CLINICAL INTEGRITY & PATIENT SAFETY

Proposed Addition to S.3829 — Corporate Crimes Against Healthcare Act

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S.3829 targets executives. This amendment targets the mechanism. Together they close the Wrongful Denial Echo Chamber.

§ 1 PROHIBITION OF PRIOR KNOWLEDGE OMISSION

(a) Continuity of Clinical Baselines.

When a Medicare Advantage organization or ERISA plan has previously approved a specific functional classification, medical baseline, or K-Level for a beneficiary, that classification shall be deemed an Established Medical Fact for a period of not less than 12 months.

(b) Prohibition on Retroactive Denial.

A plan may not subsequently deny coverage for a related service by claiming the beneficiary does not meet the criteria of the Established Medical Fact, unless the plan provides new, objective clinical evidence proving a material regression in the beneficiary's condition.

Example: If UHC acknowledges a beneficiary's K3 functional mobility status in March, it may not deny a permanent prosthetic in September by claiming the same mobility threshold is unmet — unless it can produce new clinical evidence of decline.

VIOLATION: Denial issued against an Established Medical Fact without documented evidence of regression shall be deemed void ab initio and subject to the Buffer Fund penalty under § 3.

§ 2 THE CLINICAL INTEGRITY RULE — The Act 146 Standard

(a) Specialty Matching Requirement.

Any adverse benefit determination based on medical necessity must be reviewed and certified by a physician holding current, valid Board Certification in the same or a directly relevant specialty as the treating physician.

A pediatrician may not review an adult bariatric claim. A general practitioner may not review a specialized prosthetic claim. A non-vascular physician may not review a vascular surgical necessity determination.

(b) Mandatory Data Review.

The reviewing physician must certify, under penalty of perjury, that they have reviewed all objective clinical data submitted — including physical therapy and occupational therapy

evaluations, imaging, and standardized assessment scores. Failure to review submitted evidence renders the denial void.

VIOLATION: Denial issued by a physician outside the required specialty, or without certified review of submitted clinical data, shall be void and trigger mandatory board reporting under § 5.

§ 3 THE PATIENT SAFETY BUFFER FUND

(a) Presumption of Coverage.

Upon submission of a medical necessity override by the treating physician, coverage shall be provisionally granted through the Patient Safety Buffer Fund while the determination is under review. Patients shall not be denied care during the appeals process.

(b) Funding Mechanism.

The Buffer Fund shall be capitalized and sustained by the 500% clawback penalties generated under S.3829 (Corporate Crimes Against Healthcare Act) when IRE overturns are issued. The insurer funds the safety net their denials necessitate.

IF DENIAL IS UPHELD	IF DENIAL IS OVERTURNED
The treating provider shall repay the Buffer Fund in full.	The insurer shall reimburse the Buffer Fund at 300% of the claim rate.

§ 4 THE ADMINISTRATIVE CURE MANDATE

(a) Prohibition on Pretextual Administrative Denials.

A plan may not issue a final denial for administrative reasons without first providing the provider a 48-Hour Cure Period to correct the identified clerical or procedural deficiency.

(b) Misclassification Penalty.

If a plan classifies a denial as administrative to circumvent the Clinical Integrity review process when the submitted record contained sufficient clinical data to warrant medical review, the plan shall be subject to a civil monetary penalty of $10,000 per violation.

This provision closes the loophole by which insurers reject claims on paperwork pretexts to avoid the specialty-matching and data-review requirements of § 2.

§ 5 PHYSICIAN ACCOUNTABILITY — The Malpractice Trigger

(a) Reportable Conduct.

Any physician acting as a medical director or reviewer who issues a denial that is subsequently overturned by an IRE — due to a demonstrable failure to adhere to established clinical

standards (including Medicare LCDs and FDA labeling) or failure to review submitted evidence — shall be deemed to have engaged in Unprofessional Conduct.

(b) Mandatory Board Reporting.

The Independent Review Entity shall be statutorily required, upon issuing an overturn under this section, to report the name and license number of the reviewing physician to their respective State Medical Board for investigation into malpractice and negligence.

(c) Pierce the Corporate Veil.

Reviewing physicians shall not be shielded from personal liability for patient harm caused by denials issued in contradiction to established medical consensus, regardless of their employment relationship with the plan.

A prosecutor who hides exculpatory evidence faces disbarment. A corporate reviewer who ignores qualifying clinical data faces nothing — until now.

HOW THIS AMENDMENT COMPLETES S.3829

- S.3829 punishes the corporation. This amendment strips the license from the physician who pulled the trigger.
- S.3829 generates penalty revenue. The Buffer Fund deploys it to protect the next patient in line.
- S.3829 calls for investigation. The mandatory board reporting pipeline makes every IRE overturn a self-executing referral.
- S.3829 is the sword. This amendment is the shield. The Buffer Fund is the refuge. The Department of Recovery is the courthouse.
