CM and future ICD systems.	
D-70.947	Uncoupling of CPT from ICD-10	Our American Medical Association recommends that the Comptroller General of the Government Accountability Office not address uncoupling the ICD diagnosis code from the CPT procedure code at the present time but this may be reconsidered in the future if new mechanisms are developed for payment of physician services.	Retain; still relevant, as it outlines reconsideration "if new mechanisms are developed for payment of physician services."
D-70.948	ICD-10 Transparency and Conversion	1. The provisions of the Protecting Access to Medicare Act of 2014 delaying the compliance date for the ICD-10 transition are consistent with and supported by existing AMA policy. 2. During the delay in implementation of the ICD-10 transition our AMA will seek and support efforts to ensure that any health plan (commercial, Medicare, Medicaid, or other) operating in the United States, shall provide to their provider network sufficient and timely information apprising providers of all planned changes, including coverage, guidelines, authorization, certifications, claims adjudications, pricing, payment, reporting, incentives and other rules, as well as	Rescind: ICD-10-CM was implemented on 10/1/15.

POLICY #	Title	Text	Recommendation
		resources such as crosswalks or maps, based on the conversion from ICD-9 to ICD-10.	
D-70.949	Stop the Implementation of ICD-10	1. Our AMA will continue to work diligently and actively with Congress to permanently remove the unnecessary administrative burden on physicians of ICD-10 implementation. 2. Our AMA will advocate that Congress ask the Comptroller General of the United States, in consultation with stakeholders in the medical community, to conduct a study to identify steps that can be taken to mitigate the disruption on health care providers resulting from a replacement of ICD-9 in the future; and that the Comptroller General shall submit to each House of Congress a report on such study no later than May 1, 2015 and such report shall include appropriate recommendations. 3. The Comptroller General's report should at least address these issues: 1) decreasing the massive number of codes down to a reasonable number such as Canada did; 2) putting the replacement of ICD-9 on hold until physicians fully implement the new Electronic Medical Record systems, the new government regulations and the Affordable Care Act regulations; and 3) consider adopting a policy for Medicare that provides a two year implementation period during which Medicare will not be allowed to deny payment based on the specificity of the ICD-10 code.	Rescind: ICD-10-CM was implemented on 10/1/15.
D-70.951	Alleviating the Financial Burdens Associated with ICD-10 Implementation	1. Our AMA will seek federal legislative and regulatory reform to require funding assistance be provided to physician practices to alleviate the financial burdens associated with the implementation costs, upgrades	Rescind: ICD-10-CM was implemented on 10/1/15.

POLICY #	Title	Text	Recommendation
		and staff training necessitated as part of the transition to ICD-10. 2. Our AMA will work toward the goal of having insurance companies and governmental entities reimburse physicians for the extra cost of increasingly complex and mandatory changes in coding.	
D-70.952	Stop the Implementation of ICD-10	1. Our AMA will: (A) vigorously work to stop the implementation of ICD-10 and to reduce its unnecessary and significant burdens on the practice of medicine; (B) do everything possible to let the physicians of America know that our AMA is fighting to repeal the onerous ICD-10 requirements on their behalf; (C) work with other national and state medical and informatics associations to assess an appropriate replacement for ICD-9; and (D) evaluate the feasibility of moving from ICD-9 to ICD-11 as an alternative to ICD-10 and report back to the House of Delegates. 2. In order to alleviate the increasing bureaucratic and financial burden on physicians, our AMA will vigorously advocate that the Centers for Medicare & Medicaid Services eliminate the implementation of ICD-10. 3. Our AMA will immediately reiterate to the Centers for Medicare & Medicaid Services that the burdens imposed by ICD-10 will force many physicians in small practices out of business. This communication will be sent to all in Congress and displayed prominently on our AMA website. 4. Our AMA: (A) will educate US physicians on the burdens of ICD-10 and how our AMA is fighting to repeal the onerous ICD-10 requirements on their	Rescind: ICD-10-CM was implemented on 10/1/15.

POLICY #	Title	Text	Recommendation
		behalf; (B) supports federal legislation to stop the implementation of ICD-10 and remain with ICD-9 until ICD-11 can be properly evaluated; and (C) supports federal legislation to mandate a two-year "implementation" period by all payers, including CMS, if ICD-10 or ICD-11 is implemented. During this time, payers will not be allowed to deny payment based on specificity of ICD-10/11 diagnosis. However, they will be required to provide feedback for incorrect diagnosis. In addition, no payer will be allowed to ask for "takebacks" due to lack of ICD-10/11 diagnosis code specificity for the aforementioned two-year implementation period.	
D-70.960	Implementation of ICD-10-CM	Our AMA will work for delayed implementation of a simplified, modified ICD-10-CM coding system which is less burdensome on practicing physicians, hospitals, and the health insurance industry.	Rescind: ICD-10-CM was implemented on 10/1/15.
D-90.994	Threats Against Physicians Based on Americans With Disabilities Act	Our American Medical Association encourages AMA members who are threatened with non-meritorious lawsuits, supposedly founded on the Americans with Disabilities Act, to contact the AMA's Private Sector Advocacy Group for assistance. The AMA will post a notice on its web site, informing physicians how to report such incidents.	Retain-in-part: Our American Medical Association encourages AMA members who are threatened with non-meritorious lawsuits, supposedly founded on the Americans with Disabilities Act, to contact the AMA. ~~'s Private Sector Advocacy Group for assistance. The AMA will post a notice on its web site, informing physicians how to report such incidents.~~
H-120.933	Emergency Prescription Drug Refills	Our AMA will advocate the following principles to guide the dispensing of emergency refills of prescription drugs: 1. Emergency refills should only be authorized if, in the pharmacist's professional judgment, failure to refill the prescription might result in an important interruption of a therapeutic regimen that could cause patient harm. 2. Emergency refills should only be dispensed if the pharmacy is	Retain.

POLICY #	Title	Text	Recommendation
		unable to readily obtain refill authorization from the prescriber; prior authorization cannot be obtained in a timely manner from the patient's health plan; or when an emergency order or a proclamation of a state of emergency is declared by a state's governor. 3. Schedule II controlled substances can be dispensed on an emergency basis as allowed under Drug Enforcement Administration protocol. 4. In general, the pharmacist may dispense a sufficient supply of the medication to maintain the prescribed treatment until prescriber authorization can be achieved. 5. If an emergency order or proclamation of a state of emergency is issued by a state's governor, an executive order may allow pharmacists to dispense up to a 30-day supply of a prescription drug, or other amount as provided for under existing state law. 6. The dispensing pharmacist should notify the prescriber of the emergency refill within 72 hours of dispensing. 7. Emergency refills should not be a regular occurrence. 8. The pharmacist should inform the patient or the patient's agent at the time of dispensing that the refill is being provided without the prescriber's authorization and that authorization of the prescriber is required for a future refill. 9. The pharmacist should notify the patient or the patient's agent of any cost-sharing responsibilities prior to dispensing. 10. A prescriber should not be subject to liability for any damages resulting from an emergency refill of a prescription drug by a pharmacist.	

POLICY #	Title	Text	Recommendation
H-120.935	Medication Administration in Assisted Living Facilities	Our AMA supports medication administration by appropriately trained facility staff for residents of assisted living and dementia care facilities who require assistance in taking their medications.	Retain.
H-155.956	Make Simplicity the Foremost Criteria for Any CMS Program	Our American Medical Association will: (1) continue to advocate for simplicity in any current or future programs initiated by the Centers for Medicare & Medicaid Services (CMS) that impact physicians; and (2) continue to advocate by all means necessary that any current or future programs initiated by the Centers for Medicare and Medicaid Services be summarized into an executive summary format or other format that is easily comprehensible to physicians, medical staff and administration in a medical office.	Retain.
H-155.965	Health Care Rationing	The AMA defines "health care rationing" as follows: "a process of allocating health care resources that results in limitations or denials of medical services."	Retain.
H-155.980	Patient and Public Education about Cost of Care	The AMA, as a part of its program to strengthen the US health care system, supports intensifying its efforts to better understand patient concerns regarding fees and other costs of health care in all settings, including the cost of medication, and supports attempts to relieve these concerns.	Retain.
H-155.994	Sharing of Diagnostic Findings	The AMA (1) urges all physicians, when admitting patients to hospitals, to send pertinent abstracts of the patients' medical records, including histories and diagnostic procedures, so that the hospital physicians sharing in the care of those patients can practice more cost-effective and better medical care; (2) urges the hospital to return all information on in-hospital care to the attending	Retain.

POLICY #	Title	Text	Recommendation
		physician upon patient discharge; and (3) encourages providers, working at the local level, to develop mechanisms for the sharing of diagnostic findings for a given patient in order to avoid duplication of expensive diagnostic tests and procedures.	
H-160.922	Physician and Health Plan Provision of Uncompensated Care	The AMA: (1) continues to urge physicians to share in the provision of uncompensated care to the uninsured indigent. (2) opposes any health plan-originated prohibition or discouragement of the provision of any uncompensated care by the plan's employed or participating physicians, in the absence of any external legislative or regulatory prohibition of such pro bono activities. (3) supports legislation prohibiting health plan-originated attempts to prohibit the provision of any uncompensated care by the plan's employed or participating physicians. (4) encourages physicians to contract wherever possible only with those health care delivery or financing plans that contribute in some way to care of the uninsured indigent and/or other community health needs, and that allow individual participating physicians to provide uncompensated care. (5) encourages all health care delivery or financing plans that control the source of covered services and the amount of payment for such services, including plans owned or sponsored by physicians, to contribute to the care of the uninsured indigent or to other community health needs through such means as: (a) Offering direct plan enrollment to individuals and families lacking group coverage and/or offering special coverages or premium subsidies for older, lower-income, and/or less healthy populations; (b)	Retain.

POLICY #	Title	Text	Recommendation
		Provision of preventive or basic care services to disadvantaged populations at reduced or no charge; (c) Health education programs for the community at large; and (d) Provision of professional staff services, training, equipment and/or other assistance to public health clinics, community health centers or other care resources serving the disadvantaged. (6) encourages organizations and entities that accredit or develop and apply performance measures for health plans to consider inclusion of recognition for such contributions in their evaluation criteria. (7) urges state medical societies to collect information on, recognize, and publicize the pro bono activities of health plans. (8) encourages state medical societies to support development of state assistance with malpractice premiums, caps on liability, or immunity from liability for services provided to uninsured indigent patients. (9) continues to support state legislation requiring diversion of assets to charitable causes by non-profit health plans converting to for-profit status.	
H-160.945	Subacute Care Standards for Physicians	AMA guidelines for physicians' responsibilities in subacute care include: (1) Physicians are responsible to their patients for delivery of care in all subacute care settings, 24 hours a day, 7 days a week. (2) Patients who might benefit from subacute care should be admitted to and discharged under the orders of the physician who is responsible for the continuous medical management needed to meet the patient's needs and safety and maintaining quality of care. (3) Physicians are responsible for coordinating care for their patients with other physicians	Retain.

POLICY #	Title	Text	Recommendation
		including medical directors, primary care physicians, and appropriate specialists, to optimize the quality of care in subacute settings. (4) Physicians are responsible for supervision and coordination of the medical care for their patients and providing leadership for all other health care providers in subacute care. (5) Physicians should guide procedures for their patients performed within integrated practices and direct other health care providers, consistent with federal and state regulations. (6) Physicians are responsible for: (a) Fulfilling their roles and identifying the medical skills needed to deliver care in subacute facilities and for creating and developing continuing medical education to meet the special needs of patients in subacute care. (b) Identifying and appropriately utilizing subacute care facilities in their communities. (c) Oversight of physician credentialing in subacute settings (d) Promoting medical staff organization and by-laws that may be needed to support peer evaluations. (e) Planning care of their patients with acute and chronic conditions in subacute care, as well as pursuing efforts to restore and maintain functions for quality of life. (7) Subacute units and/or programs need physician medical directors to assure quality of medical care, provide peer group liaisons, and coordinate and supervise patients and families input and needs. (8) Physicians provide a plan of care for medically necessary visits after completing an initial assessment within 24 hours of admission that identifies the medical services expected during subacute care.	

POLICY #	Title	Text	Recommendation
		(9) Attending physicians should: (a) make an on-site visit to review the interdisciplinary care plan within seventy two hours of admission. (b) Determine the number of medically necessary follow up visits; these may occur daily but never less often than weekly. (c) Document active involvement of physicians in interdisciplinary care and all major components of the patient care plan including completing a progress note for each patient visit. (10) Physicians should implement these guidelines through organized medical staff by-laws in subacute settings to assure quality patient care.	
H-160.971	Uncompensated Care	Our AMA supports (1) communicating to the public the problem of uncompensated care and the ever increasing regulations involving such care as well as the detrimental effect that uncompensated care has on the availability of necessary health care services to many citizens; and (2) publicizing the programs currently instituted to address uncompensated care and pursuing additional solutions for dealing with the problem of uncompensated care.	Retain.
H-165.854	Health Reimbursement Arrangements	It is the policy of the AMA: (1) to support Health Reimbursement Arrangements (HRAs) as one mechanism for empowering patients to have greater control over their health care decision-making; and (2) that employers offering HRAs be encouraged to consider: (a) making HRAs into real (rather than notional) accounts; (b) allowing rollover of all unspent HRA balances annually; and (c) making unspent HRA balances available to employees upon their retirement or departure from the company.	Retain.
H-165.863	Flexible Spending	1. Along with other efforts to liberalize the Health Savings Account rules, our AMA places a	Retain.

POLICY #	Title	Text	Recommendation
	Accounts (FSAs)	top priority on allowing employees to roll-over any unexpended funds in a Flexible Spending Account into a Health Savings Account. 2. Our AMA will advocate for a reasonable increase in Section 125 Flex Spending accounts.	
H-170.991	Information on Products and Services	The AMA strongly urges firms advising purchasers to seek medical advice regarding use of any product or service to include the name, address and telephone number of a responsible contact from whom information can be readily accessible to physicians on request (e.g., toll-free access or prompt delivery of printed matter about the product or service).	Retain.
H-180.956	Physician Privileges Application - Timely Review by Managed Care	Our AMA policy is that: (1) final acceptance of residents who otherwise are approved by a health plan should be contingent upon the receipt of a letter from their program director stating that their training has been satisfactorily completed; (2) health plans which require board certification should allow the completing resident to be included in their plan after showing evidence of having completed the required training and of working towards fulfilling the requirements in the time frame established by their respective Board for completion of certification; and (3) Medicare, Medicaid, and managed care organizations should (a) make final physician credentialing determinations within 45 calendar days of receipt of a completed application; (b) grant provisional credentialing pending a final credentialing decision if the credentialing process exceeds 45 calendar days; and (c) retroactively compensate physicians for services rendered from the date of their credentialing.	Retain.

POLICY #	Title	Text	Recommendation
H-185.928	Burdensome Paperwork for Breast Pumps	Our AMA will vigorously oppose unnecessary and burdensome paperwork which presents barriers to lactation support, such as prescriptions to support physiologic functions; and further, to ensure that The Joint Commission and Healthy People 2020 breastfeeding goals are met.	Retain-in-part: Our AMA will vigorously oppose unnecessary and burdensome paperwork which presents barriers to lactation support, such as prescriptions to support physiologic functions.~~; and further, to ensure that The Joint Commission and Healthy People 2020 breastfeeding goals are met.~~
H-185.930	Notification to Physicians Regarding COBRA Grace Period	Our American Medical Association will advocate for notification to physicians where patients are within the 45-day or 30-day COBRA grace periods in a manner similar to the ACA-required insurance marketplace 90-day notifications to physicians and, if possible, require such information to be provided in real-time.	Retain.
H-185.944	Subscriber Identification Cards	Our AMA: (1) urges any pertinent official or governmental agency to require health insurance plans to issue identification cards to its subscribers which prominently identify the full legal name of the insured; name of the policy holder; identification numbers needed for claim submission; and the primary insurance company name with its appropriate mailing address; and (2) will advocate for legislative and regulatory sanctions against insurance companies which present obstacles to the timely filing of claims which result in the denial of benefits.	Retain.
H-185.952	Elimination of Lifetime Maximums of Health Insurance Benefits	It is the policy of our AMA that employers and health insurers should eliminate the lifetime maximums of health insurance benefits.	Retain.
H-185.953	Health Insurance Coverage of Specialty Pharmaceuticals	Our AMA supports complete transparency of health care coverage policies related to specialty pharmaceuticals, including co-payment or co-insurance levels and how these levels are determined.	Retain.

POLICY #	Title	Text	Recommendation
H-185.955	Pap Smears as a Clinical Laboratory Test	The AMA: (1) advocates that it is imperative that Pap smear screening have sufficient payment levels to support the technology and personnel costs required to provide the service, and (2) seeks legislative and regulatory change in the Medicare payment policy for Pap smears so that payment for the technical component of the service is adequate to cover the cost of providing the service, and that pathologists are reimbursed for interpretation of abnormal Pap smears based on the RBRVS.	Retain.
H-185.956	Health Plan Coverage for Over-the-Counter Drugs	Our AMA: (1) opposes mandated health plan coverage for over-the-counter (OTC) pharmaceuticals, including those that had previously been available only with a prescription; (2) encourages health insurers and health plans to cover medically necessary OTC drugs for which no prescription alternative exists; and (3) continues to support efforts to study the effects of converting medically necessary drugs from prescription to over-the-counter status on the costs and access to such medications.	Retain.
H-185.957	Coverage for Strabismus Surgery	Our American Medical Association supports legislation that requires all third party payers that cover surgical benefits to cover all strabismus surgery where medically indicated.	Retain.
H-185.958	Equity in Health Care for Domestic Partnerships	Our AMA: (1) encourages the development of domestic partner health care benefits in the public and private sector; and (2) supports equity of pre-tax health care benefits for domestic partnerships.	Retain; Policy H-140.901 is identically titled; recommend amending title by addition as follows: "Equity in Health Care Benefits for Domestic Partnerships."
H-185.959	Health Care Benefit Discrepancies for Small Employers Under COBRA	Our AMA supports the principle that small employers who provide their employees with a group health insurance benefit, and who can afford to do so, should be encouraged to provide continuation coverage for their former employees, ideally	Retain.

POLICY #	Title	Text	Recommendation
		consistent with the 18 months of coverage under COBRA.	
H-210.978	Improving Home Health Care	Our American Medical Association: (1) supports the appropriate training of home health aides to ensure the quality of services they provide, guided by the standards of the Medicare Conditions of Participation, accreditation entities and the Institute of Medicine; (2) supports regulatory oversight of home health agencies that employ home health aides; and (3) will work with interested state medical associations to support state legislation that requires home health aides to obtain appropriate training before caring for patients.	Retain.
H-215.967	For-Profit Conversions of Health Care Organizations	The AMA adopts as policy the following principles regarding the for-profit conversion of not-for-profit health care organizations: (1) Representatives of state government (e.g. state attorney general, state insurance commissioner) should oversee all for-profit conversions of health care organizations; (2) Public notice and subsequent public hearings should be required prior to the approval of a for profit-conversion; (3) The health care organization converting to for-profit status should be required to obtain an independent appraisal of its assets prior to the conversion. This appraisal should be made available to the representatives of state government (e.g., state attorney general, state insurance commissioner) overseeing the for-profit conversion; (4) For-profit conversions should be structured to prohibit private inurement from officers, directors and key employees of the converting health care organization, as well as private benefit from other individuals; (5) If the establishment of a charitable foundation is required	Retain.

POLICY #	Title	Text	Recommendation
		as part of the for-profit conversion, the mission of the foundation, as well as its proposed program agenda, should be determined and offered for public comment prior to the completion of the conversion; (6) The mission of a charitable foundation resulting from a for-profit conversion should closely reflect the original mission of the not-for-profit health care organization; (7) A designated proportion of the members serving on the board of directors of a charitable foundation should be new, independent members not previously affiliated with the converting organization, who are selected based on their experience relative to the mission of the foundation; (8) The level of compensation received by members serving on the board of directors of a charitable foundation should be consistent with that received by board members of similar types and sizes of foundations; (9) Representatives of state government (e.g., state attorney general, state insurance commissioner) should approve the mission and governance of any charitable foundation established as a result of for-profit conversions; (10) Once a charitable foundation has been established as a result of a for-profit conversion, ongoing community liaison with the foundation should occur on a regular basis (e.g., community advisory committees, periodic public reports); and (11) There should be meaningful physician presence on the board of directors of a charitable foundation formed as a result of the conversion of a not-for-profit health care organization to a for-profit organization	

POLICY #	Title	Text	Recommendation
H-215.992	Hospital Security	Our AMA supports efforts by physicians and other hospital staff to encourage all hospitals to institute and/or maintain appropriate and adequate security measures, such as general identification, patrols, visual monitoring systems and metal detectors, in order to protect staff and patients.	Retain.
H-215.993	Medical Society-Governing Body (Trustee) Liaison Program	Our AMA (1) encourages state medical associations to maintain this activity to assure ongoing communication with hospital governing bodies; and (2) encourages state medical associations to draw upon all sources, including national level activities, to enhance their own direct communication with hospital governing bodies.	Retain.
H-220.980	Credentialing Procedure	The AMA encourages The Joint Commission to continue to monitor medical staff credentialing procedures to include clearly delineated authority to an elected physician of the medical staff for access, review and judgment over contents, to ensure that the individual medical staff member's credentials file contains only well documented and appropriate data and does not include information that is immaterial, misleading or of questionable value.	Retain.
H-220.989	Physician Credentialing	The AMA encourages The Joint Commission to develop standards that permit hospital medical staffs to establish educational needs as one of the criteria for medical staff privileges in teaching hospitals, to assure an appropriate number and variety of patients for educational purposes	Retain.
H-220.990	Principles for Revision of the Medical Staff Section of The Joint Commission "Accreditation	The AMA supports adherence to the following principles as the basis for any revision of the Medical Staff Section of the "Accreditation Manual for Hospitals": (1) continued use of the term "Medical Staff" in the title of the chapter and throughout	Retain.

POLICY #	Title	Text	Recommendation
	Manual for Hospitals"	the Manual; (2) deletion of any specific reference to limited licensed practitioners without precluding such practitioners from having hospital privileges consonant with their training, experience and current competence, if approved by the normal credentialing process; (3) consideration of qualified limited licensed practitioners in accordance with state law, and when approved by the executive committee of the medical staff, by the governing board, and when their services are appropriate to the goals and missions of that hospital, taking into account the training, experience and current clinical competence of the practitioners; (4) provision that the executive committee of the medical staff is composed of members selected by the medical staff, or appointed in accordance with the hospital bylaws. All members of the active medical staff, as defined in the Medical Staff Bylaws, are eligible for membership on the executive committee, and a majority of the executive committee members must be fully licensed physician members (Doctors of Medicine or Doctors of Osteopathy) of the active medical staff in the hospital; (5) assurance that the medical care of all patients remains under the supervision and direction of qualified, fully licensed physicians (Doctors of Medicine or Doctors of Osteopathy); and (6) assurance that the continued high quality of care, credentialing of physicians and other licensed practitioners, and effective quality assurance programs remain under the supervision and direction of fully licensed physicians.	
H-225.945	Temporary Medical Staff Privileges	Our AMA: (1) supports the use of temporary privileges in the following situations: (a) to fulfill	Retain.

POLICY #	Title	Text	Recommendation
		an important patient care, treatment, or service need, or (b) when an applicant for new privileges with a 'clean' application is awaiting review and approval by the medical staff executive committee and the governing body; and (2) will work with other stakeholders to preserve the use of temporary privileges in the following situations: (a) to fulfill an important patient care, treatment, or service need, or (b) when an applicant for new privileges with a 'clean' application is awaiting review and approval by the medical staff executive committee and the governing body.	
H-225.987	Reporting of Incidents	The AMA believes that (1) all hospital reports mandated by state agencies or outside authorities involving individual physician care of patients should be reviewed by an appropriate medical staff committee prior to reporting; (2) hospital medical staffs should be given a reasonable period of time to evaluate any reports pertaining to a physician's care of patients; and (3) the organized medical staff should seek the assurance of the state agency or outside authority that the report will remain strictly confidential.	Retain.
H-225.988	Hospital-Medical Staff Joint Ventures	The AMA believes it is vital for physicians to appraise responsibly the benefits and risks of specific hospital medical staff joint venture activities in light of their individual circumstances and the advice of knowledgeable and independent financial advisors and legal counsel.	Retain.
H-225.993	Medical Staff Policy Determination	The AMA believes that only fully licensed physicians on the medical staff should establish overall medical staff standards and policy for quality medical care, where consistent with local, state and federal laws.	Retain.

POLICY #	Title	Text	Recommendation
H-230.955	Clarification of Medical Staff Rights in Granting Clinical Staff Privileges	Our AMA: (1) policy is that medical staffs may establish any method of granting clinical privileges that complies with The Joint Commission standard MS.06.01.05; and (2) requests that its Commissioners to The Joint Commission ask The Joint Commission to notify all hospitals and medical staffs that there can be multiple ways to comply with The Joint Commission standards.	Retain.
H-230.957	Access to Hospital Records	Our AMA will support legislation guaranteeing that physicians engaged in staff privileges disputes have free and full access to all medical records related to those disputes so they can adequately defend themselves.	Retain.
H-230.958	Economic Loyalty Criteria for Medical Staff Privileges	Our AMA strongly opposes the implementation of economic loyalty criteria for medical staff privileges.	Retain.
H-230.971	Economic Credentialing	Our AMA will work with The Joint Commission to assure, through the survey process, that any criteria used in the credentialing process are directly related to the quality of patient care.	Retain.
H-230.985	Medical Staff Privileges	The AMA believes that if, under the principle of self-governance, a medical staff determines that productivity, as it has a direct relationship to quality of care, is a reasonable criterion to use in its consideration of reappointment, it should be permitted to do so. However, the AMA does not believe that economic productivity should be a factor in medical staff reappointment.	Retain.
H-230.987	Hospital Decisions to Grant Exclusive Contracts	Our American Medical Association supports the concept that individual medical staff members who have been granted clinical privileges are entitled to full due process in any attempt to abridge those privileges by granting of exclusive contracts by the hospital governing body.	Retain.

POLICY #	Title	Text	Recommendation
H-230.988	Guidelines for Maintenance and Exchange of Credentialing Information	The AMA supports the development of guidelines for the maintenance and exchange of credentialing information and encourages all health care facilities, including the military, the Veterans Administration and the Public Health Service, to comply with such guidelines.	Retain.
H-230.993	Physician Credentialing	The AMA recommends that hospital medical staffs adopt bylaws which enable them to retain the prerogative and responsibility, as granted by the hospital governing body, for credentialing all physicians and other licensees who apply for clinical privileges, including those who seek to enter into contractual arrangements with hospitals.	Retain.
H-235.980	Hospital Medical Staff Self-Governance	1. Our AMA: supports essentials of self-governance for hospital medical staffs which, at a minimum include the right to: (a) initiation, development and adoption of medical staff bylaws, rules and regulations; (b) approval or disapproval of amendments to the medical staff bylaws, rules and regulations; (c) selection and removal of medical staff officers; (d) establishment and enforcement of criteria and standards for medical staff membership; (e) establishment and maintenance of patient care standards; (f) accessibility to and use of independent legal counsel; (g) credentialing and delineation of clinical privileges; (h) medical staff control of its funds; and (i) successor-in-interest rights. 2. Our AMA opposes any attempts to reengineer or otherwise amend medical staff bylaws or split the bylaws into a variety of separate and unincorporated manuals or policies, thereby eliminating the control and approval rights of the medical staff as required by the	Retain.

POLICY #	Title	Text	Recommendation
		principles of medical staff self-governance. 3. Our AMA will ask its Commissioners to the Joint Commission on Accreditation of Healthcare Organizations to require that JCAHO medical staff standards require the following components to be an integral part of the medical staff bylaws, and not separate "governance documents," requiring approval by the entire medical staff. The medical staff is responsible for the following: (a) Application, reapplication, credentialing and privileging standards; (b) Fair hearing and appeal process; (c) Selection, election and removal of medical staff officers; (d) Clinical criteria and standards which manage quality assurance, utilization review; (e) Structure of the medical staff organization; (f) Rules and regulations that affect the entire medical staff. 4. Our AMA recognizes that hospital non-compliance with JCAHO Standard MS 1.20 will be treated in the same way as hospital non-compliance with any other standard.	
H-235.983	AMA Response to Hospital Governing Bodies in Challenging Medical Staff Self-Governance	The AMA (1) reaffirms its policy in support of medical staff self-governance, including the process of electing and seating officers of the staff in accordance with medical staff bylaws, and its policy in opposition to improper interference by the governing body in that process; and (2) supports working with state hospital medical staff sections, state medical societies, and individual medical staffs to support medical staff self-governance in appropriate situations.	Retain.

POLICY #	Title	Text	Recommendation
H-235.993	Representation of the Medical Staff on All Committees of the Governing Board and Administration of American Hospitals	The AMA supports (1) medical staff representation on all committees of the governing board and administration of American hospitals; and (2) hospital administration representation on administrative committees of the medical staff.	Retain.
H-235.996	Bylaws and Rules and Regulations - No Incorporation by Reference	The AMA encourages medical staffs to develop their own bylaws, rules and regulations and not to incorporate other documents by reference.	Retain.
H-240.979	Intrusion by Hospitals into the Private Practice of Medicine	The AMA urges private third party payers to implement coverage policies that do not unfairly discriminate between hospital-owned and independently-owned outpatient facilities with respect to payment of "facility" costs.	Retain.
H-240.995	Diagnostic Related Groups	The AMA (1) supports input by hospital medical staffs into the DRG process to insure that quality of care is not compromised; and (2) supports the concept that the individual hospital medical staff's responsibility is to ensure appropriate quality of care for patients.	Retain.
H-245.970	Early Hearing Detection and Intervention	Our AMA: 1) supports early hearing detection and intervention to ensure that every infant receives proper hearing screening, diagnostic evaluation, intervention, and follow-up in a timely manner; and 2) supports federal legislation that provides for the development and monitoring of statewide programs and systems for hearing screening of newborns and infants, prompt evaluation and diagnosis of children referred from screening programs, and appropriate medical, educational, and audiological interventions and follow-up for children identified with hearing loss.	Retain.
H-280.974	Medically Necessary	Our AMA (1) defines a "medically necessary" visit to a	Retain.

POLICY #	Title	Text	Recommendation
	Nursing Facility Visits	Medicare/Medicaid resident in a nursing facility as any physician visit necessary to complete comprehensive nursing facility assessments and other assessments that are required as a condition of Medicare or state statute, as well as those visits that respond to a patient's development of a significant complication or a significant new problem which requires the creation of a new medical plan of care or visits that respond to the reported possibility of a change in patient condition; (2) supports the concepts embodied in the CPT Evaluation and Management codes for Nursing Facility services, including the concept that counseling and/or coordination of care that are provided consistent with the patient and/or family's needs be recognized as medically appropriate and necessary; (3) will monitor the use of the CPT codes for Nursing Facility Services and Medicare's determination of medical necessity to determine if revisions to the definitions of medical necessity are necessary; (4) supports eliminating the Medicare established arbitrary visit frequency parameters (inclusive of multiple same day visits where quality of care and severity of condition necessitates such encounters); (5) supports eliminating required documentation for obtaining such payments which place a significant burden on physician endeavors to provide quality care; (6) urges carrier refrainment from references to bona fide multiple patient visits on the same day as "gang visits," which unjustly	

POLICY #	Title	Text	Recommendation
		impugn the quality of medical care provided; (7) supports establishment of a moratorium by CMS on any carrier collection of past "overpayments" for such multiple visits, and (8) will use whatever means necessary to achieve these objectives.	
H-280.995	Medicare Coverage of "Skilled Nursing Care"	The AMA encourages CMS to (1) clarify the Medicare definitions of "skilled nursing care" and "custodial care"; (2) identify and implement appropriate measures to assure greater consistency in the administrative interpretation of rules governing coverage of nursing home care; and (3) better explain to beneficiaries the exclusion for custodial care services.	Rescind: Accomplished by Centers for Medicare & Medicaid Services document that explains the definitions of "skilled nursing care" and "custodial care."
H-285.906	Protecting Against Forced Network Exclusivity of Specialist Physicians	Our AMA supports allowing specialty physicians to have primary contract status in more than one network.	Retain.
H-285.907	Out of Network Restrictions of Physicians	Our American Medical Association opposes the denial of payment for a medically necessary prescription of a drug or service covered by the policy based solely on the network participation of the duly licensed physician ordering it.	Retain.
H-285.969	Managed Care Education	The AMA will continue to emphasize professionalism, patient and physician autonomy, patient and physician rights, and practical assistance to physicians as key principles to guide AMA advocacy efforts related to managed care.	Retain.
H-285.970	Physician Office Review by Third Party Payers	The AMA supports development of standardized criteria to be used in managed care contracts for reviewing physicians' office and medical records in order to avoid multiple review.	Retain.

POLICY #	Title	Text	Recommendation
H-285.987	Guidelines for Qualifications of Managed Care Medical Directors	The AMA has adopted the following "Guidelines for Qualifications of Medical Directors of Managed Care Organizations": To the greatest extent possible, physicians who are employed as medical directors of managed care organizations shall: (1) hold an unlimited current license to practice medicine in one of the states served by the managed care organization, and where that Medical Director will be making clinical decisions or be involved in peer review that Medical Director should have a current license in each applicable state; (2) meet credentialing requirements equivalent to those met by plan providers; (3) be familiar with local medical practices and standards in the plan's service area; (4) be knowledgeable concerning the applicable accreditation or "program approval" standards for preferred provider organizations and health maintenance organizations; (5) possess good interpersonal and communications skills; (6) demonstrate knowledge of risk management standards; (7) be experienced in and capable of overseeing the commonly used processes and techniques of peer review, quality assurance, and utilization management; (8) demonstrate knowledge of due process procedures for resolving issues between the participating physicians and the health plan administration, including those related to medical decision-making and utilization review; (9) be able to establish fair and effective grievance resolution mechanisms for enrollees; (10) be able to review, advise, and take action on questionable hospital admissions, medically	Retain.

POLICY #	Title	Text	Recommendation
		unnecessary days, and all other medical care cost issues; and (11) be willing to interact with physicians on denied authorizations. The AMA strongly encourages managed care organizations and payer groups to utilize these guidelines in their recruitment and retention of medical directors.	
H-285.989	AMA Opposition to All Products Clauses	Our AMA will seek legislative action to prohibit tying a physician's membership in an insurance product (e.g., a PPO) to that physician's participation in any other insurance product (e.g., an HMO, workers' compensation, automobile personal injury protection insurance, Medicare and Medicaid).	Retain.
H-290.974	Status Report on the Medicaid Program	1. It is the policy of our AMA that in the absence of private sector reforms that would enable persons with low-incomes to purchase health insurance, our AMA supports eligibility expansions of public sector programs, such as Medicaid and the Children's Health Insurance Program, with the goal of improving access to health care coverage to otherwise uninsured groups. 2. Our AMA advocates that any tax treatment applied to health insurance for the purpose of encouraging individual ownership also apply to long-term care insurance. 3. Our AMA urges Congress and the Administration to develop proposals and enact solutions to address the pending growth of long-term care needs of the American population.	Retain.
H-290.995	Case Management System for Outpatient Clinics	The AMA has adopted the following policy: (1) That states be given the authority to establish primary care case management programs for populations whose medical care is provided through	Retain.

POLICY #	Title	Text	Recommendation
		Medicaid or other public welfare funding: (a) on a voluntary basis with incentives provided toward a prudent choice of care source; and (b) on a mandatory basis only for those recipients in a given area who have been identified as overutilizers or misutilizers of services; and (2) that comparative analyses of these programs be undertaken to determine their relative effectiveness regarding patient access, quality of and satisfaction with care, and cost reduction.	
H-320.955	Conflict of Interest in Care Review	AMA policy is that utilization review organizations make every effort to avoid potential conflicts of interest for physician reviewers by not assigning cases to a physician reviewer who (1) is an associate or competitor of the physician under review, (2) actively practices in the same hospital as the physician under review when feasible, (3) participated in the development or execution of the patient's treatment plan, or (4) is a member of the patient's family.	Retain.
H-320.969	Concurrent Review Procedures of Inpatient Care by HMO Representatives	The AMA encourages state regulation of third party reviewers who are on site in hospitals evaluating inpatient management so that these representatives: (1) must accrue clinical data in the hospital only under the control of hospital-based utilization review/quality assurance (UR/QA) personnel; (2) must not be enabled to have any direct inpatient contact; (3) must both communicate such suggestions directly to the attending physician and document all actions in the hospital's utilization office if they wish to provide input regarding patient management; (4) it is the role of the utilization review program or managed care plan to credential/certify that its reviewers are appropriately licensed and have the required	Retain.

POLICY #	Title	Text	Recommendation
		experience to perform review; (5) prior to the on-site review, the utilization review program or managed care plan should provide upon request the name(s), credentials and background of their reviewers to the medical staff credentials committee and/or quality assurance/utilization review committee; and (6) the medical staff should have: (a) established protocol for reviewers entry into the hospital and (b) a process for monitoring the reviewer's activities and the confidentiality of the records they review.	
H-320.993	Utilization Management	The AMA encourages physicians to take a leadership role in implementing and maintaining utilization management programs within their hospitals.	Retain.
H-330.881	Medicare Coverage for Evidence-Based Lymphedema Treatment	Our AMA supports Medicare coverage for appropriate and evidence-based treatment of lymphedema.	Retain.
H-330.882	Oppose Local Coverage Determination for Lower Limb Prostheses	Our AMA (1) opposes local coverage determinations on lower limb prostheses that undermine physician judgment and compromise patient access; and (2) will request that the Centers for Medicare and Medicaid Services expeditiously host a national meeting open to all interested parties to focus on appropriate standards for lower limb prostheses that optimize care for patients.	Retain.
H-330.883	Parity of Payment for Administering Biologic Medications	Our AMA supports and encourages interested national medical specialty societies and other stakeholders to submit a request to Medicare for a national coverage determination directing Medicare Administrative Contractors to consider all biologics as complex injections or infusions.	Retain.
H-373.994	Patient Navigation Programs	1. Our AMA recognizes the increasing use of patient navigator and patient advocacy services to help improve access to	Retain.

POLICY #	Title	Text	Recommendation
		care and help patients manage complex aspects of the health care system. In order to ensure that patient navigator services enhance the delivery of high-quality patient care, our AMA supports the following guidelines for patient navigator programs: a) The primary role of a patient navigator should be to foster patient empowerment, and to provide patients with information that enhances their ability to make appropriate health care choices and to receive medical care with an enhanced sense of confidence about risks, benefits, and responsibilities. b) Patient navigator programs should establish procedures to ensure direct communication between the navigator and the patient's medical team. c) Patient navigators should refrain from any activity that could be construed as clinical in nature, including interpreting test results or medical symptoms, offering second opinions, or making treatment recommendations. Patient navigators should provide a supportive role for patients and, when necessary, help them understand medical information provided by physicians and other members of their medical care team. d) Patient navigators should fully disclose relevant training, experience, and credentials, in order to help patients understand the scope of services the navigator is qualified to provide. e) Patient navigators should fully disclose potential conflicts of interest to those whom they serve, including employment arrangements.	

POLICY #	Title	Text	Recommendation
		2. Our AMA will work with the American College of Surgeons and other entities and organizations to ensure that patient navigators are free of bias, do not have any role in directing referrals, do not usurp the physician's role in and responsibility for patient education or treatment planning, and act under the direction of the physician or physicians primarily responsible for each patient's care. 3. Policy provisions for patient navigators are also relevant for community health workers and other non-clinical public health workers.	
H-375.994	Peer Review in All Health Care Facilities	The AMA supports the provision of comparable peer review systems of medical services offered in public, private and governmental hospitals.	Retain.
H-385.915	Integrating Physical and Behavioral Health Care	Our American Medical Association: (1) encourages private health insurers to recognize CPT codes that allow primary care physicians to bill and receive payment for physical and behavioral health care services provided on the same day; (2) encourages all state Medicaid programs to pay for physical and behavioral health care services provided on the same day; (3) encourages state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings; (4) encourages practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care; and (5) promotes the development of sustainable payment models that would be used to fund the necessary services inherent in integrating	Retain.

POLICY #	Title	Text	Recommendation
		behavioral health care services into primary care settings.	
H-385.955	Denial of Payment for Treatment of Immediate Family Members	The AMA calls upon CMS to amend its regulations denying payment for physician services and services incident to a physician's professional services for treatment of immediate family members by permitting an exception applicable to the services of any physician who is the single source of medical care in the community.	Retain.
H-385.989	Payment for Physicians Services	Our AMA: (1) supports a pluralistic approach to third party payment methodology under fee-for-service, and does not support a preference for "usual and customary or reasonable" (UCR) or any other specific payment methodology; (2) affirms the following four principles: (a) Physicians have the right to establish their fees at a level which they believe fairly reflects the costs of providing a service and the value of their professional judgment. (b) Physicians should continue to volunteer fee information to patients, to discuss fees in advance of service where feasible, to expand the practice of accepting any third-party allowances as payment in full in cases of financial hardship, and to communicate voluntarily to their patients their willingness to make appropriate arrangements in cases of financial need. (c) Physicians should have the right to choose the basic mechanism of payment for their services, and specifically to choose whether or not to participate in a particular insurance plan or method of payment, and to accept or decline a third-party allowance as payment in full for a service. (d) All methods of physician payment should incorporate mechanisms to foster increased cost-awareness by both providers and recipients of service; and (3) supports modification of current	Retain.

POLICY #	Title	Text	Recommendation
		legal restrictions, so as to allow meaningful involvement by physician groups in: (a) negotiations on behalf of those physicians who do not choose to accept third party allowances as full payment, so that the amount of such allowances can be more equitably determined; (b) establishing additional limits on the amount or the rate of increase in charge-related payment levels when appropriate; and (c) professional fee review for the protection of the public.	
H-390.840	Update on Payment Mechanisms for Physician-Led Team-Based Health Care	1. Our AMA encourages public and private health insurers to develop and offer a variety of value-based contracting options so that physician practices can select payment models that best suit their delivery of care. 2. Our AMA encourages the Centers for Medicare & Medicaid Services (CMS) to ensure that Medicare Alternative Payment Models (APMs) do not require physicians to assume responsibility for costs they cannot control because such a requirement could potentially create an ethical conflict of interest. 3. Our AMA will continue to actively advocate to CMS that physicians in all specialties and modes of practice must have at least one Medicare APM in which they can feasibly participate. 4. Our AMA will advocate to CMS that any review process of alternative payment models proposed by stakeholders be completed in a timely manner, include an administratively simple appeals process and access to an ombudsman.	Retain.
H-390.841	Value Based Modifier and Flawed Drug Cost Attribution	Our American Medical Association will work with the Centers for Medicare & Medicaid Services to modify Value Based Modifier cost attribution with regard to all drug costs, to ensure	Retain.

POLICY #	Title	Text	Recommendation
		the cost calculation does not unfairly disadvantage certain providers.	
H-390.842	Include Physicians in CMS Rate Increases to Medicare Advantage Plans	Our American Medical Association (1) encourages Medicare Advantage plans to be transparent with respect to the allocation of their rate increases, and (2) encourages individual physicians to negotiate rate increases that parallel or improve upon the percentage increases received by the Medicare Advantage plans with which they contract.	Retain.
H-390.843	Physician-Led, Single and Multi-Specialty, Organized Group Practice Models	1. Our AMA recognizes that physician-led, single and multi-specialty group practices, integrated delivery systems, and other organized systems of care demonstrating the following attributes: (a) efficient provision of services, (b) organized system of care, (c) quality measurement and improvement activities, (d) care coordination, (e) use of IT and evidence-based medicine, (f) compensation practices that promote all aforementioned attributes, and (g) accountability, are credible models for providing coordinated, comprehensive, accountable, cost-effective, patient-centered care. 2. Our AMA will continue its involvement in activities that support physicians in all practice settings to implement solutions and strategies that can improve practice efficiency, helping them achieve improved quality at an affordable cost.	Retain.
H-390.872	Compensation for Physicians Who Accompany Seriously Ill or Injured Patients to Hospitals	The AMA: (1) urges CMS to allow payment for the services of physicians who accompany seriously ill or injured patients in the ambulance to hospitals and who report the appropriate level of evaluation and management service along with Prolonged Physician Service with Direct (Face-to-Face) Patient Contact (codes 99354 and 99355) or the	Retain.

POLICY #	Title	Text	Recommendation
		Critical Care Services codes (99291 and 99292); and (2) urges CMS to expand its guidelines to carriers to allow payment for a physician's return trip from accompanying an ambulance-borne patient, consistent with above, using code 99082, Unusual travel (e.g., transportation and escort of patient).	
H-390.880	Interest Rates Charged and Paid by CMS	1. (A) Our AMA will (1) determine if the recent interest rate changes implemented by CMS comply with current Medicare laws; (2) seek to ensure that CMS's interest charges do not exceed legal limits; and (3) work with CMS to ensure parity in interest rates assessed against physicians by CMS and interest rates paid to physicians by CMS. (B) If an agreement cannot be reached with CMS, the AMA will seek legislation to correct this situation. 2. Our AMA supports amending federal Medicare law to require that interest on both overpayments and underpayments to providers attaches upon notice of the error to the appropriate party in either instance.	Retain.
H-390.921	Uniformity of Operations of Medicare Administrative Contractors	It is the policy of the AMA (1) to use its influence and resources to bring about uniformity of business policies and procedures among the Medicare Administrative Contractors, and (2) to investigate and monitor the differing policies and procedures among the Medicare Administrative Contractors with respect to physician reimbursement.	Retain.
H-390.991	CMS Reimbursement Policy for Physicians in Solo Practice "Covering" Medicare	The AMA supports permitting physicians in solo practice, and those in different groups, to "cover" Medicare patients for each other, and making it possible for the personal physicians of Medicare patients	Retain.

POLICY #	Title	Text	Recommendation
	Patients for Each Other	to bill and to receive reimbursement for professional services rendered by their colleagues who "cover" for them.	
H-400.955	Establishing Capitation Rates	1. Our AMA believes Geographic variations in capitation rates from public programs (e.g., Medicare or Medicaid) should reflect only demonstrable variations in practice costs and correctly validated variations in utilization that reflect legitimate and demonstrable differences in health care need. In particular, areas that have relatively low utilization rates due to cost containment efforts should not be penalized with unrealistically low reimbursement rates. In addition, these payments should be adjusted at the individual level with improved risk adjustors that include demographic factors, health status, and other useful and cost-effective predictors of health care use. 2. Our AMA will work to assure that any current or proposed Medicare or Medicaid (including waivers) capitated payments should be set at levels that would establish and maintain access to quality care. 3. Our AMA seeks modifications as appropriate to the regulations and/or statues affecting Medicare HMOs and other Medicare managed care arrangements to incorporate the revised Patient Protection Act and to ensure equal access to Medicare managed care contracts for physician-sponsored managed care organizations. 4. Our AMA supports development of a Medicare risk payment methodology that would set payment levels that are fair and equitable across geographic regions; in particular, such methodology should allow for	Retain.

POLICY #	Title	Text	Recommendation
		equitable payment rates in those localities with relatively low utilization rates due to cost containment efforts.	
H-400.956	RBRVS Development	(1) That the AMA strongly advocate CMS adoption and implementation of all the RUC's recommendations for the five-year review; (2) That the AMA closely monitor all phases in the development of resource-based practice expense relative values to ensure that studies are methodologically sound and produce valid data, that practicing physicians and organized medicine have meaningful opportunities to participate, and that any implementation plans are consistent with AMA policies; (3) That the AMA work to ensure that the integrity of the physician work relative values is not compromised by annual budget neutrality or other adjustments that are unrelated to physician work; (4) That the AMA encourage payers using the relative work values of the Medicare RBRVS to also incorporate the key assumptions underlying these values, such as the Medicare global periods; and (5) That the AMA continue to pursue a favorable advisory opinion from the Federal Trade Commission regarding AMA provision of a valid RBRVS as developed by the RUC process to private payers and physicians.	Retain.
H-405.956	Transparency of Health Care Provider Profiles in Commercial and Federal Physician Comparison Databases	1. Our AMA encourages accurate and transparent listings of professional degree(s), post-graduate specialty education, and naming of the certifying agency with board certification data released to the public for comparison of healthcare providers or other healthcare services, in accordance with existing AMA policy.	Retain.

POLICY #	Title	Text	Recommendation
		2. Our AMA urges commercial entities and federal programs providing healthcare provider ratings, comparisons, referrals, direct appointments, telehealth, or other services to revise the search and reporting methodology used for profiling of all healthcare providers so as to increase transparency requirements, including the description of professional degree(s), post graduate specialty education, and naming of the certifying board(s), in accordance with existing AMA policy.	
H-405.995	Administration and Supervision of Rehabilitation Units	The AMA believes that (1) third party coverage for the administration and supervision of patient rehabilitation in the office, hospital, and free-standing units should continue to be determined by physician competence based on training and experience, and should not be denied on the basis of specialty certification; and (2) the determination of criteria for qualification in the administration and supervision of rehabilitation units should be based on competence gained by training and experience, and should not be arbitrarily restricted by specialty designation.	Retain.
H-406.993	Development and Use of Physician Profiles	The AMA: (1) urges state medical associations, national medical specialty societies, hospital medical staff, and individual physicians to seek active involvement in the development, implementation, and evaluation of physician profiling initiatives; (2) encourages research to develop improved data sources, methods, and feedback approaches to physician profiling initiatives; (3) opposes the use of profiling procedures that do not meet AMA principles for the credentialing or termination of physicians by managed care plans; (4) opposes physician profiling data being used for	Retain.

POLICY #	Title	Text	Recommendation
		economic credentialing purposes; (5) believes that any disclosure or release of physician profiles shall follow strict conformance to AMA policy on the use and release of physician-specific health care data (Policy 406.996); and (6) will monitor the use of profiling procedures related to physician profiling.	
H-406.994	Principles of Physician Profiling	Our AMA advocates that managed care organizations, third party payers, government entities, and others that develop physician profiles adhere to the following principles: (1) The active involvement of physician organizations and practicing physicians in all aspects of physician profiling shall be essential. (2) The methods for collecting and analyzing data and developing physician profiles shall be disclosed to relevant physician organizations and physicians under review. (3) Valid data collection and profiling methodologies, including establishment of a statistically significant sample size, shall be developed. (4) The limitations of the data sources used to develop physician profiles shall be clearly identified and acknowledged. (5) Physician profiles shall be based on valid, accurate, and objective data and used primarily for educational purposes. (6) To the greatest extent possible, physician profiling initiatives shall use standards-based norms derived from widely accepted, physician-developed practice parameters. (7) Physician profiles and any other information that have been	Retain.

POLICY #	Title	Text	Recommendation
		compiled related to physician performance shall be shared with physicians under review. (8) Comparisons among physician profiles shall adjust for patient case-mix, control for physician specialty, and distinguish between the ordering or referring physician and the physician providing the service or procedure. (9) Effective safeguards to protect against the unauthorized use or disclosure of physician profiles shall be developed. (10) The quality and accuracy of physician profiles, data sources, and methodologies shall be evaluated regularly.	
H-406.997	Collection and Analysis of Physician-Specific Health Care Data	1. Our AMA advocates that third party payers, government entities, and others that collect and analyze physician-specific health care data adhere to the following principles: (a) The methods for collecting and analyzing physician-specific health care data shall be disclosed to physicians under review and the public. (b) Physician-specific health care data shall be valid, accurate, objective and used primarily for the education of both consumers and physicians. (c) Data elements used in the collection of physician-specific health care data, including severity adjustment factors, shall be determined by advisory committees which include actively practicing, and where relevant, specialty-specific, physicians from the region where the data are being collected. (d) Statistically valid data collection, analysis, and reporting methodologies, including establishment of a statistically significant minimum number of cases, shall be developed and appropriately implemented prior	Retain.

POLICY #	Title	Text	Recommendation
		to the release of physician-specific health care data. (e) The quality and accuracy of the physician-specific health care data shall be evaluated by conducting periodic medical record audits. 2. Our AMA believes that health care coalitions which include physicians as full voting members are an appropriate forum for undertaking health care data collection and analysis activities; in consideration of the potential for misinterpretation, violation of privacy rights, and antitrust concerns, it is recommended that charge or utilization data provided to such entities by government, third party payers, and self-insureds companies be in the form of ranges or averages and not be physician-specific.	
H-406.998	Role of Physicians and Physician Organizations in Efforts to Collect Physician-Specific Health Care Data	Our AMA: (1) believes that physicians, as patient advocates and possessing unique qualifications in the review and analysis of health care data, must take the initiative in developing data collection systems at the local level which maintain high standards of confidentiality, accuracy and fairness; (2) urges state medical societies, national medical specialty societies, hospital medical staffs and individual physicians to: (a) participate in health care data collection programs designed to improve the quality of care; (b) be aware of the limitations of health care data; (c) encourage active involvement of physician organizations and practicing physicians in all aspects of health care data collection and interpretation; and (d) develop strategies to assist state agencies and others in improving the collection and interpretation of health data;	Retain.

POLICY #	Title	Text	Recommendation
		(3) urges health data commissions and other entities that collect, evaluate, and disseminate health care data to: (a) facilitate active involvement of physician organizations and practicing physicians in all aspects of the efforts to collect health care data; (b) provide adequate opportunity for physician organizations and practicing physicians to review and respond to proposed data interpretations and disclosures; (c) ensure accuracy of information in the data base; and (d) assure valid interpretation and use of health care data; (4) encourages relevant physician organizations to develop effective mechanisms to assist physicians in evaluating, using, and responding to physician-specific health care data; (5) encourages medical societies to use this information for educational purposes and for addressing such areas as utilization variation, quality assessment and appropriate cost containment activities; (6) encourages medical societies to play an active role in appropriate data collection and dissemination activities at the local level; and (7) urges state medical societies, hospital medical staffs and physicians to propose, monitor, and seek to influence quality of care and cost containment legislation to comply with AMA principles.	
H-435.955	Administrative and Liability Surcharges	Our AMA supports the ability of physicians to institute an "administrative surcharge" and/or a "liability surcharge."	Retain.
H-450.936	Physician Quality	Our AMA will continue to advocate for improvements in the	Rescind: The Physician Quality Reporting Initiative was replaced by

POLICY #	Title	Text	Recommendation
	Reporting Initiative Payment	Physician Quality Reporting Initiative (PQRI) including early education and outreach to physicians by the Centers for Medicare and Medicaid Services (CMS), the provision of confidential interim and final feedback reports from CMS to physicians on potential problems in their PQRI reporting, easier access to feedback reports, development of meaningful dispute resolution processes, and the provision to our AMA of the 2007 PQRI data set file.	the Merit-based Incentive Payment System (MIPS) in 2017.
H-465.986	Rural Health	1. The AMA urges CMS to disseminate widely information on the Rural Health Clinics Program, not only to states and health facilities but to state medical associations as well. 2. The AMA encourages state medical associations to evaluate the potential benefits and drawbacks to rural practices of seeking certification as rural health clinics, and transmit the result of such evaluation to their members. 3. The AMA encourages state medical associations to carefully evaluate the relevant practice acts in their jurisdictions to identify any modifications needed to allow the most effective use of mid-level practitioners in improving access to care, while assuring appropriate physician direction and supervision of such practitioners.	Retain; Policy H-465.989 is identically titled; recommend amending title by addition as follows: "Rural Health Clinics."
H-465.989	Rural Health	It is the policy of the AMA that: (1) the AMA closely monitor the impact of balance billing restrictions mandated by the Budget Reconciliation legislation on reimbursement levels and access to care in rural areas, and take action as needed to moderate that impact; (2) the AMA closely monitor implementation of the legislation establishing essential access community hospitals and	Retain.

POLICY #	Title	Text	Recommendation
		rural primary care hospitals, to ensure that this program is implemented in a manner conducive to high quality of patient care and consistent with Association policy concerning the functions and supervision of physician assistants and nurse practitioners; (3) state medical associations be encouraged to monitor similarly and to influence any legislation or regulations governing the development and operation of such limited service rural hospital facilities in their own jurisdictions; and (4) the AMA establish liaison with the American Hospital Association, Congress and the Centers for Medicare & Medicaid Services regarding any further development of essential access community hospitals and rural primary care hospitals grants.	
H-70.916	Delay or Canceling of ICD-10	Our AMA supports delaying or canceling the implementation of ICD-10.	Rescind: ICD-10-CM was implemented on 10/1/15.