

110TH CONGRESS
2D SESSION

H. R. 6102

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

MAY 20, 2008

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

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 2008”.

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 AND SIMPLIFIED FORMS.**—
9 Standardizing and simplifying credentialing and bill-
10 ing forms respecting health care claims, that all
11 Federal Government agencies would use and that
12 the private sector is able (and is encouraged, but not
13 required) to use.

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

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

1 (4) ELECTRONIC FORMS AND PAYMENTS.—Sim-
2 plifying and updating electronic forms of the Centers
3 for Medicare & Medicaid Services to insure sim-
4 plicity as well as privacy.

5 (c) MEMBERSHIP.—

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

9 (A) four shall be appointed by the Presi-
10 dent;

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

15 (C) six shall be appointed by the Speaker
16 of the House of Representatives, in consultation
17 with the minority leader of the House of Rep-
18 resentatives, of whom not more than 4 shall be
19 of the same political party; and

20 (D) one, who shall serve as Chairman of
21 the Commission, appointed jointly by the Presi-
22 dent, majority leader of the Senate, and the
23 Speaker of the House of Representatives.

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

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

11 (e) REPORT.—Not later than December 31, 2008, the
12 Commission shall submit a report to the President and
13 Congress which shall contain a detailed statement of only
14 those recommendations, findings, and conclusions of the
15 Commission that receive the approval of at least 11 mem-
16 bers of the Commission.

17 (f) TERMINATION.—The Commission shall terminate
18 30 days after the date of submission of the report required
19 in subsection (e).

20 **SEC. 3. EDUCATION OF PHYSICIANS AND PROVIDERS CON-**
21 **CERNING MEDICARE PROGRAM PAYMENTS.**

22 (a) WRITTEN REQUESTS.—

23 (1) IN GENERAL.—The Secretary of Health and
24 Human Services shall establish a process under
25 which a physician may request, in writing from a

1 carrier, assistance in addressing questionable codes
2 and procedures under the Medicare program under
3 title XVIII of the Social Security Act and then the
4 carrier shall respond in writing within 30 business
5 days with the correct billing or procedural answer.

6 (2) USE OF WRITTEN STATEMENT.—

7 (A) IN GENERAL.—Subject to subpara-
8 graph (B), a written statement under para-
9 graph (1) may be used as proof against a fu-
10 ture audit or overpayment under the Medicare
11 program.

12 (B) LIMIT ON APPLICATION.—Subpara-
13 graph (A) shall not apply retroactively and shall
14 not apply to cases of fraudulent billing.

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

16 (1) IN GENERAL.—The Administrator of the
17 Centers for Medicare & Medicaid Services shall re-
18 store the toll-free telephone hotline so that physi-
19 cians may call for information and questions about
20 the Medicare program.

21 (2) AUTHORIZATION OF APPROPRIATIONS.—

22 There are authorized to be appropriated such sums
23 as may be necessary to carry out paragraph (1).

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

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

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

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

11 (a) IN GENERAL.—The Administrator of the Centers
12 for Medicare & Medicaid Services may not implement any
13 new evaluation and management guidelines (in this section
14 referred to as “E&M guidelines”) under the Medicare pro-
15 gram, unless the Administrator—

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

18 (2) has established a plan that contains specific
19 goals, including a schedule, for improving participa-
20 tion of physicians;

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

1 (4) finds that the objectives described in sub-
2 section (c) will be met in the implementation of such
3 guidelines.

4 (b) PILOT PROJECTS.—

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

7 (A) be of sufficient length to allow for pre-
8 paratory physician and carrier education, anal-
9 ysis, and use and assessment of potential E&M
10 guidelines; and

11 (B) be conducted, throughout the planning
12 and operational stages of the project, in con-
13 sultation with national and State medical soci-
14 eties.

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

18 (A) at least one shall focus on a peer re-
19 view method by physicians which evaluates
20 medical record information for statistical outlier
21 services relative to definitions and guidelines
22 published in the CPT book, instead of an ap-
23 proach using the review of randomly selected
24 medical records using non-clinical personnel;
25 and

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

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

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

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

9 (4) REPORT ON HOW MET OBJECTIVES.—Not
10 later than 6 months after the date of the conclusion
11 of the pilot projects under this subsection, the Ad-
12 ministrators of the Centers for Medicare & Medicaid
13 Services shall submit a report to the Committees on
14 Commerce and Ways and Means of the House of
15 Representatives, the Committee on Finance of the
16 Senate, and the Practicing Physicians Advisory
17 Council, on such pilot projects. Such report shall in-
18 clude the extent to which the pilot projects met the
19 objectives specified in subsection (c).

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

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

4 (2) Reducing administrative burdens.

5 (3) Decreasing the level of non-clinically perti-
6 nent and burdensome documentation time and con-
7 tent in the record.

8 (4) Increased accuracy by carrier reviewers.

9 (5) Education of both physicians and reviewers.

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

12 (7) The extent to which the tested E&M docu-
13 mentation guidelines substantially adhere to the
14 CPT coding rules.

15 (8) Simplifying electronic billing.

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

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

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

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

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

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

7 (a) INDIVIDUALIZED NOTICE.—If a carrier proceeds
8 with a post-payment audit of a physician under the Medi-
9 care program, the carrier shall provide the physician with
10 an individualized notice of billing problems, such as a per-
11 sonal visit or carrier-to-physician telephone conversation
12 during normal working hours, within 3 months of initi-
13 ating such audit. The notice should include suggestions
14 to the physician on how the billing problem may be rem-
15 edied.

16 (b) REPAYMENT OF OVERPAYMENTS WITHOUT PEN-
17 ALTY.—The Secretary of Health and Human Services
18 shall permit physicians to repay Medicare overpayments
19 within 3 months without penalty or interest and without
20 threat of denial of other claims based upon extrapolation.
21 If a physician should discover an overpayment before a
22 carrier notifies the physician of the error, the physician
23 may reimburse the Medicare program without penalty and
24 the Secretary may not audit or target the physician on

1 the basis of such repayment, unless other evidence of
2 fraudulent billing exists.

3 (c) TREATMENT OF FIRST-TIME BILLING ERRORS.—

4 If a physician's Medicare billing error was a first-time
5 error and the physician has not previously been the subject
6 of a post-payment audit, the carrier may not assess a fine
7 through extrapolation of such an error to other claims,
8 unless the physician has submitted a fraudulent claim.

9 (d) TIMELY NOTICE OF PROBLEM CLAIMS BEFORE

10 USING EXTRAPOLATION.—A carrier may seek reimburse-
11 ment or penalties against a physician based on extrapo-
12 lation of a Medicare claim only if the carrier has informed
13 the physician of potential problems with the claim within
14 one year after the date the claim was submitted for reim-
15 bursement.

16 (e) SUBMISSION OF ADDITIONAL INFORMATION.—A

17 physician may submit additional information and docu-
18 mentation to dispute a carrier's charges of overpayment
19 without waiving the physician's right to a hearing by an
20 administrative law judge.

21 (f) LIMITATION ON DELAY IN PAYMENT.—Following

22 a post-payment audit, a carrier that is conducting a pre-
23 payment screen on a physician service under the Medicare
24 program may not delay reimbursements for more than one
25 month and as soon as the physician submits a corrected

- 1 claim, the carrier shall eliminate application of such a pre-
- 2 payment screen.

