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107TH CONGRESS
1ST SESSION

H. R. 868

To amend title XVIII of the Social Security Act to ensure that the Secretary of Health and Human Services provides appropriate guidance to physicians, providers of services, and ambulance providers that are attempting to properly submit claims under the Medicare Program and to ensure that the Secretary does not target inadvertent billing errors.

IN THE HOUSE OF REPRESENTATIVES

MARCH 6, 2001

Mr. TOOMEY (for himself, Ms. BERKLEY, Mr. PAUL, Mr. SCHAFFER, Mr. DEMINT, Mr. VITTER, Mr. SESSIONS, Mr. MCHUGH, Mr. SAXTON, Mrs. MYRICK, Mr. GOODE, Mr. MILLER of Florida, Mr. PITTS, Mr. HILLEARY, Mr. CRAMER, Mr. ISTOOK, Mr. HILLIARD, Mr. SOUDER, Mr. TANCREDO, Mr. JONES of North Carolina, Mr. HASTINGS of Washington, Mr. SHAW, Mr. TIAHRT, Mr. STENHOLM, Mrs. JO ANN DAVIS of Virginia, Mr. SMITH of New Jersey, Mrs. KELLY, Mr. FLETCHER, Mr. MCGOVERN, Mr. GORDON, Mr. BAKER, Mr. SHOWS, Mr. GOODLATTE, Mr. CUNNINGHAM, Mr. SIMMONS, Mr. NEY, Mr. REYNOLDS, Mr. CAPUANO, Mr. RYUN of Kansas, Mr. TIBERI, Mr. FOLEY, and Mr. SHADEGG) 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 amend title XVIII of the Social Security Act to ensure that the Secretary of Health and Human Services provides appropriate guidance to physicians, providers of services, and ambulance providers that are attempting to properly submit claims under the Medicare Program

and to ensure that the Secretary does not target inadvertent billing errors.

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 Education and Regulatory Fairness Act of 2001''.

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

TITLE V—POLICY DEVELOPMENT REGARDING E&M GUIDELINES

Sec. 501. Policy development regarding E&M Documentation Guidelines.

SEC. 2. FINDINGS.

Congress finds the following:

(1) Congress should focus more resources on and work with physicians and health care providers to combat fraud in the medicare program.

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

(3) Physicians and other providers of services that participate in the medicare program often have trouble wading through a confusing and sometimes even contradictory maze of medicare regulations. Keeping track of the morass of medicare regulations detracts from the time that physicians have to treat patients.

(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, limiting the number of medicare patients they see, or refusing to accept new medicare patients at all. If this trend continues, health care for the millions of patients nationwide who depend on medicare will be seriously

compromised. Congress has an obligation to prevent this from happening.

(5) Regulatory fairness for physicians and providers as well as increased access to education about medicare regulations are necessary to preserve the integrity of our health care system and provide for the health of our population.

SEC. 3. DEFINITIONS.

In this Act:

(1) BILLING.—The term ''billing'' includes any requirement related to the content and timing of an order for care or a plan of treatment by a physician, a provider of service, or a provider of ambulance services.

(2) 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.

(3) EXTRAPOLATION.—The term ''extrapolation'' has the meaning given such term in section 1861(ww)(1) of the Social Security Act (as added by section 203(a)).

(4) FISCAL INTERMEDIARY.—The term ''fiscal intermediary'' means a fiscal intermediary (as de-

fined 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 B of such title.

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

(6) MEDICARE PROGRAM.—The term ''medicare program'' means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(7) 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)).

(8) PREPAYMENT REVIEW.—The term ''prepayment review'' has the meaning given such term in section 1861(ww)(2) of the Social Security Act (as added by section 203(a)).

(9) PROVIDER OF SERVICES.—The term ''provider of services'' has the meaning given such term in section 1861(u) of the Social Security Act (42 U.S.C. 1395x(u)).

(10) PROVIDER OF AMBULANCE SERVICES.—The term ''provider of ambulance services'' means a provider of ambulance services described in section

1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7)).

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

TITLE I—REGULATORY REFORM

SEC. 101. PROSPECTIVE APPLICATION OF CERTAIN REGULATIONS.

Section 1871(a) of the Social Security Act (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraphs:

''(3) Any regulation described under paragraph (2) shall not take effect earlier than the effective date of the final regulation. Any regulation described under such paragraph that applies to an agency action, including any agency determination, shall only apply as that regulation is in effect at the time that agency action is taken.

''(4) The Secretary shall issue a final rule within 12 months of the date of publication of an interim final rule. Such final rule shall provide responses to comments submitted in response to the interim final rule. Such final rule shall not establish or change a legal standard not raised in the interim final rule unless a new 60-day comment period is provided.

''(5) Carriers, fiscal intermediaries, and States pursuant to an agreement under section 1864 shall not apply new policy guidances or policy changes retroactively to services provided before the date the new policy was issued.''.

SEC. 102. REQUIREMENTS FOR JUDICIAL AND REGULATORY CHALLENGES OF REGULATIONS.

(a) RIGHT TO CHALLENGE CONSTITUTIONALITY AND STATUTORY AUTHORITY OF HCFA REGULATIONS.—Section 1872 of the Social Security Act (42 U.S.C. 1395ii) is amended to read as follows:

''APPLICATION OF CERTAIN PROVISIONS OF TITLE II

''SEC. 1872. Subject to subparagraphs (A), (B), (D), and (E) of section 1848(i)(1), the provisions of sections 206 and 216(j), and of subsections (a), (d), (e), (h), (i), (j), (k), and (l) of section 205, shall also apply with respect to this title to the same extent as they are applicable with respect to title II, except that—

''(1) in applying such provisions with respect to this title, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively; and

''(2) section 205(h) shall not apply with respect to any action brought against the Secretary under

section 1331, 1346, 1361, or 2201 of title 28, United States Code, regardless of whether such action is unrelated to a specific determination of the Secretary, that challenges—

''(A) the constitutionality of any provision of this title;

''(B) the constitutionality of substantive or interpretive rules of general applicability issued by the Secretary to carry out this title'';

''(C) the Secretary's statutory authority to promulgate such substantive or interpretive rules of general applicability; or

''(D) a finding of good cause under subparagraph (B) of the third sentence of section 553(b)(3) of title 5, United States Code, if used in the promulgation of such substantive or interpretive rules of general applicability.''.

(b) ADMINISTRATIVE AND JUDICIAL REVIEW OF SECRETARY DETERMINATIONS.—Section 1866(h) of the Act (42 U.S.C. 1395cc(h)) is amended—

(1) in paragraph (1), by striking ''(1)'' and all that follows and inserting the following: ''(1) Except as provided in paragraph (3), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a deter-

mination described in subsection (b)(2) (regardless of whether such determination has been made by the Secretary or by a State pursuant to an agreement entered into with the Secretary under section 1864 and regardless of whether the Secretary has imposed or may impose a remedy, penalty, or other sanction on the institution or agency in connection with such determination) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g), except that, in so applying such sections and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively, and such hearings are subject to the deadlines specified in paragraph (2)f.'';

(2) by redesignating paragraph (2) as paragraph (3);

(3) by inserting after paragraph (1) the following new paragraph:

''(2)(A)(i) Except as provided in clause (ii), an administrative law judge shall conduct and conclude a hearing on a determination described in subsection (b)(2) and render a decision on such hearing by not later than the end of the 90-day period beginning on the date a request for hearing has been timely filed.

''(ii) The 90-day period under clause (i) shall not apply in the case of a motion or stipulation by the party requesting the hearing to waive such period.

''(B) The Department Appeals Board of the Department of Health and Human Services shall conduct and conclude a review of the decision on a hearing described in subparagraph (A) and make a decision or remand the case to the administrative law judge for reconsideration by not later than the end of the 90-day period beginning on the date a request for review has been timely filed.

''(C) In the case of a failure by an administrative law judge to render a decision by the end of the period described in subparagraph (A)(i), the party requesting the hearing may request a review by the Departmental Appeals Board of the Departmental of Health and Human Services, notwithstanding any requirements for a hearing for purposes of the party's right to such a review.

''(D) In the case of a request described in subparagraph (D), the Departmental Appeals Board shall review

the case de novo. In the case of the failure of the Departmental Appeals Board to render a decision on such hearing by not later than the end of the 60-day period beginning on the date a request for such a Department Appeals Board hearing has been filed, the party requesting the hearing may seek judicial review of the Secretary's decision, notwithstanding any requirements for a hearing for purposes of the party's right to such review.

''(E) In the case of a request described in subparagraph (D), the court shall review the case de novo.''; and

(4) by adding at the end the following new paragraph:

''(4) An institution or agency dissatisfied with a finding or determination by the Secretary, or by a State pursuant to an agreement under section 1864, that the institution or agency if out of compliance with any standard or condition of participation under this title (except a determination described in subsection (b)(2)) shall be entitled to a formal review or reconsideration of the finding or determination, in accordance with the regulations prescribed by the Secretary, prior to the imposition of any remedy, penalty, corrective action, or other sanction in connection with the finding or determination.''.

SEC. 103. PROHIBITION OF RECOVERING PAST OVERPAYMENTS BY CERTAIN MEANS.

(a) IN GENERAL.—Subject to section 104 and except as provided in subsection (b) and notwithstanding sections 1815(a), 1842(b), and 1861(v)(1)(A)(ii) of the Social Security Act (42 U.S.C. 1395g(a), 1395u(a), and 1395x(v)(1)(A)(ii)), or any other provision of law, for purposes of applying sections 1842(b)(3)(B)(ii), 1866(a)(1)(B)(ii), 1870, and 1893 of such Act (42 U.S.C. 1395u(b)(3)(B)(ii), 1395cc(a)(1)(B)(ii), 1395gg, and 1395ddd) to pending and future audits, the Secretary shall give a physician, provider of services, or provider of ambulance services the option of entering into an arrangement to offset alleged overpayments against future payments or entering into a repayment plan with its carrier or fiscal intermediary to recoup such an overpayment. Under such an arrangement or plan, a physician, provider of services, or provider of ambulance services shall have up to 3 years to offset or repay the overpayment if the amount of such overpayment exceeds $5,000.

(b) EXCEPTION.—This section shall not apply to cases in which the Secretary finds clear and convincing evidence of fraud or similar fault on the part of the physician, provider of services, or provider of ambulance services or in the case of overpayments for which an offset

arrangement is in place as of the date of the enactment of this Act.

SEC. 104. PROHIBITION OF RECOVERING PAST OVERPAYMENTS IF APPEAL PENDING.

Notwithstanding any provision of law, for purposes of applying sections 1842(b)(3)(B)(ii), 1866(a)(1)(B)(ii), 1870, and 1893 of the Social Security Act (42 U.S.C. 1395u(b)(3)(B)(ii), 1395cc(a)(1)(B)(ii), 1395gg, and 1395ddd), the Secretary may not take any action (or authorize any other person, including any fiscal intermediary, carrier, and contractor under section 1893 of such Act (42 U.S.C. 1395ddd)) to recoup an overpayment or to impose a penalty during the period in which a physician, provider of services, or provider of ambulance services is appealing a determination that such an overpayment has been made or the amount of the overpayment.

SEC. 105. PROHIBITION OF RANDOM PREPAYMENT AUDITS.

Carriers may not, prior to paying a claim under the medicare program, demand the production of records or documentation absent cause.

SEC. 106. EXCEPTION ON PROHIBITION OF WAIVING MEDICARE COPAYMENT.

(a) IN GENERAL.—Section 1128A(i)(6)(A) of the Social Security Act (42 U.S.C. 1320a–7a(i)(6)(A)) is amend-

ed by inserting ", except for written, mailed communication with existing patients," before "waiver is not".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to communications made on or after the date of the enactment of this Act.

SEC. 107. EFFECTIVE DATE.

Except as otherwise provided in section 106(b), the amendments made by this title shall take effect 60 days after the date of enactment of this Act.

TITLE II—APPEALS PROCESS REFORMS

SEC. 201. CONSTRUCTION OF HEARING RIGHTS RELATED TO DECISIONS TO DENY OR NOT RENEW A PHYSICIAN ENROLLMENT AGREEMENT.

Section 1842 of the Social Security Act (42 U.S.C. 1395u) is amended by adding at the end the following new subsection:

"(u) A carrier decision to deny an initial physician enrollment application and a carrier decision not to renew a physician enrollment agreement shall be treated as an initial determination subject to the same course of appeals as other initial determinations under section 1869.".

SEC. 202. REFORM OF POST-PAYMENT AUDIT PROCESS.

(a) CARRIERS.—Section 1842 of the Social Security Act (42 U.S.C. 1395u), as amended by section 201, is fur-

ther amended by adding at the end the following new subsection:

''(v) In carrying out its contract under subsection (b)(3), with respect to physicians' services or ambulance services, the carrier shall provide for the recoupment of overpayments in the following manner:

''(1)(A) During the 1-year period (or 18-month period in the case of a physician who is in a practice with fewer than 10 full-time equivalent employees, including physicians) beginning on the date on which a physician or provider of ambulance services receives an overpayment, the physician or provider of ambulance services may return the overpayment without penalty or interest to the carrier making such overpayment if—

''(i) the carrier has not requested any relevant record or file; or

''(ii) the case has not been referred before the date of repayment to the Department of Justice or the Office of Inspector General.

''(B) If a physician or provider of ambulance services returns an overpayment under subparagraph (A), neither the carrier, contractor under section 1893, nor any law enforcement agency may begin an investigation or target such physician or

provider of ambulance services based on any claim associated with the amount the physician or provider of ambulance services has repaid.

''(2) If a carrier has decided to conduct a post-payment audit of the physician or provider of ambulance services, the carrier shall send written notice to the physician or provider of ambulance services. If the physician or provider of ambulance services practices in a rural area (as defined in section 1886(d)(2)(D)), such notice must be sent by registered mail.

''(3) The carrier or a contractor under section 1893 may not recoup or offset payment amounts based on extrapolation (as defined in section 1861(ww)(1)) for the first time that the physician or provider of ambulance services is alleged as a result of a post-payment audit to have received an overpayment.

''(4) As part of any written consent settlement communication, the carrier or a contractor under section 1893 shall clearly state that the physician or provider of ambulance services may submit additional information (including evidence other than medical records) to dispute the overpayment amount

without waiving any administrative remedy or right to appeal the amount of the overpayment.

''(5)(A) Each consent settlement communication from the carrier or a contractor under section 1893 shall clearly state that prepayment review (as defined in section 1861(ww)(2)) may be imposed where the physician or provider of ambulance services submits an actual or projected repayment to the carrier or a contractor under section 1893. Subject to subparagraph (D), any prepayment review shall cease when the physician or provider of ambulance services has submitted claims, found by carrier to be covered services and coded properly for the same services that were the basis for instituting the prepayment review, in a 180-day period or after processing claims of at least 75 percent of the volume of the claims (whichever occurs first) received by the carrier in the full month preceding the start of the prepayment review. The 180-day period begins with the date of the carrier's written notification that the physician or provider of ambulance services is being placed on prepayment review.

''(B) Prepayment review may not be applied under this part as a result of the voluntary submission of a claim or record under section 1897(b)(2)

or as a result of information provided pursuant to a request under section 302(b) of the Medicare Education and Regulatory Fairness Act of 2001.

''(C) Carrier prepayment and coverage policies and claims processing screens used to identify claims for medical review must be incorporated as part of the education programs on medicare policy and proper coding made available to physicians and providers of ambulance services.

''(D) The time and percentage claim limitations in paragraph (5)(A) shall not apply to cases that have been referred to the Department of Justice or the Office of the Inspector General.''.

(b) FISCAL INTERMEDIARIES.—Section 1816 of such Act (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

''(m) In carrying out its agreement under this section, with respect to payment for items and services furnished under this part, the fiscal intermediary shall provide for the recoupment of overpayments in the following manner:

''(1)(A) During the 1-year period beginning on the date on which a provider of services receives an overpayment, the provider of services may return the

overpayment without penalty or interest to the fiscal intermediary making such overpayment if—

"(i) the fiscal intermediary has not requested any relevant record or file; or

"(ii) the case has not been referred before the date of repayment to the Department of Justice or the Office of Inspector General.

"(B) If a provider of services returns an overpayment under subparagraph (A), neither the fiscal intermediary, contractor under section 1893, nor any law enforcement agency may begin an investigation or target such provider of services based on any claim associated with the amount the provider of services has repaid.

"(2) If a fiscal intermediary has decided to conduct a post-payment audit of the provider of services, the fiscal intermediary shall send written notice to the provider of services. If the provider of services practices in a rural area (as defined in section 1886(d)(2)(D)), such notice must be sent by registered mail.

"(3) The fiscal intermediary or a contractor under section 1893 may not recoup or offset payment amounts based on extrapolation (as defined in section 1861(ww)(1)) for the first time that the pro-

vider of services is alleged as a result of a post-payment audit to have received an overpayment.

''(4) As part of any written consent settlement communication, the fiscal intermediary or a contractor under section 1893 shall clearly state that the provider of services may submit additional information (including evidence other than medical records) to dispute the overpayment amount without waiving any administrative remedy or right to appeal the amount of the overpayment.

''(5)(A) Each consent settlement communication from the fiscal intermediary or a contractor under section 1893 shall clearly state that prepayment review (as defined in section 1861(ww)(2)) may be imposed where the provider of services submits an actual or projected repayment to the fiscal intermediary or a contractor under section 1893. Subject to subparagraph (D), any prepayment review shall cease when the provider of services has submitted claims, found by the fiscal intermediary to be covered services and coded properly for the same services that were the basis for instituting the prepayment review, in a 180-day period or after processing claims of at least 75 percent of the volume of the claims (whichever occurs first) received by the

fiscal intermediary in the full month preceding the start of the prepayment review. The 180-day period begins with the date of the fiscal intermediary's written notification that the provider of services is being placed on prepayment review.

''(B) Prepayment review may not be applied under this part as a result of the voluntary submission of a claim, cost report, or record under section 1897(b)(2) or as a result of information provided pursuant to a request under section 302(b) of the Medicare Education and Regulatory Fairness Act of 2001.

''(C) Fiscal intermediary prepayment and coverage policies and claims processing screens used to identify claims for medical review must be incorporated as part of the education programs on medicare policy and proper coding made available to providers of services.

''(D) The time and percentage claim limitations in paragraph (5)(A) shall not apply to cases that have been referred to the Department of Justice or the Office of the Inspector General.''.

SEC. 203. DEFINITIONS RELATING TO PHYSICIANS, PROVIDERS OF SERVICES, AND PROVIDERS OF AMBULANCE SERVICES.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 102(b) and 105(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), is amended by adding at the end the following new subsection:

''Definitions Relating to Physicians, Providers of Services, and Providers of Ambulance Services

''(ww) For purposes of provisions of this title relating to physicians, providers of services, and providers of ambulance services:

''(1) EXTRAPOLATION.—The term 'extrapolation' means the application of an overpayment dollar amount to a larger grouping of claims than those in the audited sample to calculate a projected overpayment figure.

''(2) PREPAYMENT REVIEW.—The term 'prepayment review' means a carrier's and fiscal intermediary's practice of withholding claim reimbursements from physicians, providers of services, and providers of ambulance services pending review

of a claim even if the claims have been properly submitted and reflect medical services provided.''.

SEC. 204. RIGHT TO APPEAL ON BEHALF OF DECEASED BENEFICIARIES.

Notwithstanding section 1870 of the Social Security Act (42 U.S.C. 1395gg) or any other provision of law, the Secretary shall permit any physician, provider of services, and provider of ambulance services to appeal any determination of the Secretary under the medicare program on behalf of a deceased beneficiary where no substitute party is available.

SEC. 205. EFFECTIVE DATE.

The amendments made by this title shall take effect at the end of the 180-day period beginning on the date of the enactment of this Act.

TITLE III—EDUCATION COMPONENTS

SEC. 301. DESIGNATED FUNDING LEVELS FOR PHYSICIAN AND PROVIDER EDUCATION.

(a) EDUCATION PROGRAMS FOR PHYSICIANS, PROVIDERS OF SERVICES, AND PROVIDERS OF AMBULANCE SERVICES.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''EDUCATION PROGRAMS FOR PHYSICIANS, PROVIDERS OF SERVICES, AND PROVIDERS OF AMBULANCE SERVICES

''SEC. 1897. (a) EDUCATION PROGRAM DEFINED.—In this section, the term 'education programs' means programs undertaken in conjunction with health care associations that focus on current billing, coding, cost reporting, and documentation laws, regulations, program memoranda, instructions to regional offices, and fiscal intermediary and carrier manual instructions that place special emphasis on billing, coding, cost reporting, and documentation errors that the Secretary has found occur frequently and remedies for these improper billing, coding, cost reporting, and documentation practices.

''(b) CONDUCT OF EDUCATION PROGRAMS.—

''(1) IN GENERAL.—Carriers, fiscal intermediaries, and contractors under section 1893 shall conduct education programs for any physician (or a designee), provider of services, or provider of ambulance services that submits a claim or cost report under paragraph (2)(A). Such carriers, intermediaries, and contractors under section 1893 shall conduct outreach to specifically contact physicians and their designees, providers of services, and providers of ambulance services with fewer than 10 full-time-equivalent employees (including physicians) to

implement education programs tailored to their education needs and in proximity to their practices.

''(2) PROVIDER EDUCATION.—

''(A) SUBMISSION OF CLAIMS, COST REPORTS, AND RECORDS.—Any physician, provider of services, or provider of ambulance services may voluntarily submit any present or prior claim, cost report, or medical record to the carrier or fiscal intermediary to determine whether the billing, coding, and documentation associated with the claim or cost report is appropriate.

''(B) PROHIBITION OF EXTRAPOLATION.—No claim submitted under subparagraph (A) is subject to any type of extrapolation (as defined in section 1861(ww)(1)).

''(C) SAFE HARBOR.—No submission of a claim, cost report, or record under this section shall result in the carrier, fiscal intermediary, a contractor under section 1893, or any law enforcement agency beginning an investigation or targeting an investigation based on any claim, cost report, or record submitted under such subparagraph.

''(3) TREATMENT OF CLAIMS.—If the carrier or fiscal intermediary finds a claim or cost report under paragraph (2) to be improper, the physician, provider of services, or provider of ambulance services shall have the following options:

''(A) CORRECTION OF PROBLEMS.—To correct the documentation, coding, or billing problem to appropriately substantiate the claim or cost report and either—

''(i) remit the actual overpayment; or

''(ii) receive the appropriate additional payment from the carrier or fiscal intermediary.

''(B) REPAYMENT.—To repay the actual overpayment amount if the service is excluded from medicare coverage under this title or if adequate documentation does not exist.

''(4) PROHIBITION OF PHYSICIAN AND PROVIDER OF SERVICES TRACKING.—Carriers, fiscal intermediaries, and contractors under section 1893 may not use the record of attendance or information gathered during an education program conducted under this section or the inquiry regarding claims or cost reports under paragraph (2)(A) to select, identify, or track such physician, provider of services, or

provider of ambulance services for the purpose of conducting any type of audit or prepayment review.''.

(b) FUNDING OF EDUCATION PROGRAMS.—

(1) MEDICARE INTEGRITY PROGRAM.—Section 1893(b)(4) of such Act (42 U.S.C. 1395ddd(b)(4)) is amended by adding at the end the following new sentence: ''No less than 10 percent of the program funds shall be devoted to the education programs for physicians, providers of services, and providers of ambulance services under section 1897.''.

(2) CARRIERS.—Section 1842(b)(3)(H) of such Act (42 U.S.C. 1395u(b)(3)(H)) is amended by adding at the end the following new clause:

''(iii) No less than 2 percent of carrier funds shall be devoted to the education programs for physicians under section 1897.''.

(3) FISCAL INTERMEDIARIES.—Section 1816(b)(1) of such Act (42 U.S.C. 1395h(b)(1)) is amended—

(A) in subparagraph (A), by striking ''and'' at the end;

(B) in subparagraph (B), by striking ''; and'' and inserting a comma; and

(C) by adding at the end the following new subparagraph:

"(C) that such agency or organization is using no less than 1 percent of its funding for education programs for providers of services and providers of ambulance services under section 1897.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to fiscal years beginning after the date of the enactment of this Act.

SEC. 302. INFORMATION REQUESTS.

(a) CLEAR, CONCISE, AND ACCURATE ANSWERS.—Fiscal intermediaries and carriers shall do their utmost to provide physicians, providers of services, and providers of ambulance services with a clear, concise, and accurate answer regarding billing and cost reporting questions under the medicare program, and will give their true first and last names to such physicians, providers of services, and providers of ambulance services.

(b) WRITTEN REQUESTS.—

(1) IN GENERAL.—The Secretary shall establish a process under which a physician, provider of services, or provider of ambulance services may request, free of charge and in writing from a fiscal intermediary or carrier, assistance in addressing ques-

tions regarding coverage, billing, documentation, coding, and cost reporting procedures under the medicare program and then the fiscal intermediary or carrier shall respond in writing within 30 business days with the correct substantive or procedural answer.

(2) USE OF WRITTEN STATEMENT.—

(A) IN GENERAL.—Subject to subparagraph (C), a written statement under paragraph (1) may be used by the physician, provider of services, or provider of ambulance services who submitted the information request and submitted claims in conformance with the answer of the carrier or fiscal intermediary as proof against a future audit or overpayment allegation under the medicare program.

(B) EXTRAPOLATION PROHIBITION.—Subject to subparagraph (C), no claim submitted under this section shall be subject to extrapolation, if the claim adheres to the conditions set forth in the information response.

(C) LIMITATION ON APPLICATION.—Subparagraphs (A) and (B) shall not apply to cases of fraudulent billing.

(3) SAFE HARBOR.—If a physician, provider of services, or provider of ambulance services requests information under this subsection, neither the fiscal intermediary, the carrier, a contractor under section 1893 of the Social Security Act (42 U.S.C. 1395ddd), nor any law enforcement agency may begin an investigation or target such physician or provider based on the request.

(c) BROAD POLICY GUIDANCE BY THE SECRETARY.—The Secretary shall develop a mechanism to address written questions regarding medicare policy and regulations, which are submitted by health care associations. The Secretary shall issue such answers within 90 calendar days from the date of the receipt of the question and shall make the responses available to the public in an indexed, easily accessible format.

(d) NOTICE OF CHANGES IN POLICY.—Carriers and fiscal intermediaries shall provide written, mailed notice within 30 calendar days to physicians, providers of services, and providers of ambulance services of all policy or operational changes to the medicare program. Physicians, providers of services, and providers of ambulance services shall have not less than 30 days to comply with such policy changes.

(e) EFFECTIVE DATE.—This section shall take effect 180 days after the date of the enactment of this Act.

TITLE IV—SUSTAINABLE GROWTH RATE REFORMS

SEC. 401. INCLUSION OF REGULATORY COSTS IN THE CALCULATION OF THE SUSTAINABLE GROWTH RATE.

(a) IN GENERAL.—Section 1848(f)(2) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)) is amended—

(1) by redesignating subparagraphs (A) through (D) as clauses (i) through (iv), respectively;

(2) by striking ''SPECIFICATION OF GROWTH RATE.—The sustainable growth rate'' and inserting ''SPECIFICATION OF GROWTH RATE.—

''(A) IN GENERAL.—The sustainable growth rate''; and

(3) by adding at the end the following new subparagraphs:

''(B) INCLUSION OF SGR REGULATORY COSTS.—The estimate established under clause (iv) or any successor thereto shall include—

''(i) the impact on costs for physicians' services resulting from regulations implemented by the Secretary during the year for which the sustainable growth rate

is estimated, including those regulations that may be implemented during such year; and

"(ii) the costs described in subparagraph (C).

"(C) INCLUSION OF OTHER REGULATORY COSTS.—The costs described in this subparagraph are per procedure costs incurred by physicians' practices in complying with regulations promulgated by the Secretary, regardless of whether such regulation affects the fee schedule established under subsection (b)(1).

"(D) INCLUSION OF COSTS IN REGULATORY IMPACT ANALYSES.—With respect to any regulation promulgated that may impose a regulatory cost described in subparagraph (B)(i) or (C) on a physician, the Secretary shall include in the regulatory impact analysis accompanying such regulation an estimate of any such cost.

"(E) INCLUSION OF ESTIMATED COST ON RURAL PHYSICIANS.—In promulgating regulations, the Secretary shall specifically estimate the costs to rural physicians and physicians practices in rural areas and the estimated num-

ber of hours needed to comply with the regulation.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to any estimate made (or regulation promulgated) by the Secretary of Health and Human Services on or after 1 year after the date of enactment of this Act.

TITLE V—POLICY DEVELOPMENT REGARDING E&M GUIDELINES

SEC. 501. POLICY DEVELOPMENT REGARDING E&M DOCUMENTATION GUIDELINES.

(a) IN GENERAL.—HCFA may not implement any new evaluation and management documentation 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 organizations representing physicians;

(2) has established a plan that contains specific goals, including a schedule, for improving use of such guidelines;

(3) has completed a minimum of 4 pilot projects consistent with subsection (b) in at least 4 different HCFA regions administered by 4 different

carriers (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 organizations representing physicians.

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

(A) at least one shall focus on a peer review method by physicians (not employed by a carrier) which evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to definitions published in the CPT book;

(B) at least one shall be conducted for services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act, 42 U.S.C. 1395ww(d)(2)(D)); and

(C) at least one shall be conducted in a setting where physicians bill under physicians services in teaching settings (described in section 415.150 of title 42, Code of Federal Regulations).

(3) BANNING OF TARGETING OF PILOT PROJECT PARTICIPANTS.—Data collected under this subsection shall not be used as the basis for overpayment demands or post-payment audits.

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

(A) different types of physician practices, including those with fewer than 10 full-time employees (including physicians); and

(B) the costs of physician compliance, including education, implementation, auditing, and monitoring.

(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 code accurately and assess coding levels accurately.

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

(3) Increased accuracy by carrier reviewers.

(4) Education of both physicians and reviewers.

(5) Promote appropriate use of E&M codes by physicians and their staffs.

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

(d) REPORT ON HOW MET PILOT PROJECT OBJECTIVES.—HCFA shall submit a report to the Committees on Energy and 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 subsections (b)(4) and (c).

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