Southeast Resolutions – 2014 AMA Annual Meeting

*Please click on the underlined resolution number to see the full resolution.

Reference Committee A

**Resolution # 104** – Physician Payment by Medicare – Louisiana

**Resolution # 106** – Endorse Medicare Part D Educational Website – Georgia

**Resolution # 108** – Modernizing Tricare Payment Policies – Virginia, West Virginia, Kentucky, South Carolina, Maryland, California

**Resolution # 114** – Lung Cancer Screening to be Considered Standard Care – Florida

**Resolution # 124** – Generic Changes in Medicare (Part D) Plans – Georgia

Reference Committee B

**Resolution # 203** – E-Prescribing and Meaningful Use – Virginia, Kentucky, Mississippi, North Carolina

**Resolution # 207** – ICD-10 Transparency and Conversion – Louisiana

Reference Committee C

**Resolution # 313** – Opposition to the FSMB Maintenance of Licensure Program – Florida

Reference Committee F

**Resolution # 602** – AMA Election Activities – Alabama, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, New Jersey, North Carolina, Puerto Rico, South Carolina, Tennessee, Virginia, West Virginia

**Resolution #615** – AMA Advocacy Analysis – Florida

Reference Committee G

**Resolution # 709** – Change of Coumadin Regulation by CMS – Georgia

**Resolution # 710** – Reimbursement for Audit Requests – Georgia

**Resolution # 711** – Reimbursement for Prior Approval Requirements – Georgia
Whereas, For the last several year Congress has acted at the last minute to avoid the Medicare SGR massive reduction in physician reimbursement, and instead allow for a “1-2% increase OR a freezing” of the reimbursement amounts, but a check of the published Louisiana Medicare payment amounts demonstrated that from 1997-2002 allowables varied widely over the codes, and then from 2005-2008 across the schedule allowables actually decreased by around 11%; then with no public notification in July of 2008 their allowables were increased on average 13% and again in November 2008 increased another 6%; and

Whereas, There was never a simple % payment increase across the board, but rather wide variation across the codes in what seems an erratic fashion with no detectible logic. From 2005 to 2008 the reimbursement or “fee allowance” by Medicare declined by around 11% for most codes, yet surprisingly, and with no notification, in July of 2008 La. Medicare increased fees for physicians by around 13% for most codes (Attachment 2); and

Whereas, There is never a simple % increase across the board, but rather wide variation across the codes including same payment, reductions and increases in payment in what seems an erratic fashion with no detectible logic; and

Whereas, Medicare appears to have chosen to “subsidize the corporate practice of medicine” by paying far more for “hospital-based clinics” than for private offices, i.e., the “facility fee” reimbursement paid plus the “facility doctor’s” reimbursement combined is dramatically greater than that provided for a private doctor for the same service, thereby increasing the cost of healthcare and causing more consolidation/employment arrangements with hospitals (Attachment 3); therefore be it

RESOLVED, That our American Medical Association AMA annually examine the methodology for determining “allowable” Medicare fee schedules (E&M and CPT code) to determine if the reimbursement is consistent with the government’s stated amounts and alert its membership as to that consistency or lack thereof (Directive to Take Action); and be it further

RESOLVED, That our AMA examine the reason that Medicare pays far more for “hospital-based” clinics/doctors than for private practice physicians. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/21/14
### Attachment 1

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits - New</td>
<td>99201</td>
<td>28.69</td>
<td>28.69</td>
<td>33.00</td>
<td>39.55</td>
<td>39.78</td>
<td>30.18</td>
<td>1.49</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>99202</td>
<td>45.84</td>
<td>45.84</td>
<td>53.00</td>
<td>62.02</td>
<td>60.93</td>
<td>54.58</td>
<td>8.74</td>
<td>19%</td>
</tr>
<tr>
<td></td>
<td>99203</td>
<td>63.64</td>
<td>63.64</td>
<td>74.00</td>
<td>87.40</td>
<td>90.03</td>
<td>81.55</td>
<td>17.91</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>99204</td>
<td>94.78</td>
<td>94.78</td>
<td>109.00</td>
<td>126.27</td>
<td>130.66</td>
<td>116.52</td>
<td>21.74</td>
<td>23%</td>
</tr>
<tr>
<td>Office Visits - New</td>
<td>99205</td>
<td>119.45</td>
<td>119.45</td>
<td>157.16</td>
<td>165.14</td>
<td>148.78</td>
<td>29.33</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Office Visits - Estab.</td>
<td>99211</td>
<td>24.93</td>
<td>24.93</td>
<td>29.00</td>
<td>33.64</td>
<td>35.14</td>
<td>32.02</td>
<td>7.09</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>99213</td>
<td>35.88</td>
<td>35.88</td>
<td>40.00</td>
<td>46.20</td>
<td>49.44</td>
<td>44.64</td>
<td>8.76</td>
<td>24%</td>
</tr>
<tr>
<td></td>
<td>99214</td>
<td>54.39</td>
<td>54.39</td>
<td>62.00</td>
<td>71.45</td>
<td>77.20</td>
<td>70.33</td>
<td>15.94</td>
<td>29%</td>
</tr>
<tr>
<td>Office Visits - Estab.</td>
<td>99215</td>
<td>86.21</td>
<td>86.21</td>
<td>106.94</td>
<td>115.04</td>
<td>103.62</td>
<td>17.41</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Hosp Initial Care</td>
<td>99221</td>
<td>63.16</td>
<td>63.16</td>
<td>69.40</td>
<td>70.77</td>
<td>59.18</td>
<td>-3.98</td>
<td>-6%</td>
<td></td>
</tr>
<tr>
<td>Consults - Office</td>
<td>99241</td>
<td>43.03</td>
<td>43.03</td>
<td>48.00</td>
<td>54.29</td>
<td>48.76</td>
<td>41.58</td>
<td>-1.45</td>
<td>-3%</td>
</tr>
<tr>
<td></td>
<td>99242</td>
<td>67.69</td>
<td>67.69</td>
<td>78.00</td>
<td>89.82</td>
<td>88.23</td>
<td>77.19</td>
<td>9.50</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>99243</td>
<td>87.76</td>
<td>87.76</td>
<td>101.00</td>
<td>114.65</td>
<td>116.34</td>
<td>102.09</td>
<td>14.33</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td>99244</td>
<td>123.09</td>
<td>123.09</td>
<td>141.00</td>
<td>159.06</td>
<td>165.07</td>
<td>146.71</td>
<td>23.62</td>
<td>19%</td>
</tr>
<tr>
<td>Hospital Visit</td>
<td>99233</td>
<td>77.81</td>
<td>80.64</td>
<td>69.57</td>
<td>69.57</td>
<td>-5.33</td>
<td>-8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consults - Hosp.</td>
<td>99252</td>
<td>68.30</td>
<td>68.30</td>
<td>74.00</td>
<td>75.61</td>
<td>76.95</td>
<td>62.77</td>
<td>-5.53</td>
<td>-8%</td>
</tr>
<tr>
<td></td>
<td>99253</td>
<td>90.27</td>
<td>90.27</td>
<td>99.00</td>
<td>101.26</td>
<td>103.76</td>
<td>85.97</td>
<td>4.25</td>
<td>-5%</td>
</tr>
<tr>
<td>Consults - Hosp-Initial</td>
<td>99254</td>
<td>123.95</td>
<td>123.95</td>
<td>141.41</td>
<td>146.87</td>
<td>124.01</td>
<td>0.06</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>99255</td>
<td>168.16</td>
<td>168.16</td>
<td>193.62</td>
<td>201.06</td>
<td>170.99</td>
<td>2.83</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>Consults - E.R.</td>
<td>99281</td>
<td>20.64</td>
<td>20.64</td>
<td>20.00</td>
<td>19.86</td>
<td>18.60</td>
<td>14.39</td>
<td>-6.25</td>
<td>-30%</td>
</tr>
<tr>
<td>E.R. Visit</td>
<td>99283</td>
<td>58.64</td>
<td>58.64</td>
<td>63.64</td>
<td>64.48</td>
<td>53.57</td>
<td>-5.07</td>
<td>-9%</td>
<td></td>
</tr>
</tbody>
</table>

### Attachment 2

<table>
<thead>
<tr>
<th>E &amp; M CODE</th>
<th>CPT</th>
<th>1.a. 2005</th>
<th>2008</th>
<th>Diff M-C</th>
<th>7/31/08</th>
<th>% Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>MC</td>
<td>M-C</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits - New</td>
<td>99201</td>
<td>35.96</td>
<td>32.15</td>
<td>-11%</td>
<td>36.16</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>99202</td>
<td>63.91</td>
<td>55.14</td>
<td>-14%</td>
<td>62.05</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>99203</td>
<td>95.33</td>
<td>80.87</td>
<td>-15%</td>
<td>91.04</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>99204</td>
<td>134.96</td>
<td>123.06</td>
<td>-9%</td>
<td>138.65</td>
<td>13%</td>
</tr>
<tr>
<td>Office Visits - Estab.</td>
<td>99205</td>
<td>170.93</td>
<td>154.47</td>
<td>-10%</td>
<td>174.10</td>
<td>13%</td>
</tr>
<tr>
<td>Hosp Initial Care</td>
<td>99212</td>
<td>37.75</td>
<td>33.17</td>
<td>-12%</td>
<td>37.30</td>
<td>12%</td>
</tr>
<tr>
<td>Hospital Visit</td>
<td>99213</td>
<td>51.46</td>
<td>53.04</td>
<td>3%</td>
<td>50.73</td>
<td>13%</td>
</tr>
<tr>
<td>Consults - Hosp.</td>
<td>99214</td>
<td>80.84</td>
<td>79.74</td>
<td>-1%</td>
<td>80.81</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>99215</td>
<td>117.98</td>
<td>107.79</td>
<td>-9%</td>
<td>121.44</td>
<td>13%</td>
</tr>
<tr>
<td>Consults - Hosp-Initial</td>
<td>99221</td>
<td>67.88</td>
<td>75.25</td>
<td>11%</td>
<td>85.91</td>
<td>13%</td>
</tr>
<tr>
<td>Consults - E.R.</td>
<td>99233</td>
<td>78.57</td>
<td>80.28</td>
<td>2%</td>
<td>90.69</td>
<td>13%</td>
</tr>
<tr>
<td>E.R. Visit</td>
<td>99252</td>
<td>72.01</td>
<td>64.56</td>
<td>-10%</td>
<td>72.88</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>99253</td>
<td>98.32</td>
<td>96.26</td>
<td>-2%</td>
<td>108.68</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>99254</td>
<td>141.04</td>
<td>138.75</td>
<td>-2%</td>
<td>156.66</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>99255</td>
<td>194.46</td>
<td>171.22</td>
<td>-12%</td>
<td>193.29</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>99281</td>
<td>16.64</td>
<td>17.21</td>
<td>3%</td>
<td>19.46</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>99283</td>
<td>62.18</td>
<td>52.40</td>
<td>-16%</td>
<td>59.21</td>
<td>13%</td>
</tr>
</tbody>
</table>
### Attachment 3

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>CPT</th>
<th>Mcare 2013</th>
<th>Mcare 2013</th>
<th>Differ 2013</th>
<th>Mcare 2013</th>
<th>TOTAL FacFee &amp;Fac Dr vsPrvDr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits - New</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99201</td>
<td></td>
<td>43.15</td>
<td>25.55</td>
<td>-41%</td>
<td>56.77</td>
<td>82.32</td>
</tr>
<tr>
<td>99202</td>
<td></td>
<td>73.35</td>
<td>48.45</td>
<td>-34%</td>
<td>73.68</td>
<td>122.13</td>
</tr>
<tr>
<td>99203</td>
<td></td>
<td>106.49</td>
<td>74.28</td>
<td>-30%</td>
<td>96.96</td>
<td>171.24</td>
</tr>
<tr>
<td>99204</td>
<td></td>
<td>162.27</td>
<td>126.74</td>
<td>-22%</td>
<td>128.48</td>
<td>255.22</td>
</tr>
<tr>
<td>Office Visits - Estab.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99212</td>
<td></td>
<td>43.15</td>
<td>24.23</td>
<td>-44%</td>
<td>73.68</td>
<td>97.91</td>
</tr>
<tr>
<td>99213</td>
<td></td>
<td>71.72</td>
<td>49.14</td>
<td>-31%</td>
<td>96.96</td>
<td>146.10</td>
</tr>
<tr>
<td>99214</td>
<td></td>
<td>105.31</td>
<td>75.75</td>
<td>-28%</td>
<td>128.48</td>
<td>204.23</td>
</tr>
<tr>
<td>Office Visits - Estab.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99215</td>
<td></td>
<td>140.93</td>
<td>106.73</td>
<td>-24%</td>
<td>175.79</td>
<td>282.52</td>
</tr>
</tbody>
</table>
WHEREAS, Medication is an integral part of our patients’ medical treatment plan; and

WHEREAS, The cost of medications for our older population of patients is a reason many patients are non-compliant with their medical treatment plan; and

WHEREAS, Simplifying the process for Medicare Part D will decrease the cost for our Medicare patients, thus increasing the compliance with the patients’ drug therapy; and

WHEREAS, In many urban areas, our patients can choose from more than 50 possible plans, which cover different medicines, and have different co-pays, premiums and deductibles; therefore be it

RESOLVED, That our American Medical Association request that the federal government provide on an annual basis to the Medicare population an individualized report showing the estimated out of pocket costs for each of the available Medicare D and Advantage plans, based on the medications taken during the prior year, similar to the report which an individual can obtain on medicare.gov; and that the AMA ask electronic medical record vendors to provide the capability to give patients on Medicare such reports. (Directive to Take Action)

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

Received: 04/25/14
RELEVANT AMA POLICY

D-330.933 Restoring High Quality Care to the Medicare Part D Prescription Drug Program
Our AMA will:  a. work to eliminate prior authorizations under the Medicare Part D Prescription Drug Program which undermine a physician’s best medical judgment;  b. work with the Centers for Medicare and Medicaid Services (CMS) to enforce the Medicare Part D Prescription Drug Program statutory requirement that all Part D plans include at least two drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients;  c. work with CMS to place reasonable copays in the Medicare Part D Prescription Drug Program;  d. work with other interested parties to simplify the CMS prior authorization process such that a diagnosis or reason written on the prescription should be accepted as documentation for non formulary request; and  e. work with CMS to develop a one-page form for physicians and patients to utilize in appealing a prescription coverage denial. (Res. 106, A-07; Reaffirmation A-08)

D-330.947 Educational Materials for Physicians on Medicare Part D
Our AMA will (1) prepare a report on available educational programs for physicians on Medicare Part D issues, and (2) make available appropriate educational materials targeted for physicians on Medicare Part D issues, so that they may best assist patients and effectively meet their responsibilities, under Medicare Part D laws and regulations. (Res. 105, A-05; Reaffirmation A-06)

H-330.894 Demonstration Project Regarding Medicare Part D
Our AMA will continue its policy of promoting beneficiary choice and market based options in the context of the Medicare prescription drug benefit program (Part D). (BOT Action in response to referred for decision Res. 142, A-07)
Whereas, Tricare is the health insurance plan for this nation’s military dependents and retirees, covering hundreds of thousands of lives and affecting many physician practices; and

Whereas, Payment levels exactly reflect Medicare’s fee schedule, but many of their policies do not; and

Whereas, As an example, Tricare ignores the “incident to” policy of Medicare regarding payment for services rendered by mid-level providers under the general supervision of a physician, only paying 85% of allowable charges unless the physician also sees the patient. Tricare is actively auditing and penalizing practices who bill under the physician’s NPI. This policy is very old and does not reflect the current model of team care, and it is negatively impacting the financial well-being of many practices that accept Tricare, resulting in a limitation of access for these patients; and

Whereas, Certain Tricare regions have ignored national policy on mental health parity, and will not pay primary care physicians who treat and manage common conditions such as depression and anxiety, again resulting in reduced access; and

Whereas, The AMA CPT panel was recently successful in having Medicare adopt the transition care codes (99495, 99496). Medicare now pays for this critical aspect of patient care, and almost all Medicare secondary policies cover the 20% copay for this service. However, Tricare does not, leaving the patient responsible for this payment; and

Whereas, Tricare often is not adherent to ACIP recommendations for immunizations, such as Zostavax (shingles) and TDAP (acellular pertussis), specifically regarding age of coverage; therefore be it

RESOLVED, That our American Medical Association help to insure the continued access of our nation’s military dependents and retirees to the services of civilian physicians by actively pursuing the modernization of Tricare policies to reflect standard fair payment policies to physicians, specifically with regard to a) accepting the “incident to” Medicare model for payment for mid-level provider services, if under the general supervision of a physician, b) paying for treatment of mental health conditions, regardless of the specialty of the treating physician, and c) covering the copayment of a Medicare patient who receives transition of care services (CPT 99495, 99496) by a physician (Directive to Take Action); and be it further

RESOLVED, That a progress report on these discussions be presented to this House, if possible at the 2014 Interim Meeting, but no later than the 2015 Annual Meeting. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000
Received: 04/29/14
WHEREAS, Lung cancer is the number one cancer killer of men and women in the US and the world; and

WHEREAS, There are 160,000 lung cancer deaths in the US each year; and

WHEREAS, Lung cancer kills more Americans than breast, colorectal, prostate, and pancreas cancers combined; and

WHEREAS, There is very strong evidence, as a result of the National Lung Screening Trial in 2010, that screening at-risk patients with Low Dose CT has a reduction of 20% in mortality; and

WHEREAS, The composite survival for all stages of lung cancer at 5 years is 16%; and

WHEREAS, The survival for stage 1, detected early, may be as high as 92%; and

WHEREAS, Lung cancer screening can increase survival of our lung cancer patients from 16% to 92%; therefore be it

RESOLVED, That our American Medical Association recommend that coverage of lung cancer screening for high risk patients by Medicare, Medicaid, and private insurance be a required covered benefit to ensure that everyone at risk has a fair and equitable opportunity to survive a lung cancer diagnosis. (New HOD Policy)

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

Received: 04/30/14
Whereas, The Medicare Prescription Drug Plan adds drug coverage to original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service Plans, and Medicare Medical Savings Account (MSA) Plans; and

Whereas, Most Medicare Prescription plans offered by insurance companies approved by Medicare Advantage have prescription drug coverage that follows the same rule as Medicare prescription Drug Plans; and

Whereas, These drug plans have multiple tiers with differing amounts of co-pays and coinsurance; and

Whereas, Medicare Part D plans consists of four payment stages, including annual deductible, initial coverage, coverage gaps, and catastrophic coverage; and in each stage, the amount you pay and your plan pays for your medication varies; and

Whereas, the reason for this is that these medications are either non-formulary, step-therapy, or require prior approval; and

Whereas, When patients sign up for a new drug plan, they often realize their current medications may not be in their new plan and patients are allowed only a 30-day supply of their drug within the first 90-day of the plan before it is stopped; and

Whereas, The patient and the doctor, within 30 days, then have to take extra time and expense in an office visit to discuss changing to a new medication due to cost reasons and not due to clinical reasons; and

Whereas, In the past year or so, the request to change medications has not only been for trade name drugs to generic drugs, but also from generic drugs to generic drugs with no apparent cost savings; and

Whereas, The cost and time spent for physicians and their staff in prior approvals and appeals is cost prohibitive in this day of health cost savings; therefore be it

RESOLVED, That our American Medical Association investigate the incidence and reasoning behind the conversion of one generic drug to another generic drug of the same class in Medicare Advantage drug plans (Directive to Take Action); and be it further
RESOLVED, That our AMA request Centers for Medicare & Medicaid Services to ensure that pharmaceutical vendors, when they do ask for generic transitions of drugs, list the drugs they believe are more cost effective along with their tier price and alternative drug names. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000.

Received: 05/05/14

RELEVANT AMA POLICY

H-125.982 Medicare Part D Modifications
Our AMA will seek necessary federal legislative changes to: a. have all pharmacy benefit programs participating in Medicare Part D offer at least one program that eliminates the coverage gap; and b. require that all pharmacy benefit programs participating in Medicare Part D inform the enrollees of lower cost/generic alternatives for each prescribed medication. (Res. 130, A-07)

D-330.933 Restoring High Quality Care to the Medicare Part D Prescription Drug Program
Our AMA will: a. work to eliminate prior authorizations under the Medicare Part D Prescription Drug Program which undermine a physician’s best medical judgment; b. work with the Centers for Medicare and Medicaid Services (CMS) to enforce the Medicare Part D Prescription Drug Program statutory requirement that all Part D plans include at least two drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients; c. work with CMS to place reasonable copays in the Medicare Part D Prescription Drug Program; d. work with other interested parties to simplify the CMS prior authorization process such that a diagnosis or reason written on the prescription should be accepted as documentation for non formulary request; and e. work with CMS to develop a one-page form for physicians and patients to utilize in appealing a prescription coverage denial. (Res. 106, A-07; Reaffirmation A-08)

D-330.931 Adequate Formularies for Dual Eligible Patients Under Medicare Part D
Our AMA will: (1) continue working through our AMA-convened Part D Implementation Workgroup to identify Part D problems and advocate that the Centers for Medicare and Medicaid Services and the Medicare prescription drug plans (PDPs) address them; (2) survey state medical associations regarding problems that Medicare/Medicaid dual eligibles are having with the PDPs in their states and mechanisms for effectively resolving them; and (3) monitor opportunities to provide input into Medicare Payment Advisory Commission recommendations and proposed regulations, guidance and legislation that will address problems in Medicare Part D. (BOT Action in response to referred for decision Res. 710, I-06)
Whereas, The federal government has instituted numerous requirements for practicing physicians with the meaningful use program started in 2011; and

Whereas, In 2014, meaningful use progresses to Stage 2 of the program with increasing requirements on physicians, including an increase in e-prescribing from 40% to 50% of their total prescriptions; and

Whereas, The federal government through its military and government pharmacies, such as Tricare, accept only printed prescriptions as they do not have the capability of receiving e-prescriptions from practicing physicians. This reduces the percentage of e-prescribing physicians can accomplish during any given year and places them in a position not to achieve the requirements of e-prescribing for meaningful use; therefore be it

RESOLVED, That our American Medical Association petition the Centers for Medicare & Medicaid Services and the federal government to have all government pharmacies accept e-prescriptions or to temporarily halt the e-prescribing requirements of meaningful use until this is accomplished. (Directive to Take Action)

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

Received: 03/31/14
Whereas, Pursuant to certain provisions of the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Department of Health and Human Services (HHS) has modified two of the code set standards adopted in the Transactions and Code Sets final rule, replacing the International Classification of Diseases, 9th Revision, Clinical Modification, Volumes 1 and 2 and the International Classification of Diseases, 9th Revision, Clinical Modification, Volume 3 (hereinafter collectively referred to as ICD-9) as the standard medical data code sets for coding diagnoses and inpatient hospital procedures by concurrently adopting the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding, including the Official ICD-10-CM Guidelines for Coding and Reporting, as maintained and distributed by the US Department of Health and Human Services (HHS), and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding, including the Official ICD-10-PCS Guidelines for Coding and Reporting, as maintained and distributed by the HHS (hereinafter collectively referred to as ICD-10); and

Whereas, HHS has published compliance dates as the date on which entities are required to have implemented the policies adopted in this rule; and

Whereas, The policies of our AMA concerning the transition from ICD-9 to ICD-10 specify that our AMA advocate for delay, cancellation, cessation, and elimination of the transition, specifying that:

- Our AMA supports delaying or canceling the implementation of ICD-10 (H-70.916 Delay or Canceling of ICD-10, Res. 220, I-13),
- Our AMA will vigorously work to stop the implementation of ICD-10 (D-70.952 Stop the Implementation of ICD-10, Sub. Res. 216, I-11),
- Our AMA will vigorously advocate that the Centers for Medicare & Medicaid Services eliminate the implementation of ICD-10 (D-70.952 Stop the Implementation of ICD-10, Res. 209, I-12),
- Our AMA will support federal legislation to stop the implementation of ICD-10 and remain with ICD-9 until ICD-11 can be properly evaluated (D-70.952 Stop the Implementation of ICD-10, Res. 236, A-13); and
Whereas, The policies of our AMA concerning the transition from ICD-9 to ICD-10 also specify that, while opposing the transition, our AMA will also provide education to AMA members regarding ICD-10 costs, develop administrative support systems facilitating compliance with the transition, advocate for reduction of and compensation of the administrative burdens of ICD-10, and advocate for new requirements for health plans implementing payments based on ICD-10, specifying that:

- Our AMA will continue to monitor developments related to ICD-10-PCS and inform AMA members about proposed users and potential costs of the system (D-70.999 Diagnostic Procedural Coding System, BOT Rep. 4, I-98; Reaffirmed: CMS Rep. 4, A-08),
- Our AMA will educate US physicians on the burdens of ICD-10 (D-70.952 Stop the Implementation of ICD-10, Res. 236, A-13),
- Our AMA will develop systems to help physicians transition to the ICD-10 coding system (D-70.954 Transition to ICD-10 Code Sets, Res. 810, I-09),
- 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 (D-70.960 Implementation of ICD-10-CM, Res. 719, A-06),
- Our AMA will vigorously work to reduce its [ICD-10] unnecessary and significant burdens on the practice of medicine (D-70.952 Stop the Implementation of ICD-10, Sub. Res. 216, I-11),
- 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 and staff training necessitated as part of the transition to ICD-10 (D-70.951 Alleviating the Financial Burdens Associated with ICD-10 Implementation, Res. 205, I-13)
- Our AMA will support 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 (D-70.952 Stop the Implementation of ICD-10, Res. 236, A-13); and

Whereas, The Protecting Access to Medicare Act of 2014 provides that “the Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD-10 code sets as the standard for codes sets under section 1173 (c) of the Social Security Act (42 U.S.C. 1320d-2 (c)) and section 162.1002 of title 45, Code of Federal Regulations”; therefore be it

RESOLVED, That our American Medical Association affirm that 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 (New HOD Policy); and be it further
RESOLVED, That during the delay in implementation of the ICD-10 transition, our AMA will seek and support new federal legislation and/or administrative rules that ensure that:

- any health plan operating in the United States, whether in the commercial or Medicare or Medicaid markets, shall provide to their provider network sufficient information apprising providers of all planned changes to coverage, guidelines, authorizations, certifications, claims adjudications, pricing, payment, reporting, incentives and other rules based on the conversion from ICD-9 to ICD-10,

- and that such information shall include but not be limited to any "cross-walk" or "map" which will be used internally by the health plan to achieve the conversion from ICD-9 to ICD-10. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 04/29/14

RELEVANT AMA POLICY

D-70.951 Alleviating the Financial Burdens Associated with ICD-10 Implementation
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 and staff training necessitated as part of the transition to ICD-10. (Res. 205, I-13)

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 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. (Sub. Res. 216, I-11; Appended: Res. 236, A-12; Appended: Res. 209, I-12; Appended: Res. 236, A-13)

D-70.954 Transition to ICD-10 Code Sets
Our American Medical Association will develop systems to help physicians transition to the ICD-10 coding system. (Res. 810, I-09)
D-70.999 Diagnostic Procedural Coding System
Our AMA will continue: (1) to monitor developments related to ICD-10-PCS and inform AMA members about proposed users and potential costs of the system; (2) its work on the development of CPT-5, addressing such key issues as the maintenance process, hierarchical code structure, code specificity, and costs of adoption and maintenance, and seek to maintain its leadership position in code development and maintenance; (3) to explore opportunities to include medical specialty societies and other organizations with expertise in the formulation of clinical terminology in the development of CPT-5; and (4) inform physicians and other users of CPT about the development of CPT-5 and provide updates on its progress, as they become available. (BOT Rep. 4, I-98; Reaffirmed: CMS Rep. 4, A-08)

H-70.916 Delay or Canceling of ICD-10
Our AMA supports delaying or canceling the implementation of ICD-10. (Res. 220, I-13)
Whereas, In 2010 the Federation of State Medical Boards, Inc., (FSMB) House of Delegates adopted the Maintenance of Licensure (MOL) framework, a process by which physicians periodically provide, as a condition of license renewal, evidence that they are actively participating in a program of continuous professional development that is relevant to their areas of practice, measured against objective data sources and aimed at improving performance over time; and state licensing boards may elect to substantially or fully qualify licensees engaged in these activities; and

Whereas, Physicians are lifelong learners by nature and many states already have an established mandatory Continuing Education requirement for licensure; and

Whereas, Medical organizations have for years opposed any effort to regulate the content of continuing medical education (CME) mandated for licensure because physicians themselves are in the best position to determine what educational opportunities will be most helpful in improving their practice, based on the type of patients that they see and the procedures that they perform; and

Whereas, Maintenance of board certification (MOC) is extremely costly and time consuming, requiring time away from patient care or from more relevant study, and greatly exceeds the level of knowledge needed for basic medical licensure; and there is no evidence that physicians who have completed the MOC procedure make more accurate diagnoses or are more skillful at performing their treatments; and

Whereas, The Association of American Physicians & Surgeons (AAPS) has recently filed suit in federal court against the American Board of Medical Specialties (ABMS) for restraining trade and causing a reduction in access by patients to their physicians; and

Whereas, Legislation has greatly expanded the scope of practice to lesser educated “midlevel providers” (i.e. nurse practitioners, optometrists, physician’s assistants, CRNAs, etc.) without requirements for the same certification; while expanding physician requirements and driving experienced physicians out of practice because of onerous, costly requirements will result in still more patients being forced to turn to non-physicians for care; therefore be it

RESOLVED, That our American Medical Association oppose any efforts by the Federation of State Medical Boards, Inc., (FSMB) to implement a “maintenance of licensure (MOL)” program in any state (New HOD Policy); and be it further
RESOLVED, That our AMA oppose any maintenance of certification (MOC) or recertification by a specialty medical board as a condition of licensure in any state. (New HOD Policy)

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

Received: 04/30/14

RELEVANT AMA POLICY

H-275.923 Maintenance of Certification / Maintenance of Licensure
Our AMA will: 1. Continue to work with the Federation of State Medical Boards (FSMB) to establish and assess maintenance of licensure (MOL) principles with the AMA to assess the impact of MOC and MOL on the practicing physician and the FSMB to study the impact on licensing boards. 2. Recommend that the American Board of Medical Specialties (ABMS) not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety. 3. Encourage rigorous evaluation of the impact on physicians of future proposed changes to the MOC and MOL processes including cost, staffing, and time. 4. Review all AMA policies regarding medical licensure; determine if each policy should be reaffirmed, expanded, consolidated or is no longer relevant; and in collaboration with other stakeholders, update the policies with the view of developing AMA Principles of Maintenance of Licensure in a report to the HOD at the 2010 Annual Meeting. 5. Urge the National Alliance for Physician Competence (NAPC) to include a broader range of practicing physicians and additional stakeholders to participate in discussions of definitions and assessments of physician competence. 6. Continue to participate in the NAPC forums. 7. Encourage members of our House of Delegates to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups. 8. Continue to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for post graduate medical education in the US, including the Performance Improvement CME (PICME) format; and continue to develop relationships and agreements that may lead to standards, accepted by all US licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME. 9. Collaborate with the American Osteopathic Association and its eighteen specialty boards in implementation of the recommendations in CME Report 16-A-09, Maintenance of Certification / Maintenance of Licensure. 10. Continue to support the AMA Principles of Maintenance of Certification (MOC). 11. Monitor MOL as being led by the Federation of State Medical Boards (FSMB), and work with FSMB and other stakeholders to develop a coherent set of principles for MOL. 12. Our AMA will 1) advocate that if state medical boards move forward with the more intense MOL program, each state medical board be required to accept evidence of successful ongoing participation in the American Board of Medical Specialties Maintenance of Certification and American Osteopathic Association-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL if performed, and 2) also advocate to require state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians choices in what programs they participate to fulfill their MOL criteria. (CME Rep. 16, A-09; Appended: CME Rep. 3, A-10; Reaffirmed: CME Rep. 3, A-10; Appended: Res. 322, A-11; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: CME Rep. 4, A-13; Reaffirmed in lieu of Res. 919, I-13)
D-275.960 An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure

1. Our AMA will encourage the American Board of Medical Specialties (ABMS) and the specialty certification boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients as an alternative to high stakes closed book examinations. 2. Our AMA will continue to monitor the evolution of Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC), and Maintenance of Licensure (MOL), continue its active engagement in discussions regarding their implementation, and report back to the House of Delegates on these issues. 3. Our AMA will (a) work with the ABMS and ABMS specialty boards to continue to examine the evidence supporting the value of specialty board certification and MOC and to determine the continued need for the mandatory high-stakes examination; and (b) work with the ABMS to explore alternatives to the mandatory high-stakes examination. 4. Our AMA encourages the ABMS to ensure that all ABMS specialty boards provide full transparency related to the costs of preparing, administering, scoring, and reporting MOC and certifying/recertifying examinations and ensure that MOC and certifying/recertifying examinations do not result in significant financial gain to the ABMS specialty boards. 5. Our AMA will work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, in particular to ensure that MOC is specifically relevant to the physician’s current practice. 6. Our AMA will solicit an independent entity to commission and pay for a study to evaluate the impact that MOL and MOC requirements have on physicians’ practices, including but not limited to: physician workforce, physicians’ practice costs, patient outcomes, patient safety and patient access. Such study will look at the examination processes of the ABMS, the American Osteopathic Association, and the Federation of State Medical Boards. Such study is to be presented to the AMA HOD, for deliberation and consideration before any entity, agency, board or governmental body requires physicians to sit for MOL licensure examinations. Progress report is to be presented at Annual 2014; complete report by Annual 2015. 7. Our AMA: (a) supports ongoing ABMS specialty board efforts to allow other physician educational and quality improvement activities to count for MOC; (b) supports specialty board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs such as pay for quality/performance or PQRS reimbursement; (c) encourages the ABMS specialty boards to enhance the consistency of such programs across all boards; and (d) will work with specialty societies and specialty boards to develop tools and services that facilitate the physician’s ability to meet MOC requirements. (CME Rep. 10, A-12; Modified: CME Rep. 4, A-13)
Whereas, The AMA Election Manual quoting from the House of Delegates Reference Manual Chapter 11 in the Section named “Campaign Rules: Expenses, Events, Parties and Other Activities” Paragraph #2 reads as follows:

“There will be only one big party at the Annual Meeting financed by a coalition or a state or specialty delegation irrespective of the number of candidates from that society or coalition. At these events, alcohol may be served only on a cash or no-host bar basis. This would limit a candidate to only one big party at the Annual Meeting whether financed by a coalition or a state or specialty delegation. This would also limit a state or specialty society or delegation to one big party irrespective of the number of candidates from that society or coalition. (I 92, Reaffirmed and Revised, A-97, G 610.020[6]); and

Whereas, The last two sentences of this election policy are vague and open to different interpretations and thus their intent should be clarified by the action of AMA House of Delegates; and

Whereas, This ambiguity has recently led the AMA Speaker and Vice Speaker to issue their opinion that if a delegation or coalition has a big campaign event, then none of their individual state or medical specialty societies should be allowed to host a campaign party, even though for different candidates, at the same AMA Annual Meeting; and

Whereas, The current financial situation of many state medical or specialty societies precludes many smaller societies from hosting their own candidate campaign events, while other societies can still afford and prefer to do so; and

Whereas, Multi-state or multi-specialty society delegations, coalitions or section councils of the AMA HOD may have some societies that prefer a separate party for their candidate(s) and other states or entities that would rather feature their candidates at a major coalition event; and

Whereas, For over twenty years the focus of the AMA election campaign policy has been that any one candidate can be featured at only one society or coalition event, but not both; therefore be it
RESOLVED, That American Medical Association Policy G-610.020[6], Election Campaigns, be amended by addition to read as follows: (Modify Current HOD Policy)

(6) A coalition or a state or specialty delegation may finance only one big party at the Annual Meeting irrespective of the number of candidates from the society or coalition. This rule limits a candidate to only one big party at the Annual Meeting whether financed by a coalition or a state or specialty delegation. This rule also limits a state or specialty society or coalition to one big party irrespective of the number of candidates from that society or coalition. At these events, alcohol may be served only on a cash or no-host bar basis; A member of a coalition or section council such as an individual state or medical specialty society, may sponsor a separate party for its candidate(s) only if none of their sponsored candidates are also featured at any coalition or section council’s main event, even if the society otherwise participates in other coalition or section council activities. This will not affect candidate endorsements by societies that are not sponsoring the candidate’s campaign;

Fiscal Note: None

Received: 2/26/14

RELEVANT AMA POLICY

G-610.020 Election Campaigns
AMA policy on election campaigns includes the following:

(1) Active campaigning for AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the nominees for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates;

(2) A campaign manual containing information on all candidates for election shall continue to be developed and distributed;

(3) Campaign expenditures and activities should be limited to prudent and reasonable levels necessary for adequate candidate exposure to the delegates. The Speaker of the House should meet with all announced candidates and campaign managers at each meeting of the House of Delegates to agree on general campaign procedures;

(4) At the Interim Meeting, campaign-related expenditures and activities shall be discouraged, and there shall be no large campaign receptions, luncheons, or other formal campaign activities. This rule does not preclude distribution of a declaration of candidacy on the last day of the Annual Meeting, last day of the Interim Meeting, or one announcement of candidacy by a mailing prior to the Interim Meeting. An announcement of candidacy includes only the candidate’s name, photograph, email address, URL, the office sought and a list of endorsing societies. This rule prohibits campaign parties at the Interim Meeting and the distribution of campaign literature and gifts at the Interim Meeting. It is permissible at the Interim Meeting for candidates seeking election at the next Annual Meeting to engage in individual outreach, such as small group meetings, including informal dinners, meant to familiarize others with a candidate’s opinions and positions on issues;

(5) The AMA believes that: (a) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials sent to the House and on the ballot as the representative of that society and not by the state in which the candidate resides; (b) elected specialty society members should be identified in that capacity while serving their term of office; and (c) nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose;
(6) A coalition or a state or specialty delegation may finance only one big party at the Annual Meeting irrespective of the number of candidates from the society or coalition. This rule limits a candidate to only one big party at the Annual Meeting whether financed by a coalition or a state or specialty delegation. This rule also limits a state or specialty society or coalition to one big party irrespective of the number of candidates from that society or coalition. At these events, alcohol may be served only on a cash or no-host bar basis;

(7) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited. Displays of campaign posters, signs, and literature in public areas of hotels in which Annual Meetings are held detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at campaign parties and campaign literature may be distributed in the non-official business folder for members of the House of Delegates. No campaign literature shall be distributed and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates;

(8) A reduction in the volume of telephone calls from candidates, and literature and letters by or on behalf of candidates is encouraged. The use of electronic messages to contact electors should be minimized, and if used must allow recipients to opt out of receiving future messages. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings;

(9) Campaign gifts can be distributed only at the Annual Meeting in the non-official business folder and at one campaign party. Campaign gifts should only be distributed during the Annual Meeting and not mailed to Delegates and Alternate Delegates in advance of the meeting. Campaign memorabilia are limited to either a button, pin, sticker, or other low-cost item, the maximum cost of which shall be determined by the Speaker of the House. No other campaign memorabilia shall be distributed at any time;

(10) The Speaker's office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker);

(11) Candidates for AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society;

(12) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities; and

(13) Our AMA (a) requires completion of Disclosure of Affiliation forms by all candidates for election to our AMA Board of Trustees and Councils prior to their election; and (b) will expand accessibility to completed Disclosure of Affiliation information by posting such information on the "Members Only" section of the AMA website before election by the House of Delegates.

Whereas, There is deep appreciation for the efforts put forth by our AMA legislative and advocacy teams on difficult legislative agenda items; and

Whereas, Recent high priority issues such as the elimination of the Sustainable Growth Rate (SGR) and reform of the Medicare physician payment system with bipartisan, bicameral support, have not been enacted by Congress despite another strong effort by organized medicine to pass such legislation; and

Whereas, Despite a lack of adequate data to justify the adoption of the ICD-10 Coding and Billing System, this financial and administrative burden to the practicing physician in America is once again looming after another one-year delay in its implementation was granted; and

Whereas, The advocacy efforts by all of organized medicine have not secured the passage of the current high priority issues set forth by our AMA House of Delegates despite an engaged and dedicated team working together; therefore be it

RESOLVED, That an independent committee of the American Medical Association House of Delegates be established and sufficiently funded to evaluate all aspects of the AMA's advocacy efforts regarding our priority issues and present a report to the AMA HOD no later than at the 2015 Annual Meeting. The analysis will be coordinated through a professional consulting firm and shall include but not be limited to:

1. Evaluation of the major issues and the factors contributing to their non-passage as well as their potential for future success;
2. The AMA lobbying team and potential improvements;
3. The potential use and/or expanded use of contract lobbying firms;
4. Evaluation of the structure and function of the AMA's Council on Legislation and potential opportunities for improvement;
5. Evaluation of the structure and function of AMPAC and potential opportunities for improvement as well as better methods to involve more physicians in the process; and
6. Evaluate ways for the HOD and other interested physicians to effectively support the legislative and advocacy teams in promoting legislative issues (Directive to Take Action); and be it further
RESOLVED, That this independent committee of the AMA HOD be appointed by the Speaker of the HOD and elected from the HOD members in the following manner:

1. One member elected from the AMA Board of Trustees by the AMA BOT;
2. One past AMPAC Board member not currently serving on an AMA council or committee selected by the current AMPAC Board;
3. One past Council on Legislation member not currently serving on an AMA council or committee selected by the current Council on Legislation board;
4. Two members elected from the state delegations with PAC or legislative experience. The best way to accomplish this is to have each state regional delegation submit one individual to enter a “pool” of applicants. A simple ballot will be sent to each of the states’ delegations. Each delegate from the states will vote for one candidate. Votes will be collated by AMA staff.
5. Two members elected from the specialty society delegations with PAC or legislative experience nominated by their specialty society. The best way to accomplish this is to have each specialty submit one individual to enter a “pool” of applicants. A simple ballot will be sent to each specialty delegation. Each specialty will vote for one candidate. Votes will be collated by AMA staff.
6. One member elected by the Medical Student Section, Resident and Fellow Section and Young Physicians Section from among the members of their respective delegations. The candidate must have PAC or legislative experience. The best way to accomplish this is each organization (MSS, RFS and YPS) submit one name. Each delegate (from the MSS, RFS and YPS) will vote for one candidate. Votes will be collated by AMA staff.
7. One member selected by the Speaker from the remaining groups represented in the AMA HOD with PAC or legislative experience and a currently seated delegate or alternate in the AMA HOD. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 04/30/14
Whereas, The number of “baby boomers” reaching the age of 65 years continues to increase and the diagnosis of atrial fibrillation and other potentially life threatening diseases have subsequently increased; and

Whereas, Despite the development of several new anti-thrombotic medications, the use of warfarin is still considered the primary treatment of choice, mainly because of its lower cost and its multiple medical indications; and

Whereas, There is a need to regularly monitor the protime/INR to maintain anti-coagulant activity; and

Whereas, The testing is performed at the physician’s office, coumadin clinics, or at hospitals. However, the Centers for Medicare & Medicaid Services (CMS), has ruled that nurses through home health cannot solely test the protime/INR unless they are seeing the elderly patients for concurrent medical problems. Otherwise, these patients are expected to use a device to check their protime/INR at home; and

Whereas, Many of these debilitated patients or their families are neither able to perform this test nor able to reliably notify the clinician of their results; and

Whereas, The recent policies of CMS have been to penalize clinicians and hospitals for medical errors in medical care; and

Whereas, The cost to patients from inpatient, outpatient, and prescription drug services affected by medical errors was estimated to be approximately $17 billion according to a study by the Society of Actuaries in 2008; and

Whereas, It makes little sense for CMS in its efforts to decrease medical errors to restrict testing to a group of patients who are going to have errors either due to lack of education, miscommunication, or forgetfulness; therefore be it

RESOLVED, That our American Medical Association assist in the effort to change the thrombotic disease patient care discrepancy and request a change in this regulation to allow a nurse to visit a patient who cannot travel, has no family who can reliably test, or is unable to test on his/her own to obtain and perform a protime/INR without restrictions. (Directive to Take Action)

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

Received: 04/25/14
RELEVANT AMA POLICY

H-160.930 Home Health Care
Our AMA takes the position that the attending physician should provide all initial orders for patient care (to include medication, lab and ancillary services) and request an evaluation of unique home environmental concerns by an appropriately qualified home care registered nurse with recommendations for additional forms of care for the physician’s approval. This nursing assessment should include as a minimum a recommended plan of care, supplies or DME needs, frequency of visits by nurses, aides or other ancillary personnel, and shall be returned to the attending physician for approval. (Res. 812, A-98; Reaffirmed: CMS Rep. 4, A-08)
Whereas, Physician's offices are required to comply with audit requests for the physician's previous care of his or her patients; and

Whereas, This can include anything from completion of forms, requirement of a paper copy of the complete chart (even when the practice has electronic records), to requiring an actual physician to physician peer to peer discussion; and

Whereas, This requirement is very costly to physician's offices and in 2009 it was estimated that complying with the practice of insurance companies cost each physician's practice at least $88,000 in unreimbursed expenses, including time and materials; therefore be it

RESOLVED, That our American Medical Association develop a methodology for physician reimbursement from insurance companies to compensate for the medical practice expenses of completing audits. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

RELEVANT AMA POLICY

D-320.991 Creating a Fair and Balanced Medicare and Medicaid RAC Program

1. Our AMA will continue to monitor Medicare and Medicaid Recovery Audit Contractor (RAC) practices and recovery statistics and continue to encourage the Centers for Medicare and Medicaid Services (CMS) to adopt new regulations which will impose penalties against RACs for abusive practices. 2. Our AMA will continue to encourage CMS to adopt new regulations which require physician review of all medical necessity cases in post-payment audits, as medical necessity is quintessentially a physician determination and judgment. 3. Our AMA will assist states by providing recommendations regarding state implementation of Medicaid RAC rules and regulations in order to lessen confusion among physicians and to ensure that states properly balance the interest in overpayment and underpayment audit corrections for Recovery Contractors. 4. Our AMA will petition CMS to amend CMS' rules governing the use of extrapolation in the RAC audit process, so that the amended CMS rules conform to Section 1893 of the Social Security Act Subsection (f) (3) - Limitation on Use of Extrapolation; and insists that the amended rules state that when an RAC initially contacts a physician, the RAC is not permitted to use extrapolation to determine overpayment amounts to be recovered from that physician by recoupment, offset, or otherwise, unless (as per Section 1893 of the Social Security Act) the Secretary of Health and Human Services has already determined, before the RAC audit, either that (a) previous, routine pre- or post-payment audits of the physician's claims
by the Medicare Administrative Contractor have found a sustained or high level of previous payment errors, or that (b) documented educational intervention has failed to correct those payment errors. 5. Our AMA, in coordination with other stakeholders such as the American Hospital Association, will seek to influence Congress to eliminate the current RAC system and ask CMS to consolidate its audit systems into a more balanced, transparent, and fair system, which does not increase administrative burdens on physicians. 6. Our AMA will: (A) seek to influence CMS and Congress to require that a physician, and not a lower level provider, review and approve any RAC claim against physicians or physician-decision making, (B) seek to influence CMS and Congress to allow physicians to be paid any denied claim if appropriate services are rendered, and (C) seek the enactment of fines, penalties and the recovery of costs incurred in defending against RACs whenever an appeal against them is won in order to discourage inappropriate and illegitimate audit work by RACs. 7. Our AMA will advocate for penalties and interest to be imposed on the auditor and payable to the physician when a RAC audit or appeal for a claim has been found in favor of the physician. (Res. 215, I-11; Appended: Res. 209, A-13; Appended: Res. 229, A-13; Appended: Res. 216, I-13; Reaffirmed: Res. 223, I-13)

H-330.921 Medicare Prepayment and Postpayment Audits
1. AMA policy is that with respect to prepayment and postpayment audits by the Medicare program, the following principles guide AMA advocacy efforts: (a) The confidential medical record should be preserved as an instrument of clinical care, with strong confidentiality protections and, we oppose its use as an accounting document; (b) CMS should discontinue random prepayment audits of E&M services; (c) In lieu of prepayment audits, CMS should use focused medical review of outliers based on reviews of patterns of services, using an independent medical peer review process, where physicians practicing in the same specialty, review their peers; (d) No financial or legal penalties should be assessed based on one level of disagreement in E&M code assignment; and (e) CMS must stop the practice of requiring physicians to repay alleged Medicare overpayments before an actual appeal is rejected or a final administrative decision or a court order is rendered. Legislative relief will be sought if advocacy with CMS is not successful in this regard. 2. Our AMA advocates that all government recovery programs contain complete physician access to any data mining criteria and programs, that there is same-specialty/same-subspecialty physician review prior to denial of claims, and that any denial of claims be based on medical necessity review as determined by that same-specialty/same-subspecialty physician reviewer, and will explore options for increased reimbursement of physician costs related to government audits, including remedies available through the Equal Access to Justice Act. 3. Our AMA supports the enactment of federal legislation that requires fairness in the practice of conducting physicians’ post-payment audits as contained in paragraph 1 above, and which would include the following: (a) The requirement for such audits to be reviewed by a physician board certified within the same specialty prior to any requirement for repayment by the audited physician (b) The requirement for the repayment to be placed in escrow until the appeals process is complete (c) The removal of any incentives that are based upon a percentage of recovery for contracted government auditors (d) The establishment of a mechanism for recovery of a practice’s legal fees incurred for unsuccessful audits (e) The full disclosure of contract terms with audit contractors (Sub. Res. 801, A-98; Reaffirmed: Res. 804, I-98; Reaffirmed: Sub. Res. 815, I-00; Res. 815, I-09; Res. 816, I-09)
Whereas, Physician’s offices are required to complete prior approval requests for their patients to obtain some of their medications; and

Whereas, This can include anything from the completion of forms to actual physician to physician peer to peer discussions; and

Whereas, This requirement is very costly to the physicians’ offices and has been estimated to cost each physician $80,000 per year in unreimbursed medical practice expenses; therefore be it RESOLVED, That our American Medical Association develop a methodology for physician reimbursement from insurance companies to compensate for the medical practice expenses of completing prior approval requirements. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/14
RELEVANT AMA POLICY

D-125.992 Opposition to Prescription Prior Approval
Our AMA will urge public and private payers who use prior authorization programs for prescription drugs to minimize administrative burdens on prescribing physicians. (Sub. Res. 529, A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 822, I-11)

H-385.948 Reasonable Charge for Preauthorization
The AMA strongly supports and advocates fair compensation for a physician's administrative costs when providing service to managed care patients. (Res. 815, A-97; Reaffirmation A-04; Reaffirmation A-10; Reaffirmed: CMS Rep. 4, I-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11)

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