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112TH CONGRESS
2D SESSION

H. R. 6575

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.

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 16, 2012

Mr. GRAVES of Missouri (for himself, Mr. SCHIFF, Mr. LONG, and Mr. AKIN) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, 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 improve operations of recovery auditors under the Medicare integrity program, to increase transparency and accuracy in audits conducted by contractors, and for other purposes.

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 Audit Improvement Act of 2012''.

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

SEC. 2. COMBINED ADDITIONAL DOCUMENTATION REQUEST LIMIT.

(a) ESTABLISHMENT OF ANNUAL LIMITS.—The Secretary of Health and Human Services shall establish a process under which the number of additional documentation requests made by a Medicare contractor (as defined in subsection (b)(1)) pursuant to a complex prepayment audit or complex postpayment audit under chapter 3 of the Medicare Program Integrity Manual, or otherwise, with respect to part A claims (as defined in subsection (b)(2)) of a hospital in a year may not exceed, across all such contractors with respect to such claims of such hospital, the lesser of—

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

(2) 500 additional documentation requests during any 45-day period.

(b) DEFINITIONS.—In this section:

(1) MEDICARE CONTRACTOR.—The term ''Medicare contractor'' means any of the following:

(A) A Medicare administrative contractor under section 1874A of the Social Security Act (42 U.S.C. 1395kk), including a fiscal intermediary and a carrier under sections 1816 and 1842, respectively.

(B) A recovery audit contractor, zone program integrity contractor, and program safeguard or integrity contractor under section 1893(h) of such Act (42 U.S.C. 1395ddd(h)).

(C) A Comprehensive Error Rate Testing (CERT) program contractor with a contract with the Secretary of Health and Human Services to review error rates under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) PART A CLAIM.—The term ''part A claim'' means a claim for payment under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) made by a hospital for furnishing inpatient hospital services to individuals entitled to have payment made on their behalf under such part A for the furnishing of such services.

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

1395x), and includes a psychiatric hospital as defined in subsection (f) of such section. In applying such definition for purposes of this section, such term means the campus of the hospital, as identified by the tax identification number of the hospital, and includes all inpatient hospital facilities under such number located in the same area.

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

SEC. 3. IMPROVEMENT OF RECOVERY AUDITOR OPERATIONS.

(a) RECOVERY AUDITORS.—

(1) IN GENERAL.—Section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) is amended by adding at the end the following new paragraph:

''(10) MANDATORY TERMS AND CONDITIONS UNDER CONTRACTS WITH RECOVERY AUDIT CONTRACTORS.—In addition to such other terms and conditions as the Secretary may require under contracts with recovery audit contractors under this

subsection with respect to a hospital, including a psychiatric hospital (as defined in section 1861(f)), the Secretary shall ensure each of the following requirements are included under such contracts:

"(A) PENALTIES FOR CERTAIN COMPLIANCE FAILURES.—

"(i) IN GENERAL.—Each such contract shall provide for the imposition of financial penalties by the Secretary under such contract in the case of any recovery audit contractor with respect to which the Secretary determines there is a pattern of failure by such contractor to meet any program requirement described in clause (ii). The Secretary shall establish the amount of financial penalties and the periodicity under which such penalties shall be imposed under this subparagraph, in no case less often than annually.

"(ii) PROGRAM REQUIREMENT DESCRIBED.—For purposes of this subparagraph, each of the following requirements under the statement of work for a recovery audit contractor constitutes a program requirement with respect to which failure to

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

"(I) AUDIT DEADLINE.—Completing a determination with respect to each audit of a hospital the recovery audit contractor conducts within the timeframes applicable under guidelines of the Secretary.

"(II) TIMELY COMMUNICATION.—In the case of a denial of a claim of a hospital, furnishing the hospital a demand letter in a timely fashion under claims and appeals timeframes applicable under guidelines of the Secretary.

"(B) PENALTY FOR OVERTURNED APPEALS.—

"(i) IN GENERAL.—Each such contract shall require a recovery audit contractor to pay a fee to the prevailing party in the case of a claim denial that is overturned on appeal.

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

tractor to a prevailing party under clause (i) shall be determined under a fee schedule established by the Secretary for such purpose.

''(C) POSTPAYMENT AND PREPAYMENT AUDITS.—

''(i) REQUIRING FOCUS ON WIDESPREAD PAYMENT ERRORS.—

''(I) IN GENERAL.—The Secretary shall not approve the conduct of a postpayment or prepayment medical necessity audit by a recovery audit contractor unless such review addresses a widespread payment error rate (as defined in clause (ii)).

''(II) CESSATION OF AUDIT.—A recovery audit contractor that commences an audit under subclause (I) shall cease such audit or any similar audits, if upon annual review, the applicable payment error rate is no longer a widespread payment error rate (as so defined).

''(ii) WIDESPREAD PAYMENT ERROR RATE DEFINED.—

"(I) IN GENERAL.—In this subparagraph, the term 'widespread payment error rate' means, with respect to medical necessity reviews conducted by a recovery audit contractor, a payment error rate that exceeds the rate specified in subclause (II) for a particular medical necessity audit determined by the Secretary using a statistically significant sampling of claims submitted by hospitals in the jurisdiction of the recovery audit contractor and adjusted to take into account claim denials overturned on appeal.

"(II) RATE SPECIFIED.—The rate specified in this subclause is 40 percent, except that the Secretary shall annually evaluate such rate and reduce it as necessary to account for changes in payment error rates with the aim of continued, steady improvement of billing practices.

"(D) GUIDELINES FOR PREPAYMENT REVIEW.—

"(i) IN GENERAL.—A recovery audit contractor may only conduct prepayment review in the manner provided under prepayment review guidelines (described in clause (ii)) established by the Secretary.

"(ii) CONSISTENT PREPAYMENT REVIEW GUIDELINES.—For purposes of prepayment review activities authorized under this subsection and section 1874A(h) (relating to prepayment review by medicare administrative contractors), the Secretary shall establish guidelines under which consistent criteria for minimum payment error rates or improper billing practices occasion prepayment review by contractors under this subsection and section 1874A. Such guidelines shall include criteria for termination, including termination dates, of prepayment review.".

(2) CONFORMING AMENDMENT TO APPLY FINANCIAL PENALTIES IMPOSED ON RECOVERY CONTRACTORS TO THE TRUST FUNDS.—Section 1893(h)(2) of the Social Security Act (42 U.S.C. 1395ddd(h)(2)) is amended by inserting ", and amounts collected by the Secretary under paragraph

(10)(A)(i) (relating to financial penalties for contractor compliance failures),'' after ''paragraph (1)(C)''.

(b) CONFORMING AMENDMENT FOR MEDICARE ADMINISTRATIVE CONTRACTORS.—Section 1874A of the Social Security Act (42 U.S.C. 1395kk–1) is amended by adding at the end the following new subsection:

''(h) MANDATORY TERMS AND CONDITIONS UNDER CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS.—In addition to such other terms and conditions as the Secretary may require under contracts with medicare administrative contractors under this section with respect to a hospital, including a psychiatric hospital (as defined in section 1861(f)), the Secretary shall ensure each of the following requirements are included under such contracts:

''(1) POSTPAYMENT AND PREPAYMENT AUDITS.—

''(A) REQUIRING FOCUS ON WIDESPREAD PAYMENT ERRORS.—

''(i) IN GENERAL.—The Secretary shall not approve the conduct of a postpayment or prepayment medical necessity audit by a medicare administrative contractor unless such review addresses a

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

''(ii) CESSATION OF AUDIT.—A medicare administrative contractor that commences an audit under clause (i) shall cease such audit or any similar audits, if upon annual review, the applicable payment error rate is no longer a widespread payment error rate (as so defined).

''(B) WIDESPREAD PAYMENT ERROR RATE DEFINED.—In this paragraph, the term 'widespread payment error rate' means, with respect to medical necessity reviews conducted by a medicare administrative contractor, a payment error rate of 40 percent or greater for a particular medical necessity audit determined by the Secretary using a statistically significant sampling of claims submitted by hospitals in the jurisdiction of the medicare administrative contractor and adjusted to take into account claim denials overturned on appeal.

''(2) GUIDELINES FOR PREPAYMENT REVIEW.—A medicare administrative contractor may only conduct prepayment review in the manner provided

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

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

SEC. 4. GREATER TRANSPARENCY OF RECOVERY AUDITOR PERFORMANCE.

(a) ANNUAL PUBLICATION OF RELEVANT PERFORMANCE INFORMATION.—Section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)), as amended by section 3(a), is further amended by adding at the end the following new paragraph:

''(11) INFORMATION ON RECOVERY AUDIT CONTRACTOR PERFORMANCE.—With respect to each recovery audit contractor with a contract under this section for a contract year, the Secretary shall publish on the Internet website of the Centers for Medicare & Medicaid Services the following information with respect to the performance of each such recovery audit contractor:

"(A) PUBLICLY AVAILABLE INFORMATION ON AUDIT RATES, DENIALS, AND APPEALS OUTCOMES.—With respect to the performance of each such recovery audit contractor during a contract year, the Secretary shall post on such Internet website the following information:

"(i) AUDITS.—The aggregate number of audits conducted by the recovery audit contractor during the contract year involved, as well as the number of audits of each of the following audit types (each in this paragraph referred to as an 'audit type'):

"(I) Automated.

"(II) Complex.

"(III) Medical necessity review.

"(IV) Part A claims.

"(V) Part B claims.

"(VI) Durable medical equipment claims.

"(VII) Part A medical necessity.

"(ii) DENIALS.—The aggregate number of denials for each audit type made by the recovery audit contractor during the contract year involved.

''(iii) DENIAL RATES.—The denial rate of the recovery audit contractor during the contract year involved for part A claims, part B claims, and durable medical equipment claims.

''(iv) APPEALS.—The aggregate number of appeals filed by providers of services and suppliers with respect to denials for each audit type made by the recovery audit contractor during the contract year involved.

''(v) APPEALS RATES.—The aggregate rate of appeals filed by providers of services and suppliers with respect to denials for each audit type made by the recovery audit contractor during the contract year involved.

''(vi) APPEALS OUTCOMES AT EACH OF THE 5 STAGES OF APPEAL.—The outcome of each appeal filed by a provider of services or supplier of a denial made by a recovery audit contractor at each level of appeal as follows:

''(I) Reconsideration by the relevant medicare contractor.

"(II) Redetermination by a qualified independent contractor.

"(III) Administrative law judge hearing.

"(IV) Medicare Appeals Council review.

"(V) United States District Court judicial review.

"(vii) NET DENIALS.—The net denial for each audit type, calculated as the difference between the number of denials for such audit type under clause (ii) and the number of denials for such audit type overturned on appeal.

"(B) PUBLIC AVAILABILITY OF INDEPENDENT PERFORMANCE EVALUATION.—The Secretary shall make available on such Internet website the results of any performance evaluation with respect to each recovery audit contractor conducted by an independent entity selected by the Secretary for such purpose. Each performance evaluation shall include in its results for posting on such Internet website a determination of annual error rates of the recovery audit contractor for each audit type and the

net denials described in subparagraph (A)(vii).''.

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

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

(a) CLARIFICATION OF AVAILABILITY OF ALL APPEAL RIGHTS.—In conducting the AB Rebilling Demonstration (as defined in subsection (b)), the Secretary of Health and Human Services may not prohibit any appeal from, or any form of appeal available to, a hospital with respect to the inpatient hospital services furnished for which payment may be made under part A of title XVIII of the Social Security Act for which the claim submitted by such hospital was denied as an inpatient admission by a recovery auditor with a contract under section 1893(h) of such Act (42 U.S.C. 1395ddd(h)) due to a finding by the contractor that the inpatient admission was not reasonable and medically necessary.

(b) AB REBILLING DEMONSTRATION DEFINED.—In this section, the term ''AB Rebilling Demonstration''

means the Medicare Part A to Part B Rebilling (AB Rebilling) Demonstration conducted during calendar years 2012 through 2014 by the Secretary of Health and Human Services through the Administrator of the Centers for Medicare & Medicaid Services under which a hospital with a participation agreement under the Medicare program may receive 90 percent of the allowable part B payment for part A short-stay claims that are denied on the basis that the inpatient admission was not reasonable and necessary.

SEC. 6. ACCURATE PAYMENT FOR REBILLED CLAIMS.

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

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

"(12) TREATMENT OF RESUBMISSION OF SPECIFIED CLAIMS AS ORIGINAL CLAIMS.—

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

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

"(i) payment under part B; and

"(ii) provisions under this title relating to—

"(I) the authority of a hospital to resubmit a claim for payment under the appropriate section of this title; and

"(II) requirements for the timely submission of claims, including under sections 1814(a), 1842(b)(3), and 1835(a).

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

"(C) DEFINITIONS.—In this paragraph:

"(i) SPECIFIED CLAIM.—The term 'specified claim' means a claim submitted by a hospital for payment under part A for inpatient hospital services which a recovery audit contractor determines—

''(I) the inpatient hospital services were not medically necessary and reasonable under section 1862(a)(1)(A) based on site of service; and

''(II) the services furnished would be medically necessary and reasonable in an outpatient setting of the hospital.

''(ii) RESUBMISSION.—The term 'resubmission' includes, with respect to a specified claim of a hospital, the submission by the hospital of a new claim or of an adjusted original claim.''.

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

''(3) TREATMENT OF RESUBMISSION OF SPECIFIED CLAIMS AS ORIGINAL CLAIMS.—

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

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

"(i) payment under part B; and

"(ii) provisions under this title relating to—

"(I) the authority of a hospital to resubmit a claim for payment under the appropriate section of this title; and

"(II) requirements for the timely submission of claims, including under sections 1814(a), 1842(b)(3), and 1835(a).

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

"(C) DEFINITIONS.—In this paragraph:

"(i) SPECIFIED CLAIM.—The term 'specified claim' means a claim submitted by a hospital for payment under part A for inpatient hospital services which a medi-

care administrative contractor determines—

"(I) the inpatient hospital services were not medically necessary and reasonable under section 1862(a)(1)(A) based on site of service; and

"(II) the services furnished would be medically necessary and reasonable in an outpatient setting of the hospital.

"(ii) RESUBMISSION.—The term 'resubmission' includes, with respect to a specified claim of a hospital, the submission by the hospital of a new claim or of an adjusted original claim.".

(3) CONFORMING REQUIREMENT FOR CERT CONTRACTORS.—

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

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

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

(ii) provisions under such title relating to—

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

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

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

(C) DEFINITIONS.—In this paragraph:

(i) SPECIFIED CLAIM.—The term ''specified claim'' means a claim submitted by a hospital (as defined in section 1861(e) of such Act (42 U.S.C. 1395x(e))) for payment under title XVIII of such Act for inpatient hospital services which a Comprehensive Error Rate Testing (CERT) program contractor determines—

(I) the inpatient hospital services were not medically necessary and reasonable under section 1862(a)(1)(A) of such Act based on site of service; and

(II) the services furnished would be medically necessary and reasonable in an outpatient setting of the hospital.

(ii) RESUBMISSION.—The term ''resubmission'' includes, with respect to a specified claim of a hospital, the submission by the hospital of a new claim or of an adjusted original claim.

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

or renewed with recovery audit contractors under section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)), medicare administrative contractors under section 1874A of the Social Security Act (42 U.S.C. 1395kk–1) and Comprehensive Error Rate Testing (CERT) program contractors, respectively, on or after the date of the enactment of this Act.

(b) TREATMENT OF AUDITED CLAIMS AS REOPENED.—

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

''For purposes of the ability of a hospital to resubmit a claim for payment under the appropriate section of this title and for purposes of requirements for the timely submission of claims by hospitals, including under sections 1814(a), 1842(b)(3), and 1835(a), any claim that is the subject of an audit by a recovery audit contractor with a contract under this section shall be deemed to be a reopened claim.''.

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

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

''(4) TREATMENT OF AUDITED CLAIMS AS REOPENED.—For purposes of the ability of a hospital to resubmit a claim for payment under the appropriate provisions of this title and for purposes of requirements for the timely submission of claims by hospitals, including under sections 1814(a), 1842(b)(3), and 1835(a), any claim that is the subject of an audit by a medicare administrative contractor with a contract under this section shall be deemed to be a reopened claim.''.

(3) CONFORMING REQUIREMENT FOR CERT CONTRACTORS.—

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

of the ability of such hospital to resubmit a claim for payment under the appropriate provisions of such title XVIII and for purposes of requirements for the timely submission of claims by hospitals under such title XVIII, including under sections 1814(a), 1842(b)(3), and 1835(a) of the Social Security Act (42 U.S.C. 1395f(a), 1395u(b)(3), and 1395n(a), respectively).

(B) DEFINITION.—In this paragraph, the term ''hospital'' has the meaning given such term in subsection (e) of section 1861 of the Social Security Act (42 U.S.C. 1395x), and includes a psychiatric hospital as defined in subsection (f) of such section.

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

SEC. 7. REQUIREMENT FOR PHYSICIAN VALIDATION FOR MEDICAL NECESSITY DENIALS.

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

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

"(13) PHYSICIAN VALIDATION OF MEDICAL NECESSITY DENIALS MADE BY NON-PHYSICIAN REVIEWERS.—

"(A) IN GENERAL.—Each contract under this section for a recovery audit contractor shall require that a physician (as defined in section 1861(r)(1)) review each denial of a claim for medical necessity when a medical necessity review of such claim is performed and a denial is made by an employee of the contractor who is not a physician (as so defined).

"(B) DETERMINATION; VALIDATION.—A physician reviewing a claim under subparagraph (A) shall—

"(i) make a determination whether the denial of the claim under the medical necessity review by the non-physician employee is appropriate;

"(ii) sign and certify such determination; and

"(iii) append such signed and certified determination to the claim file.

"(C) TREATMENT AS MEDICALLY NECESSARY.—A claim with respect to which a denial has been made as described in subparagraph (A) for which the physician determines the denial is not appropriate under subparagraph (B) shall be deemed to be medically necessary.

"(D) MEDICAL NECESSITY REVIEW DEFINED.—In this paragraph, the term 'medical necessity review' means, with respect to an audit of a claim of a provider of services or supplier, a review conducted by a recovery audit contractor for the purpose of determining whether an item or service furnished for which the claim is filed by such provider of services or supplier is reasonable and necessary for the diagnosis or treatment of illness or injury under section 1862(a)(1)(A).".

(b) CONFORMING AMENDMENT TO MEDICARE ADMINISTRATIVE CONTRACTORS.—Subsection (h) of section 1874A of the Social Security Act (42 U.S.C. 1395kk–1), as added by section 3(b) and as amended by subsections (a)(2) and (b)(2) of section 6, is further amended by adding at the end the following new paragraph:

''(5) PHYSICIAN VALIDATION OF MEDICAL NECESSITY DENIALS MADE BY NON-PHYSICIAN REVIEWERS.—

''(A) IN GENERAL.—A physician (as defined in section 1861(r)(1)) shall review each denial of a claim for medical necessity when a medical necessity review of such claim is performed and a denial is made by an employee of the contractor who is not a physician (as so defined).

''(B) DETERMINATION; VALIDATION.—A physician reviewing a claim under subparagraph (A) shall—

''(i) make a determination whether the denial of the claim under the medical necessity review by the non-physician employee is appropriate;

''(ii) sign and certify such determination; and

''(iii) append such signed and certified determination to the claim file.

''(C) TREATMENT AS MEDICALLY NECESSARY.—A claim with respect to which a denial has been made as described in subparagraph (A) for which the physician determines

the denial is not appropriate under subparagraph (B) shall be deemed to be medically necessary.

''(D) MEDICAL NECESSITY REVIEW DEFINED.—In this paragraph, the term 'medical necessity review' means, with respect to an audit of a claim of a provider of services or supplier, a review conducted by a medicare administrative contractor for the purpose of determining whether an item or service furnished for which the claim is filed by such provider of services or supplier is reasonable and necessary for the diagnosis or treatment of illness or injury under section 1862(a)(1)(A).''.

(c) CONFORMING REQUIREMENT FOR CERT CONTRACTORS.—

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

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

(2) DETERMINATION; VALIDATION.—A physician reviewing a claim under paragraph (1) shall—

(A) make a determination whether the denial of the claim under the medical necessity review by the non-physician employee is appropriate;

(B) sign and certify such determination; and

(C) append such signed and certified determination to the claim file.

(3) TREATMENT AS MEDICALLY NECESSARY.—A claim with respect to which a denial has been made as described in paragraph (1) for which the physician determines the denial is not appropriate under paragraph (2) shall be deemed to be medically necessary.

(4) MEDICAL NECESSITY REVIEW DEFINED.—In this subsection, the term ''medical necessity review'' means, with respect to an audit of a claim of

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

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (b), and the provisions of subsection (c), shall apply to contracts entered into or renewed with recovery audit contractors under section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)), medicare administrative contractors under section 1874A of the Social Security Act (42 U.S.C. 1395kk–1) and Comprehensive Error Rate Testing (CERT) program contractors, respectively, on or after the date of the enactment of this Act.

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