

113TH CONGRESS
1ST SESSION

H. R. 2914

To prevent abusive billing of ancillary services to the Medicare program,
and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

AUGUST 1, 2013

Ms. SPEIER (for herself, Ms. TITUS, and Mr. McDERMOTT) 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

A BILL

To prevent abusive billing of ancillary services to the
Medicare program, and for other purposes.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Promoting Integrity
5 in Medicare Act of 2013”.

6 **SEC. 2. FINDINGS; PURPOSES.**

7 (a) FINDINGS.—Congress finds the following:

1 (1) Recent studies by the Government Account-
2 ability Office (GAO) examining self-referral practices
3 in advanced diagnostic imaging and anatomic pa-
4 thology determined that financial incentives were the
5 most likely cause of increases in self-referrals.

6 (2) For advanced diagnostic imaging, GAO
7 stated that “providers who self-referred made
8 400,000 more referrals for advanced imaging serv-
9 ices than they would have if they were not self-refer-
10 ring”, at a cost of “more than \$100 million” in
11 2010.

12 (3) For anatomic pathology, GAO found that
13 “self-referring providers likely referred over 918,000
14 more anatomic pathology services” than they would
15 have if they were not self-referring, costing Medicare
16 approximately \$69 million more in 2010 than if self-
17 referral was not permitted.

18 (4) Noting the rapid growth of services covered
19 by the in-office ancillary services (IOAS) exception
20 and evidence that these services are sometimes fur-
21 nished inappropriately by referring physicians, the
22 Medicare Payment Advisory Commission (MedPAC)
23 stated that physician self-referral of ancillary serv-
24 ices creates incentives to increase volume under
25 Medicare’s current fee-for-service payment systems

1 and the rapid volume growth contributes to Medi-
2 care's rising financial burden on taxpayers and bene-
3 ficiaries.

4 (5) According to the Centers for Medicare &
5 Medicaid Services, a key rationale for the IOAS ex-
6 ception was to permit physicians to provide ancillary
7 services in their offices to better inform diagnosis
8 and treatment decisions at the time of the patient's
9 initial office visit.

10 (6) It is necessary, therefore, to distinguish be-
11 tween services and procedures that were intended to
12 be covered by the IOAS exception, such as routine
13 clinical laboratory services or simple x-rays that are
14 provided during the patient's initial office visit, and
15 other health care services which were clearly not en-
16 visioned to be covered by that exception because they
17 cannot be performed during the patient's initial of-
18 fice visit.

19 (7) According to a 2010 Health Affairs study,
20 less than 10 percent of CT, MRI, and Nuclear Medi-
21 cine scans take place on the same day as the initial
22 patient office visit.

23 (8) According to a 2012 Health Affairs study,
24 urologists' self-referrals for anatomic pathology serv-
25 ices of biopsy specimens is linked to increased use

1 and volume billed along with a lower detection of
2 prostate cancer.

3 (9) According to an October 2011 Laboratory
4 Economics report, there has been an increase in the
5 number of anatomic pathology specimen units billed
6 to the Medicare part B program from 2006 through
7 2010, specifically for CPT Code 88305, and the rate
8 of increase billed by physician offices for this service
9 is accelerating at a far greater pace than the rest of
10 the provider segments.

11 (10) According to a 2013 American Academy of
12 Dermatology Pathology Billing paper, arrangements
13 involving the split of the technical and professional
14 components of anatomic pathology services among
15 different providers may endanger patient safety and
16 undermine quality of care.

17 (11) In November 2012, Bloomberg News re-
18 leased an investigative report that scrutinized or-
19 deals faced by California prostate cancer patients
20 treated by a urology clinic that owns radiation ther-
21 apy equipment. The report found that physician self-
22 referral resulted in a detrimental impact on patient
23 care and drove up health care costs in the Medicare
24 program. The Wall Street Journal, the Washington
25 Post, and the Baltimore Sun have also published in-

1 investigations showing that urology groups owning ra-
2 diation therapy machines have utilization rates that
3 rise quickly and are well above national norms for
4 radiation therapy treatment of prostate cancer.

5 (12) According to a 2010 MedPAC report, only
6 3 percent of outpatient physical therapy services
7 were provided on the same day as an office visit,
8 only 9 percent within 7 days of an office visit, and
9 only 14 percent within 14 days of an office visit.
10 These services are not integral to the physician’s ini-
11 tial diagnosis and do not improve patient conven-
12 ience because patients must return for physical ther-
13 apy treatments.

14 (13) Those services intended to be covered
15 under the IOAS exception are not affected by this
16 legislation.

17 (14) The exception to the ownership or invest-
18 ment prohibition for rural providers in the “Stark”
19 rule is not affected by this legislation.

20 (b) PURPOSES.—The purposes of this Act are the fol-
21 lowing:

22 (1) Maintain the in-office ancillary services ex-
23 ception and preserve its original intent by removing
24 certain complex services from the exception—specifi-

1 cally, advanced imaging, anatomic pathology, radi-
2 ation therapy, and physical therapy.

3 (2) Protect patients from misaligned provider
4 financial incentives.

5 (3) Protect Medicare resources by saving bil-
6 lions of dollars.

7 (4) Accomplish the purposes described in para-
8 graphs (1), (2), and (3) in a manner that does not
9 alter the existing exception to the ownership or in-
10 vestment prohibition for rural providers.

11 **SEC. 3. LIMITATION ON APPLICATION OF PHYSICIANS’**
12 **SERVICES AND IN-OFFICE ANCILLARY SERV-**
13 **ICES EXCEPTIONS.**

14 (a) IN GENERAL.—Section 1877(b) of the Social Se-
15 curity Act (42 U.S.C. 1395nn(b)) is amended—

16 (1) in paragraph (1), by inserting “, other than
17 specified non-ancillary services,” after “section
18 1861(q)”; and

19 (2) in paragraph (2), by inserting “, specified
20 non-ancillary services,” after “(excluding infusion
21 pumps)”.

22 (b) INCREASE OF CIVIL MONEY PENALTIES.—Sec-
23 tion 1877(g) of the Social Security Act (42 U.S.C.
24 1395nn(g)) is amended—

1 (1) in paragraph (3), by inserting “, unless
2 such bill or claim included a bill or claim for a speci-
3 fied non-ancillary service, in which case the civil
4 money penalty shall be not more than \$25,000 for
5 each such service” before the period at the end of
6 the first sentence; and

7 (2) in paragraph (4), by inserting “(or
8 \$150,000 if such referrals are for specified non-an-
9 cillary services)” after “\$100,000”.

10 (c) ENHANCED SCREENING OF CLAIMS.—Section
11 1877(g) of the Social Security Act (42 U.S.C. 1395nn(g))
12 is further amended by adding at the end the following new
13 paragraph:

14 “(7) COMPLIANCE REVIEW FOR SPECIFIED
15 NON-ANCILLARY SERVICES.—

16 “(A) IN GENERAL.—Not later than 180
17 days after the date of the enactment of this
18 paragraph, the Secretary, in consultation with
19 the Inspector General of the Department of
20 Health and Human Services, shall review com-
21 pliance with subsection (a)(1) with respect to
22 referrals for specified non-ancillary services in
23 accordance with procedures established by the
24 Secretary.

1 “(B) FACTORS IN COMPLIANCE REVIEW.—

2 Such procedures—

3 “(i) shall, for purposes of targeting
4 types of entities that the Secretary deter-
5 mines represent a high risk of noncompli-
6 ance with subsection (a)(1) with respect to
7 such billing for such specified non-ancillary
8 services, apply different levels of review
9 based on such type; and

10 “(ii) may include prepayment reviews,
11 claims audits, focused medical review, com-
12 puter algorithms designed to identify pay-
13 ment or billing anomalies.”.

14 (d) DEFINITION OF SPECIFIED NON-ANCILLARY
15 SERVICES.—Section 1877(h) of the Social Security Act
16 (42 U.S.C. 1395nn(h)) is amended by adding at the end
17 the following new paragraph:

18 “(8) SPECIFIED NON-ANCILLARY SERVICES.—

19 The term ‘specified non-ancillary service’ means a
20 service that the Secretary has determined is not usu-
21 ally provided and completed during an office visit to
22 a physician’s office in which the service is deter-
23 mined to be necessary, and includes the following:

24 “(A) Anatomic pathology services, as de-
25 fined by the Secretary and including the tech-

1 nical or professional component of the fol-
2 lowing:

3 “(i) Surgical pathology.

4 “(ii) Cytopathology.

5 “(iii) Hematology.

6 “(iv) Blood banking.

7 “(v) Pathology consultation and clin-
8 ical laboratory interpretation services.

9 “(B) Radiation therapy services and sup-
10 plies, as defined by the Secretary.

11 “(C) Advanced diagnostic imaging studies
12 (as defined in section 1834(e)(1)(B)).

13 “(D) Physical therapy services (as de-
14 scribed in paragraph (6)(B)).”.

15 (e) CONSTRUCTION.—Nothing in this section (or the
16 amendments made by this section) shall be construed to
17 affect the authority of the Secretary of Health and Human
18 Services to waive the requirements imposed under the pro-
19 visions of this section (or such amendments) under section
20 1899 of the Social Security Act (42 U.S.C. 1395jjj).

21 (f) EFFECTIVE DATE.—The amendments made by
22 subsections (a) and (b) shall apply to items and services
23 furnished on or after the first day of the first month be-
24 ginning more than 12 months after the date of the enact-
25 ment of this Act.

1 **SEC. 4. CLARIFICATION OF CERTAIN ENTITIES SUBJECT TO**
2 **STARK RULE AND ANTI-MARKUP RULE.**

3 Section 1877(h) of the Social Security Act (42 U.S.C.
4 1395nn(h)) is further amended by adding at the end the
5 following new paragraph:

6 “(9) CLARIFICATION OF CERTAIN ENTITIES
7 SUBJECT TO ANTI-MARKUP RULE.—In applying this
8 section, the term ‘entity’ shall include a physician’s
9 practice when it bills under this title for the tech-
10 nical component or the professional component of a
11 specified non-ancillary service, including when such
12 service is billed in compliance with section
13 1842(n)(1).”.

14 **SEC. 5. CLARIFICATION OF SUPERVISION OF TECHNICAL**
15 **COMPONENT OF ANATOMIC PATHOLOGY**
16 **SERVICES.**

17 Section 1861(s)(17) of the Social Security Act (42
18 U.S.C. 1395x(s)(17)) is amended—

19 (1) by striking “and” at the end of subpara-
20 graph (A);

21 (2) by redesignating subparagraph (B) as sub-
22 paragraph (C); and

23 (3) by inserting after subparagraph (A) the fol-
24 lowing new subparagraph:

25 “(B) with regard to the provision of the tech-
26 nical component of anatomic pathology services,

1 meets the applicable supervision requirements for
2 laboratories certified in the subspecialty of
3 histopathology, pursuant to section 353 of the Pub-
4 lic Health Services Act; and”.

5 **SEC. 6. EXEMPTION FROM BUDGET NEUTRALITY UNDER**
6 **PHYSICIAN FEE SCHEDULE.**

7 Section 1848(e)(2)(B)(v) of the Social Security Act
8 (42 U.S.C. 1395w-4(e)(2)(B)(v)) is amended by adding
9 at the end the following new subclause:

10 “(VIII) CHANGES TO LIMITA-
11 TIONS ON CERTAIN PHYSICIAN REFER-
12 RALS.—Effective for fee schedules es-
13 tablished beginning with 2014, re-
14 duced expenditures attributable to the
15 Promoting Integrity in Medicare Act
16 of 2013.”.

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