3, 1982, see section 149 of Pub. L. 97–248, set out as an Effective Date note under section 1320c of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Pub. L. 96–499, title IX, § 956(b), Dec. 5, 1980, 94 Stat. 2648, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect on January 1, 1981.''

EFFECTIVE DATE

Pub. L. 92–603, title II, § 213(b), Oct. 30, 1972, 86 Stat. 1386, provided that: ''The amendments made by this section [enacting this section] shall be effective with respect to claims under part A or part B of title XVIII of the Social Security Act [part A or part B of this subchapter], filed with respect to items or services furnished after the date of the enactment of this Act [Oct. 30, 1972].''

PROVISIONS RELATING TO ADVANCE BENEFICIARY NOTICES; REPORT ON PRIOR DETERMINATION PROCESS

Pub. L. 108–173, title IX, § 938(c), Dec. 8, 2003, 117 Stat. 2415, provided that:

''(1) DATA COLLECTION.—The Secretary [of Health and Human Services] shall establish a process for the collection of information on the instances in which an advance beneficiary notice (as defined in paragraph (5)) has been provided and on instances in which a beneficiary indicates on such a notice that the beneficiary does not intend to seek to have the item or service that is the subject of the notice furnished.

''(2) OUTREACH AND EDUCATION.—The Secretary shall establish a program of outreach and education for beneficiaries and providers of services and other persons on the appropriate use of advance beneficiary notices and coverage policies under the medicare program.

''(3) GAO REPORT ON USE OF ADVANCE BENEFICIARY NOTICES.—Not later than 18 months after the date on which section 1869(h) of the Social Security Act [section 1395ff(h) of this title] (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of advance beneficiary notices under title XVIII of such Act [this subchapter]. Such report shall include information concerning the providers of services and other persons that have provided such notices and the response of beneficiaries to such notices.

''(4) GAO REPORT ON USE OF PRIOR DETERMINATION PROCESS.—Not later than 36 months after the date on which section 1869(h) of the Social Security Act [section 1395ff(h) of this title] (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of the prior determination process under such section. Such report shall include—

''(A) information concerning—

''(i) the number and types of procedures for which a prior determination has been sought;

''(ii) determinations made under the process;

''(iii) the percentage of beneficiaries prevailing;

''(iv) in those cases in which the beneficiaries do not prevail, the reasons why such beneficiaries did not prevail; and

''(v) changes in receipt of services resulting from the application of such process;

''(B) an evaluation of whether the process was useful for physicians (and other suppliers) and beneficiaries, whether it was timely, and whether the amount of information required was burdensome to physicians and beneficiaries; and

''(C) recommendations for improvements or continuation of such process.

''(5) ADVANCE BENEFICIARY NOTICE DEFINED.—In this subsection, the term 'advance beneficiary notice' means a written notice provided under section 1879(a) of the Social Security Act (42 U.S.C. 1395pp(a)) to an individual entitled to benefits under part A or enrolled under part B of title XVIII of such Act [part A and part B of this subchapter] before items or services are furnished under such part in cases where a provider of services or other person that would furnish the item or service believes that payment will not be made for some or all of such items or services under such title [this subchapter].''

REPORTS TO CONGRESS ON DENIALS OF BILLS FOR PAYMENT

Pub. L. 99–509, title IX, § 9305(g)(2), Oct. 21, 1986, 100 Stat. 1992, directed Secretary of Health and Human Services to report to Congress annually in March of 1987 and 1988 information on frequency and distribution (by type of provider) of denials of bills for payment under this subchapter for extended care services, home health services, and hospice care, by reason of section 1395y(a)(1) or (9) of this title, and coverage denials described in subsec. (g) of this section, and such other information as appropriate to evaluate the appropriateness of any percentage standards established for the granting of favorable presumptions with respect to such denials.

§ 1395qq. Indian Health Service facilities

(a) Eligibility for payments; conditions and requirements

A hospital or skilled nursing facility of the Indian Health Service, whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 1603 of title 25), shall be eligible for payments under this subchapter, notwithstanding sections 1395f(c) and 1395n(d) of this title, if and for so long as it meets all of the conditions and requirements for such payments which are applicable generally to hospitals or skilled nursing facilities (as the case may be) under this subchapter.

(b) Eligibility based on submission of plan to achieve compliance with conditions and requirements; twelve-month period

Notwithstanding subsection (a) of this section, a hospital or skilled nursing facility of the Indian Health Service which does not meet all of the conditions and requirements of this subchapter which are applicable generally to hospitals or skilled nursing facilities (as the case may be), but which submits to the Secretary within six months after September 30, 1976, an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for payments under this subchapter), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.

(c) Payments into special fund for improvements to achieve compliance with conditions and requirements; certification of compliance by Secretary

Notwithstanding any other provision of this subchapter, payments to which any hospital or skilled nursing facility of the Indian Health Service is entitled by reason of this section shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the hospitals and skilled nursing facilities of such Service which may be necessary to achieve compliance with the applica-

ble conditions and requirements of this subchapter. The preceding sentence shall cease to apply when the Secretary determines and certifies that substantially all of the hospitals and skilled nursing facilities of such Service in the United States are in compliance with such conditions and requirements.

(d) Report by Secretary; status of facilities in complying with conditions and requirements

The annual report of the Secretary which is required by section 1671 of title 25 shall include (along with the matters specified in section 1643 of title 25) a detailed statement of the status of the hospitals and skilled nursing facilities of the Service in terms of their compliance with the applicable conditions and requirements of this subchapter and of the progress being made by such hospitals and facilities (under plans submitted under subsection (b) of this section and otherwise) toward the achievement of such compliance.

(e) Services provided by Indian Health Service, Indian tribe, or tribal organization

(1)(A) Notwithstanding section 1395n(d) of this title, subject to subparagraph (B), the Secretary shall make payment under part B of this subchapter to a hospital or an ambulatory care clinic (whether provider-based or freestanding) that is operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined for purposes of subsection (a) of this section) for services described in paragraph (2) (and for items and services furnished on or after January 1, 2005, all items and services for which payment may be made under part B of this subchapter) furnished in or at the direction of the hospital or clinic under the same situations, terms, and conditions as would apply if the services were furnished in or at the direction of such a hospital or clinic that was not operated by such Service, tribe, or organization.

(B) Payment shall not be made for services under subparagraph (A) to the extent that payment is otherwise made for such services under this subchapter.

(2) The services described in this paragraph are the following:

(A) Services for which payment is made under section 1395w–4 of this title.

(B) Services furnished by a practitioner described in section 1395u(b)(18)(C) of this title for which payment under part B of this subchapter is made under a fee schedule.

(C) Services furnished by a physical therapist or occupational therapist as described in section 1395x(p) of this title for which payment under part B of this subchapter is made under a fee schedule.

(3) Subsection (c) of this section shall not apply to payments made under this subsection.

(f) Cross reference

For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or organizations and for which payment may be made under this subchapter, see section 1645 of title 25.[1]

(Aug. 14, 1935, ch. 531, title XVIII, § 1880, as added Pub. L. 94–437, title IV, § 401(b), Sept. 30, 1976, 90 Stat. 1408; amended Pub. L. 102–573, title VII, § 701(d), Oct. 29, 1992, 106 Stat. 4572; Pub. L. 106–417, § 3(b)(1), Nov. 1, 2000, 114 Stat. 1815; Pub. L. 106–554, § 1(a)(6) [title IV, § 432(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–525; Pub. L. 108–173, title VI, § 630, Dec. 8, 2003, 117 Stat. 2321; Pub. L. 111–148, title II, § 2902(a), title X, § 10221(a), (b)(4), Mar. 23, 2010, 124 Stat. 333, 935, 936.)

REFERENCES IN TEXT

Section 1645 of title 25, referred to in subsec. (f), was amended generally by section 10221(a) of title X of Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 935, and, as so amended, no longer contains provisions relating to direct billing of medicare, medicaid, and other third party payors.

CODIFICATION

Pub. L. 111–148, § 10221(a), enacted into law S. 1790, One Hundred Eleventh Congress, as reported by the Committee on Indian Affairs of the Senate in Dec. 2009, ''[e]xcept as provided in'' section 10221(b) of Pub. L. 111–148. Section 201(a) of S. 1790 would have amended this section but was stricken out by section 10221(b)(4) of Pub. L. 111–148.

AMENDMENTS

2010—Subsec. (e)(1)(A). Pub. L. 111–148, § 2902(a), substituted ''on or after'' for ''during the 5-year period beginning on''.

2003—Subsec. (e)(1)(A). Pub. L. 108–173 inserted ''(and for items and services furnished during the 5-year period beginning on January 1, 2005, all items and services for which payment may be made under part B of this subchapter)'' after ''for services described in paragraph (2)''.

2000—Subsec. (e). Pub. L. 106–554, § 1(a)(6) [title IV, § 432(a)(2)], added subsec. (e). Former subsec. (e) redesignated (f).

Pub. L. 106–417 added subsec. (e).

Subsec. (f). Pub. L. 106–554, § 1(a)(6) [title IV, § 432(a)(1)], redesignated subsec. (e) as (f).

1992—Subsec. (d). Pub. L. 102–573 made technical amendment to the reference to section 1671 of title 25 to reflect renumbering of corresponding section of original act.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–148, title II, § 2902(b), Mar. 23, 2010, 124 Stat. 333, provided that: ''The amendments made by this section [amending this section] shall apply to items or services furnished on or after January 1, 2010.''

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title IV, § 432(a)] of Pub. L. 106–554 applicable to services furnished on or after July 1, 2001, see section 1(a)(6) [title IV, § 432(c)] of Pub. L. 106–554, set out as a note under section 1395u of this title.

Amendment by Pub. L. 106–417 effective Oct. 1, 2000, see section 3(c) of Pub. L. 106–417, set out as a note under section 1645 of Title 25, Indians.

MEDICARE PAYMENTS NOT CONSIDERED IN DETERMINING APPROPRIATIONS FOR INDIAN HEALTH CARE

Pub. L. 94–437, title IV, § 401(c), Sept. 30, 1976, 90 Stat. 1409, provided that any payments received for services provided to beneficiaries under this section were not to be considered in determining appropriations for health care and services to Indians, prior to the general

[1] See References in Text note below.

amendment of section 401 of Pub. L. 94–437 by Pub. L. 102–573, title IV, § 401(a), Oct. 29, 1992, 106 Stat. 4565. Similar provisions are contained in section 401(a) of Pub. L. 94–437, which is classified to section 1641(a) of Title 25, Indians.

PREFERENCE IN SERVICES FOR INDIANS WITH MEDICARE COVERAGE NOT AUTHORIZED

Pub. L. 94–437, title IV, § 401(d), Sept. 30, 1976, 90 Stat. 1409, which provided that nothing in this section authorized the Secretary to provide services to an Indian beneficiary with coverage under this subchapter, in preference to an Indian beneficiary without such coverage, prior to the general amendment of section 401 of Pub. L. 94–437 by Pub. L. 102–573, title IV, § 401(a), Oct. 29, 1992, 106 Stat. 4565. Similar provisions are contained in section 401(b) of Pub. L. 94–437, which is classified to section 1641(b) of Title 25, Indians.

§ 1395rr. End stage renal disease program

(a) Type, duration, and scope of benefits

The benefits provided by parts A and B of this subchapter shall include benefits for individuals who have been determined to have end stage renal disease as provided in section 426–1 of this title, and benefits for kidney donors as provided in subsection (d) of this section. Notwithstanding any other provision of this subchapter, the type, duration, and scope of the benefit provided by parts A and B of this subchapter with respect to individuals who have been determined to have end stage renal disease and who are entitled to such benefits without regard to section 426–1 of this title shall in no case be less than the type, duration, and scope of the benefits so provided for individuals entitled to such benefits solely by reason of that section.

(b) Payments with respect to services; dialysis; regulations; physicians' services; target reimbursement rates; home dialysis supplies and equipment; self-care home dialysis support services; self-care dialysis units; hepatitis B vaccine

(1) Payments under this subchapter with respect to services, in addition to services for which payment would otherwise be made under this subchapter, furnished to individuals who have been determined to have end stage renal disease shall include (A) payments on behalf of such individuals to providers of services and renal dialysis facilities which meet such requirements as the Secretary shall by regulation prescribe for institutional dialysis services and supplies (including self-dialysis services in a self-care dialysis unit maintained by the provider or facility), transplantation services, self-care home dialysis support services which are furnished by the provider or facility, and routine professional services performed by a physician during a maintenance dialysis episode if payments for his other professional services furnished to an individual who has end stage renal disease are made on the basis specified in paragraph (3)(A) of this subsection, (B) payments to or on behalf of such individuals for home dialysis supplies and equipment, and (C) payments to a supplier of home dialysis supplies and equipment that is not a provider of services, a renal dialysis facility, or a physician for self-administered erythropoietin as described in section 1395x(s)(2)(P)[1] of this title if the Secretary finds that the patient receiving such drug from such a supplier can safely and effectively administer the drug (in accordance with the applicable methods and standards established by the Secretary pursuant to such section). The requirements prescribed by the Secretary under subparagraph (A) shall include requirements for a minimum utilization rate for transplantations.

(2)(A) With respect to payments for dialysis services furnished by providers of services and renal dialysis facilities to individuals determined to have end stage renal disease for which payments may be made under part B of this subchapter, such payments (unless otherwise provided in this section) shall be equal to 80 percent of the amounts determined in accordance with subparagraph (B); and with respect to payments for services for which payments may be made under part A of this subchapter, the amounts of such payments (which amounts shall not exceed, in respect to costs in procuring organs attributable to payments made to an organ procurement agency or histocompatibility laboratory, the costs incurred by that agency or laboratory) shall be determined in accordance with section 1395x(v) of this title or section 1395ww of this title (if applicable). Payments shall be made to a renal dialysis facility only if it agrees to accept such payments as payment in full for covered services, except for payment by the individual of 20 percent of the estimated amounts for such services calculated on the basis established by the Secretary under subparagraph (B) and the deductible amount imposed by section 1395*l*(b) of this title.

(B) The Secretary shall prescribe in regulations any methods and procedures to (i) determine the costs incurred by providers of services and renal dialysis facilities in furnishing covered services to individuals determined to have end stage renal disease, and (ii) determine, on a cost-related basis or other economical and equitable basis (including any basis authorized under section 1395x(v) of this title) and consistent with any regulations promulgated under paragraph (7), the amounts of payments to be made for part B services furnished by such providers and facilities to such individuals.

(C) Such regulations, in the case of services furnished by proprietary providers and facilities (other than hospital outpatient departments) may include, if the Secretary finds it feasible and appropriate, provision for recognition of a reasonable rate of return on equity capital, providing such rate of return does not exceed the rate of return stipulated in section 1395x(v)(1)(B) of this title.

(D) For purposes of section 1395*oo* of this title, a renal dialysis facility shall be treated as a provider of services.

(3) With respect to payments for physicians' services furnished to individuals determined to have end stage renal disease, the Secretary shall pay 80 percent of the amounts calculated for such services—

(A) on a reasonable charge basis (but may, in such case, make payment on the basis of the prevailing charges of other physicians for comparable services or, for services furnished on or after January 1, 1992, on the basis described in section 1395w–4 of this title) except

[1] See References in Text note below.