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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.

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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

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# 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.

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

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Audit Improvement Act of 2013''.

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



**SEC. 2. COMBINED ADDITIONAL DOCUMENTATION REQUEST LIMIT.**

(a) ESTABLISHMENT OF LIMITS PER HOSPITAL.—The Secretary of Health and Human Services shall establish a process under which the number of additional documentation requests made to a hospital (as defined in subsection (c)(3)) by Medicare contractors (as defined in subsection (c)(1)) pursuant to prepayment and postpayment audits that require a hospital to submit a medical record for audit purposes, as required under chapter 3 of the Medicare Program Integrity Manual, or otherwise, shall be subject to a single, combined maximum limit of additional documentation requests per year for the Medicare contractors specified in subsection (c)(1). However, such maximum limit shall be applied incrementally as a limit for requests for additional documentation in 45-day periods during the year so that the maximum number of such requests in a 45-day period is 500 or, in the case of a

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

(b) ESTABLISHMENT OF PERCENTAGE-BASED LIMITS PER CLAIM TYPE.—In addition to the limit established under subsection (a), the Secretary shall establish a distinct additional documentation request limit for each hospital claim type (as defined in subsection (c)(2)) for each hospital for a 45-day period in a year. For a hospital for each hospital claim type for a 45-day period in a calendar year, the additional documentation request limit under this subsection for a claim type shall be 2 percent of the total number of hospital discharges for such hospital for the previous calendar year divided by 8.

(c) DEFINITIONS.—In this section:

(1) MEDICARE CONTRACTOR.—The term ''Medicare contractor'' means any of the following:

(A) A Medicare administrative contractor under section 1874A of the Social Security Act (42 U.S.C. 1395kk), including a fiscal intermediary and a carrier under sections 1816 and 1842, respectively.

(B) A recovery audit contractor under section 1893(h) of such Act (42 U.S.C. 1395ddd(h)).

(C) A Comprehensive Error Rate Testing (CERT) program contractor with a contract with the Secretary of Health and Human Services to review error rates under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) HOSPITAL CLAIM TYPE.—Each of the following shall be considered a separate ''hospital claim type'':

(A) IPPS.—A claim for payment under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) made by a hospital for furnishing inpatient hospital services.

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

(C) CAH SERVICES.—A claim for payment for inpatient or outpatient critical access hospital services, whether under section 1814(l) of such Act (42 U.S.C. 1395f(l)) or under section 1834(g) of such Act (42 U.S.C. 1395m(g)).

(D) INPATIENT REHABILITATION SERVICES.—A claim for payment under section 1886(j) of such Act (42 U.S.C. 1395ww(j))

made by a hospital for furnishing inpatient rehabilitation services.

(E) OTHER INPATIENT SERVICES.—A claim for payment under any other provision of section 1886 of such Act (42 U.S.C. 1395ww) made by a hospital for furnishing inpatient hospital services, such as subsection (s) (relating to inpatient hospital services furnish by a psychiatric hospital) or subsection (m) (relating to inpatient hospital services furnish by a long term care hospital).

(F) SKILLED NURSING FACILITY SERVICES.—A claim for payment under section 1888(e) of such Act (42 U.S.C. 1395yy(e)) made by a hospital for furnishing covered skilled nursing facility services.

(3) HOSPITAL.—The term ''hospital'' means the campus of a hospital (as defined in subsection (e) of section 1861 of the Social Security Act (42 U.S.C. 1395x)) or of a psychiatric hospital (as defined in subsection (f) of such section), a comprehensive outpatient rehabilitation facility (as defined in subsection (cc)(2) of such section), a critical access hospital (as defined in subsection (mm) of such section), or a long-term care hospital (as de-

fined in subsection (ccc) of such section), as identified by the tax identification number of the hospital, and includes all inpatient hospital facilities under such number located in the same area as such campus.

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

**SEC. 3. IMPROVEMENT OF RECOVERY AUDITOR OPERATIONS.**

(a) RECOVERY AUDITORS.—

(1) IN GENERAL.—Section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) is amended by adding at the end the following new paragraph:

''(10) MANDATORY TERMS AND CONDITIONS UNDER CONTRACTS WITH RECOVERY AUDIT CONTRACTORS.—In addition to such other terms and conditions as the Secretary may require under contracts with recovery audit contractors under this subsection with respect to a hospital, including a

psychiatric hospital (as defined in section 1861(f)), the Secretary shall ensure each of the following requirements are included under such contracts:

"(A) PENALTIES FOR CERTAIN COMPLIANCE FAILURES.—

"(i) IN GENERAL.—Each such contract shall provide for the imposition of financial penalties by the Secretary under such contract in the case of any recovery audit contractor with respect to which the Secretary determines there is a pattern of failure by such contractor to meet any program requirement described in clause (ii). The Secretary shall establish the amount of financial penalties and the periodicity under which such penalties shall be imposed under this subparagraph, in no case less often than annually.

"(ii) PROGRAM REQUIREMENT DESCRIBED.—For purposes of this subparagraph, each of the following requirements under the statement of work for a recovery audit contractor constitutes a program requirement with respect to which failure to meet such requirement shall result in the

imposition of a financial penalty under clause (i):

"(I) AUDIT DEADLINE.—Completing a determination with respect to each audit of a hospital the recovery audit contractor conducts within the timeframes applicable under guidelines of the Secretary.

"(II) TIMELY COMMUNICATION.—In the case of a denial of a claim of a hospital, furnishing the hospital the required notice of the pending denial in a timely fashion consistent with claims and appeals timeframes specified in guidelines of the Secretary.

"(B) PENALTY FOR OVERTURNED APPEALS.—

"(i) IN GENERAL.—Each such contract shall require a recovery audit contractor to pay a fee to the prevailing party in the case of a claim denial that is overturned on appeal.

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

tractor to a prevailing party under clause (i) shall be determined under a fee schedule established by the Secretary for such purpose. The amount of such fee under such fee schedule shall reflect the cost incurred by a typical hospital in appealing a claim denied by a recovery audit contractor.

''(C) POSTPAYMENT AND PREPAYMENT AUDITS.—

''(i) REQUIRING FOCUS ON WIDESPREAD PAYMENT ERRORS.—

''(I) IN GENERAL.—The Secretary shall not approve the conduct of a postpayment or prepayment medical necessity audit by a recovery audit contractor unless such review addresses a widespread payment error rate (as defined in clause (ii)).

''(II) CESSATION OF AUDIT.—A recovery audit contractor that commences an audit under subclause (I) shall cease such audit or any similar audits, if upon annual review, the applicable payment error rate is no

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

''(ii) WIDESPREAD PAYMENT ERROR RATE DEFINED.—

''(I) IN GENERAL.—In this subparagraph, the term 'widespread payment error rate' means, with respect to medical necessity reviews conducted by a recovery audit contractor, a payment error rate that exceeds the rate specified in subclause (II) for a particular medical necessity audit determined by the Secretary using a statistically significant sampling of claims submitted by hospitals in the jurisdiction of the recovery audit contractor and adjusted to take into account claim denials overturned on appeal.

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

the aim of continued, steady improvement of billing practices.

''(D) GUIDELINES FOR PREPAYMENT REVIEW.—

''(i) IN GENERAL.—A recovery audit contractor may conduct prepayment review only in the manner provided under prepayment review guidelines (described in clause (ii)) established by the Secretary.

''(ii) CONSISTENT PREPAYMENT REVIEW GUIDELINES.—For purposes of prepayment review activities authorized under this subsection and section 1874A(h) (relating to prepayment review by medicare administrative contractors), the Secretary shall establish guidelines under which consistent criteria for minimum payment error rates or improper billing practices occasion prepayment review by contractors under this subsection and section 1874A. Such guidelines shall include criteria and timeframes for termination of prepayment review.''.

(2) CONFORMING AMENDMENT TO APPLY FINANCIAL PENALTIES IMPOSED ON RECOVERY CON-

TRACTORS TO THE TRUST FUNDS.—Section 1893(h)(2) of the Social Security Act (42 U.S.C. 1395ddd(h)(2)) is amended by inserting ", and amounts collected by the Secretary under paragraph (10)(A)(i) (relating to financial penalties for contractor compliance failures)," after "paragraph (1)(C)".

(b) CONFORMING AMENDMENT FOR MEDICARE ADMINISTRATIVE CONTRACTORS.—Section 1874A of the Social Security Act (42 U.S.C. 1395kk–1) is amended by adding at the end the following new subsection:

"(h) MANDATORY TERMS AND CONDITIONS UNDER CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS.—In addition to such other terms and conditions as the Secretary may require under contracts with medicare administrative contractors under this section with respect to a hospital, including a psychiatric hospital (as defined in section 1861(f)), the Secretary shall ensure each of the following requirements are included under such contracts:

"(1) POSTPAYMENT AND PREPAYMENT AUDITS.—

"(A) REQUIRING FOCUS ON WIDESPREAD PAYMENT ERRORS.—

"(i) IN GENERAL.—The Secretary shall not approve the conduct of a postpayment or prepayment medical necessity audit by a medicare administrative contractor unless such review addresses a widespread payment error rate (as defined in subparagraph (B)).

"(ii) CESSATION OF AUDIT.—A medicare administrative contractor that commences an audit under clause (i) shall cease such audit or any similar audits, if upon annual review, the applicable payment error rate is no longer a widespread payment error rate (as so defined).

"(B) WIDESPREAD PAYMENT ERROR RATE DEFINED.—In this paragraph, the term 'widespread payment error rate' means, with respect to medical necessity reviews conducted by a medicare administrative contractor, a payment error rate of 40 percent or greater for a particular medical necessity audit determined by the Secretary using a statistically significant sampling of claims submitted by hospitals in the jurisdiction of the medicare administrative

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

''(2) GUIDELINES FOR PREPAYMENT REVIEW.—A medicare administrative contractor may only conduct prepayment review in the manner provided under prepayment review guidelines established by the Secretary under section 1893(h)(10)(D)(ii).''.

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

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

(a) ANNUAL PUBLICATION OF RELEVANT PERFORMANCE INFORMATION.—Section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)), as amended by section 3(a), is further amended by adding at the end the following new paragraph:

''(11) INFORMATION ON RECOVERY AUDIT CONTRACTOR PERFORMANCE.—With respect to each recovery audit contractor with a contract under this

section for a contract year, the Secretary shall publish on the Internet website of the Centers for Medicare & Medicaid Services the following information with respect to the performance of each such recovery audit contractor:

''(A) PUBLICLY AVAILABLE INFORMATION ON AUDIT RATES, DENIALS, AND APPEALS OUTCOMES.—With respect to the performance of each such recovery audit contractor during a contract year, the Secretary shall post on such Internet website the following information:

''(i) AUDITS.—The aggregate number of claims audited by the recovery audit contractor during the contract year involved, as well as the number of audits of each of the following audit types (each in this paragraph referred to as an 'audit type'):

''(I) Automated.

''(II) Complex.

''(III) Medical necessity review.

''(IV) Part A claims.

''(V) Part B claims.

''(VI) Durable medical equipment claims.

''(VII) Part A medical necessity.

''(ii) ADR REQUESTS.—The aggregate number of requests for medical records, referred to as additional documentation requests, for each audit type during the contract year involved.

''(iii) DENIALS.—The aggregate number of denials for each audit type made by the recovery audit contractor during the contract year involved.

''(iv) DENIAL RATES.—The denial rate of the recovery audit contractor during the contract year involved for part A claims, part B claims, and durable medical equipment claims for each audit type during the contract year involved.

''(v) APPEALS.—The aggregate number of appeals filed by providers of services and suppliers with respect to denials for each audit type made by the recovery audit contractor during the contract year involved.

''(vi) APPEALS RATES.—The aggregate rate of appeals filed by providers of services and suppliers with respect to deni-

als for each audit type made by the recovery audit contractor during the contract year involved.

''(vii) APPEALS VOLUME AND OUTCOMES AT EACH OF THE 5 STAGES OF APPEAL.—For claims denied by a recovery audit contractor, the number of claims during the contract year that were appealed by the provider, the number of concluded appeals that did not advance to a subsequent appeals stage, and the number and percentage of completed appeals that were decided in favor of the provider, for each level of appeal as follows:

''(I) Reconsideration by the relevant medicare contractor.

''(II) Redetermination by a qualified independent contractor.

''(III) Administrative law judge hearing.

''(IV) Medicare Appeals Council review.

''(V) United States District Court judicial review.

"(viii) NET DENIALS; NET DENIAL RATES.—The net denials for each audit type, calculated as the number of denials for such audit type under clause (iii) minus the number of such denials that are overturned on appeal and the net denial rate for each audit type, calculated in the same manner as denial rates under clause (iv) but subtracting from denials those denials that are overturned on appeal

"(B) PUBLIC AVAILABILITY OF INDEPENDENT PERFORMANCE EVALUATION.—The Secretary shall make available on such Internet website the results of any performance evaluation with respect to each recovery audit contractor conducted by an independent entity selected by the Secretary for such purpose. Each performance evaluation shall include in its results for posting on such Internet website a determination of annual error rates of the recovery audit contractor for each audit type and the net denials and net denial rates described in subparagraph (A)(viii).".

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

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

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

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

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

''(12) TREATMENT OF RESUBMISSION OF SPECIFIED CLAIMS AS ORIGINAL CLAIMS.—

''(A) TREATMENT AS ORIGINAL CLAIM.—The resubmission of a specified claim (as defined in subparagraph (C)) shall be deemed to be an original claim for purposes of—

''(i) payment under part B; and

''(ii) provisions under this title relating to—

''(I) the authority of a hospital to resubmit a claim for payment under

the appropriate section of this title; and

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

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

"(C) DEFINITIONS.—In this paragraph:

"(i) SPECIFIED CLAIM.—

"(I) IN GENERAL.—The term 'specified claim' means a claim submitted by a hospital for payment under part A for inpatient hospital services which a recovery audit contractor (or entity adjudicating a provider appeal of a Medicare claim denied payment by a recovery audit contractor) determines, subject to subclause (II), that the inpatient hospital services were not medically necessary

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

''(II) REQUIREMENTS FOR DETERMINATION.—A recovery audit contractor or entity adjudicating such provider appeal shall, before completing a determination described in subclause (I), assess and make a specific finding as to whether the denied inpatient hospital services were medically necessary and reasonable in an outpatient setting of the hospital.

''(ii) RESUBMISSION.—The term 'resubmission' includes, with respect to a specified claim of a hospital, the submission by the hospital of a new claim or of an adjusted original claim.''.

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

''(3) TREATMENT OF RESUBMISSION OF SPECIFIED CLAIMS AS ORIGINAL CLAIMS.—

"(A) TREATMENT AS ORIGINAL CLAIM.—The resubmission of a specified claim (as defined in subparagraph (C)) shall be deemed to be an original claim for purposes of—

"(i) payment under part B; and

"(ii) provisions under this title relating to—

"(I) the authority of a hospital to resubmit a claim for payment under the appropriate section of this title; and

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

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

"(C) DEFINITIONS.—In this paragraph:

"(i) SPECIFIED CLAIM.—

"(I) IN GENERAL.—The term 'specified claim' means a claim sub-

mitted by a hospital for payment under part A for inpatient hospital services which a medicare administrative contractor (or entity adjudicating a hospital appeal of a Medicare claim denied payment by a medicare administrative contractor) determines, subject to subclause (II), that the inpatient hospital services were not medically necessary and reasonable under section 1862(a)(1)(A).

''(II) REQUIREMENTS FOR DETERMINATION.—A medicare administrative contractor or entity adjudicating such provider appeal shall, before completing a determination described in subclause (I), assess and make a specific finding as to whether the denied inpatient hospital services were medically necessary and reasonable in an outpatient setting of the hospital.

''(ii) RESUBMISSION.—The term 'resubmission' includes, with respect to a specified claim of a hospital, the submis-

sion by the hospital of a new claim or of an adjusted original claim.''.

(3) CONFORMING AMENDMENT FOR CERT CONTRACTORS.—

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

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

(ii) provisions under such title relating to—

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

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

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

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

(C) DEFINITIONS.—In this paragraph:

(i) SPECIFIED CLAIM.—

(I) IN GENERAL.—The term ''specified claim'' means a claim submitted by a hospital (as defined in section 1861(e) of such Act (42 U.S.C. 1395x(e))) for payment under title XVIII of such Act for inpatient hospital services which a Comprehensive Error Rate Testing (CERT) program contractor (or entity adjudicating a hospital appeal of a Medicare claim denied payment by a CERT program contractor) determines the inpatient hospital services were not medically necessary and reasonable

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

(II) REQUIREMENTS FOR DETERMINATION.—A CERT program contractor or entity adjudicating such provider appeal shall, before completing a determination described in subclause (I), assess and make a specific finding as to whether the denied inpatient hospital services were medically necessary and reasonable in an outpatient setting of the hospital.

(ii) RESUBMISSION.—The term ''resubmission'' includes, with respect to a specified claim of a hospital, the submission by the hospital of a new claim or of an adjusted original claim.

(iii) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2), and the provisions of paragraph (3), shall apply to contracts entered into or renewed with recovery audit contractors under section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)), medicare administrative contractors under section 1874A of

the Social Security Act (42 U.S.C. 1395kk–1) and Comprehensive Error Rate Testing (CERT) program contractors, respectively, on or after the date of the enactment of this Act.

(b) TREATMENT OF AUDITED CLAIMS AS REOPENED.—

(1) RECOVERY AUDITORS.—Section 1893(h)(4) of the Social Security Act (42 U.S.C. 1395ddd(h)(4)) is amended by adding after and below subparagraph (B) the following: ''For purposes of the ability of a hospital to resubmit a claim for payment under the appropriate section of this title and for purposes of requirements for the timely submission of claims by hospitals, including under sections 1814(a), 1842(b)(3), and 1835(a), any claim that is the subject of an audit by a recovery audit contractor with a contract under this section shall be deemed to be a reopened claim. Such reopened claims are not subject to the timely filing limitations under such sections (and related regulations) and shall be adjusted and paid without regard to such timely filing limitations.''.

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

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

''(4) TREATMENT OF AUDITED CLAIMS AS REOPENED.—For purposes of the ability of a hospital to resubmit a claim for payment under the appropriate provisions of this title and for purposes of requirements for the timely submission of claims by hospitals, including under sections 1814(a), 1842(b)(3), and 1835(a), any claim that is the subject of an audit by a medicare administrative contractor with a contract under this section shall be deemed to be a reopened claim. Such reopened claims are not subject to the timely filing limitations under such sections (and related regulations) and shall be adjusted and paid without regard to such timely filing limitations.''.

(3) CONFORMING AMENDMENT FOR CERT CONTRACTORS.—

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

a Comprehensive Error Rate Testing (CERT) program contractor with a contract with the Secretary of Health and Human Services shall be deemed to be a reopened claim for purposes of the ability of such hospital to resubmit a claim for payment under the appropriate provisions of such title XVIII and for purposes of requirements for the timely submission of claims by hospitals under such title XVIII, including under sections 1814(a), 1842(b)(3), and 1835(a) of the Social Security Act (42 U.S.C. 1395f(a), 1395u(b)(3), and 1395n(a), respectively). Such reopened claims are not subject to the timely filing limitations under such sections (and related regulations) and shall be adjusted and paid without regard to such timely filing limitations.

(B) DEFINITION.—In this paragraph, the term ''hospital'' has the meaning given such term in subsection (e) of section 1861 of the Social Security Act (42 U.S.C. 1395x), and includes a psychiatric hospital as defined in subsection (f) of such section.

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

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

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

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

''(13) PHYSICIAN VALIDATION OF MEDICAL NECESSITY DENIALS MADE BY NON-PHYSICIAN REVIEWERS.—

''(A) IN GENERAL.—Each contract under this section for a recovery audit contractor shall require that a physician (as defined in section 1861(r)(1)) review each denial of a claim for medical necessity when a medical necessity review of such claim is performed and a denial is made by an employee of the contractor who is not a physician (as so defined).

''(B) DETERMINATION; VALIDATION.—A physician reviewing a claim under subparagraph (A) shall—

''(i) make a determination whether the denial of the claim under the medical

necessity review by the non-physician employee is appropriate;

"(ii) sign and certify such determination; and

"(iii) append such signed and certified determination to the claim file.

"(C) TREATMENT AS MEDICALLY NECESSARY.—A claim with respect to which a denial has been made as described in subparagraph (A) for which the physician determines the denial is not appropriate under subparagraph (B) shall be deemed to be medically necessary.

"(D) MEDICAL NECESSITY REVIEW DEFINED.—In this paragraph, the term 'medical necessity review' means, with respect to an audit of a claim of a provider of services or supplier, a review conducted by a recovery audit contractor for the purpose of determining whether an item or service furnished for which the claim is filed by such provider of services or supplier is reasonable and necessary for the diagnosis or treatment of illness or injury under section 1862(a)(1)(A).".

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

"(5) PHYSICIAN VALIDATION OF MEDICAL NECESSITY DENIALS MADE BY NON-PHYSICIAN REVIEWERS.—

"(A) IN GENERAL.—A physician (as defined in section 1861(r)(1)) shall review each denial of a claim for medical necessity when a medical necessity review of such claim is performed and a denial is made by an employee of the contractor who is not a physician (as so defined).

"(B) DETERMINATION; VALIDATION.—A physician reviewing a claim under subparagraph (A) shall—

"(i) make a determination whether the denial of the claim under the medical necessity review by the non-physician employee is appropriate;

"(ii) sign and certify such determination; and

"(iii) append such signed and certified determination to the claim file.

"(C) TREATMENT AS MEDICALLY NECESSARY.—A claim with respect to which a denial has been made as described in subparagraph (A) for which the physician determines the denial is not appropriate under subparagraph (B) shall be deemed to be medically necessary.

"(D) MEDICAL NECESSITY REVIEW DEFINED.—In this paragraph, the term 'medical necessity review' means, with respect to an audit of a claim of a provider of services or supplier, a review conducted by a medicare administrative contractor for the purpose of determining whether an item or service furnished for which the claim is filed by such provider of services or supplier is reasonable and necessary for the diagnosis or treatment of illness or injury under section 1862(a)(1)(A).".

(c) CONFORMING REQUIREMENT FOR CERT CONTRACTORS.—

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

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

(2) DETERMINATION; VALIDATION.—A physician reviewing a claim under paragraph (1) shall—

(A) make a determination whether the denial of the claim under the medical necessity review by the non-physician employee is appropriate;

(B) sign and certify such determination; and

(C) append such signed and certified determination to the claim file.

(3) TREATMENT AS MEDICALLY NECESSARY.—A claim with respect to which a denial has been made as described in paragraph (1) for which the

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

(4) MEDICAL NECESSITY REVIEW DEFINED.—In this subsection, the term ''medical necessity review'' means, with respect to an audit of a claim of a provider of services or supplier, a review conducted by a CERT program contractor for the purpose of determining whether an item or service furnished for which the claim is filed by such provider of services or supplier is reasonable and necessary for the diagnosis or treatment of illness or injury under section 1862(a)(1)(A) of the Social Security Act (42 U.S.C. 1395y(a)(1)(A)).

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (b), and the provisions of subsection (c), shall apply to contracts entered into or renewed with recovery audit contractors under section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)), medicare administrative contractors under section 1874A of the Social Security Act (42 U.S.C. 1395kk–1) and Comprehensive Error Rate Testing (CERT) program contractors, respectively, on or after the date of the enactment of this Act.

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

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

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