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112TH CONGRESS
1ST SESSION

H. R. 315

To reduce the amount of paperwork and improve payment policies for health care services, to prevent fraud and abuse through health care provider education, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 18, 2011

Mr. THORNBERRY introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To reduce the amount of paperwork and improve payment policies for health care services, to prevent fraud and abuse through health care provider education, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Care Paperwork Reduction and Fraud Prevention Act''.

SEC. 2. NATIONAL BIPARTISAN COMMISSION ON BILLING CODES AND FORMS SIMPLIFICATION.

(a) ESTABLISHMENT.—There is hereby established the Commission on Health Care Billing Codes and Forms Simplification (in this section referred to as the ''Commission'').

(b) DUTIES.—The Commission shall make recommendations regarding the following:

(1) STANDARDIZED AND SIMPLIFIED FORMS.—Standardizing and simplifying credentialing and billing forms respecting health care claims, that all Federal Government agencies would use and that the private sector is able (and is encouraged, but not required) to use.

(2) REDUCTION IN BILLING CODES.—A significant reduction and simplification in the number of billing codes for health care claims.

(3) REGULATORY AND APPEALS PROCESS REFORM.—Reforms in the regulatory and appeals processes under the Medicare program under title XVIII of the Social Security Act in order to ensure that the Secretary of Health and Human Services provides appropriate guidance to suppliers and providers of services (as such terms are defined in subsections (d) and (u), respectively, of section 1861 of such Act), including physicians and providers and sup-

pliers of ambulance services, that are attempting to properly submit claims under the Medicare program and to ensure that the Secretary does not target inadvertent billing errors.

(4) ELECTRONIC FORMS AND PAYMENTS.—Simplifying and updating electronic forms of the Centers for Medicare & Medicaid Services to ensure simplicity as well as patient privacy.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 17 members, of whom—

(A) four shall be appointed by the President;

(B) six shall be appointed by the majority leader of the Senate, in consultation with the minority leader of the Senate, of whom not more than 4 shall be of the same political party;

(C) six shall be appointed by the Speaker of the House of Representatives, in consultation with the minority leader of the House of Representatives, of whom not more than 4 shall be of the same political party; and

(D) one, who shall serve as Chairman of the Commission, shall be appointed jointly by

the President, majority leader of the Senate, and the Speaker of the House of Representatives.

(2) APPOINTMENT.—Members of the Commission shall be appointed by not later than 90 days after the date of the enactment of this Act.

(d) INCORPORATION OF BIPARTISAN COMMISSION PROVISIONS.—The provisions of paragraphs (3) through (8) of subsection (c) and subsections (d), (e), and (h) of section 4021 of the Balanced Budget Act of 1997 shall apply to the Commission under this section in the same manner as they applied to the National Bipartisan Commission on the Future of Medicare under such section.

(e) REPORT.—Not later than December 31, 2011, the Commission shall submit to the President and Congress a report which shall contain a detailed statement of only those recommendations, findings, and conclusions of the Commission that receive the approval of at least 11 members of the Commission.

(f) TERMINATION.—The Commission shall terminate 30 days after the date of submission of the report required in subsection (e).

SEC. 3. EDUCATION OF PHYSICIANS AND PROVIDERS CONCERNING MEDICARE PROGRAM PAYMENTS.

(a) WRITTEN REQUESTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall establish a process under which a physician may request, in writing from a carrier, assistance in addressing questionable codes and procedures under the Medicare program under title XVIII of the Social Security Act and then the carrier shall respond in writing within 30 business days with the correct billing or procedural answer.

(2) USE OF WRITTEN STATEMENT.—

(A) IN GENERAL.—Subject to subparagraph (B), a written statement under paragraph (1) may be used as proof against a future audit or overpayment under the Medicare program.

(B) LIMIT ON APPLICATION.—Subparagraph (A) shall not apply retroactively and shall not apply to cases of fraudulent billing.

(b) DEFINITIONS.—For purposes of this section:

(1) PHYSICIAN.—The term ''physician'' has the meaning given such term in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

(2) CARRIER.—The term ''carrier'' means a carrier (as defined in section 1842(f) of the Social Security Act (42 U.S.C. 1395u(f))) with a contract

under title XVIII of such Act to administer benefits under part B of such title.

SEC. 4. POLICY DEVELOPMENT REGARDING E&M GUIDELINES UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—The Administrator of the Centers for Medicare & Medicaid Services may not implement any new evaluation and management guidelines (in this section referred to as ''E&M guidelines'') under the Medicare program, unless the Administrator—

(1) has provided for an assessment of the proposed guidelines by physicians;

(2) has established a plan that contains specific goals, including a schedule, for improving participation of physicians in the assessment described in paragraph (1);

(3) has carried out a minimum of 4 pilot projects consistent with subsection (b) in at least 4 different regions (to be specified by the Secretary) to test such guidelines; and

(4) finds that the objectives described in subsection (c) will be met in the implementation of such guidelines.

(b) PILOT PROJECTS.—

(1) LENGTH AND CONSULTATION.—Each pilot project under this subsection shall—

(A) be of sufficient length to allow for preparatory physician and carrier education, analysis, and use and assessment of potential E&M guidelines; and

(B) be conducted, throughout the planning and operational stages of the project, in consultation with national and State medical societies.

(2) PEER REVIEW AND RURAL PILOT PROJECTS.—Of the pilot projects conducted under this subsection—

(A) at least one shall focus on a peer review method by physicians which evaluates medical record information for statistical outlier services relative to definitions and guidelines published in the most recent Current Procedural Terminology book, instead of an approach using the review of randomly selected medical records using non-clinical personnel; and

(B) at least one shall be conducted for services furnished in a rural area.

(3) STUDY OF IMPACT.—Each pilot project shall examine the effect of the potential E&M guidelines on—

(A) different types of physician practices, such as large and small groups; and

(B) the costs of compliance, and patient and physician satisfaction.

(4) REPORT ON HOW MET OBJECTIVES.—Not later than 6 months after the date of the conclusion of all of the pilot projects under this subsection, the Administrator of the Centers for Medicare & Medicaid Services shall submit a report to the Committees on Commerce and Ways and Means of the House of Representatives, the Committee on Finance of the Senate, and the Practicing Physicians Advisory Council, on such pilot projects. Such report shall include the extent to which the pilot projects met the objectives specified in subsection (c).

(c) OBJECTIVES FOR E&M GUIDELINES.—The objectives for E&M guidelines specified in this subsection are as follows (relative to the E&M guidelines and review policies in effect as of the date of the enactment of this Act):

(1) Enhancing clinically relevant documentation needed to accurately code and assess coding levels accurately.

(2) Reducing administrative burdens.

(3) Decreasing the level of non-clinically pertinent and burdensome documentation time and content in the record.

(4) Increased accuracy by carrier reviewers.

(5) Education of both physicians and reviewers.

(6) Appropriate use of evaluation and management codes by physicians and their staffs.

(7) The extent to which the tested evaluation and management documentation guidelines substantially adhere to the CPT coding rules.

(8) Simplifying electronic billing.

(d) DEFINITIONS.—For purposes of this section and section 5:

(1) PHYSICIAN.—The term ''physician'' has the meaning given such term in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

(2) CARRIER.—The term ''carrier'' means a carrier (as defined in section 1842(f) of the Social Security Act (42 U.S.C. 1395u(f))) with a contract under title XVIII of such Act to administer benefits under part B of such title.

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(4) MEDICARE PROGRAM.—The term ''Medicare program'' means the program under title XVIII of the Social Security Act.

SEC. 5. OVERPAYMENTS UNDER THE MEDICARE PROGRAM.

(a) INDIVIDUALIZED NOTICE.—If a carrier proceeds with a post-payment audit of a physician under the Medicare program, the carrier shall provide the physician with an individualized notice of billing problems, such as a personal visit or carrier-to-physician telephone conversation during normal working hours, within 3 months of initiating such audit. The notice should include suggestions to the physician on how the billing problem may be remedied.

(b) REPAYMENT OF OVERPAYMENTS WITHOUT PENALTY.—The Secretary of Health and Human Services shall permit a physician to repay Medicare overpayments made to such physician without penalty or interest and without threat of denial of other claims based upon extrapolation, if such repayment is made not later than 3 months after such physician receives notification of such overpayment and if such overpayment was not determined by a final adverse action to be the result of fraudulent billing. If a physician should discover an overpayment before a carrier notifies the physician of the error, the physician may reimburse the Medicare program without penalty

and the Secretary may not audit or target the physician on the basis of such repayment, unless other evidence of fraudulent billing exists.

(c) TREATMENT OF FIRST-TIME BILLING ERRORS.—If a physician's Medicare billing error was a first-time error and the physician has not previously been the subject of a post-payment audit, the carrier may not assess a fine through extrapolation of such an error to other claims, unless the physician has submitted a fraudulent claim.

(d) TIMELY NOTICE OF PROBLEM CLAIMS BEFORE USING EXTRAPOLATION.—A carrier may seek reimbursement or penalties against a physician based on extrapolation of a Medicare claim only if the carrier has informed the physician of potential problems with the claim not later than one year after the date the claim was submitted for reimbursement.

(e) SUBMISSION OF ADDITIONAL INFORMATION.—A physician may submit additional information and documentation to dispute a carrier's charges of overpayment without waiving the physician's right to a hearing by an administrative law judge.

(f) LIMITATION ON DELAY IN PAYMENT.—Following a post-payment audit, a carrier that is conducting a pre-payment screen on a physician service under the Medicare program may not delay reimbursements for more than one

month and as soon as the physician submits a corrected claim, the carrier shall eliminate application of such a pre-payment screen.

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