AMENDMENT

OFFERED BY MR. THORNBERRY OF TEXAS

[H.R. 3962]

Add at the end of title I of division A the following (and conform the table of contents for such division appropriately):

1 **SEC. 116. HEALTH CARE PAPERWORK REDUCTION AND**
2 **FRAUD PREVENTION.**

3 (a) NATIONAL BIPARTISAN COMMISSION ON BILLING
4 CODES AND FORMS SIMPLIFICATION.—

5 (1) ESTABLISHMENT.—There is hereby estab-
6 lished the Commission on Health Care Billing Codes
7 and Forms Simplification (in this subsection re-
8 ferred to as the "Commission").

9 (2) DUTIES.—The Commission shall make rec-
10 ommendations regarding the following:

11 (A) STANDARDIZED AND SIMPLIFIED
12 FORMS.—Standardizing and simplifying
13 credentialing and billing forms respecting
14 health care claims, that all Federal Government
15 agencies would use and that the private sector
16 is able (and is encouraged, but not required) to
17 use.

1 (B) REDUCTION IN BILLING CODES.—A
2 significant reduction and simplification in the
3 number of billing codes for health care claims.
4 (C) REGULATORY AND APPEALS PROCESS
5 REFORM.—Reforms in the regulatory and ap-
6 peals processes under the Medicare program
7 under title XVIII of the Social Security Act in
8 order to ensure that the Secretary of Health
9 and Human Services provides appropriate guid-
10 ance to suppliers and providers of services (as
11 such terms are defined in subsections (d) and
12 (u), respectively, of section 1861 of such Act),
13 including physicians and providers and sup-
14 pliers of ambulance services, that are attempt-
15 ing to properly submit claims under the Medi-
16 care program and to ensure that the Secretary
17 does not target inadvertent billing errors.
18 (D) ELECTRONIC FORMS AND PAY-
19 MENTS.—Simplifying and updating electronic
20 forms of the Centers for Medicare & Medicaid
21 Services to ensure simplicity as well as patient
22 privacy.
23 (3) MEMBERSHIP.—

1 (A) NUMBER AND APPOINTMENT.—The
2 Commission shall be composed of 17 members,
3 of whom—
4 (i) four shall be appointed by the
5 President;
6 (ii) six shall be appointed by the ma-
7 jority leader of the Senate, in consultation
8 with the minority leader of the Senate, of
9 whom not more than 4 shall be of the
10 same political party;
11 (iii) six shall be appointed by the
12 Speaker of the House of Representatives,
13 in consultation with the minority leader of
14 the House of Representatives, of whom not
15 more than 4 shall be of the same political
16 party; and
17 (iv) one, who shall serve as Chairman
18 of the Commission, shall be appointed
19 jointly by the President, majority leader of
20 the Senate, and the Speaker of the House
21 of Representatives.
22 (B) APPOINTMENT.—Members of the Com-
23 mission shall be appointed by not later than 90
24 days after the date of the enactment of this sec-
25 tion.

1 (4) INCORPORATION OF BIPARTISAN COMMIS-
2 SION PROVISIONS.—The provisions of paragraphs
3 (3) through (8) of subsection (c) and subsections
4 (d), (e), and (h) of section 4021 of the Balanced
5 Budget Act of 1997 shall apply to the Commission
6 under this subsection in the same manner as they
7 applied to the National Bipartisan Commission on
8 the Future of Medicare under such section.
9 (5) REPORT.—Not later than December 31,
10 2010, the Commission shall submit to the President
11 and Congress a report which shall contain a detailed
12 statement of only those recommendations, findings,
13 and conclusions of the Commission that receive the
14 approval of at least 11 members of the Commission.
15 (6) TERMINATION.—The Commission shall ter-
16 minate 30 days after the date of submission of the
17 report required in paragraph (5).
18 (b) EDUCATION OF PHYSICIANS AND PROVIDERS
19 CONCERNING MEDICARE PROGRAM PAYMENTS.—
20 (1) WRITTEN REQUESTS.—
21 (A) IN GENERAL.—The Secretary of
22 Health and Human Services shall establish a
23 process under which a physician may request,
24 in writing from a carrier, assistance in address-
25 ing questionable codes and procedures under

1 the Medicare program under title XVIII of the
2 Social Security Act and then the carrier shall
3 respond in writing within 30 business days with
4 the correct billing or procedural answer.
5 (B) USE OF WRITTEN STATEMENT.—
6 (i) IN GENERAL.—Subject to clause
7 (ii), a written statement under subpara-
8 graph (A) may be used as proof against a
9 future audit or overpayment under the
10 Medicare program.
11 (ii) LIMIT ON APPLICATION.—Clause
12 (i) shall not apply retroactively and shall
13 not apply to cases of fraudulent billing.
14 (2) DEFINITIONS.—For purposes of this sub-
15 section:
16 (A) PHYSICIAN.—The term "physician"
17 has the meaning given such term in section
18 1861(r) of the Social Security Act (42 U.S.C.
19 1395x(r)).
20 (B) CARRIER.—The term "carrier" means
21 a carrier (as defined in section 1842(f) of the
22 Social Security Act (42 U.S.C. 1395u(f))) with
23 a contract under title XVIII of such Act to ad-
24 minister benefits under part B of such title.

1 (c) POLICY DEVELOPMENT REGARDING E&M
2 GUIDELINES UNDER THE MEDICARE PROGRAM.—
3 (1) IN GENERAL.—The Administrator of the
4 Centers for Medicare & Medicaid Services may not
5 implement any new evaluation and management
6 guidelines (in this subsection referred to as "E&M
7 guidelines") under the Medicare program, unless the
8 Administrator—
9 (A) has provided for an assessment of the
10 proposed guidelines by physicians;
11 (B) has established a plan that contains
12 specific goals, including a schedule, for improv-
13 ing participation of physicians in the assess-
14 ment described in subparagraph (A);
15 (C) has carried out a minimum of 4 pilot
16 projects consistent with paragraph (2) in at
17 least 4 different regions (to be specified by the
18 Secretary) to test such guidelines; and
19 (D) finds that the objectives described in
20 paragraph (3) will be met in the implementa-
21 tion of such guidelines.
22 (2) PILOT PROJECTS.—
23 (A) LENGTH AND CONSULTATION.—Each
24 pilot project under this subsection shall—

1 (i) be of sufficient length to allow for
2 preparatory physician and carrier edu-
3 cation, analysis, and use and assessment of
4 potential E&M guidelines; and
5 (ii) be conducted, throughout the
6 planning and operational stages of the
7 project, in consultation with national and
8 State medical societies.
9 (B) PEER REVIEW AND RURAL PILOT
10 PROJECTS.—Of the pilot projects conducted
11 under this subsection—
12 (i) at least one shall focus on a peer
13 review method by physicians which evalu-
14 ates medical record information for statis-
15 tical outlier services relative to definitions
16 and guidelines published in the most recent
17 Current Procedural Terminology book, in-
18 stead of an approach using the review of
19 randomly selected medical records using
20 non-clinical personnel; and
21 (ii) at least one shall be conducted for
22 services furnished in a rural area.
23 (C) STUDY OF IMPACT.—Each pilot project
24 shall examine the effect of the potential E&M
25 guidelines on—

1 (i) different types of physician prac-
2 tices, such as large and small groups; and
3 (ii) the costs of compliance, and pa-
4 tient and physician satisfaction.
5 (D) REPORT ON HOW MET OBJECTIVES.—
6 Not later than 6 months after the date of the
7 conclusion of all of the pilot projects under this
8 subsection, the Administrator of the Centers for
9 Medicare & Medicaid Services shall submit a re-
10 port to the Committees on Commerce and Ways
11 and Means of the House of Representatives, the
12 Committee on Finance of the Senate, and the
13 Practicing Physicians Advisory Council, on such
14 pilot projects. Such report shall include the ex-
15 tent to which the pilot projects met the objec-
16 tives specified in paragraph (3).
17 (3) OBJECTIVES FOR E&M GUIDELINES.—The
18 objectives for E&M guidelines specified in this sub-
19 section are as follows (relative to the E&M guide-
20 lines and review policies in effect as of the date of
21 the enactment of this section):
22 (A) Enhancing clinically relevant docu-
23 mentation needed to accurately code and assess
24 coding levels accurately.
25 (B) Reducing administrative burdens.

1 (C) Decreasing the level of non-clinically
2 pertinent and burdensome documentation time
3 and content in the record.
4 (D) Increased accuracy by carrier review-
5 ers.
6 (E) Education of both physicians and re-
7 viewers.
8 (F) Appropriate use of evaluation and
9 management codes by physicians and their
10 staffs.
11 (G) The extent to which the tested evalua-
12 tion and management documentation guidelines
13 substantially adhere to the CPT coding rules.
14 (H) Simplifying electronic billing.
15 (4) DEFINITIONS.—For purposes of this sub-
16 section and subsection (d):
17 (A) PHYSICIAN.—The term "physician"
18 has the meaning given such term in section
19 1861(r) of the Social Security Act (42 U.S.C.
20 1395x(r)).
21 (B) CARRIER.—The term "carrier" means
22 a carrier (as defined in section 1842(f) of the
23 Social Security Act (42 U.S.C. 1395u(f))) with
24 a contract under title XVIII of such Act to ad-
25 minister benefits under part B of such title.

1 (C) SECRETARY.—The term "Secretary"
2 means the Secretary of Health and Human
3 Services.
4 (D) MEDICARE PROGRAM.—The term
5 "Medicare program" means the program under
6 title XVIII of the Social Security Act.
7 (d) OVERPAYMENTS UNDER THE MEDICARE PRO-
8 GRAM.—
9 (1) INDIVIDUALIZED NOTICE.—If a carrier pro-
10 ceeds with a post-payment audit of a physician
11 under the Medicare program, the carrier shall pro-
12 vide the physician with an individualized notice of
13 billing problems, such as a personal visit or carrier-
14 to-physician telephone conversation during normal
15 working hours, within 3 months of initiating such
16 audit. The notice should include suggestions to the
17 physician on how the billing problem may be rem-
18 edied.
19 (2) REPAYMENT OF OVERPAYMENTS WITHOUT
20 PENALTY.—The Secretary of Health and Human
21 Services shall permit a physician to repay Medicare
22 overpayments made to such physician without pen-
23 alty or interest and without threat of denial of other
24 claims based upon extrapolation, if such repayment
25 is made not later than 3 months after such physi-

1 cian receives notification of such overpayment and if
2 such overpayment was not determined by a final ad-
3 verse action to be the result of fraudulent billing. If
4 a physician should discover an overpayment before a
5 carrier notifies the physician of the error, the physi-
6 cian may reimburse the Medicare program without
7 penalty and the Secretary may not audit or target
8 the physician on the basis of such repayment, unless
9 other evidence of fraudulent billing exists.
10 (3) TREATMENT OF FIRST-TIME BILLING ER-
11 RORS.—If a physician's Medicare billing error was a
12 first-time error and the physician has not previously
13 been the subject of a post-payment audit, the carrier
14 may not assess a fine through extrapolation of such
15 an error to other claims, unless the physician has
16 submitted a fraudulent claim.
17 (4) TIMELY NOTICE OF PROBLEM CLAIMS BE-
18 FORE USING EXTRAPOLATION.—A carrier may seek
19 reimbursement or penalties against a physician
20 based on extrapolation of a Medicare claim only if
21 the carrier has informed the physician of potential
22 problems with the claim not later than one year
23 after the date the claim was submitted for reim-
24 bursement.

1 (5) SUBMISSION OF ADDITIONAL INFORMA-
2 TION.—A physician may submit additional informa-
3 tion and documentation to dispute a carrier's
4 charges of overpayment without waiving the physi-
5 cian's right to a hearing by an administrative law
6 judge.
7 (6) LIMITATION ON DELAY IN PAYMENT.—Fol-
8 lowing a post-payment audit, a carrier that is con-
9 ducting a pre-payment screen on a physician service
10 under the Medicare program may not delay reim-
11 bursements for more than one month and as soon as
12 the physician submits a corrected claim, the carrier
13 shall eliminate application of such a pre-payment
14 screen.