

113TH CONGRESS
1ST SESSION

H. R. 1250

To amend title XVIII of the Social Security Act to improve operations of recovery auditors under the Medicare integrity program, to increase transparency and accuracy in audits conducted by contractors, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 19, 2013

Mr. GRAVES of Missouri (for himself, Mr. SCHIFF, Mr. HANNA, Mr. HUELSKAMP, Mr. LOEBSACK, Mr. OWENS, Mr. FARR, Mr. POMPEO, Mr. LONG, Mr. KING of Iowa, and Mr. KING of New York) 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 amend title XVIII of the Social Security Act to improve operations of recovery auditors under the Medicare integrity program, to increase transparency and accuracy in audits conducted by contractors, 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; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Medicare Audit Improvement Act of 2013”.

1 (b) TABLE OF CONTENTS.—The table of contents of
 2 this Act is as follows:

- Sec. 1. Short title; table of contents.
- Sec. 2. Combined additional documentation request limit.
- Sec. 3. Improvement of recovery auditor operations.
- Sec. 4. Greater transparency of recovery auditor performance.
- Sec. 5. Accurate payment for rebilled claims.
- Sec. 6. Requirement for physician validation for medical necessity denials.
- Sec. 7. Assuring due process in application of guidelines for reopening and revision of determinations.

3 **SEC. 2. COMBINED ADDITIONAL DOCUMENTATION RE-**
 4 **QUEST LIMIT.**

5 (a) ESTABLISHMENT OF LIMITS PER HOSPITAL.—
 6 The Secretary of Health and Human Services shall estab-
 7 lish a process under which the number of additional docu-
 8 mentation requests made to a hospital (as defined in sub-
 9 section (c)(3)) by Medicare contractors (as defined in sub-
 10 section (c)(1)) pursuant to prepayment and postpayment
 11 audits that require a hospital to submit a medical record
 12 for audit purposes, as required under chapter 3 of the
 13 Medicare Program Integrity Manual, or otherwise, shall
 14 be subject to a single, combined maximum limit of addi-
 15 tional documentation requests per year for the Medicare
 16 contractors specified in subsection (c)(1). However, such
 17 maximum limit shall be applied incrementally as a limit
 18 for requests for additional documentation in 45-day peri-
 19 ods during the year so that the maximum number of such
 20 requests in a 45-day period is 500 or, in the case of a

1 hospital that receives less than \$100,000,000 in Medicare
2 inpatient hospital payments in the previous year, 350.

3 (b) ESTABLISHMENT OF PERCENTAGE-BASED LIM-
4 ITS PER CLAIM TYPE.—In addition to the limit estab-
5 lished under subsection (a), the Secretary shall establish
6 a distinct additional documentation request limit for each
7 hospital claim type (as defined in subsection (c)(2)) for
8 each hospital for a 45-day period in a year. For a hospital
9 for each hospital claim type for a 45-day period in a cal-
10 endar year, the additional documentation request limit
11 under this subsection for a claim type shall be 2 percent
12 of the total number of hospital discharges for such hos-
13 pital for the previous calendar year divided by 8.

14 (c) DEFINITIONS.—In this section:

15 (1) MEDICARE CONTRACTOR.—The term
16 “Medicare contractor” means any of the following:

17 (A) A Medicare administrative contractor
18 under section 1874A of the Social Security Act
19 (42 U.S.C. 1395kk), including a fiscal inter-
20 mediary and a carrier under sections 1816 and
21 1842, respectively.

22 (B) A recovery audit contractor under sec-
23 tion 1893(h) of such Act (42 U.S.C.
24 1395ddd(h)).

1 (C) A Comprehensive Error Rate Testing
2 (CERT) program contractor with a contract
3 with the Secretary of Health and Human Serv-
4 ices to review error rates under title XVIII of
5 the Social Security Act (42 U.S.C. 1395 et
6 seq.).

7 (2) HOSPITAL CLAIM TYPE.—Each of the fol-
8 lowing shall be considered a separate “hospital claim
9 type”:

10 (A) IPPS.—A claim for payment under
11 section 1886(d) of the Social Security Act (42
12 U.S.C. 1395ww(d)) made by a hospital for fur-
13 nishing inpatient hospital services.

14 (B) OUTPATIENT HOSPITAL SERVICES.—A
15 claim for payment under section 1833(t) of
16 such Act (42 U.S.C. 1395l(t)) made by a hos-
17 pital for furnishing covered OPD services.

18 (C) CAH SERVICES.—A claim for payment
19 for inpatient or outpatient critical access hos-
20 pital services, whether under section 1814(l) of
21 such Act (42 U.S.C. 1395f(l)) or under section
22 1834(g) of such Act (42 U.S.C. 1395m(g)).

23 (D) INPATIENT REHABILITATION SERV-
24 ICES.—A claim for payment under section
25 1886(j) of such Act (42 U.S.C. 1395ww(j))

1 made by a hospital for furnishing inpatient re-
2 habilitation services.

3 (E) OTHER INPATIENT SERVICES.—A
4 claim for payment under any other provision of
5 section 1886 of such Act (42 U.S.C. 1395ww)
6 made by a hospital for furnishing inpatient hos-
7 pital services, such as subsection (s) (relating to
8 inpatient hospital services furnish by a psy-
9 chiatric hospital) or subsection (m) (relating to
10 inpatient hospital services furnish by a long
11 term care hospital).

12 (F) SKILLED NURSING FACILITY SERV-
13 ICES.—A claim for payment under section
14 1888(e) of such Act (42 U.S.C. 1395yy(e))
15 made by a hospital for furnishing covered
16 skilled nursing facility services.

17 (3) HOSPITAL.—The term “hospital” means
18 the campus of a hospital (as defined in subsection
19 (e) of section 1861 of the Social Security Act (42
20 U.S.C. 1395x)) or of a psychiatric hospital (as de-
21 fined in subsection (f) of such section), a com-
22 prehensive outpatient rehabilitation facility (as de-
23 fined in subsection (cc)(2) of such section), a critical
24 access hospital (as defined in subsection (mm) of
25 such section), or a long-term care hospital (as de-

1 fined in subsection (ccc) of such section), as identi-
2 fied by the tax identification number of the hospital,
3 and includes all inpatient hospital facilities under
4 such number located in the same area as such cam-
5 pus.

6 (d) EFFECTIVE DATE.—This section takes effect on
7 the date of the enactment of this Act and shall apply with
8 respect to claims submitted for payment under title XVIII
9 of the Social Security Act for items or services furnished
10 by providers of services or suppliers on or after the first
11 day of the first month beginning 60 days after the date
12 of the enactment of this Act.

13 **SEC. 3. IMPROVEMENT OF RECOVERY AUDITOR OPER-**
14 **ATIONS.**

15 (a) RECOVERY AUDITORS.—

16 (1) IN GENERAL.—Section 1893(h) of the So-
17 cial Security Act (42 U.S.C. 1395ddd(h)) is amend-
18 ed by adding at the end the following new para-
19 graph:

20 “(10) MANDATORY TERMS AND CONDITIONS
21 UNDER CONTRACTS WITH RECOVERY AUDIT CON-
22 TRACTORS.—In addition to such other terms and
23 conditions as the Secretary may require under con-
24 tracts with recovery audit contractors under this
25 subsection with respect to a hospital, including a

1 psychiatric hospital (as defined in section 1861(f)),
2 the Secretary shall ensure each of the following re-
3 quirements are included under such contracts:

4 “(A) PENALTIES FOR CERTAIN COMPLI-
5 ANCE FAILURES.—

6 “(i) IN GENERAL.—Each such con-
7 tract shall provide for the imposition of fi-
8 nancial penalties by the Secretary under
9 such contract in the case of any recovery
10 audit contractor with respect to which the
11 Secretary determines there is a pattern of
12 failure by such contractor to meet any pro-
13 gram requirement described in clause (ii).
14 The Secretary shall establish the amount
15 of financial penalties and the periodicity
16 under which such penalties shall be im-
17 posed under this subparagraph, in no case
18 less often than annually.

19 “(ii) PROGRAM REQUIREMENT DE-
20 SCRIBED.—For purposes of this subpara-
21 graph, each of the following requirements
22 under the statement of work for a recovery
23 audit contractor constitutes a program re-
24 quirement with respect to which failure to
25 meet such requirement shall result in the

1 imposition of a financial penalty under
2 clause (i):

3 “(I) AUDIT DEADLINE.—Com-
4 pleting a determination with respect
5 to each audit of a hospital the recov-
6 ery audit contractor conducts within
7 the timeframes applicable under
8 guidelines of the Secretary.

9 “(II) TIMELY COMMUNICA-
10 TION.—In the case of a denial of a
11 claim of a hospital, furnishing the
12 hospital the required notice of the
13 pending denial in a timely fashion
14 consistent with claims and appeals
15 timeframes specified in guidelines of
16 the Secretary.

17 “(B) PENALTY FOR OVERTURNED AP-
18 PEALS.—

19 “(i) IN GENERAL.—Each such con-
20 tract shall require a recovery audit con-
21 tractor to pay a fee to the prevailing party
22 in the case of a claim denial that is over-
23 turned on appeal.

24 “(ii) FEE AMOUNT.—The amount of
25 the fee payable by a recovery audit con-

1 tractor to a prevailing party under clause
2 (i) shall be determined under a fee sched-
3 ule established by the Secretary for such
4 purpose. The amount of such fee under
5 such fee schedule shall reflect the cost in-
6 curred by a typical hospital in appealing a
7 claim denied by a recovery audit con-
8 tractor.

9 “(C) POSTPAYMENT AND PREPAYMENT AU-
10 DITS.—

11 “(i) REQUIRING FOCUS ON WIDE-
12 SPREAD PAYMENT ERRORS.—

13 “(I) IN GENERAL.—The Sec-
14 retary shall not approve the conduct
15 of a postpayment or prepayment med-
16 ical necessity audit by a recovery
17 audit contractor unless such review
18 addresses a widespread payment error
19 rate (as defined in clause (ii)).

20 “(II) CESSATION OF AUDIT.—A
21 recovery audit contractor that com-
22 mences an audit under subclause (I)
23 shall cease such audit or any similar
24 audits, if upon annual review, the ap-
25 plicable payment error rate is no

1 longer a widespread payment error
2 rate (as so defined).

3 “(ii) WIDESPREAD PAYMENT ERROR
4 RATE DEFINED.—

5 “(I) IN GENERAL.—In this sub-
6 paragraph, the term ‘widespread pay-
7 ment error rate’ means, with respect
8 to medical necessity reviews conducted
9 by a recovery audit contractor, a pay-
10 ment error rate that exceeds the rate
11 specified in subclause (II) for a par-
12 ticular medical necessity audit deter-
13 mined by the Secretary using a statis-
14 tically significant sampling of claims
15 submitted by hospitals in the jurisdic-
16 tion of the recovery audit contractor
17 and adjusted to take into account
18 claim denials overturned on appeal.

19 “(II) RATE SPECIFIED.—The
20 rate specified in this subclause is 40
21 percent, except that the Secretary
22 shall annually evaluate such rate and
23 reduce it as necessary to account for
24 changes in payment error rates with

1 the aim of continued, steady improve-
2 ment of billing practices.

3 “(D) GUIDELINES FOR PREPAYMENT RE-
4 VIEW.—

5 “(i) IN GENERAL.—A recovery audit
6 contractor may conduct prepayment review
7 only in the manner provided under prepay-
8 ment review guidelines (described in clause
9 (ii)) established by the Secretary.

10 “(ii) CONSISTENT PREPAYMENT RE-
11 VIEW GUIDELINES.—For purposes of pre-
12 payment review activities authorized under
13 this subsection and section 1874A(h) (re-
14 lating to prepayment review by medicare
15 administrative contractors), the Secretary
16 shall establish guidelines under which con-
17 sistent criteria for minimum payment error
18 rates or improper billing practices occasion
19 prepayment review by contractors under
20 this subsection and section 1874A. Such
21 guidelines shall include criteria and time-
22 frames for termination of prepayment re-
23 view.”.

24 (2) CONFORMING AMENDMENT TO APPLY FI-
25 NANCIAL PENALTIES IMPOSED ON RECOVERY CON-

1 TRACTORS TO THE TRUST FUNDS.—Section
2 1893(h)(2) of the Social Security Act (42 U.S.C.
3 1395ddd(h)(2)) is amended by inserting “, and
4 amounts collected by the Secretary under paragraph
5 (10)(A)(i) (relating to financial penalties for con-
6 tractor compliance failures),” after “paragraph
7 (1)(C)”.

8 (b) CONFORMING AMENDMENT FOR MEDICARE AD-
9 MINISTRATIVE CONTRACTORS.—Section 1874A of the So-
10 cial Security Act (42 U.S.C. 1395kk–1) is amended by
11 adding at the end the following new subsection:

12 “(h) MANDATORY TERMS AND CONDITIONS UNDER
13 CONTRACTS WITH MEDICARE ADMINISTRATIVE CON-
14 TRACTORS.—In addition to such other terms and condi-
15 tions as the Secretary may require under contracts with
16 medicare administrative contractors under this section
17 with respect to a hospital, including a psychiatric hospital
18 (as defined in section 1861(f)), the Secretary shall ensure
19 each of the following requirements are included under
20 such contracts:

21 “(1) POSTPAYMENT AND PREPAYMENT AU-
22 DITS.—

23 “(A) REQUIRING FOCUS ON WIDESPREAD
24 PAYMENT ERRORS.—

1 “(i) IN GENERAL.—The Secretary
2 shall not approve the conduct of a
3 postpayment or prepayment medical neces-
4 sity audit by a medicare administrative
5 contractor unless such review addresses a
6 widespread payment error rate (as defined
7 in subparagraph (B)).

8 “(ii) CESSATION OF AUDIT.—A medi-
9 care administrative contractor that com-
10 mences an audit under clause (i) shall
11 cease such audit or any similar audits, if
12 upon annual review, the applicable pay-
13 ment error rate is no longer a widespread
14 payment error rate (as so defined).

15 “(B) WIDESPREAD PAYMENT ERROR RATE
16 DEFINED.—In this paragraph, the term ‘wide-
17 spread payment error rate’ means, with respect
18 to medical necessity reviews conducted by a
19 medicare administrative contractor, a payment
20 error rate of 40 percent or greater for a par-
21 ticular medical necessity audit determined by
22 the Secretary using a statistically significant
23 sampling of claims submitted by hospitals in
24 the jurisdiction of the medicare administrative

1 contractor and adjusted to take into account
2 claim denials overturned on appeal.

3 “(2) GUIDELINES FOR PREPAYMENT REVIEW.—

4 A medicare administrative contractor may only con-
5 duct prepayment review in the manner provided
6 under prepayment review guidelines established by
7 the Secretary under section 1893(h)(10)(D)(ii).”.

8 (c) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to contracts entered into or re-
10 newed with recovery audit contractors under section
11 1893(h) of the Social Security Act (42 U.S.C.
12 1395ddd(h)) and medicare administrative contractors
13 under section 1874A of the Social Security Act (42 U.S.C.
14 1395kk–1) on or after the date of the enactment of this
15 Act.

16 **SEC. 4. GREATER TRANSPARENCY OF RECOVERY AUDITOR**
17 **PERFORMANCE.**

18 (a) ANNUAL PUBLICATION OF RELEVANT PERFORM-
19 ANCE INFORMATION.—Section 1893(h) of the Social Secu-
20 rity Act (42 U.S.C. 1395ddd(h)), as amended by section
21 3(a), is further amended by adding at the end the fol-
22 lowing new paragraph:

23 “(11) INFORMATION ON RECOVERY AUDIT CON-
24 TRACTOR PERFORMANCE.—With respect to each re-
25 covery audit contractor with a contract under this

1 section for a contract year, the Secretary shall pub-
2 lish on the Internet website of the Centers for Medi-
3 care & Medicaid Services the following information
4 with respect to the performance of each such recov-
5 ery audit contractor:

6 “(A) PUBLICLY AVAILABLE INFORMATION
7 ON AUDIT RATES, DENIALS, AND APPEALS OUT-
8 COMES.—With respect to the performance of
9 each such recovery audit contractor during a
10 contract year, the Secretary shall post on such
11 Internet website the following information:

12 “(i) AUDITS.—The aggregate number
13 of claims audited by the recovery audit
14 contractor during the contract year in-
15 volved, as well as the number of audits of
16 each of the following audit types (each in
17 this paragraph referred to as an ‘audit
18 type’):

19 “(I) Automated.

20 “(II) Complex.

21 “(III) Medical necessity review.

22 “(IV) Part A claims.

23 “(V) Part B claims.

24 “(VI) Durable medical equipment
25 claims.

1 “(VII) Part A medical necessity.

2 “(ii) ADR REQUESTS.—The aggregate
3 number of requests for medical records, re-
4 ferred to as additional documentation re-
5 quests, for each audit type during the con-
6 tract year involved.

7 “(iii) DENIALS.—The aggregate num-
8 ber of denials for each audit type made by
9 the recovery audit contractor during the
10 contract year involved.

11 “(iv) DENIAL RATES.—The denial
12 rate of the recovery audit contractor dur-
13 ing the contract year involved for part A
14 claims, part B claims, and durable medical
15 equipment claims for each audit type dur-
16 ing the contract year involved.

17 “(v) APPEALS.—The aggregate num-
18 ber of appeals filed by providers of services
19 and suppliers with respect to denials for
20 each audit type made by the recovery audit
21 contractor during the contract year in-
22 volved.

23 “(vi) APPEALS RATES.—The aggre-
24 gate rate of appeals filed by providers of
25 services and suppliers with respect to deni-

1 als for each audit type made by the recov-
2 ery audit contractor during the contract
3 year involved.

4 “(vii) APPEALS VOLUME AND OUT-
5 COMES AT EACH OF THE 5 STAGES OF AP-
6 PEAL.—For claims denied by a recovery
7 audit contractor, the number of claims
8 during the contract year that were ap-
9 pealed by the provider, the number of con-
10 cluded appeals that did not advance to a
11 subsequent appeals stage, and the number
12 and percentage of completed appeals that
13 were decided in favor of the provider, for
14 each level of appeal as follows:

15 “(I) Reconsideration by the rel-
16 evant medicare contractor.

17 “(II) Redetermination by a quali-
18 fied independent contractor.

19 “(III) Administrative law judge
20 hearing.

21 “(IV) Medicare Appeals Council
22 review.

23 “(V) United States District
24 Court judicial review.

1 “(viii) NET DENIALS; NET DENIAL
2 RATES.—The net denials for each audit
3 type, calculated as the number of denials
4 for such audit type under clause (iii)
5 minus the number of such denials that are
6 overturned on appeal and the net denial
7 rate for each audit type, calculated in the
8 same manner as denial rates under clause
9 (iv) but subtracting from denials those de-
10 nials that are overturned on appeal

11 “(B) PUBLIC AVAILABILITY OF INDE-
12 PENDENT PERFORMANCE EVALUATION.—The
13 Secretary shall make available on such Internet
14 website the results of any performance evalua-
15 tion with respect to each recovery audit con-
16 tractor conducted by an independent entity se-
17 lected by the Secretary for such purpose. Each
18 performance evaluation shall include in its re-
19 sults for posting on such Internet website a de-
20 termination of annual error rates of the recov-
21 ery audit contractor for each audit type and the
22 net denials and net denial rates described in
23 subparagraph (A)(viii).”.

24 (b) EFFECTIVE DATE.—The amendment made by
25 subsection (a) shall apply to contracts entered into or re-

1 newed with recovery audit contractors under section
 2 1893(h) of the Social Security Act (42 U.S.C.
 3 1395ddd(h)) on or after the date of the enactment of this
 4 Act.

5 **SEC. 5. ACCURATE PAYMENT FOR REBILLED CLAIMS.**

6 (a) REBILLING UNDER PART B INPATIENT CLAIMS
 7 DENIED BASED ON SITE OF SERVICE WHERE SERVICES
 8 FOUND MEDICALLY NECESSARY AT THE OUTPATIENT
 9 LEVEL.—

10 (1) RECOVERY AUDITORS.—Section 1893(h) of
 11 the Social Security Act (42 U.S.C. 1395ddd(h)), as
 12 amended by sections 3(a) and 4(a), is further
 13 amended by adding at the end the following new
 14 paragraph:

15 “(12) TREATMENT OF RESUBMISSION OF SPEC-
 16 IFIED CLAIMS AS ORIGINAL CLAIMS.—

17 “(A) TREATMENT AS ORIGINAL CLAIM.—

18 The resubmission of a specified claim (as de-
 19 fined in subparagraph (C)) shall be deemed to
 20 be an original claim for purposes of—

21 “(i) payment under part B; and

22 “(ii) provisions under this title relat-
 23 ing to—

24 “(I) the authority of a hospital to
 25 resubmit a claim for payment under

1 the appropriate section of this title;
2 and

3 “(II) requirements for the timely
4 submission of claims, including under
5 sections 1814(a), 1842(b)(3), and
6 1835(a).

7 “(B) PAYMENT FOR ITEMS AND SERVICES
8 UNDER RESUBMITTED CLAIM.—Payment shall
9 be made for a specified claim resubmitted under
10 subparagraph (A) for all the items and services
11 furnished for which payment may be made
12 under part B.

13 “(C) DEFINITIONS.—In this paragraph:

14 “(i) SPECIFIED CLAIM.—

15 “(I) IN GENERAL.—The term
16 ‘specified claim’ means a claim sub-
17 mitted by a hospital for payment
18 under part A for inpatient hospital
19 services which a recovery audit con-
20 tractor (or entity adjudicating a pro-
21 vider appeal of a Medicare claim de-
22 nied payment by a recovery audit con-
23 tractor) determines, subject to sub-
24 clause (II), that the inpatient hospital
25 services were not medically necessary

1 and reasonable under section
2 1862(a)(1)(A).

3 “(II) REQUIREMENTS FOR DE-
4 TERMINATION.—A recovery audit con-
5 tractor or entity adjudicating such
6 provider appeal shall, before com-
7 pleting a determination described in
8 subclause (I), assess and make a spe-
9 cific finding as to whether the denied
10 inpatient hospital services were medi-
11 cally necessary and reasonable in an
12 outpatient setting of the hospital.

13 “(ii) RESUBMISSION.—The term ‘re-
14 submission’ includes, with respect to a
15 specified claim of a hospital, the submis-
16 sion by the hospital of a new claim or of
17 an adjusted original claim.”.

18 (2) CONFORMING AMENDMENT FOR MEDICARE
19 ADMINISTRATIVE CONTRACTORS.—Subsection (h) of
20 section 1874A of the Social Security Act (42 U.S.C.
21 1395kk-1), as added by section 3(b), is further
22 amended by adding at the end the following new
23 paragraph:

24 “(3) TREATMENT OF RESUBMISSION OF SPECI-
25 FIED CLAIMS AS ORIGINAL CLAIMS.—

1 “(A) TREATMENT AS ORIGINAL CLAIM.—

2 The resubmission of a specified claim (as de-
3 fined in subparagraph (C)) shall be deemed to
4 be an original claim for purposes of—

5 “(i) payment under part B; and

6 “(ii) provisions under this title relat-
7 ing to—

8 “(I) the authority of a hospital to
9 resubmit a claim for payment under
10 the appropriate section of this title;
11 and

12 “(II) requirements for the timely
13 submission of claims, including under
14 sections 1814(a), 1842(b)(3), and
15 1835(a).

16 “(B) PAYMENT FOR ITEMS AND SERVICES
17 UNDER RESUBMITTED CLAIM.—Payment shall
18 be made for a specified claim resubmitted under
19 subparagraph (A) for all the items and services
20 furnished for which payment may be made
21 under part B.

22 “(C) DEFINITIONS.—In this paragraph:

23 “(i) SPECIFIED CLAIM.—

24 “(I) IN GENERAL.—The term
25 ‘specified claim’ means a claim sub-

1 mitted by a hospital for payment
2 under part A for inpatient hospital
3 services which a medicare administra-
4 tive contractor (or entity adjudicating
5 a hospital appeal of a Medicare claim
6 denied payment by a medicare admin-
7 istrative contractor) determines, sub-
8 ject to subclause (II), that the inpa-
9 tient hospital services were not medi-
10 cally necessary and reasonable under
11 section 1862(a)(1)(A).

12 “(II) REQUIREMENTS FOR DE-
13 TERMINATION.—A medicare adminis-
14 trative contractor or entity adjudi-
15 cating such provider appeal shall, be-
16 fore completing a determination de-
17 scribed in subclause (I), assess and
18 make a specific finding as to whether
19 the denied inpatient hospital services
20 were medically necessary and reason-
21 able in an outpatient setting of the
22 hospital.

23 “(ii) RESUBMISSION.—The term ‘re-
24 submission’ includes, with respect to a
25 specified claim of a hospital, the submis-

1 sion by the hospital of a new claim or of
2 an adjusted original claim.”.

3 (3) CONFORMING AMENDMENT FOR CERT CON-
4 TRACTORS.—

5 (A) TREATMENT OF RESUBMISSION OF
6 SPECIFIED CLAIMS AS ORIGINAL CLAIMS.—A
7 Comprehensive Error Rate Testing (CERT)
8 program contractor with a contract with the
9 Secretary of Health and Human Services to re-
10 view error rates under title XVIII of the Social
11 Security Act (42 U.S.C. 1395 et seq.) shall
12 deem the resubmission of a specified claim (as
13 defined in subparagraph (C)) as an original
14 claim for purposes of—

15 (i) payment under part B of such title
16 XVII; and

17 (ii) provisions under such title relating
18 to—

19 (I) the authority of a hospital to
20 resubmit a claim for payment under
21 the appropriate section of such title;
22 and

23 (II) requirements for the timely
24 submission of claims, including under
25 sections 1814(a), 1842(b)(3), and

1 1835(a) of such Act (42 U.S.C.
2 1395f(a), 1395u(b)(3), and 1395n(a),
3 respectively).

4 (B) PAYMENT FOR ITEMS AND SERVICES
5 UNDER RESUBMITTED CLAIM.—Payment shall
6 be made for a specified claim resubmitted under
7 subparagraph (A) for all the items and services
8 furnished for which payment may be made
9 under part B of such title XVIII.

10 (C) DEFINITIONS.—In this paragraph:

11 (i) SPECIFIED CLAIM.—

12 (I) IN GENERAL.—The term
13 “specified claim” means a claim sub-
14 mitted by a hospital (as defined in
15 section 1861(e) of such Act (42
16 U.S.C. 1395x(e))) for payment under
17 title XVIII of such Act for inpatient
18 hospital services which a Comprehen-
19 sive Error Rate Testing (CERT) pro-
20 gram contractor (or entity adjudi-
21 cating a hospital appeal of a Medicare
22 claim denied payment by a CERT
23 program contractor) determines the
24 inpatient hospital services were not
25 medically necessary and reasonable

1 under section 1862(a)(1)(A) of such
2 Act (42 U.S.C. 1395y(a)(1)(A)).

3 (II) REQUIREMENTS FOR DETER-
4 MINATION.—A CERT program con-
5 tractor or entity adjudicating such
6 provider appeal shall, before com-
7 pleting a determination described in
8 subclause (I), assess and make a spe-
9 cific finding as to whether the denied
10 inpatient hospital services were medi-
11 cally necessary and reasonable in an
12 outpatient setting of the hospital.

13 (ii) RESUBMISSION.—The term “re-
14 submission” includes, with respect to a
15 specified claim of a hospital, the submis-
16 sion by the hospital of a new claim or of
17 an adjusted original claim.

18 (iii) EFFECTIVE DATE.—The amend-
19 ments made by paragraphs (1) and (2),
20 and the provisions of paragraph (3), shall
21 apply to contracts entered into or renewed
22 with recovery audit contractors under sec-
23 tion 1893(h) of the Social Security Act (42
24 U.S.C. 1395ddd(h)), medicare administra-
25 tive contractors under section 1874A of

1 the Social Security Act (42 U.S.C.
2 1395kk-1) and Comprehensive Error Rate
3 Testing (CERT) program contractors, re-
4 spectively, on or after the date of the en-
5 actment of this Act.

6 (b) TREATMENT OF AUDITED CLAIMS AS RE-
7 OPENED.—

8 (1) RECOVERY AUDITORS.—Section 1893(h)(4)
9 of the Social Security Act (42 U.S.C.
10 1395ddd(h)(4)) is amended by adding after and
11 below subparagraph (B) the following: “For pur-
12 poses of the ability of a hospital to resubmit a claim
13 for payment under the appropriate section of this
14 title and for purposes of requirements for the timely
15 submission of claims by hospitals, including under
16 sections 1814(a), 1842(b)(3), and 1835(a), any
17 claim that is the subject of an audit by a recovery
18 audit contractor with a contract under this section
19 shall be deemed to be a reopened claim. Such re-
20 opened claims are not subject to the timely filing
21 limitations under such sections (and related regula-
22 tions) and shall be adjusted and paid without regard
23 to such timely filing limitations.”.

24 (2) CONFORMING AMENDMENT FOR MEDICARE
25 ADMINISTRATIVE CONTRACTORS.—Section 1874A(h)

1 of the Social Security Act (42 U.S.C. 1395kk–1(h)),
2 as added by section 3(b) and as amended by sub-
3 section (a)(2), is further amended by adding at the
4 end the following new paragraph:

5 “(4) TREATMENT OF AUDITED CLAIMS AS RE-
6 OPENED.—For purposes of the ability of a hospital
7 to resubmit a claim for payment under the appro-
8 priate provisions of this title and for purposes of re-
9 quirements for the timely submission of claims by
10 hospitals, including under sections 1814(a),
11 1842(b)(3), and 1835(a), any claim that is the sub-
12 ject of an audit by a medicare administrative con-
13 tractor with a contract under this section shall be
14 deemed to be a reopened claim. Such reopened
15 claims are not subject to the timely filing limitations
16 under such sections (and related regulations) and
17 shall be adjusted and paid without regard to such
18 timely filing limitations.”.

19 (3) CONFORMING AMENDMENT FOR CERT CON-
20 TRACTORS.—

21 (A) TREATMENT OF AUDITED CLAIMS AS
22 REOPENED.—Any claim made for payment for
23 services furnished by a hospital under title
24 XVIII of the Social Security Act (42 U.S.C.
25 1395 et seq.) that is the subject of an audit by

1 a Comprehensive Error Rate Testing (CERT)
2 program contractor with a contract with the
3 Secretary of Health and Human Services shall
4 be deemed to be a reopened claim for purposes
5 of the ability of such hospital to resubmit a
6 claim for payment under the appropriate provi-
7 sions of such title XVIII and for purposes of re-
8 quirements for the timely submission of claims
9 by hospitals under such title XVIII, including
10 under sections 1814(a), 1842(b)(3), and
11 1835(a) of the Social Security Act (42 U.S.C.
12 1395f(a), 1395u(b)(3), and 1395n(a), respec-
13 tively). Such reopened claims are not subject to
14 the timely filing limitations under such sections
15 (and related regulations) and shall be adjusted
16 and paid without regard to such timely filing
17 limitations.

18 (B) DEFINITION.—In this paragraph, the
19 term “hospital” has the meaning given such
20 term in subsection (e) of section 1861 of the
21 Social Security Act (42 U.S.C. 1395x), and in-
22 cludes a psychiatric hospital as defined in sub-
23 section (f) of such section.

24 (4) EFFECTIVE DATE.—The amendments made
25 by paragraphs (1) and (2), and the provisions of

1 paragraph (3), shall take effect on the date of the
2 enactment of this Act and apply to claims subject to
3 audit on or after September 1, 2010.

4 **SEC. 6. REQUIREMENT FOR PHYSICIAN VALIDATION FOR**
5 **MEDICAL NECESSITY DENIALS.**

6 (a) RECOVERY AUDITORS.—Section 1893(h) of the
7 Social Security Act (42 U.S.C. 1395ddd(h)), as amended
8 by sections 3(a), 4(a), and 6(a)(1), is further amended by
9 adding at the end the following new paragraph:

10 “(13) PHYSICIAN VALIDATION OF MEDICAL NE-
11 CESSITY DENIALS MADE BY NON-PHYSICIAN REVIEW-
12 ERS.—

13 “(A) IN GENERAL.—Each contract under
14 this section for a recovery audit contractor shall
15 require that a physician (as defined in section
16 1861(r)(1)) review each denial of a claim for
17 medical necessity when a medical necessity re-
18 view of such claim is performed and a denial is
19 made by an employee of the contractor who is
20 not a physician (as so defined).

21 “(B) DETERMINATION; VALIDATION.—A
22 physician reviewing a claim under subparagraph
23 (A) shall—

24 “(i) make a determination whether
25 the denial of the claim under the medical

1 necessity review by the non-physician em-
2 ployee is appropriate;

3 “(ii) sign and certify such determina-
4 tion; and

5 “(iii) append such signed and certified
6 determination to the claim file.

7 “(C) TREATMENT AS MEDICALLY NEC-
8 ESSARY.—A claim with respect to which a de-
9 nial has been made as described in subpara-
10 graph (A) for which the physician determines
11 the denial is not appropriate under subpara-
12 graph (B) shall be deemed to be medically nec-
13 essary.

14 “(D) MEDICAL NECESSITY REVIEW DE-
15 FINED.—In this paragraph, the term ‘medical
16 necessity review’ means, with respect to an
17 audit of a claim of a provider of services or sup-
18 plier, a review conducted by a recovery audit
19 contractor for the purpose of determining
20 whether an item or service furnished for which
21 the claim is filed by such provider of services or
22 supplier is reasonable and necessary for the di-
23 agnosis or treatment of illness or injury under
24 section 1862(a)(1)(A).”.

1 (b) CONFORMING AMENDMENT TO MEDICARE AD-
2 MINISTRATIVE CONTRACTORS.—Subsection (h) of section
3 1874A of the Social Security Act (42 U.S.C. 1395kk–1),
4 as added by section 3(b) and as amended by subsections
5 (a)(2) and (b)(2) of section 6, is further amended by add-
6 ing at the end the following new paragraph:

7 “(5) PHYSICIAN VALIDATION OF MEDICAL NE-
8 CESSITY DENIALS MADE BY NON-PHYSICIAN REVIEW-
9 ERS.—

10 “(A) IN GENERAL.—A physician (as de-
11 fined in section 1861(r)(1)) shall review each
12 denial of a claim for medical necessity when a
13 medical necessity review of such claim is per-
14 formed and a denial is made by an employee of
15 the contractor who is not a physician (as so de-
16 fined).

17 “(B) DETERMINATION; VALIDATION.—A
18 physician reviewing a claim under subparagraph
19 (A) shall—

20 “(i) make a determination whether
21 the denial of the claim under the medical
22 necessity review by the non-physician em-
23 ployee is appropriate;

24 “(ii) sign and certify such determina-
25 tion; and

1 “(iii) append such signed and certified
2 determination to the claim file.

3 “(C) TREATMENT AS MEDICALLY NEC-
4 CESSARY.—A claim with respect to which a de-
5 nial has been made as described in subpara-
6 graph (A) for which the physician determines
7 the denial is not appropriate under subpara-
8 graph (B) shall be deemed to be medically nec-
9 essary.

10 “(D) MEDICAL NECESSITY REVIEW DE-
11 FINED.—In this paragraph, the term ‘medical
12 necessity review’ means, with respect to an
13 audit of a claim of a provider of services or sup-
14 plier, a review conducted by a medicare admin-
15 istrative contractor for the purpose of deter-
16 mining whether an item or service furnished for
17 which the claim is filed by such provider of
18 services or supplier is reasonable and necessary
19 for the diagnosis or treatment of illness or in-
20 jury under section 1862(a)(1)(A).”.

21 (c) CONFORMING REQUIREMENT FOR CERT CON-
22 TRACTORS.—

23 (1) CONTRACT REQUIREMENT FOR PHYSICIAN
24 VALIDATION OF MEDICAL NECESSITY DENIALS MADE
25 BY NON-PHYSICIAN REVIEWERS.—The Secretary of

1 Health and Human Services shall require under
2 each contract with a Comprehensive Error Rate
3 Testing (CERT) program contractor to review error
4 rates under title XVIII of the Social Security Act
5 (42 U.S.C. 1395 et seq.) that the CERT program
6 contractor ensure that a physician (as defined in
7 section 1861(r)(1) of such Act (42 U.S.C.
8 1395x(r)(1))) reviews each denial of a claim for
9 medical necessity when a medical necessity review of
10 such claim is performed and a denial is made by an
11 employee of the contractor who is not a physician
12 (as so defined).

13 (2) DETERMINATION; VALIDATION.—A physi-
14 cian reviewing a claim under paragraph (1) shall—

15 (A) make a determination whether the de-
16 nial of the claim under the medical necessity re-
17 view by the non-physician employee is appro-
18 priate;

19 (B) sign and certify such determination;
20 and

21 (C) append such signed and certified deter-
22 mination to the claim file.

23 (3) TREATMENT AS MEDICALLY NECESSARY.—

24 A claim with respect to which a denial has been
25 made as described in paragraph (1) for which the

1 physician determines the denial is not appropriate
2 under paragraph (2) shall be deemed to be medically
3 necessary.

4 (4) MEDICAL NECESSITY REVIEW DEFINED.—

5 In this subsection, the term “medical necessity re-
6 view” means, with respect to an audit of a claim of
7 a provider of services or supplier, a review conducted
8 by a CERT program contractor for the purpose of
9 determining whether an item or service furnished for
10 which the claim is filed by such provider of services
11 or supplier is reasonable and necessary for the diag-
12 nosis or treatment of illness or injury under section
13 1862(a)(1)(A) of the Social Security Act (42 U.S.C.
14 1395y(a)(1)(A)).

15 (d) EFFECTIVE DATE.—The amendments made by
16 subsections (a) and (b), and the provisions of subsection
17 (c), shall apply to contracts entered into or renewed with
18 recovery audit contractors under section 1893(h) of the
19 Social Security Act (42 U.S.C. 1395ddd(h)), medicare ad-
20 ministrative contractors under section 1874A of the Social
21 Security Act (42 U.S.C. 1395kk–1) and Comprehensive
22 Error Rate Testing (CERT) program contractors, respec-
23 tively, on or after the date of the enactment of this Act.

1 **SEC. 7. ASSURING DUE PROCESS IN APPLICATION OF**
2 **GUIDELINES FOR REOPENING AND REVISION**
3 **OF DETERMINATIONS.**

4 Section 1869(b)(1)(G) of the Social Security Act (42
5 U.S.C. 1395ff(b)(1)(G)) is amended by adding at the end
6 the following: “The Secretary’s compliance with such
7 guidelines shall be subject to administrative and judicial
8 review under this section.”.

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