AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 716
(A-19)

Introduced by: Texas

Subject: Health Plan Claim Auditing Programs

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

Whereas, In recent years there has been an observable increase in health plans using third-party software to analyze and audit claims for payment based solely on the diagnosis code, Current Procedural Terminology (CPT) code(s) and modifier(s); and

Whereas, The patient's previous claims history with the health plan is sometimes used as part of the software "equation" to determine if the claim should be paid; and

Whereas, The physician's billing patterns compared with his or her peers' is another possible part of the software "equation"; and

Whereas, The review of a patient's medical record is necessary to determine if it clearly documents the necessity of the diagnosis code(s), CPT code(s), and/or modifier(s); and

Whereas, There are no nationally recognized billing, coding, and payment guidelines that support the use of these software programs; and

Whereas, These software programs should not be used as the sole determinant of claim payment or denial; therefore be it

RESOLVED, That our American Medical Association vigorously oppose the exclusive use of software or other methodologies, with no review of the patient's medical record, to determine payment and/or denial of a claim based solely on the CPT codes, ICD-10 codes, and modifiers submitted on the claim (New HOD Policy); and be it further

RESOLVED, That our AMA vigorously oppose the exclusive use of the patient's medical claim history, with no review of the patient's medical record, as a tool to deny or pay a claim (New HOD Policy); and be it further

RESOLVED, That our AMA vigorously support the use of coding methods that adhere to CPT guidelines, rules, and conventions. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 05/24/19

RELEVANT AMA POLICY

Bundling and Downcoding of CPT Codes H-70.937
Our AMA: (1) vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers;
(2) makes it a priority to establish national standards for the appropriate use of CPT codes, guidelines, and modifiers and to advocate the adoption of these standards;
(3) formulates a national policy for intervention with carriers or payers who use unreasonable business practices to unilaterally recode or inappropriately bundle physician services, and support legislation to accomplish this; and
(4) along with medical specialty societies, calls on its members to identify to our AMA specific CPT code bundling problems by payers in their area and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers.
Citation: Res. 802, I-98; Reaffirmed: Res. 814, A-00; Modified: Sub. Res. 817; Reaffirmed: BOT Rep. 8, I-00; Reaffirmation I-01; Reaffirmation I-04; Reaffirmation A-06; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17

CPT Modifiers D-70.959
AMA policy is that a CPT code representing a service or procedure that is covered and paid for separately should also be paid for when performed at the same time as another service or procedure, unless CPT coding guidelines specifically direct users not to report the service or procedure (i.e., separate procedure codes), and that if the service or procedure is reimbursed zero dollars, or otherwise not recognized by an insurer, the service or procedure should be considered uncovered and thus billable to the patient.
Citation: (BOT Action in response to referred for decision Res. 828, I-05; Modified: CMS Rep. 1, A-15

Uses and Abuses of CPT Modifier -25 D-70.971
(1) Our AMA Private Sector Advocacy Group will continue to collect information on the use and acceptance of CPT modifiers, particularly modifier -25, and that it continue to advocate for the acceptance of modifiers and the appropriate alteration of payment based on CPT modifiers.
(2) The CPT Editorial Panel in coordination with the CPT/HCPAC Advisory Committee will continue to monitor the use and acceptance of CPT Modifiers by all payers and work to improve coding methods as appropriate.
(3) Our AMA will collect information on the use and acceptance of modifier -25 among state Medicaid plans and use this information to advocate for consistent acceptance and appropriate payment adjustment for modifier -25 across all Medicaid plans.
(4) Our AMA will encourage physicians to pursue, in their negotiations with third party payers, contract provisions that will require such payers to adhere to CPT rules concerning modifiers.
(5) Our AMA will include in its model managed care contract, provisions that will require managed care plans to adhere to CPT rules concerning modifiers.
(6) Our AMA will continue to educate physicians on the appropriate use of CPT rules concerning modifiers.
(7) Our AMA will actively work with third party payers to encourage their disclosure to physician providers any exceptions by those payers to CPT guidelines, rules and conventions.
(8) Our AMA will include in CPT educational publications (i.e. CPT Assistant) examples of commonly encountered situations where the -25 modifier would and would not apply.
Citation: (BOT Rep. 10, I-03; Reaffirmation A-10

Third Party Payer Coverage Process Reform and Advocacy D-185.986
1. Our AMA, working with interested state medical and national specialty societies, will develop model legislation and/or regulations to require that commercial insurance companies, state Medicaid agencies, or other third party payers utilize transparent and accountable processes for developing and implementing coverage decisions and policies, and will actively seek the implementation of such model legislation and/or regulations at the national and state levels.
2. Our AMA will work with specialty and service organizations to advocate that private insurance plans and benefit management companies develop transparent clinical protocols as well as formal processes to write / revise them; that those processes should seek input from the relevant national physician organizations; and that such clinical coverage protocols should be easily and publicly accessible on their

websites, just as Medicare national and local coverage determinations are publically available.
3. Our AMA will advocate that when private insurance plans and benefit management companies make changes to or revise clinical coverage protocols, said companies must inform all insured individuals and participating providers in writing no less than 90 days prior to said change(s) going into effect.
Citation: (Res. 820, I-11; Appended: Res. 807, I-12

Requiring Third Party Reimbursement Methodology be Published for Physicians H-185.975
Our AMA:
(1) urges all third party payers and self-insured plans to publish their payment policies, rules, and fee schedules;
(2) pursues all appropriate means to make publication of payment policies and fee schedules a requirement for third party payers and self-insured plans;
(3) will develop model state and federal legislation that would require that all third party payers and self-insured plans publish all payment schedule updates, and changes at least 60 days before such changes in payment schedules are enacted, and that all participating physicians be notified of such changes at least 60 days before changes in payment schedules are enacted.
(4) seeks legislation that would mandate that insurers make available their complete payment schedules, coding policies and utilization review protocols to physicians prior to signing a contract and at least 60 days prior to any changes being made in these policies;
(5) works with the National Association of Insurance Commissioners, develop model state legislation, as well developing national legislation affecting those entities that are subject to ERISA rules; and explore the possibility of adding payer publication of payment policies and fee schedules to the Patient Protection Act; and
(6) supports the following requirements: (a) that all payers make available a copy of the executed contract to physicians within three business days of the request; (b) that all health plan EOBs contain documentation regarding the precise contract used for determining the reimbursement rate; (c) that once a year, all contracts must be made available for physician review at no cost; (d) that no contract may be changed without the physician's prior written authorization; and (e) that when a contract is terminated pursuant to the terms of the contract, the contract may not be used by any other payer.
Citation: (Sub. Res. 805, I-95; Appended: Res. 117, A-98; Reaffirmation A-99; Appended: Res. 219, and Reaffirmed: CMS Rep. 6, A-00; Reaffirmation I-01; Reaffirmed and Appended: Res. 704, A-03; Reaffirmation I-04; Reaffirmation A-08; Reaffirmation I-08; Reaffirmed: CMS Rep. 3, I-09; Reaffirmation A-14