

118TH CONGRESS
1ST SESSION

H. R. 5213

To ensure that prior authorization medical decisions under Medicare are determined by physicians.

IN THE HOUSE OF REPRESENTATIVES

AUGUST 15, 2023

Mr. GREEN of Tennessee introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, 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

A BILL

To ensure that prior authorization medical decisions under Medicare are determined by physicians.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Reducing Medically
5 Unnecessary Delays in Care Act of 2023”.

6 **SEC. 2. DEFINITIONS.**

7 In this Act:

8 (1) **ADVERSE DETERMINATION.**—The term “ad-
9 verse determination” means a decision by a medicare

1 administrative contractor, Medicare Advantage plan,
2 or prescription drug plan that administers prior au-
3 thorization programs under the Medicare program
4 under title XVIII of the Social Security Act or such
5 plan that the health care services furnished or pro-
6 posed to be furnished to an individual entitled to
7 benefits or enrolled under the Medicare program are
8 not medically necessary, or are experimental or in-
9 vestigational; and benefit coverage under such pro-
10 gram or plan for such services is therefore denied,
11 reduced, or terminated.

12 (2) AUTHORIZATION.—The term “authoriza-
13 tion” means a determination by a medicare adminis-
14 trative contractor, Medicare Advantage plan, or pre-
15 scription drug plan that administers prior authoriza-
16 tion programs under the Medicare program under
17 title XVIII of the Social Security Act or such plan
18 that a health care service has been reviewed and,
19 based on the information provided, satisfies the utili-
20 zation review entity’s requirements for medical ne-
21 cessity and appropriateness and that payment will
22 be made under the Medicare program under title
23 XVIII of the Social Security Act or such plan for
24 that health care service.

1 (3) CLINICAL CRITERIA.—The term “clinical
2 criteria” means the written policies, written screen-
3 ing procedures, drug formularies, or lists of covered
4 drugs, decision rules, decision abstracts, clinical pro-
5 tocols, practice guidelines, and medical protocols
6 used by a medicare administrative contractor, Medi-
7 care Advantage plan, or prescription drug plan to
8 determine the necessity and appropriateness of
9 health care services.

10 (4) FINAL ADVERSE DETERMINATION.—The
11 term “final adverse determination” means an ad-
12 verse determination that has been upheld by a medi-
13 care administrative contractor, Medicare Advantage
14 plan, or prescription drug plan at the completion of
15 the contractor’s appeals process.

16 (5) HEALTH CARE SERVICE.—The term “health
17 care service” means a health care item, service, pro-
18 cedure, treatment, or prescription drug provided by
19 a facility licensed in the State involved or provided
20 by a doctor of medicine, a doctor of osteopathy, or
21 a health care professional licensed in such State.

22 (6) MEDICALLY NECESSARY HEALTH CARE
23 SERVICE.—The term “medically necessary health
24 care services” means health care services that a pru-
25 dent physician would provide to a patient for the

1 purpose of preventing, diagnosing, or treating an ill-
2 ness, injury, disease, or its symptoms in a manner
3 that is—

4 (A) in accordance with generally accepted
5 standards of medical practice;

6 (B) clinically appropriate in terms of type,
7 frequency, extent, site, and duration; and

8 (C) not primarily for the economic benefit
9 of the health plans and purchasers or for the
10 convenience of the patient, treating physician,
11 or other health care provider.

12 (7) MEDICARE ADMINISTRATIVE CON-
13 TRACTOR.—The term “medicare administrative con-
14 tractor” means a medicare administrative contractor
15 with a contract under section 1874A of the Social
16 Security Act (42 U.S.C. 1395kk–1).

17 (8) MEDICARE ADVANTAGE PLAN.—The term
18 “Medicare Advantage plan” means a Medicare Ad-
19 vantage plan under part C of title XVIII of the So-
20 cial Security Act.

21 (9) PREAUTHORIZATION.—The term
22 “preauthorization”—

23 (A) means the process by which a medicare
24 administrative contractor, Medicare Advantage
25 plan, or prescription drug plan determines the

1 medical necessity or medical appropriateness of
 2 health care services for which benefits are oth-
 3 erwise provided under the Medicare program
 4 under title XVIII of the Social Security Act or
 5 such plan prior to the rendering of such health
 6 care services, including preadmission review,
 7 pretreatment review, utilization, and case man-
 8 agement; and

9 (B) includes any requirement that a pa-
 10 tient or health care provider notify the Centers
 11 for Medicare & Medicaid Services prior to pro-
 12 viding a health care service.

13 (10) PRESCRIPTION DRUG PLAN.—The term
 14 “prescription drug plan” means a prescription drug
 15 plan under part D of title XVIII of the Social Secu-
 16 rity Act.

17 **SEC. 3. CONTRACT REQUIREMENTS FOR PRIOR AUTHOR-**
 18 **IZATION MEDICAL DECISIONS FOR MEDI-**
 19 **CARE ADMINISTRATIVE CONTRACTORS,**
 20 **MEDICARE ADVANTAGE PLANS, AND PRE-**
 21 **SCRIPTION DRUG PLANS.**

22 Any contract that applies on or after the date that
 23 is 90 days after the date of the enactment of this Act,
 24 between the Secretary of Health and Human Services and
 25 a medicare administrative contractor under section 1874A

1 of the Social Security Act, a Medicare Advantage organi-
2 zation under section 1857 of such Act with respect to the
3 offering of a Medicare Advantage plan, or a PDP sponsor
4 under section 1860D–12 of such Act with respect to the
5 offering of a prescription drug plan shall require such
6 medicare administrative contractor, Medicare Advantage
7 plan, or prescription drug plan, respectively, to comply
8 with each of the following requirements:

9 (1) MEDICAL NECESSITY.—Any restriction,
10 preauthorization, adverse determination, or final ad-
11 verse determination that the medicare administrative
12 contractor, Medicare Advantage plan, or prescription
13 drug plan, respectively, places on the provision of a
14 health care service for the purposes of coverage or
15 payment of such service under the Medicare pro-
16 gram under title XVIII of such Act, or under such
17 plan, shall be based on the medical necessity or ap-
18 propriateness of such service and on written clinical
19 criteria.

20 (2) EVIDENCE-BASED STANDARDS.—If no inde-
21 pendently developed evidence-based standards exist
22 for a particular health care service, the medicare ad-
23 ministrative contractor, Medicare Advantage plan, or
24 prescription drug plan, respectively, may not deny
25 coverage of the health care service based solely on

1 the grounds that the health care service does not
2 meet an evidence-based standard.

3 (3) INPUT FROM PHYSICIANS.—Prior to estab-
4 lishing, or substantially or materially altering, writ-
5 ten clinical criteria for purpose of preauthorization
6 review, the medicare administrative contractor,
7 Medicare Advantage plan, or prescription drug plan,
8 respectively, shall obtain input from actively prac-
9 ticing physicians within the service area where the
10 written clinical criteria are to be employed. Such
11 physicians must represent major areas of specialty
12 and be certified by the boards of the American
13 Board of Medical Specialties. The medicare adminis-
14 trative contractor, Medicare Advantage plan, or pre-
15 scription drug plan shall seek input from physicians
16 who are not employees of the medicare administra-
17 tive contractor, Medicare Advantage plan, or pre-
18 scription drug plan.

19 (4) WRITTEN CLINICAL CRITERIA.—The medi-
20 care administrative contractor, Medicare Advantage
21 plan, or prescription drug plan, respectively, shall
22 apply written clinical criteria for the purpose of
23 preauthorization review consistently. Such written
24 clinical criteria must—

1 (A) be based on nationally recognized
2 standards;

3 (B) be developed in accordance with the
4 current standards of national accreditation enti-
5 ties;

6 (C) reflect community standards of care;

7 (D) ensure quality of care and access to
8 needed health care services;

9 (E) be evidence based;

10 (F) be sufficiently flexible to allow devi-
11 ations from norms when justified on case-by-
12 case bases; and

13 (G) be evaluated and updated if necessary
14 at least annually.

15 (5) WEBSITE POSTING.—The medicare adminis-
16 trative contractor, Medicare Advantage plan, or pre-
17 scription drug plan, respectively, shall make any cur-
18 rent preauthorization requirements and restrictions
19 readily accessible on its website to subscribers,
20 health care providers, and the general public. This
21 includes the written clinical criteria. Such require-
22 ments must be described in detail but also in easily
23 understandable language.

24 (6) NOTICE REQUIRED FOR NEW REQUIRE-
25 MENTS OR RESTRICTIONS.—If the medicare adminis-

1 trative contractor, Medicare Advantage plan, or pre-
2 scription drug plan, respectively, decides to imple-
3 ment a new preauthorization requirement or restric-
4 tion, or amend an existing requirement or restric-
5 tion, the medicare administrative contractor, Medi-
6 care Advantage plan, or prescription drug plan shall
7 provide contracted health care providers written no-
8 tice of the new or amended requirement or amend-
9 ment no less than 60 days before the requirement or
10 restriction is implemented and shall ensure that the
11 new or amended requirement has been updated on
12 the medicare administrative contractor, Medicare
13 Advantage plan, or prescription drug plan's website.

14 (7) AVAILABILITY OF DETERMINATIONS.—The
15 medicare administrative contractor, Medicare Advan-
16 tage plan, or prescription drug plan, respectively,
17 utilizing preauthorization shall make statistics avail-
18 able regarding preauthorization approvals and deni-
19 als for coverage or payment of health care services
20 under the Medicare program under title XVIII of
21 the Social Security Act or such plan on their website
22 in a readily accessible format. The medicare admin-
23 istrative contractor, Medicare Advantage plan, or
24 prescription drug plan shall include categories for—

25 (A) physician specialty;

1 (B) medication or diagnostic test/proce-
2 dure;

3 (C) indication offered; and

4 (D) reason for denial.

5 (8) DETERMINATIONS MADE BY PHYSICIANS.—

6 The medicare administrative contractor, Medicare
7 Advantage plan, or prescription drug plan, respec-
8 tively, shall ensure that all preauthorizations and ad-
9 verse determinations are made by a physician who
10 possesses a current and valid non-restricted license
11 to practice medicine in a State, and must be board
12 certified or eligible in the same specialty as the
13 health care provider who typically manages the med-
14 ical condition or disease or provides the health care
15 service. The physician must make the adverse deter-
16 mination under the clinical direction of one of the
17 medicare administrative contractor's, Medicare Ad-
18 vantage plan's, or prescription drug plan's medical
19 directors who is responsible for the provision of
20 health care services and who is licensed in such
21 State.

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