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106TH CONGRESS
1ST SESSION

H. R. 3300

To provide for a Doctors' Bill of Rights under the Medicare Program.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 10, 1999

Ms. BERKLEY (for herself and Mr. FLETCHER) introduced the following bill; which was referred to the Committee on 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 provide for a Doctors' Bill of Rights under the Medicare Program.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Doctors' Bill of Rights Act of 1999''.

SEC. 2. FINDINGS.

Congress finds the following:

(1) Congress should focus more resources on and work with physicians and providers to combat

fraud in the medicare program. Although the Federal government has reduced improper fee-for-service payments from 14 percent (or $23 billion) from fiscal year 1996 to 7.1 percent (or $12.6 billion) in fiscal year 1998, Congress must work hard to continue this trend.

(2) The overwhelming majority of physicians in the United States are law-abiding citizens who provide important services and care to patients each day.

(3) Congress greatly appreciates the important role physicians play in providing high-quality health care to our nation's senior citizens under the medicare program.

(4) Due to the overly complex nature of medicare regulations and the risk of being the subject of an aggressive government investigation, many physicians are leaving the medicare program.

(5) The Health Care Financing Administration (HCFA), and especially carriers administering the medicare program, should focus more attention on educational approaches to reducing billing error rates.

(6) Keeping track of the morass of medicare regulations detracts from the time that physicians have to treat patients.

SEC. 3. DEFINITIONS.

For purposes of this Act:

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

(2) FISCAL INTERMEDIARY.—The term ''fiscal intermediary'' means a fiscal intermediary (as defined in section 1816(a) of the Social Security Act (42 U.S.C. 1395h(a))) with an agreement under section 1816 of such Act to administer benefits under part A or part B of such title.

(3) CARRIER.—The term ''carrier'' means a carrier (as defined in section 1842(f) of the Social Security Act (42 U.S.C. 1395u(f))) with a contract under title XVIII of such Act to administer benefits under part B of such title.

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(5) HCFA.—The term ''HCFA'' means the Health Care Financing Administration.

(6) MEDICARE PROGRAM.—The term ''medicare program'' means the program under title XVIII of the Social Security Act.

(7) MEDICARE INTEGRITY PROGRAM.—The term ''medicare integrity program'' means the program under section 1893 of the Social Security Act (42 U.S.C. 1395ddd).

SEC. 3. EDUCATION.

(a) USE OF FUNDS.—

(1) CARRIERS.—Each carrier shall devote at least 3 percent of the funds provided to it under the medicare program each year (beginning with 2000) toward education of physicians to ensure that information about the operation of the medicare program is properly disseminated.

(2) FISCAL INTERMEDIARIES.—Each fiscal intermediary shall devote at least 3 percent of the funds provided it under the medicare program (beginning with 2000) toward education of physicians to ensure that information about the operation of the medicare program is properly disseminated.

(3) MEDICARE INTEGRITY PROGRAM.—The Secretary shall ensure that 10 percent of the funds expended under the medicare integrity program each year (beginning with 2000) are used for education of

physicians to ensure that information about the operation of the medicare program is properly disseminated.

(4) PURPOSE.—The purpose of funding under this subsection is to ensure that physicians learn of new changes to medicare laws and regulations in a timely manner.

(5) CONSTRUCTION.—Education attendance lists may not be used as evidence of possible wrongdoings by physicians under the medicare program and may not lead to fraud investigations under that program.

(b) RIGHT TO INFORMATION.—Physicians have the right to timely and accurate information about changes and modifications to local carrier guidelines under the medicare program. Each physician who so desires have the right to receive this information by electronic or certified mail (in addition to check stuffers, monthly carrier bulletins, the annual ''Dear Doctor'' letter, individual letters, seminars, and other means).

(c) ADDITIONAL EDUCATIONAL OUTREACH.—The Secretary shall initiate additional educational outreach for physicians for medicare coverage areas that have the most frequent billing errors. Such outreach shall include issue-specific e-mails, faxes, mailings, and telephone calls. If,

within 9 months after the date that the additional outreach is initiated, a carrier finds that no evidence exists that physician billing errors under the medicare program have lessened, then the carrier shall complete an in-person visit to relevant physician offices.

(d) RIGHT TO TELEPHONE CONVERSATION.—A physician may request a telephone conversation or in-person visit with a carrier, without being suspected of fraud, regarding questions about billing practices under the medicare program.

SEC. 4. INFORMATION.

(a) STRAIGHT ANSWERS.—Carriers shall do their utmost to provide physicians with one, straight and correct answer regarding billing questions under the medicare program.

(b) WRITTEN REQUESTS.—

(1) IN GENERAL.—The Secretary shall establish a process under which a physician may request, in writing from a carrier, assistance in addressing questionable codes and procedures under the medicare program and then the carrier shall respond in writing within 30 business days respond with the correct billing or procedural answer.

(2) USE OF WRITTEN STATEMENT.—

(A) IN GENERAL.—Subject to subparagraph (B), a written statement under paragraph (1) may be used as proof against a future audit or overpayment under the medicare program.

(B) LIMIT ON APPLICATION.—Subparagraph (A) shall not apply retroactively and shall not apply to cases of fraudulent billing.

(c) RESTORATION OF TOLL-FREE HOTLINE.—

(1) IN GENERAL.—HCFA shall restore the toll-free telephone hotline so that physicians may call for information and questions about the medicare program.

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

(d) RIGHT TO REVIEW OF CLAIMS.—

(1) RIGHT TO SUBMIT.—Physicians have the right to submit claims (but not to exceed 15 claims in any year) under the medicare program that have already been acted upon to the carrier for review and analysis by the carrier.

(2) RIGHT TO REPAY WITHOUT PENALTY.—In the case of such a claim, if the carrier determines that the physician—

(A) was overpaid, the physician has the opportunity to repay the claim without penalty; or

(B) was underpaid, the carrier shall make the appropriate payment adjustment.

(3) NOT TARGETED.—Regardless of what the determination may be in the case of such a claim, a physician's submission of such a claim for further review and analysis shall not subject the physician to being targeted for fraud, unless there is a documented history of fraud or abuse on the part of the physician.

SEC. 4. POLICY DEVELOPMENT REGARDING E&M GUIDELINES.

(a) IN GENERAL.—HCFA may not implement any new evaluation and management guidelines (in this section referred to as ''E&M guidelines'') under the medicare program, unless HCFA—

(1) has provided for an assessment of the proposed guidelines by physicians;

(2) has established a plan that contains specific goals, including a schedule, for improving participation of physicians;

(3) has carried out a minimum of 4 pilot projects consistent with subsection (b) in at least 4

different HCFA regions (to be specified by the Secretary) to test such guidelines; and

(4) finds that the objectives described in subsection (c) will be met in the implementation of such guidelines.

(b) PILOT PROJECTS.—

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

(A) be of sufficient length to allow for preparatory physician and carrier education, analysis, and use and assessment of potential E&M guidelines; and

(B) be conducted, throughout the planning and operational stages of the project, in consultation with national and State medical societies.

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

(A) at least one shall focus on a peer review method by physicians which evaluates medical record information for statistical outlier services relative to definitions and guidelines published in the CPT book, instead of an approach using the review of randomly selected

medical records using non-clinical personnel; and

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

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

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

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

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

(c) OBJECTIVES FOR E&M GUIDELINES.—The objectives for E&M guidelines specified in this subsection are as follows (relative to the E&M guidelines and review policies in effect as of the date of the enactment of this Act):

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

(2) Reducing administrative burdens.

(3) Decreasing the level of non-clinically pertinent and burdensome documentation time and content in the record.

(4) Increased accuracy by carrier reviewers.

(5) Education of both physicians and reviewers.

(6) Appropriate use of E&M codes by physicians and their staffs.

(7) The extent to which the tested E&M documentation guidelines substantially adhere to the CPT coding rules.

SEC. 5. OVERPAYMENTS.

(a) INDIVIDUALIZED NOTICE.—If a carrier proceeds with a post-payment audit of a physician under the medicare program, the carrier shall provide the physician with an individualized notice of billing problems, such as a personal visit or carrier-to-physician telephone conversation during normal working hours, within 3 months of initiating such audit. The notice should include suggestions to the physician on how the billing problem may be remedied.

(b) REPAYMENT OF OVERPAYMENTS WITHOUT PENALTY.—The Secretary shall permit physicians to repay medicare overpayments within 3 months without penalty or interest and without threat of denial of other claims based upon extrapolation. If a physician should discover an overpayment before a carrier notifies the physician of the error, the physician may reimburse the medicare program without penalty and the Secretary may not audit or target the physician on the basis of such repayment, unless other evidence of fraudulent billing exists.

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

(d) TIMELY NOTICE OF PROBLEM CLAIMS BEFORE USING EXTRAPOLATION.—A carrier may seek reimbursement or penalties against a physician based on extrapolation of a medicare claim only if the carrier has informed the physician of potential problems with the claim within one year after the date the claim was submitted for reimbursement.

(e) SUBMISSION OF ADDITIONAL INFORMATION.—A physician may submit additional information and docu-

mentation to dispute a carrier's charges of overpayment without waiving the physician's right to a hearing by an administrative law judge.

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

SEC. 6. ENFORCEMENT PROVISIONS.

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

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

(2) may not make such an arrest without a valid warrant of arrest, unless the physician is fleeing or deemed dangerous.

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