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(Original Signature of Member)

112TH CONGRESS  
2D SESSION

**H. R.** \_\_\_\_\_

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**

Mr. GRAVES of Missouri (for himself and Mr. SCHIFF) introduced the following bill; which was referred to the Committee on

\_\_\_\_\_  
**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.

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; TABLE OF CONTENTS.**

4       (a) SHORT TITLE.—This Act may be cited as the  
5       “Medicare Audit Improvement Act of 2012”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Combined additional documentation request limit.
- Sec. 3. Improvement of recovery auditor operations.
- Sec. 4. Greater transparency of recovery auditor performance.
- Sec. 5. Restoring due process rights under the AB rebilling demonstration.
- Sec. 6. Accurate payment for rebilled claims.
- Sec. 7. Requirement for physician validation for medical necessity denials.

3 **SEC. 2. COMBINED ADDITIONAL DOCUMENTATION RE-**  
4 **QUEST LIMIT.**

5 (a) ESTABLISHMENT OF ANNUAL LIMITS.—The Sec-  
6 retary of Health and Human Services shall establish a  
7 process under which the number of additional documenta-  
8 tion requests made by a Medicare contractor (as defined  
9 in subsection (b)(1)) pursuant to a complex prepayment  
10 audit or complex postpayment audit under chapter 3 of  
11 the Medicare Program Integrity Manual, or otherwise,  
12 with respect to part A claims (as defined in subsection  
13 (b)(2)) of a hospital in a year may not exceed, across all  
14 such contractors with respect to such claims of such hos-  
15 pital—

16 (1) 2 percent of all such claims for such year;

17 and

18 (2) 500 additional documentation requests dur-  
19 ing any 45-day period.

20 (b) DEFINITIONS.—In this section:

21 (1) MEDICARE CONTRACTOR.—The term  
22 “Medicare contractor” means any of the following:

1 (A) A Medicare administrative contractor  
2 under section 1874A of the Social Security Act  
3 (42 U.S.C. 1395kk), including a fiscal inter-  
4 mediary and a carrier under sections 1816 and  
5 1842, respectively.

6 (B) A recovery audit contractor, zone pro-  
7 gram integrity contractor, and program safe-  
8 guard or integrity contractor under section  
9 1893(h) of such Act (42 U.S.C. 1395ddd(h)).

10 (C) A Comprehensive Error Rate Testing  
11 (CERT) program contractor with a contract  
12 with the Secretary of Health and Human Serv-  
13 ices to review error rates under title XVIII of  
14 the Social Security Act (42 U.S.C. 1395 et  
15 seq.).

16 (2) PART A CLAIM.—The term “part A claim”  
17 means a claim for payment under part A of title  
18 XVIII of the Social Security Act (42 U.S.C. 1395c  
19 et seq.) made by a hospital for furnishing inpatient  
20 hospital services to individuals entitled to have pay-  
21 ment made on their behalf under such part A for the  
22 furnishing of such services.

23 (3) HOSPITAL.—The term “hospital” has the  
24 meaning given such term under subsection (e) of  
25 section 1861 of the Social Security Act (42 U.S.C.

1       1395x), and includes a psychiatric hospital as de-  
2       fined in subsection (f) of such section. In applying  
3       such definition for purposes of this section, such  
4       term means the campus of the hospital, as identified  
5       by the tax identification number of the hospital, and  
6       includes all inpatient hospital facilities under such  
7       number located in the same area.

8       (c) EFFECTIVE DATE.—This section takes effect on  
9       the date of the enactment of this Act and shall apply with  
10      respect to claims submitted for payment under title XVIII  
11      of the Social Security Act for items or services furnished  
12      by providers of services or suppliers on or after January  
13      1, 2013.

14   **SEC. 3. IMPROVEMENT OF RECOVERY AUDITOR OPER-**  
15                   **ATIONS.**

16      (a) RECOVERY AUDITORS.—

17           (1) IN GENERAL.—Section 1893(h) of the So-  
18      cial Security Act (42 U.S.C. 1395ddd(h)) is amend-  
19      ed by adding at the end the following new para-  
20      graph:

21           “(10) MANDATORY TERMS AND CONDITIONS  
22      UNDER CONTRACTS WITH RECOVERY AUDIT CON-  
23      TRACTORS.—In addition to such other terms and  
24      conditions as the Secretary may require under con-  
25      tracts with recovery audit contractors under this

1 subsection with respect to a hospital, including a  
2 psychiatric hospital (as defined in section 1861(f)),  
3 the Secretary shall ensure each of the following re-  
4 quirements are included under such contracts:

5 “(A) PENALTIES FOR CERTAIN COMPLI-  
6 ANCE FAILURES.—

7 “(i) IN GENERAL.—Each such con-  
8 tract shall provide for the imposition of fi-  
9 nancial penalties by the Secretary under  
10 such contract in the case of any recovery  
11 audit contractor with respect to which the  
12 Secretary determines there is a pattern of  
13 failure by such contractor to meet any pro-  
14 gram requirement described in clause (ii).  
15 The Secretary shall establish the amount  
16 of financial penalties and the periodicity  
17 under which such penalties shall be im-  
18 posed under this subparagraph, in no case  
19 less often than annually.

20 “(ii) PROGRAM REQUIREMENT DE-  
21 SCRIBED.—For purposes of this subpara-  
22 graph, each of the following requirements  
23 under the statement of work for a recovery  
24 audit contractor constitutes a program re-  
25 quirement with respect to which failure to

1 meet such requirement shall result in the  
2 imposition of a financial penalty under  
3 clause (i):

4 “(I) AUDIT DEADLINE.—Com-  
5 pleting a determination with respect  
6 to each audit of a hospital the recov-  
7 ery audit contractor conducts within  
8 the timeframes applicable under  
9 guidelines of the Secretary.

10 “(II) TIMELY COMMUNICA-  
11 TION.—In the case of a denial of a  
12 claim of a hospital, furnishing the  
13 hospital a demand letter in a timely  
14 fashion under claims and appeals  
15 timeframes applicable under guide-  
16 lines of the Secretary.

17 “(B) PENALTY FOR OVERTURNED AP-  
18 PEALS.—

19 “(i) IN GENERAL.—Each such con-  
20 tract shall require a recovery audit con-  
21 tractor to pay a fee to the prevailing party  
22 in the case of a claim denial that is over-  
23 turned on appeal.

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

1 tractor to a prevailing party under clause  
2 (i) shall be determined under a fee sched-  
3 ule established by the Secretary for such  
4 purpose.

5 “(C) POSTPAYMENT AND PREPAYMENT AU-  
6 DITS.—

7 “(i) REQUIRING FOCUS ON WIDE-  
8 SPREAD PAYMENT ERRORS.—

9 “(I) IN GENERAL.—The Sec-  
10 retary shall not approve the conduct  
11 of a postpayment or prepayment med-  
12 ical necessity audit by a recovery  
13 audit contractor unless such review  
14 addresses a widespread payment error  
15 rate (as defined in clause (ii)).

16 “(II) CESSATION OF AUDIT.—A  
17 recovery audit contractor that com-  
18 mences an audit under subclause (I)  
19 shall cease such audit or any similar  
20 audits, if upon annual review, the ap-  
21 plicable payment error rate is no  
22 longer a widespread payment error  
23 rate (as so defined).

24 “(ii) WIDESPREAD PAYMENT ERROR  
25 RATE DEFINED.—

1                   “(I) IN GENERAL.—In this sub-  
2                   paragraph, the term ‘widespread pay-  
3                   ment error rate’ means, with respect  
4                   to medical necessity reviews conducted  
5                   by a recovery audit contractor, a pay-  
6                   ment error rate that exceeds the rate  
7                   specified in subclause (II) for a par-  
8                   ticular medical necessity audit deter-  
9                   mined by the Secretary using a statis-  
10                  tically significant sampling of claims  
11                  submitted by hospitals in the jurisdic-  
12                  tion of the recovery audit contractor  
13                  and adjusted to take into account  
14                  claim denials overturned on appeal.

15                  “(II) RATE SPECIFIED.—The  
16                  rate specified in this subclause is 40  
17                  percent, except that the Secretary  
18                  shall annually evaluate such rate and  
19                  reduce it as necessary to account for  
20                  changes in payment error rates with  
21                  the aim of continued, steady improve-  
22                  ment of billing practices.

23                  “(D) GUIDELINES FOR PREPAYMENT RE-  
24                  VIEW.—



1           “(i) IN GENERAL.—A recovery audit  
2           contractor may only conduct prepayment  
3           review in the manner provided under pre-  
4           payment review guidelines (described in  
5           clause (ii)) established by the Secretary.

6           “(ii) CONSISTENT PREPAYMENT RE-  
7           VIEW GUIDELINES.—For purposes of pre-  
8           payment review activities authorized under  
9           this subsection and section 1874A(h) (re-  
10          lating to prepayment review by medicare  
11          administrative contractors), the Secretary  
12          shall establish guidelines under which con-  
13          sistent criteria for minimum payment error  
14          rates or improper billing practices occasion  
15          prepayment review by contractors under  
16          this subsection and section 1874A. Such  
17          guidelines shall include criteria for termi-  
18          nation, including termination dates, of pre-  
19          payment review.”.

20          (2) CONFORMING AMENDMENT TO APPLY FI-  
21          NANCIAL PENALTIES IMPOSED ON RECOVERY CON-  
22          TRACTORS TO THE TRUST FUNDS.—Section  
23          1893(h)(2) of the Social Security Act (42 U.S.C.  
24          1395ddd(h)(2)) is amended by inserting “, and  
25          amounts collected by the Secretary under paragraph

1       (10)(A)(i) (relating to financial penalties for con-  
2       tractor compliance failures),” after “paragraph  
3       (1)(C)”.

4       (b) CONFORMING AMENDMENT FOR MEDICARE AD-  
5       MINISTRATIVE CONTRACTORS.—Section 1874A of the So-  
6       cial Security Act (42 U.S.C. 1395kk–1) is amended by  
7       adding at the end the following new subsection:

8       “(h) MANDATORY TERMS AND CONDITIONS UNDER  
9       CONTRACTS WITH MEDICARE ADMINISTRATIVE CON-  
10      TRACTORS.—In addition to such other terms and condi-  
11      tions as the Secretary may require under contracts with  
12      medicare administrative contractors under this section  
13      with respect to a hospital, including a psychiatric hospital  
14      (as defined in section 1861(f)), the Secretary shall ensure  
15      each of the following requirements are included under  
16      such contracts:

17               “(1) POSTPAYMENT AND PREPAYMENT AU-  
18      DITS.—

19               “(A) REQUIRING FOCUS ON WIDESPREAD  
20      PAYMENT ERRORS.—

21               “(i) IN GENERAL.—The Secretary  
22               shall not approve the conduct of a  
23               postpayment or prepayment medical neces-  
24               sity audit by a medicare administrative  
25               contractor unless such review addresses a

1           widespread payment error rate (as defined  
2           in subparagraph (B)).

3           “(ii) CESSATION OF AUDIT.—A medi-  
4           care administrative contractor that com-  
5           mences an audit under clause (i) shall  
6           cease such audit or any similar audits, if  
7           upon annual review, the applicable pay-  
8           ment error rate is no longer a widespread  
9           payment error rate (as so defined).

10          “(B) WIDESPREAD PAYMENT ERROR RATE  
11          DEFINED.—In this paragraph, the term ‘wide-  
12          spread payment error rate’ means, with respect  
13          to medical necessity reviews conducted by a  
14          medicare administrative contractor, a payment  
15          error rate of 40 percent or greater for a par-  
16          ticular medical necessity audit determined by  
17          the Secretary using a statistically significant  
18          sampling of claims submitted by hospitals in  
19          the jurisdiction of the medicare administrative  
20          contractor and adjusted to take into account  
21          claim denials overturned on appeal.

22          “(2) GUIDELINES FOR PREPAYMENT REVIEW.—  
23          A medicare administrative contractor may only con-  
24          duct prepayment review in the manner provided

1 under prepayment review guidelines established by  
2 the Secretary under section 1893(h)(10)(D)(ii).”.

3 (c) EFFECTIVE DATE.—The amendments made by  
4 this section shall apply to contracts entered into or re-  
5 newed with recovery audit contractors under section  
6 1893(h) of the Social Security Act (42 U.S.C.  
7 1395ddd(h)) and medicare administrative contractors  
8 under section 1874A of the Social Security Act (42 U.S.C.  
9 1395kk–1) on or after the date of the enactment of this  
10 Act.

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

13 (a) ANNUAL PUBLICATION OF RELEVANT PERFORM-  
14 ANCE INFORMATION.—Section 1893(h) of the Social Secu-  
15 rity Act (42 U.S.C. 1395ddd(h)), as amended by section  
16 3(a), is further amended by adding at the end the fol-  
17 lowing new paragraph:

18 “(11) INFORMATION ON RECOVERY AUDIT CON-  
19 TRACTOR PERFORMANCE.—With respect to each re-  
20 covery audit contractor with a contract under this  
21 section for a contract year, the Secretary shall pub-  
22 lish on the Internet website of the Centers for Medi-  
23 care & Medicaid Services the following information  
24 with respect to the performance of each such recov-  
25 ery audit contractor:

1           “(A) PUBLICLY AVAILABLE INFORMATION  
2           ON AUDIT RATES, DENIALS, AND APPEALS OUT-  
3           COMES.—With respect to the performance of  
4           each such recovery audit contractor during a  
5           contract year, the Secretary shall post on such  
6           Internet website the following information:

7                   “(i) AUDITS.—The aggregate number  
8                   of audits conducted by the recovery audit  
9                   contractor during the contract year in-  
10                  volved, as well as the number of audits of  
11                  each of the following audit types (each in  
12                  this paragraph referred to as an ‘audit  
13                  type’):

14                           “(I) Automated.

15                           “(II) Complex.

16                           “(III) Medical necessity review.

17                           “(IV) Part A claims.

18                           “(V) Part B claims.

19                           “(VI) Durable medical equipment  
20                  claims.

21                           “(VII) Part A medical necessity.

22                   “(ii) DENIALS.—The aggregate num-  
23                  ber of denials for each audit type made by  
24                  the recovery audit contractor during the  
25                  contract year involved.

1           “(iii) DENIAL RATES.—The denial  
2 rate of the recovery audit contractor dur-  
3 ing the contract year involved for part A  
4 claims, part B claims, and durable medical  
5 equipment claims.

6           “(iv) APPEALS.—The aggregate num-  
7 ber of appeals filed by providers of services  
8 and suppliers with respect to denials for  
9 each audit type made by the recovery audit  
10 contractor during the contract year in-  
11 volved.

12           “(v) APPEALS RATES.—The aggregate  
13 rate of appeals filed by providers of serv-  
14 ices and suppliers with respect to denials  
15 for each audit type made by the recovery  
16 audit contractor during the contract year  
17 involved.

18           “(vi) APPEALS OUTCOMES AT EACH  
19 OF THE 5 STAGES OF APPEAL.—The out-  
20 come of each appeal filed by a provider of  
21 services or supplier of a denial made by a  
22 recovery audit contractor at each level of  
23 appeal as follows:

24           “(I) Reconsideration by the rel-  
25 evant medicare contractor.

1 “(II) Redetermination by a quali-  
2 fied independent contractor.

3 “(III) Administrative law judge  
4 hearing.

5 “(IV) Medicare Appeals Council  
6 review.

7 “(V) United States District  
8 Court judicial review

9 “(vii) NET DENIALS.—The net denial  
10 for each audit type, calculated as the dif-  
11 ference between the number of denials for  
12 such audit type under clause (ii) and the  
13 number of denials for such audit type over-  
14 turned on appeal.

15 “(B) PUBLIC AVAILABILITY OF INDE-  
16 PENDENT PERFORMANCE EVALUATION.—The  
17 Secretary shall make available on such Internet  
18 website the results of any performance evalua-  
19 tion with respect to each recovery audit con-  
20 tractor conducted by an independent entity se-  
21 lected by the Secretary for such purpose. Each  
22 performance evaluation shall include in its re-  
23 sults for posting on such Internet website a de-  
24 termination of annual error rates of the recov-  
25 ery audit contractor for each audit type and the

1 net denials described in subparagraph  
2 (A)(vii).”.

3 (b) **EFFECTIVE DATE.**—The amendment made by  
4 subsection (a) shall apply to contracts entered into or re-  
5 newed with recovery audit contractors under section  
6 1893(h) of the Social Security Act (42 U.S.C.  
7 1395ddd(h)) on or after the date of the enactment of this  
8 Act.

9 **SEC. 5. RESTORING DUE PROCESS RIGHTS UNDER THE AB**  
10 **REBILLING DEMONSTRATION.**

11 (a) **CLARIFICATION OF AVAILABILITY OF ALL AP-**  
12 **PEAL RIGHTS.**—In conducting the AB Rebilling Dem-  
13 onstration (as defined in subsection (b)), the Secretary of  
14 Health and Human Services may not prohibit any appeal  
15 from, or any form of appeal available to, a hospital with  
16 respect to the inpatient hospital services furnished for  
17 which payment may be made under part A of title XVIII  
18 of the Social Security Act for which the claim submitted  
19 by such hospital was denied as an inpatient admission by  
20 a recovery auditor with a contract under section 1893(h)  
21 of such Act (42 U.S.C. 1395ddd(h)) due to a finding by  
22 the contractor that the inpatient admission was not rea-  
23 sonable and medically necessary.

24 (b) **AB REBILLING DEMONSTRATION DEFINED.**—In  
25 this section, the term “AB Rebilling Demonstration”



1 means the Medicare Part A to Part B Rebilling (AB Re-  
2 billing) Demonstration conducted during calendar years  
3 2012 through 2014 by the Secretary of Health and  
4 Human Services through the Administrator of the Centers  
5 for Medicare & Medicaid Services under which a hospital  
6 with a participation agreement under the Medicare pro-  
7 gram may receive 90 percent of the allowable part B pay-  
8 ment for part A short-stay claims that are denied on the  
9 basis that the inpatient admission was not reasonable and  
10 necessary.

11 **SEC. 6. ACCURATE PAYMENT FOR REBILLED CLAIMS.**

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

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

21 “(12) TREATMENT OF RESUBMISSION OF SPEC-  
22 IFIED CLAIMS AS ORIGINAL CLAIMS.—

23 “(A) TREATMENT AS ORIGINAL CLAIM.—

24 The resubmission of a specified claim (as de-

1           fined in subparagraph (C)) shall be deemed to  
2           be an original claim for purposes of—

3                   “(i) payment under part B; and

4                   “(ii) provisions under this title relat-  
5           ing to—

6                   “(I) the authority of a hospital to  
7           resubmit a claim for payment under  
8           the appropriate section of this title;  
9           and

10                   “(II) requirements for the timely  
11           submission of claims, including under  
12           sections 1814(a), 1842(b)(3), and  
13           1835(a).

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

20                   “(C) DEFINITIONS.—In this paragraph:

21                   “(i) SPECIFIED CLAIM.—The term  
22           ‘specified claim’ means a claim submitted  
23           by a hospital for payment under part A for  
24           inpatient hospital services which a recovery  
25           audit contractor determines—

1                   “(I) the inpatient hospital serv-  
2                   ices were not medically necessary and  
3                   reasonable           under           section  
4                   1862(a)(1)(A) based on site of serv-  
5                   ice; and

6                   “(II) the services furnished would  
7                   be medically necessary and reasonable  
8                   in an outpatient setting of the hos-  
9                   pital.

10                  “(ii) RESUBMISSION.—The term ‘re-  
11                  submission’ includes, with respect to a  
12                  specified claim of a hospital, the submis-  
13                  sion by the hospital of a new claim or of  
14                  an adjusted original claim.”.

15                  (2) CONFORMING AMENDMENT FOR MEDICARE  
16                  ADMINISTRATIVE CONTRACTORS.—Subsection (h) of  
17                  section 1874A of the Social Security Act (42 U.S.C.  
18                  1395kk-1), as added by section 3(b), is further  
19                  amended by adding at the end the following new  
20                  paragraph:

21                  “(3) TREATMENT OF RESUBMISSION OF SPECI-  
22                  FIED CLAIMS AS ORIGINAL CLAIMS.—

23                  “(A) TREATMENT AS ORIGINAL CLAIM.—  
24                  The resubmission of a specified claim (as de-

1           fined in subparagraph (C)) shall be deemed to  
2           be an original claim for purposes of—

3                   “(i) payment under part B; and

4                   “(ii) provisions under this title relat-  
5           ing to—

6                   “(I) the authority of a hospital to  
7           resubmit a claim for payment under  
8           the appropriate section of this title;  
9           and

10                   “(II) requirements for the timely  
11           submission of claims, including under  
12           sections 1814(a), 1842(b)(3), and  
13           1835(a).

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

20                   “(C) DEFINITIONS.—In this paragraph:

21                   “(i) SPECIFIED CLAIM.—the term  
22           ‘specified claim’ means a claim submitted  
23           by a hospital for payment under part A for  
24           inpatient hospital services which a medi-

1                   care   administrative   contractor   deter-  
2                   mines—

3                   “(I) the inpatient hospital serv-  
4                   ices were not medically necessary and  
5                   reasonable           under           section  
6                   1862(a)(1)(A) based on site of serv-  
7                   ice; and

8                   “(II) the services furnished would  
9                   be medically necessary and reasonable  
10                  in an outpatient setting of the hos-  
11                  pital.

12                  “(ii) RESUBMISSION.—The term ‘re-  
13                  submission’ includes, with respect to a  
14                  specified claim of a hospital, the submis-  
15                  sion by the hospital of a new claim or of  
16                  an adjusted original claim.”.

17                  (3) CONFORMING REQUIREMENT FOR CERT  
18                  CONTRACTORS.—

19                  (A) TREATMENT OF RESUBMISSION OF  
20                  SPECIFIED CLAIMS AS ORIGINAL CLAIMS.—A  
21                  Comprehensive Error Rate Testing (CERT)  
22                  program contractor with a contract with the  
23                  Secretary of Health and Human Services to re-  
24                  view error rates under title XVIII of the Social  
25                  Security Act (42 U.S.C. 1395 et seq.) shall

1           deem the resubmission of a specified claim (as  
2           defined in subparagraph (C)) as an original  
3           claim for purposes of—

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

6                   (ii) provisions under such title relating  
7                   to—

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

12                           (II) requirements for the timely  
13                          submission of claims, including under  
14                          sections 1814(a), 1842(b)(3), and  
15                          1835(a) of such Act (42 U.S.C.  
16                          1395f(a), 1395u(b)(3), and 1395n(a),  
17                          respectively).

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

24                   (C) DEFINITIONS.—In this paragraph:

1 (i) SPECIFIED CLAIM.—The term  
2 “specified claim” means a claim submitted  
3 by a hospital (as defined in section 1861(e)  
4 of such Act (42 U.S.C. 1395x(e))) for pay-  
5 ment under title XVIII of such Act for in-  
6 patient hospital services which a Com-  
7 prehensive Error Rate Testing (CERT)  
8 program contractor determines—

9 (I) the inpatient hospital services  
10 were not medically necessary and rea-  
11 sonable under section 1862(a)(1)(A)  
12 of such Act based on site of service;  
13 and

14 (II) the services furnished would  
15 be medically necessary and reasonable  
16 in an outpatient setting of the hos-  
17 pital.

18 (ii) RESUBMISSION.—The term “re-  
19 submission” includes, with respect to a  
20 specified claim of a hospital, the submis-  
21 sion by the hospital of a new claim or of  
22 an adjusted original claim.

23 (4) EFFECTIVE DATE.—The amendments made  
24 by paragraphs (1) and (2), and the provisions of  
25 paragraph (3), shall apply to contracts entered into

1 or renewed with recovery audit contractors under  
2 section 1893(h) of the Social Security Act (42  
3 U.S.C. 1395ddd(h)), medicare administrative con-  
4 tractors under section 1874A of the Social Security  
5 Act (42 U.S.C. 1395kk–1) and Comprehensive Error  
6 Rate Testing (CERT) program contractors, respec-  
7 tively, on or after the date of the enactment of this  
8 Act.

9 (b) TREATMENT OF AUDITED CLAIMS AS RE-  
10 OPENED.—

11 (1) RECOVERY AUDITORS.—Section 1893(h)(4)  
12 of the Social Security Act (42 U.S.C.  
13 1395ddd(h)(4)) is amended by adding after and  
14 below subparagraph (B) the following:

15 “For purposes of the ability of a hospital to resub-  
16 mit a claim for payment under the appropriate sec-  
17 tion of this title and for purposes of requirements  
18 for the timely submission of claims by hospitals, in-  
19 cluding under sections 1814(a), 1842(b)(3), and  
20 1835(a), any claim that is the subject of an audit  
21 by a recovery audit contractor with a contract under  
22 this section shall be deemed to be a reopened  
23 claim.”.

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



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

5 “(4) TREATMENT OF AUDITED CLAIMS AS RE-  
6 OPENED.—For purposes of the ability of a hospital  
7 to resubmit a claim for payment under the appro-  
8 priate provisions of this title and for purposes of re-  
9 quirements for the timely submission of claims by  
10 hospital, including under sections 1814(a),  
11 1842(b)(3), and 1835(a), any claim that is the sub-  
12 ject of an audit by a medicare administrative con-  
13 tractor with a contract under this section shall be  
14 deemed to be a reopened claim.”.

15 (3) CONFORMING REQUIREMENT FOR CERT  
16 CONTRACTORS.—

17 (A) TREATMENT OF AUDITED CLAIMS AS  
18 REOPENED.—Any claim made for payment for  
19 services furnished by a hospital under title  
20 XVIII of the Social Security Act (42 U.S.C.  
21 1395 et seq.) that is the subject of an audit by  
22 a Comprehensive Error Rate Testing (CERT)  
23 program contractor with a contract with the  
24 Secretary of Health and Human Services shall  
25 be deemed to be a reopened claim for purposes

1 of the ability of such hospital to resubmit a  
2 claim for payment under the appropriate provi-  
3 sions of such title XVIII and for purposes of re-  
4 quirements for the timely submission of claims  
5 by hospitals under such title XVIII, including  
6 under sections 1814(a), 1842(b)(3), and  
7 1835(a) of the Social Security Act (42 U.S.C.  
8 1395f(a), 1395u(b)(3), and 1395n(a), respec-  
9 tively).

10 (B) DEFINITION.—In this paragraph, the  
11 term “hospital” has the meaning given such  
12 term in subsection (e) of section 1861 of the  
13 Social Security Act (42 U.S.C. 1395x), and in-  
14 cludes a psychiatric hospital as defined in sub-  
15 section (f) of such section.

16 (4) EFFECTIVE DATE.—The amendments made  
17 by paragraphs (1) and (2), and the provisions of  
18 paragraph (3), shall take effect on the date of the  
19 enactment of this Act and apply to claims subject to  
20 audit on or after September 1, 2010.

21 **SEC. 7. REQUIREMENT FOR PHYSICIAN VALIDATION FOR**  
22 **MEDICAL NECESSITY DENIALS.**

23 (a) RECOVERY AUDITORS.—Section 1893(h) of the  
24 Social Security Act (42 U.S.C. 1395ddd(h)), as amended

1 by sections 3(a), 4(a), and 6(a)(1), is further amended by  
2 adding at the end the following new paragraph:

3 “(13) PHYSICIAN VALIDATION OF MEDICAL NE-  
4 CESSITY DENIALS MADE BY NON-PHYSICIAN REVIEW-  
5 ERS.—

6 “(A) IN GENERAL.—Each contract under  
7 this section for a recovery audit contractor shall  
8 require that a physician (as defined in section  
9 1861(r)(1)) review each denial of a claim for  
10 medical necessity when a medical necessity re-  
11 view of such claim is performed and a denial is  
12 made by an employee of the contractor who is  
13 not a physician (as so defined).

14 “(B) DETERMINATION; VALIDATION.—A  
15 physician reviewing a claim under subparagraph  
16 (A) shall—

17 “(i) make a determination whether  
18 the denial of the claim under the medical  
19 necessity review by the non-physician em-  
20 ployee is appropriate;

21 “(ii) sign and certify such determina-  
22 tion; and

23 “(iii) append such signed and certified  
24 determination to the claim file.

1           “(C) TREATMENT AS MEDICALLY NEC-  
2           CESSARY.—A claim with respect to which a de-  
3           nial has been made as described in subpara-  
4           graph (A) for which the physician determines  
5           the denial is not appropriate under subpara-  
6           graph (B) shall be deemed to be medically nec-  
7           essary.

8           “(D) MEDICAL NECESSITY REVIEW DE-  
9           FINED.—In this paragraph, the term ‘medical  
10          necessity review’ means, with respect to an  
11          audit of a claim of a provider of services or sup-  
12          plier, a review conducted by a recovery audit  
13          contractor for the purpose of determining  
14          whether an item or service furnished for which  
15          the claim is filed by such provider of services or  
16          supplier is reasonable and necessary for the di-  
17          agnosis or treatment of illness or injury under  
18          section 1862(a)(1)(A).”.

19          (b) CONFORMING AMENDMENT TO MEDICARE AD-  
20          MINISTRATIVE CONTRACTORS.—Subsection (h) of section  
21          1874A of the Social Security Act (42 U.S.C. 1395kk–1),  
22          as added by section 3(b) and as amended by subsections  
23          (a)(2) and (b)(2) of section 6, is further amended by add-  
24          ing at the end the following new paragraph:

1           “(5) PHYSICIAN VALIDATION OF MEDICAL NE-  
2           CESSITY DENIALS MADE BY NON-PHYSICIAN REVIEW-  
3           ERS.—

4           “(A) IN GENERAL.—A physician (as de-  
5           fined in section 1861(r)(1)) shall review each  
6           denial of a claim for medical necessity when a  
7           medical necessity review of such claim is per-  
8           formed and a denial is made by an employee of  
9           the contractor who is not a physician (as so de-  
10          fined).

11          “(B) DETERMINATION; VALIDATION.—A  
12          physician reviewing a claim under subparagraph  
13          (A) shall—

14               “(i) make a determination whether  
15               the denial of the claim under the medical  
16               necessity review by the non-physician em-  
17               ployee is appropriate;

18               “(ii) sign and certify such determina-  
19               tion; and

20               “(iii) append such signed and certified  
21               determination to the claim file.

22          “(C) TREATMENT AS MEDICALLY NEC-  
23          CESSARY.—A claim with respect to which a de-  
24          nial has been made as described in subpara-  
25          graph (A) for which the physician determines

1 the denial is not appropriate under subpara-  
2 graph (B) shall be deemed to be medically nec-  
3 essary.

4 “(D) MEDICAL NECESSITY REVIEW DE-  
5 FINED.—In this paragraph, the term ‘medical  
6 necessity review’ means, with respect to an  
7 audit of a claim of a provider of services or sup-  
8 plier, a review conducted by a medicare admin-  
9 istrative contractor for the purpose of deter-  
10 mining whether an item or service furnished for  
11 which the claim is filed by such provider of  
12 services or supplier is reasonable and necessary  
13 for the diagnosis or treatment of illness or in-  
14 jury under section 1862(a)(1)(A).”.

15 (c) CONFORMING REQUIREMENT FOR CERT CON-  
16 TRACTORS.—

17 (1) CONTRACT REQUIREMENT FOR PHYSICIAN  
18 VALIDATION OF MEDICAL NECESSITY DENIALS MADE  
19 BY NON-PHYSICIAN REVIEWERS.—The Secretary of  
20 Health and Human Services shall require under  
21 each contract with a Comprehensive Error Rate  
22 Testing (CERT) program contractor to review error  
23 rates under title XVIII of the Social Security Act  
24 (42 U.S.C. 1395 et seq.) that the CERT program  
25 contractor ensure that a physician (as defined in

1       section 1861(r)(1) of such Act (42 U.S.C.  
2       1395x(r)(1))) reviews each denial of a claim for  
3       medical necessity when a medical necessity review of  
4       such claim is performed and a denial is made by an  
5       employee of the contractor who is not a physician  
6       (as so defined).

7               (2) DETERMINATION; VALIDATION.—A physi-  
8       cian reviewing a claim under paragraph (1) shall—

9               (A) make a determination whether the de-  
10       nial of the claim under the medical necessity re-  
11       view by the non-physician employee is appro-  
12       priate;

13              (B) sign and certify such determination;  
14       and

15              (C) append such signed and certified deter-  
16       mination to the claim file.

17              (3) TREATMENT AS MEDICALLY NECESSARY.—

18       A claim with respect to which a denial has been  
19       made as described in paragraph (1) for which the  
20       physician determines the denial is not appropriate  
21       under paragraph (2) shall be deemed to be medically  
22       necessary.

23              (4) MEDICAL NECESSITY REVIEW DEFINED.—

24       In this subsection, the term “medical necessity re-  
25       view” means, with respect to an audit of a claim of

1 a provider of services or supplier, a review conducted  
2 by a CERT program contractor for the purpose of  
3 determining whether an item or service furnished for  
4 which the claim is filed by such provider of services  
5 or supplier is reasonable and necessary for the diag-  
6 nosis or treatment of illness or injury under section  
7 1862(a)(1)(A) of the Social Security Act (42 U.S.C.  
8 1395y(a)(1)(A)).

9 (d) EFFECTIVE DATE.—The amendments made by  
10 subsections (a) and (b), and the provisions of subsection  
11 (c), shall apply to contracts entered into or renewed with  
12 recovery audit contractors under section 1893(h) of the  
13 Social Security Act (42 U.S.C. 1395ddd(h)), medicare ad-  
14 ministrative contractors under section 1874A of the Social  
15 Security Act (42 U.S.C. 1395kk–1) and Comprehensive  
16 Error Rate Testing (CERT) program contractors, respec-  
17 tively, on or after the date of the enactment of this Act.