

107<sup>TH</sup> CONGRESS  
1<sup>ST</sup> SESSION

# H. R. 1128

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.

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## IN THE HOUSE OF REPRESENTATIVES

MARCH 20, 2001

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.

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 “Health Care Paper-  
5       work Reduction and Fraud Prevention Act of 2001”.

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

3 (a) **ESTABLISHMENT.**—There is hereby established  
4 the Commission on Billing Codes and Forms Simplifica-  
5 tion (in this section referred to as the “Commission”).

6 (b) **DUTIES.**—The Commission shall make rec-  
7 ommendations regarding the following:

8 (1) **STANDARDIZED FORMS.**—Standardizing  
9 credentialing and billing forms respecting health  
10 care claims, that all Federal Government agencies  
11 would use and that the private sector is able (and  
12 is encouraged, but not required) to use.

13 (2) **REDUCTION IN BILLING CODES.**—A signifi-  
14 cant reduction and simplification in the number of  
15 billing codes.

16 (3) **REGULATORY AND APPEALS PROCESS RE-**  
17 **FORM.**—Reforms in the medicare regulatory and ap-  
18 peals processes in order to ensure that the Secretary  
19 of Health and Human Services provides appropriate  
20 guidance to physicians, providers of services, and  
21 ambulance providers that are attempting to properly  
22 submit claims under the medicare program and to  
23 ensure that the Secretary does not target inad-  
24 vertent billing errors.

25 (c) **MEMBERSHIP.**—

1           (1) NUMBER AND APPOINTMENT.—The Com-  
2 mission shall be composed of 17 members, of  
3 whom—

4           (A) four shall be appointed by the Presi-  
5 dent;

6           (B) six shall be appointed by the Majority  
7 Leader of the Senate, in consultation with the  
8 Minority Leader of the Senate, of whom not  
9 more than 4 shall be of the same political party;

10          (C) six shall be appointed by the Speaker  
11 of the House of Representatives, in consultation  
12 with the Minority Leader of the House of Rep-  
13 resentatives, of whom not more than 4 shall be  
14 of the same political party; and

15          (D) one, who shall serve as Chairman of  
16 the Commission, appointed jointly by the Presi-  
17 dent, Majority Leader of the Senate, and the  
18 Speaker of the House of Representatives.

19          (2) APPOINTMENT.—Members of the Commis-  
20 sion shall be appointed by not later than 90 days  
21 after the date of the enactment of this Act.

22          (d) INCORPORATION OF BIPARTISAN COMMISSION  
23 PROVISIONS.—The provisions of paragraphs (3) through  
24 (8) of subsection (c) and subsections (d), (e), and (h) of  
25 section 4021 of the Balanced Budget Act of 1997 shall

1 apply to the Commission under this section in the same  
2 manner as they applied to the National Bipartisan Com-  
3 mission on the Future of Medicare under such section.

4 (e) REPORT.—Not later than December 31, 2001, the  
5 Commission shall submit a report to the President and  
6 Congress which shall contain a detailed statement of only  
7 those recommendations, findings, and conclusions of the  
8 Commission that receive the approval of at least 11 mem-  
9 bers of the Commission.

10 (f) TERMINATION.—The Commission shall terminate  
11 30 days after the date of submission of the report required  
12 in subsection (e).

13 **SEC. 3. EDUCATION OF PHYSICIANS AND PROVIDERS CON-**  
14 **CERNING MEDICARE PROGRAM PAYMENTS.**

15 (a) WRITTEN REQUESTS.—

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

25 (2) USE OF WRITTEN STATEMENT.—

1           (A) IN GENERAL.—Subject to subpara-  
2           graph (B), a written statement under para-  
3           graph (1) may be used as proof against a fu-  
4           ture audit or overpayment under the medicare  
5           program.

6           (B) LIMIT ON APPLICATION.—Subpara-  
7           graph (A) shall not apply retroactively and shall  
8           not apply to cases of fraudulent billing.

9           (b) RESTORATION OF TOLL-FREE HOTLINE.—

10           (1) IN GENERAL.—The Administrator of the  
11           Health Care Financing Administration shall restore  
12           the toll-free telephone hotline so that physicians may  
13           call for information and questions about the medi-  
14           care program.

15           (2) AUTHORIZATION OF APPROPRIATIONS.—  
16           There are authorized to be appropriated such sums  
17           as may be necessary to carry out paragraph (1).

18           (c) DEFINITIONS.—For purposes of this section:

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

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

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

3 **SEC. 4. POLICY DEVELOPMENT REGARDING E&M GUIDE-**  
4 **LINES UNDER THE MEDICARE PROGRAM.**

5 (a) IN GENERAL.—HCFA may not implement any  
6 new evaluation and management guidelines (in this section  
7 referred to as “E&M guidelines”) under the medicare pro-  
8 gram, unless HCFA—

9 (1) has provided for an assessment of the pro-  
10 posed guidelines by physicians;

11 (2) has established a plan that contains specific  
12 goals, including a schedule, for improving participa-  
13 tion of physicians;

14 (3) has carried out a minimum of 4 pilot  
15 projects consistent with subsection (b) in at least 4  
16 different HCFA regions (to be specified by the Sec-  
17 retary) to test such guidelines; and

18 (4) finds that the objectives described in sub-  
19 section (c) will be met in the implementation of such  
20 guidelines.

21 (b) PILOT PROJECTS.—

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

24 (A) be of sufficient length to allow for pre-  
25 paratory physician and carrier education, anal-

1           ysis, and use and assessment of potential E&M  
2           guidelines; and

3                   (B) be conducted, throughout the planning  
4           and operational stages of the project, in con-  
5           sultation with national and State medical soci-  
6           eties.

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

10                   (A) at least one shall focus on a peer re-  
11           view method by physicians which evaluates  
12           medical record information for statistical outlier  
13           services relative to definitions and guidelines  
14           published in the CPT book, instead of an ap-  
15           proach using the review of randomly selected  
16           medical records using non-clinical personnel;  
17           and

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

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

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

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

1           (4) REPORT ON HOW MET OBJECTIVES.—  
2           HCFA shall submit a report to the Committees on  
3           Commerce and Ways and Means of the House of  
4           Representatives, the Committee on Finance of the  
5           Senate, and the Practicing Physicians Advisory  
6           Council, six months after the conclusion of the pilot  
7           projects. Such report shall include the extent to  
8           which the pilot projects met the objectives specified  
9           in subsection (c).

10          (c) OBJECTIVES FOR E&M GUIDELINES.—The objec-  
11          tives for E&M guidelines specified in this subsection are  
12          as follows (relative to the E&M guidelines and review poli-  
13          cies in effect as of the date of the enactment of this Act):

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

17               (2) Reducing administrative burdens.

18               (3) Decreasing the level of non-clinically perti-  
19               nent and burdensome documentation time and con-  
20               tent in the record.

21               (4) Increased accuracy by carrier reviewers.

22               (5) Education of both physicians and reviewers.

23               (6) Appropriate use of E&M codes by physi-  
24               cians and their staffs.

1           (7) The extent to which the tested E&M docu-  
2           mentation guidelines substantially adhere to the  
3           CPT coding rules.

4           (d) DEFINITIONS.—For purposes of this section and  
5           sections 5 and 6:

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

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

14          (3) SECRETARY.—The term “Secretary” means  
15          the Secretary of Health and Human Services.

16          (4) HCFA.—The term “HCFA” means the  
17          Health Care Financing Administration.

18          (5) MEDICARE PROGRAM.—The term “medicare  
19          program” means the program under title XVIII of  
20          the Social Security Act.

21 **SEC. 5. OVERPAYMENTS UNDER THE MEDICARE PROGRAM.**

22          (a) INDIVIDUALIZED NOTICE.—If a carrier proceeds  
23          with a post-payment audit of a physician under the medi-  
24          care program, the carrier shall provide the physician with  
25          an individualized notice of billing problems, such as a per-

1 sonal visit or carrier-to-physician telephone conversation  
2 during normal working hours, within 3 months of initi-  
3 ating such audit. The notice should include suggestions  
4 to the physician on how the billing problem may be rem-  
5 edied.

6 (b) REPAYMENT OF OVERPAYMENTS WITHOUT PEN-  
7 ALTY.—The Secretary shall permit physicians to repay  
8 medicare overpayments within 3 months without penalty  
9 or interest and without threat of denial of other claims  
10 based upon extrapolation. If a physician should discover  
11 an overpayment before a carrier notifies the physician of  
12 the error, the physician may reimburse the medicare pro-  
13 gram without penalty and the Secretary may not audit or  
14 target the physician on the basis of such repayment, un-  
15 less other evidence of fraudulent billing exists.

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

22 (d) TIMELY NOTICE OF PROBLEM CLAIMS BEFORE  
23 USING EXTRAPOLATION.—A carrier may seek reimburse-  
24 ment or penalties against a physician based on extrapo-  
25 lation of a medicare claim only if the carrier has informed

1 the physician of potential problems with the claim within  
2 one year after the date the claim was submitted for reim-  
3 bursement.

4 (e) SUBMISSION OF ADDITIONAL INFORMATION.—A  
5 physician may submit additional information and docu-  
6 mentation to dispute a carrier's charges of overpayment  
7 without waiving the physician's right to a hearing by an  
8 administrative law judge.

9 (f) LIMITATION ON DELAY IN PAYMENT.—Following  
10 a post-payment audit, a carrier that is conducting a pre-  
11 payment screen on a physician service under the medicare  
12 program may not delay reimbursements for more than one  
13 month and as soon as the physician submits a corrected  
14 claim, the carrier shall eliminate application of such a pre-  
15 payment screen.

16 **SEC. 6. ENFORCEMENT PROVISIONS UNDER THE MEDI-**  
17 **CARE PROGRAM.**

18 If a physician is suspected of fraud or wrongdoing  
19 in the medicare program, inspectors associated with the  
20 Office of Inspector General of the Department of Health  
21 and Human Services—

22 (1) may not enter the physician's private office  
23 with a gun or deadly weapon to make an arrest; and

1           (2) may not make such an arrest without a  
2           valid warrant of arrest, unless the physician is flee-  
3           ing or deemed dangerous.

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