

111TH CONGRESS  
1ST SESSION

# H. R. 2785

To reduce the amount of paperwork and improve payment policies for health care services, to prevent fraud and abuse through health care provider education, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

JUNE 10, 2009

Mr. THORNBERRY introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To reduce the amount of paperwork and improve payment policies for health care services, to prevent fraud and abuse through health care provider education, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Health Care Paper-  
5 work Reduction and Fraud Prevention Act of 2009”.

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

3 (a) ESTABLISHMENT.—There is hereby established  
4 the Commission on Health Care Billing Codes and Forms  
5 Simplification (in this section referred to as the “Commis-  
6 sion”).

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

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

15 (2) REDUCTION IN BILLING CODES.—A signifi-  
16 cant reduction and simplification in the number of  
17 billing codes for health care claims.

18 (3) REGULATORY AND APPEALS PROCESS RE-  
19 FORM.—Reforms in the regulatory and appeals proc-  
20 esses under the Medicare program under title XVIII  
21 of the Social Security Act in order to ensure that the  
22 Secretary of Health and Human Services provides  
23 appropriate guidance to suppliers and providers of  
24 services (as such terms are defined in subsections  
25 (d) and (u), respectively, of section 1861 of such  
26 Act), including physicians and providers and sup-

1       pliers of ambulance services, that are attempting to  
2       properly submit claims under the Medicare program  
3       and to ensure that the Secretary does not target in-  
4       advertent billing errors.

5               (4) ELECTRONIC FORMS AND PAYMENTS.—Sim-  
6       plifying and updating electronic forms of the Centers  
7       for Medicare & Medicaid Services to ensure sim-  
8       plicity as well as patient privacy.

9       (c) MEMBERSHIP.—

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

13              (A) four shall be appointed by the Presi-  
14       dent;

15              (B) six shall be appointed by the majority  
16       leader of the Senate, in consultation with the  
17       minority leader of the Senate, of whom not  
18       more than 4 shall be of the same political party;

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

24              (D) one, who shall serve as Chairman of  
25       the Commission, shall be appointed jointly by

1 the President, majority leader of the Senate,  
2 and the Speaker of the House of Representa-  
3 tives.

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

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

14 (e) REPORT.—Not later than December 31, 2009, the  
15 Commission shall submit to the President and Congress  
16 a report which shall contain a detailed statement of only  
17 those recommendations, findings, and conclusions of the  
18 Commission that receive the approval of at least 11 mem-  
19 bers of the Commission.

20 (f) TERMINATION.—The Commission shall terminate  
21 30 days after the date of submission of the report required  
22 in subsection (e).

23 **SEC. 3. EDUCATION OF PHYSICIANS AND PROVIDERS CON-**  
24 **CERNING MEDICARE PROGRAM PAYMENTS.**

25 (a) WRITTEN REQUESTS.—

1           (1) IN GENERAL.—The Secretary of Health and  
2 Human Services shall establish a process under  
3 which a physician may request, in writing from a  
4 carrier, assistance in addressing questionable codes  
5 and procedures under the Medicare program under  
6 title XVIII of the Social Security Act and then the  
7 carrier shall respond in writing within 30 business  
8 days with the correct billing or procedural answer.

9           (2) USE OF WRITTEN STATEMENT.—

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

15           (B) LIMIT ON APPLICATION.—Subpara-  
16 graph (A) shall not apply retroactively and shall  
17 not apply to cases of fraudulent billing.

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

19           (1) IN GENERAL.—The Administrator of the  
20 Centers for Medicare & Medicaid Services shall re-  
21 store the toll-free telephone hotline previously main-  
22 tained by the Centers for Medicare & Medicaid Serv-  
23 ices so that physicians may call for information and  
24 questions about the Medicare program.

1           (2) AUTHORIZATION OF APPROPRIATIONS.—

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

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

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

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

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

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

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

22                (2) has established a plan that contains specific  
23                goals, including a schedule, for improving participa-  
24                tion of physicians in the assessment described in  
25                paragraph (1);

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

5           (4) finds that the objectives described in sub-  
6 section (c) will be met in the implementation of such  
7 guidelines.

8 (b) PILOT PROJECTS.—

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

11           (A) be of sufficient length to allow for pre-  
12 paratory physician and carrier education, anal-  
13 ysis, and use and assessment of potential E&M  
14 guidelines; and

15           (B) be conducted, throughout the planning  
16 and operational stages of the project, in con-  
17 sultation with national and State medical soci-  
18 eties.

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

22           (A) at least one shall focus on a peer re-  
23 view method by physicians which evaluates  
24 medical record information for statistical outlier  
25 services relative to definitions and guidelines

1 published in the most recent Current Proce-  
2 dural Terminology book, instead of an approach  
3 using the review of randomly selected medical  
4 records using non-clinical personnel; and

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

7 (3) STUDY OF IMPACT.—Each pilot project  
8 shall examine the effect of the potential E&M guide-  
9 lines on—

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

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

14 (4) REPORT ON HOW MET OBJECTIVES.—Not  
15 later than 6 months after the date of the conclusion  
16 of all of the pilot projects under this subsection, the  
17 Administrator of the Centers for Medicare & Med-  
18 icaid Services shall submit a report to the Commit-  
19 tees on Commerce and Ways and Means of the  
20 House of Representatives, the Committee on Fi-  
21 nance of the Senate, and the Practicing Physicians  
22 Advisory Council, on such pilot projects. Such report  
23 shall include the extent to which the pilot projects  
24 met the objectives specified in subsection (c).

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

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

8 (2) Reducing administrative burdens.

9 (3) Decreasing the level of non-clinically perti-  
10 nent and burdensome documentation time and con-  
11 tent in the record.

12 (4) Increased accuracy by carrier reviewers.

13 (5) Education of both physicians and reviewers.

14 (6) Appropriate use of evaluation and manage-  
15 ment codes by physicians and their staffs.

16 (7) The extent to which the tested evaluation  
17 and management documentation guidelines substan-  
18 tially adhere to the CPT coding rules.

19 (8) Simplifying electronic billing.

20 (d) DEFINITIONS.—For purposes of this section and  
21 section 5:

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

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

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

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

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

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

21       (b) REPAYMENT OF OVERPAYMENTS WITHOUT PEN-  
22 ALTY.—The Secretary of Health and Human Services  
23 shall permit a physician to repay Medicare overpayments  
24 made to such physician without penalty or interest and  
25 without threat of denial of other claims based upon ex-

1 trapolation, if such repayment is made not later than 3  
2 months after such physician receives notification of such  
3 overpayment and if such overpayment was not determined  
4 by a final adverse action to be the result of fraudulent  
5 billing. If a physician should discover an overpayment be-  
6 fore a carrier notifies the physician of the error, the physi-  
7 cian may reimburse the Medicare program without penalty  
8 and the Secretary may not audit or target the physician  
9 on the basis of such repayment, unless other evidence of  
10 fraudulent billing exists.

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

17 (d) TIMELY NOTICE OF PROBLEM CLAIMS BEFORE  
18 USING EXTRAPOLATION.—A carrier may seek reimburse-  
19 ment or penalties against a physician based on extrapo-  
20 lation of a Medicare claim only if the carrier has informed  
21 the physician of potential problems with the claim not  
22 later than one year after the date the claim was submitted  
23 for reimbursement.

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

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

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

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