''(2) PUBLICATION ON INTERNET WEBSITE OF SRDP INFORMATION.—The Secretary of Health and Human Services shall post information on the public Internet website of the Centers for Medicare & Medicaid Services to inform relevant stakeholders of how to disclose actual or potential violations pursuant to an SRDP.

''(3) RELATION TO ADVISORY OPINIONS.—The SRDP shall be separate from the advisory opinion process set forth in regulations implementing section 1877(g) of the Social Security Act [42 U.S.C. 1395nn(g)].

''(b) REDUCTION IN AMOUNTS OWED.—The Secretary of Health and Human Services is authorized to reduce the amount due and owing for all violations under section 1877 of the Social Security Act [42 U.S.C. 1395nn] to an amount less than that specified in subsection (g) of such section. In establishing such amount for a violation, the Secretary may consider the following factors:

''(1) The nature and extent of the improper or illegal practice.

''(2) The timeliness of such self-disclosure.

''(3) The cooperation in providing additional information related to the disclosure.

''(4) Such other factors as the Secretary considers appropriate.

''(c) REPORT.—Not later than 18 months after the date on which the SRDP protocol is established under subsection (a)(1), the Secretary shall submit to Congress a report on the implementation of this section. Such report shall include—

''(1) the number of health care providers of services and suppliers making disclosures pursuant to the SRDP;

''(2) the amounts collected pursuant to the SRDP;

''(3) the types of violations reported under the SRDP; and

''(4) such other information as may be necessary to evaluate the impact of this section.''

APPLICATION OF EXCEPTION FOR HOSPITALS UNDER DEVELOPMENT

Pub. L. 108–173, title V, §507(b), Dec. 8, 2003, 117 Stat. 2296, provided that: ''For purposes of section 1877(h)(7)(B)(i)(II) of the Social Security Act [42 U.S.C. 1395nn(h)(7)(B)(i)(II)], as added by subsection (a)(1)(B), in determining whether a hospital is under development as of November 18, 2003, the Secretary [of Health and Human Services] shall consider—

''(1) whether architectural plans have been completed, funding has been received, zoning requirements have been met, and necessary approvals from appropriate State agencies have been received; and

''(2) any other evidence the Secretary determines would indicate whether a hospital is under development as of such date.''

STUDIES

Pub. L. 108–173, title V, §507(c), Dec. 8, 2003, 117 Stat. 2296, provided that:

''(1) MEDPAC STUDY.—The Medicare Payment Advisory Commission, in consultation with the Comptroller General of the United States, shall conduct a study to determine—

''(A) any differences in the costs of health care services furnished to patients by physician-owned specialty hospitals and the costs of such services furnished by local full-service community hospitals within specific diagnosis-related groups;

''(B) the extent to which specialty hospitals, relative to local full-service community hospitals, treat patients in certain diagnosis-related groups within a category, such as cardiology, and an analysis of the selection;

''(C) the financial impact of physician-owned specialty hospitals on local full-service community hospitals;

''(D) how the current diagnosis-related group system should be updated to better reflect the cost of delivering care in a hospital setting; and

''(E) the proportions of payments received, by type of payer, between the specialty hospitals and local full-service community hospitals.

''(2) HHS STUDY.—The Secretary [of Health and Human Services] shall conduct a study of a representative sample of specialty hospitals—

''(A) to determine the percentage of patients admitted to physician-owned specialty hospitals who are referred by physicians with an ownership interest;

''(B) to determine the referral patterns of physician owners, including the percentage of patients they referred to physician-owned specialty hospitals and the percentage of patients they referred to local full-service community hospitals for the same condition;

''(C) to compare the quality of care furnished in physician-owned specialty hospitals and in local full-service community hospitals for similar conditions and patient satisfaction with such care; and

''(D) to assess the differences in uncompensated care, as defined by the Secretary, between the specialty hospital and local full-service community hospitals, and the relative value of any tax exemption available to such hospitals.

''(3) REPORTS.—Not later than 15 months after the date of the enactment of this Act [Dec. 8, 2003], the Commission and the Secretary, respectively, shall each submit to Congress a report on the studies conducted under paragraphs (1) and (2), respectively, and shall include any recommendations for legislation or administrative changes.''

GAO STUDY OF OWNERSHIP BY REFERRING PHYSICIANS

Pub. L. 101–239, title VI, §6204(e), Dec. 19, 1989, 103 Stat. 2242, directed Comptroller General to conduct a study of ownership of hospitals and other providers of medicare services by referring physicians and, by not later than Feb. 1, 1991, report to Congress on results of such study, prior to repeal by Pub. L. 104–316, title I, §122(h)(1), Oct. 19, 1996, 110 Stat. 3837.

STATISTICAL SUMMARY OF COMPARATIVE UTILIZATION

Pub. L. 101–239, title VI, §6204(f), Dec. 19, 1989, 103 Stat. 2243, as amended by Pub. L. 101–508, title IV, §4207(e)(4)(A), formerly §4027(e)(4)(A), Nov. 5, 1990, 104 Stat. 1388–122, renumbered Pub. L. 103–432, title I, §160(d)(4), Oct. 31, 1994, 108 Stat. 4444; Pub. L. 104–316, title I, §122(h)(2), Oct. 19, 1996, 110 Stat. 3837, directed Secretary of Health and Human Services, not later than June 30, 1992, to submit to Congress a statistical profile comparing utilization of items and services by medicare beneficiaries served by entities in which the referring physician has a direct or indirect financial interest and by medicare beneficiaries served by other entities, for the States and entities specified in subsec. (f) of this section (other than entities providing clinical laboratory services).

§ 1395oo. Provider Reimbursement Review Board

(a) Establishment

Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the ''Board'') which shall be established by the Secretary in accordance with subsection (h) and (except as provided in subsection (g)(2)) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—

(1) such provider—

(A)(i) is dissatisfied with a final determination of the organization serving as its

fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1) (B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

(b) Appeals by groups

The provisions of subsection (a) shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.

(c) Right to counsel; rules of evidence

At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at any such hearing even though inadmissible under rules of evidence applicable to court procedure.

(d) Decisions of Board

A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

(e) Rules and regulations

The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this subchapter or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of section 405 of this title with respect to subpenas shall apply to the Board to the same extent as they apply to the Secretary with respect to subchapter II.

(f) Finality of decision; judicial review; determinations of Board authority; jurisdiction; venue; interest on amount in controversy

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5 notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a

hearing under subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

(2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund for the month in which the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

(3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this chapter.

(g) Certain findings not reviewable

(1) The finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1395y of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f).

(2) The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

(h) Composition and compensation

The Board shall be composed of five members appointed by the Secretary without regard to the provisions of title 5 governing appointments in the competitive services. Two of such members shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of payment of providers of services, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS–18 in section 5332 of title 5. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

(i) Technical and clerical assistance

The Board is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

(j) "Provider of services" defined

In this section, the term ''provider of services'' includes a rural health clinic and a Federally qualified health center.

(Aug. 14, 1935, ch. 531, title XVIII, § 1878, as added Pub. L. 92–603, title II, § 243(a), Oct. 30, 1972, 86 Stat. 1420; amended Pub. L. 93–484, § 3(a), Oct. 26, 1974, 88 Stat. 1459; Pub. L. 96–499, title IX, § 955, Dec. 5, 1980, 94 Stat. 2647; Pub. L. 98–21, title VI, § 602(h), Apr. 20, 1983, 97 Stat. 165; Pub. L. 98–369, div. B, title III, §§ 2351(a)(1), (b)(1), 2354(b)(39), (40), July 18, 1984, 98 Stat. 1098, 1099, 1102; Pub. L. 101–508, title IV, § 4161(a)(6), (b)(4), Nov. 5, 1990, 104 Stat. 1388–94, 1388–95; Pub. L. 103–66, title XIII, § 13503(c)(1)(B), Aug. 10, 1993, 107 Stat. 579.)

Editorial Notes

AMENDMENTS

1993—Subsec. (f)(2). Pub. L. 103–66 substituted ''the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund for the month in which'' for ''the rate of return on equity capital established by regulation pursuant to section 1395x(v)(1)(B) of this title and in effect at the time''.

1990—Subsec. (j). Pub. L. 101–508, § 4161(b)(4), inserted ''a rural health clinic and'' after ''includes''.

Pub. L. 101–508, § 4161(a)(6), added subsec. (j).

1984—Subsec. (c). Pub. L. 98–369, § 2354(b)(39), substituted ''inadmissible'' for ''inadmissable''.

Subsec. (e). Pub. L. 98–369, § 2354(b)(40), substituted ''and (e)'' for '', (e), and (f)''.

Subsec. (f)(1). Pub. L. 98–369, § 2351(a)(1), substituted ''notification of such determination is received'' for ''such determination is rendered'' in third sentence.

Pub. L. 98–369, § 2351(b)(1), inserted ''or which have obtained a hearing under subsection (b)'' after ''common ownership or control'' in last sentence.

1983—Subsec. (a). Pub. L. 98–21, § 602(h)(1)(A), inserted provision in introductory text that, except as provided in subsec. (g)(2) of this section, any hospital which receives payments in amounts computed under section 1395ww(b) or (d) of this title and which has submitted such reports within such time as Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by Board.

Subsec. (a)(1)(A). Pub. L. 98–21, § 602(h)(1)(B), (C), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(3). Pub. L. 98–21, § 602(h)(1)(D), substituted ''(1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination,'' for ''(1)(A)''.

Subsec. (f)(1). Pub. L. 98–21, § 602(h)(2), inserted ''(or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located)'' after ''the judicial district in which the provider is located'', and ''Any appeal to the Board or action for judicial review by providers which are under common ownership or control must be brought by such providers as a group with respect to any matter involving an issue common to such providers.''

Subsec. (g). Pub. L. 98–21, § 602(h)(3), designated existing provisions as par. (1) and added par. (2).

Subsec. (h). Pub. L. 98–21, § 602(h)(4), substituted ''payment of providers of services'' for ''cost reimbursement''.

1980—Subsec. (f)(1). Pub. L. 96–499 inserted provision empowering providers of services to obtain judicial review of any action of a fiscal intermediary involving a question of law or regulations relevant to matters in controversy whenever Board determined that it was without authority to decide such matters in controversy.

1974—Subsec. (f). Pub. L. 93–484 redesignated existing provisions as par. (1), inserted provisions authorizing judicial review for providers of final decisions of Board and judicial review of any affirmance by Secretary, and added pars. (2) and (3).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by Pub. L. 103–66 effective Oct. 1, 1993, see section 13503(c)(2) of Pub. L. 103–66, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4161(a)(6) of Pub. L. 101–508 applicable to cost reports for periods beginning on or after Oct. 1, 1991, see section 4161(a)(8)(C) of Pub. L. 101–508, set out as a note under section 1395k of this title.

Amendment by section 4161(b)(4) of Pub. L. 101–508 applicable to cost reports for periods beginning on or after Oct. 1, 1991, see section 4161(b)(5) of Pub. L. 101–508, set out as a note under section 1395x of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–369, div. B, title III, § 2351(a)(2), July 18, 1984, 98 Stat. 1099, provided that: ''The amendment made by paragraph (1) [amending this section] shall be effective with respect to any civil action commenced on or after the date of the enactment of this Act [July 18, 1984].''

Pub. L. 98–369, div. B, title III, § 2351(b)(2), July 18, 1984, 98 Stat. 1099, provided that: ''The amendment made by paragraph (1) [amending this section] shall be effective with respect to any appeal or action brought on or after the date of the enactment of this Act [July 18, 1984].''

Amendment by section 2354(b)(39), (40) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 98–21 applicable to items and services furnished by or under arrangement with a hospital beginning with its first cost reporting period that begins on or after Oct. 1, 1983, any change in a hospital's cost reporting period made after November 1982 to be recognized for such purposes only if the Secretary finds good cause therefor, see section 604(a)(1) of Pub. L. 98–21, set out as a note under section 1395ww of this title. See, also, section 2351(c) of Pub. L. 98–369, set out as a note below.

EFFECTIVE DATE OF 1974 AMENDMENT

Pub. L. 93–484, § 3(b), Oct. 26, 1974, 88 Stat. 1459, provided that: ''The amendment made by subsection (a) [amending this section] shall be applicable to cost reports of providers of services for accounting periods ending on or after June 30, 1973.''

EFFECTIVE DATE

Pub. L. 92–603, title II, § 243(c), Oct. 30, 1972, 86 Stat. 1422, provided that: ''The amendments made by this section [enacting this section and amending section 1395h of this title] shall apply with respect to cost reports of providers of services, as defined in title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], for accounting periods ending on or after June 30, 1973.''

REFERENCES IN OTHER LAWS TO GS–16, 17, OR 18 PAY RATES

References in laws to the rates of pay for GS–16, 17, or 18, or to maximum rates of pay under the General Schedule, to be considered references to rates payable under specified sections of Title 5, Government Organization and Employees, see section 529 [title I, § 101(c)(1)] of Pub. L. 101–509, set out in a note under section 5376 of Title 5.

REVIEW OF PROVIDER REIMBURSEMENT REVIEW BOARD DECISIONS

Pub. L. 98–369, div. B, title III, § 2351(c), July 18, 1984, 98 Stat. 1099, provided that: ''Notwithstanding section 604 of the Social Security Amendments of 1983 (Public Law 98–21) [set out as an Effective Date of 1983 Amendments note under section 1395ww of this title]—

''(1) the amendments made by section 602(h)(2)(A) of that Act [amending this section] shall be effective with respect to any appeal or action brought on or after April 20, 1983; and

''(2) the amendments made by section 602(h)(2)(B) of that Act [amending this section] shall be effective with respect to any appeal or action brought on or after the date of the enactment of this Act [July 18, 1984].''

§ 1395pp. Limitation on liability where claims are disallowed

(a) Conditions prerequisite to payment for items and services notwithstanding determination of disallowance

Where—

(1) a determination is made that, by reason of section 1395y(a)(1) or (9) of this title or by reason of a coverage denial described in subsection (g), payment may not be made under part A or part B of this subchapter for any expenses incurred for items or services furnished an individual by a provider of services or by another person pursuant to an assignment under section 1395u(b)(3)(B)(ii) of this title, and

(2) both such individual and such provider of services or such other person, as the case may be, did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under such part A or part B,

then to the extent permitted by this subchapter, payment shall, notwithstanding such determination, be made for such items or services (and for such period of time as the Secretary finds will carry out the objectives of this subchapter), as though section 1395y(a)(1) and section 1395y(a)(9) of this title did not apply and as though the coverage denial described in subsection (g) had not occurred. In each such case the Secretary shall notify both such individual and such provider of services or such other person, as the case may be, of the conditions under which payment for such items or services was made and in the case of comparable situations arising thereafter with respect to such individual or such provider or such other person, each shall, by reason of such notice (or similar notices provided before the enactment of this section), be deemed to have knowledge that payment cannot be made for such items or services or reasonably comparable items or services. Any provider or other person furnishing items or services for which payment may not be made by reason of section 1395y(a)(1) or (9) of this title or by reason of a coverage denial described in subsection (g) shall be deemed to have knowledge that payment cannot be made for such items or services if the claim relating to such items or services involves a case, provider or other person furnishing services, procedure, or test, with respect to which such provider or other person has been notified by the Secretary (including notification by a quality improvement organization) that a pattern of inappropriate utilization has occurred in the past, and such provider or other person has been allowed a reasonable time to correct such inappropriate utilization.