REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-A-25

Subject: Requiring Payment for Physician Signatures (Resolution 108-A-24)

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee G

At the 2024 Annual Meeting, the House of Delegates referred Resolution 108, which was sponsored by the Mississippi State Medical Association, and asked the American Medical Association (AMA) to advocate that insurance companies be required to pay a physician for any required physician signature and/or peer-to-peer review which is requested or required outside of a patient visit.

BACKGROUND

Physician signatures are an integral part of health care delivered by a physician, as they serve as an identifier as to who provided services, verify care, assign legal responsibility, and demonstrate that services have been accurately documented to allow eligibility for payment.[1,2,3] Ensuring program integrity, signatures verify that the services provided were accurately and thoroughly documented and reviewed.[4] Physician signatures also assure patient safety by serving to identify which physician is responsible for the patient's care and attesting that they have carefully reviewed the patient's medical information.[5] Further, most health care regulations require signatures on medical records to verify the legitimacy of services provided and proper payment. The state of Illinois, for example, requires that, "all physician's orders and plans of treatment shall have the authentication of the physician…" as "authentication means an original written signature or an electronic signature system that allows for the verification of a signer's credentials."[6]

Physician signatures are required throughout the entire course of treatment for a patient, including prescriptions, medical orders, progress notes, discharge summaries, referrals, evaluations, re-evaluations, surgical reports, pathology reports, diagnosis/treatment plans, and claim forms.[7,8,9] For a prior authorization (PA), a physician's signature is typically required to authenticate the medical necessity of the requested treatment, meaning they must personally sign the document to indicate their approval and agreement with the information provided, usually including their full name and credentials.[10,11]

A peer-to-peer medical review is a dialogue between a treating physician, usually by telephone, and a medical director from a health insurance company, where the physician is required to explain the medical necessity of a treatment or procedure for a patient.[12] Typically, it is a discussion between medical peers to clarify a patient's case when coverage is disputed and occurs by request after a payer denies coverage for services. Denials are usually made for medical orders, services, and inpatient status but can occur for medications or medical devices.[13] While the process can be tedious and frustrating, in some circumstances, it can be expeditious when it gives the treating physician the opportunity to speak with another physician.[14] However, it can be less effective when

the health plan reviewer is a physician from another specialty or subspecialty, knows little about the disease or treatment in determination, or may not be licensed in the same state.[15] Further, the process approaches futility when the assigned reviewer is not a physician.[16]

REPORTING PHYSICIAN SIGNATURES AND PEER-TO-PEER REVIEW

CPT Assistant, a digital monthly newsletter which serves as a companion to the *Current Procedural Terminology* (CPT®) code set, published an October 2024 article providing coding guidance for PA-related activities within evaluation and management (E/M) services.[17] The article describes how PA-related work of providing signatures can be reported with CPT code 99080 (*Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form*).[18] Code 99080 can be appropriately reported when a physician spends time solely on completing special reports or signing forms independent of PA-related work performed on the date of an E/M encounter, excluding time spent on the telephone or in other conversations.[19]

The article also describes how the PA-related work of peer-to-peer review can be captured in the CPT code set. When selecting a code based on total time, physicians or other qualified health care professionals may include both face-to-face and non-face-to-face time, including time spent on PA-related work, on the same date of the encounter.[20] Alternatively, if E/M reporting is based on medical decision making (MDM), the review can be accounted for in the MDM Risk Element by incorporating social drivers of health and elevating to moderate complexity. For peer-to-peer reviews that occur on a different day than the E/M encounter, a separate code for prolonged physician services can be reported.[21] A summary of the codes referenced in the article can be found in Appendix A.[22]

AMA POLICY

Policy D-320.978 advocates for the fair reimbursement of established and future CPT codes for administrative burdens. Policy D-320.993 supports the development of more stringent state laws and regulations that provide compensation to physicians for the administrative burden and costs of health plan documentation requirements. Policy D-330.919 tasks the AMA to re-engage with the Centers for Medicare & Medicaid Services to re-evaluate Medicare signature requirements. Policy H-155.976 directs the AMA to seek comprehensive reforms to reduce administrative inefficiencies, address the need to reduce administrative costs and burdens, and minimize the administrative burdens imposed on physicians Policy H-225.965 supports that, unless otherwise required by law or regulation, a single signature may document the validity of entries in the medical record. In addition, it is important to note that Policy H-70.919 delineates that the CPT Editorial Panel is the body charged with developing new and revised CPT codes, descriptors, guidelines, parenthetical statements and modifiers independent of the AMA. Therefore, the AMA cannot direct the activities of the CPT Editorial Panel, including the identification of potential gaps in the nomenclature surrounding the reporting of physician signatures and peer-to-peer review.

DISCUSSION

Resolution 108-A-24 asked the AMA to advocate for payment for physician signatures and/or peer-to-peer review requested or required outside of a patient visit. The Council understands the burden associated with required physician signatures and peer-to-peer reviews before, during, and after the treatment of a patient. However, we also believe that physician signatures are necessary to identify who provided services, ensure integrity, verify PA treatment necessity, assign legal responsibility, satisfy federal and state requirements, and demonstrate that services have been accurately

documented to allow eligibility for payment. Similarly, peer-to-peer reviews may allow a treating physician the chance to communicate the necessity of treatment as well as insight into new procedures or drugs not previously considered. Therefore, the Council recognizes that its recommendations must take each position into consideration.

Additionally, the Council's recommendations must not infringe on PA reform advocacy, which is a priority for the AMA. We are skeptical that the burden of physician signatures is confined to the PA process, as physician signatures are required throughout the entirety of a patient's treatment. Therefore, the Council recommends broadening policy to recognize this issue.

Recently, *CPT Assistant* provided coding guidance for PA-related activities, delineating how services such as signing forms may be appropriately reported with CPT codes. The Council believes that this guidance outlines infrastructure sufficient for the appropriate reporting of such services, thereby allowing eligibility for payment.

While Policy D-320.978 advocates for fair payment of established and future CPT codes for administrative burdens related to PA, the Council recommends underscoring this existing policy by creating a new, standalone policy, expanding it to include advocacy for fair payment of "all administrative tasks." The Council believes this fulfills the resolution's request, embeds seamlessly within existing policy, and provides an impactful solution.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 108-A-24 and the remainder of the report be filed:

1. That our American Medical Association (AMA) advocate for fair payment of CPT codes that accurately describe the myriad of administrative tasks performed by physicians, which can include the prior authorization process, appeals, or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials. (New HOD Policy)

2. That our AMA amend Policy D-320.978 by deletion as follows:

    1. Our American Medical Association will continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices.
    2. Our AMA will continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes.
    3. Our AMA will oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services.
    ~~4. Our AMA will advocate for fair reimbursement of established and future CPT codes for administrative burdens related to:~~
        ~~a. the prior authorization process.~~
        ~~b. appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials.~~ (Modify HOD Policy)

Fiscal Note: Minimal - less than $1,000.

REFERENCES

[1] BlueCross BlueShield of Illinois. Medical Record Documentation Guidelines. September 22nd, 2021. https://www.bcbsil.com/pdf/standards/medical_record_documentation_cpcp.pdf
[2] First Coast Service Options. Centers for Medicare and Medicaid (CMS). Physician Signature Requirements for Medical Record Documentation. https://medicare.fcso.com/education_resources/0307516.pdf.
[3] Servais, Cheryl. CMS Tightens Documentation and Signature Requirements. April 7th, 2010. Healthcare Finance News. https://www.healthcarefinancenews.com/blog/cms-tightens-documentation-and-signature-requirements.
[4] Medicare Program Integrity Manual. Chapter 3 – Verifying Potential Errors and Taking Corrective Actions. Issued: 08-09-24. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf#page=44.
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[9] *Supra* 3.
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[13] Ibid.
[14] Forrester, Caroline, PharmD. Benefits of Prior Authorizations. Journal of Managed Care & Specialty Pharmacy. Volume 26, Number 7. https://www.jmcp.org/doi/10.18553/jmcp.2020.26.7.820.
[15] *Supra* Note 11.
[16] *Supra* Note 11.
[17] CPT® Assistant. Special Edition: October Update. Reporting Prior Authorization – Related Activities Within E/M Services (99203, 99204, 99205, 99213, 99214, 99215, 99358, 99452, 99080). https://www.ama-assn.org/system/files/cpt-assistant-oct2024-prior-auth.pdf.
[18] Ibid.
[19] Ibid.
[20] Ibid.
[21] Ibid.
[22] Ibid.

Council on Medical Service Report 4-A-25
Requiring Payment for Physician Signatures
Policy Appendix

Fair Reimbursement for Administrative Burdens D-320.978

1. Our American Medical Association (AMA) will continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices.
2. Our AMA will continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes.
3. Our AMA will oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services.
4. Our AMA will advocate for fair reimbursement of established and future CPT codes for administrative burdens related to:
    a. the prior authorization process.
    b. appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials.

(Res. 701, A-22)

Insurance Coverage Appeals D-320.993

Our AMA will:
(1) continue to support the development of more stringent state laws and regulations that provide compensation to physicians for the administrative burden and costs of the health plan documentation requirements, such as the appeal process;
(2) continue to advocate to ensure that physicians receive prompt, fair payment from health plans through educational products, seminars and advocacy efforts;
(3) continue to encourage health plans to implement online appeal processes to reduce the administrative burden and cost to physicians and their patients when claims are denied inappropriately;
(4) continue to encourage health plans to streamline, provide transparency, and lessen the administrative burdens and costs that are incurred by physicians through the health plans appeals processes;
(5) remain an active participant in the standards development activities of several standards development organizations and data content committees; and
(6) continue in its leadership role in the National Uniform Claims Committee and its work with the standards development organizations.
(BOT Rep. 23, A-06 Modified: CMS Rep. 01, A-16 Reaffirmation: I-17)

Reduction of Burdensome CMS Signature Compliance Requirements D-330-919

Our AMA will re-engage the Centers for Medicare & Medicaid Services to re-evaluate Medicare signature requirements.
(Res. 813, I-10 Reaffirmed: Res. 708, A-18)

Administrative Costs and Access to Health Care H-155.976

Our American Medical Association supports accurate calculations of the administrative costs of government programs (Medicare, Medicaid, TRICARE, etc.) and private health insurance plans. It is the policy of the AMA:

(1) to begin immediately to seek comprehensive reforms to reduce the administrative inefficiencies, burdens and expenses involved in paying for health care services and to urge that proposals to increase access to health care also address the need to reduce administrative costs and burdens;
(2) that state and county medical societies and national medical specialty societies be urged to utilize the joint Guidelines for Health Benefits Administration in discussions with health care payers directed toward improving the efficiency of utilization management programs and minimizing the administrative burdens they impose on physicians and hospitals;
(3) that the AMA strongly encourage further study of the cost-effectiveness of all types of utilization management systems and programs and report further results of such study to the Federation as they become available;
(4) that state medical societies be urged to work for enactment of the AMA model state legislation governing: (a) clarity and readability of contract language and uniform policy provisions; (b) liability of review entities for injury to beneficiaries; (c) physician involvement in the review process; and (d) confidentiality of medical information requested by review entities; and
(5) that this information be conveyed to the American public through appropriate mechanisms.
(Res. 202, A-90 CMS Rep. A, A-90 Reaffirmed: BOT Rep. 40, I-93 CMS Rep. 12, A-95 Appended: Res. 715, I-02 Reaffirmation A-07 Reaffirmed in lieu of Res. 828, I-08 Reaffirmation I-11 Reaffirmation: A-17)

Activities of The Joint Commission and a Single Signature to Document the Validity of the Contents of the Medical Record H-225.965
The AMA supports the authentication of the following important entries in the medical record, history and physical examinations, operative procedures, consultations, and discharge summaries. Unless otherwise specified by the hospital or medical staff bylaws, or as required by law or regulation, a single signature may document the validity of other entries in the medical record.
(BOT Rep. 58, A-96 Reaffirmed: CLRPD Rep. 2, A-06 Modified: CMS Rep. 01, A-16 Reaffirmation: I-18)

Use of CPT Editorial Panel Process H-70.919
Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetic statements and modifiers.
(BOT Rep. 4, A-06 Reaffirmation A-07 Reaffirmation I-08 Reaffirmation A-09 Reaffirmation A-10 Reaffirmation A-11 Reaffirmation I-14 Reaffirmed: CMS Rep. 4, I-15 Reaffirmation A-16 Reaffirmed in lieu of: Res. 117, A-16 Reaffirmed in lieu of: Res. 121, A-17 Reaffirmation: A-18 Reaffirmation: I-18 Reaffirmed: Res. 816, I-19)

APPENDIX A

Reporting Prior Authorization Activities Provided as Part of Evaluation and Management Services

- 99203 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

- 99204 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

- 99205 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded. (For services 75 minutes or longer, use prolonged services code 99417)

- 99213 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

- 99214 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

- 99215 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded. (For services 55 minutes or longer, use prolonged services code 99417)

- 99358 - Prolonged evaluation and management service before and/or after direct patient care; first hour. Code 99359 can be used for each additional half hour.

- 99452 - Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional.

- 99080 - Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form.