

§ 405.380

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accrues at the rate specified in this section on outstanding unpaid balances resulting from final determinations as defined in paragraph (c) of this section.

(2) If an overpayment or an underpayment determination is reversed administratively or judicially, and the reversal is no longer subject to appeal, appropriate adjustments will be made with respect to the overpayment or underpayment and the amount of interest charged.

(i) *Nonallowable cost.* As specified in §§ 412.113 and 413.153 of this chapter, interest accrued on overpayments and interest on funds borrowed specifically to repay overpayments are not considered allowable costs, up to the amount of the overpayment, unless the provider had made a prior commitment to borrow funds for other purposes (for example, capital improvements).

(See § 413.153(a)(2) of this chapter for exceptions based on administrative or judicial reversal.)

[47 FR 54814, Dec. 6, 1982, as amended at 49 FR 36102, Sept. 14, 1984; 49 FR 44472, Nov. 7, 1984; 51 FR 34792, Sept. 30, 1986; 56 FR 31336, July 10, 1991. Redesignated at 61 FR 63745, Dec. 2, 1996]

REPAYMENT OF SCHOLARSHIPS AND LOANS

§ 405.380 Collection of past-due amounts on scholarship and loan programs.

(a) *Basis and purpose.* This section implements section 1892 of the Act, which authorizes the Secretary to deduct from Medicare payments for services amounts considered as past-due obligations under the National Health Service Corps Scholarship program, the Physician Shortage Area Scholarship program, and the Health Education Assistance Loan program.

(b) *Offsetting against Medicare payment.* (1) Medicare carriers and intermediaries offset against Medicare payments in accordance with the signed repayment agreement between the Public Health Service and individuals who have breached their scholarship or loan obligations and who—

- (i) Accept Medicare assignment for services;
- (ii) Are employed by or affiliated with a provider, HMO, or Competitive

Medical Plan (CMP) that receives Medicare payment for services; or

(iii) Are members of a group practice that receives Medicare payment for services.

(2) For purposes of this section, “provider” includes all entities eligible to receive Medicare payment in accordance with an agreement under section 1866 of the Act.

(c) *Beginning of offset.* (1) The Medicare carrier offsets Medicare payments beginning six months after it notifies the individual or the group practice of the amount to be deducted and the particular individual to whom the deductions are attributable.

(2) The Medicare intermediary offsets payments beginning six months after it notifies the provider, HMO, CMP or group practice of the amount to be deducted and the particular individuals to whom the deductions are attributable. Offset of payments is made in accordance with the terms of the repayment agreement. If the individual ceases to be employed by the provider, HMO, or CMP, or leaves the group practice, no deduction is made.

(d) *Refusal to offset against Medicare payment.* If the individual refuses to enter into a repayment agreement, or breaches any provision of the agreement, or if Medicare payment is insufficient to maintain the offset collection according to the agreed upon formula, then—

(1) The Department, within 30 days if feasible, informs the Attorney General; and

(2) The Department excludes the individual from Medicare until the entire past due obligation has been repaid, unless the individual is a sole community practitioner or the sole source of essential specialized services in a community and the State requests that the individual not be excluded.

[57 FR 19092, May 4, 1992]

Subpart D—Private Contracts

AUTHORITY: Secs. 1102, 1802, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395a, and 1395hh).

SOURCE: 63 FR 58901, Nov. 2, 1998, unless otherwise noted.

§ 405.400 Definitions.

For purposes of this subpart, the following definitions apply:

Beneficiary means an individual who is enrolled in Part B of Medicare.

Emergency care services means services furnished to an individual for treatment of an “emergency medical condition” as that term is defined in § 422.2 of this chapter.

Legal representative means one or more individuals who, as determined by applicable State law, has the legal authority to enter into the contract with the physician or practitioner on behalf of the beneficiary.

Opt-out means the status of meeting the conditions specified in § 405.410.

Opt-out period means the 2-year period beginning on the effective date of the affidavit as specified by § 405.410(c)(1) or § 405.410(c)(2), as applicable.

Participating physician means a “physician” as defined in this section who has signed an agreement to participate in Part B of Medicare.

Physician means a doctor of medicine or a doctor of osteopathy who is currently licensed as that type of doctor in each State in which he or she furnishes services to patients.

Practitioner means a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical psychologist, or clinical social worker, who is currently legally authorized to practice in that capacity by each State in which he or she furnishes services to patients or clients.

Private contract means a document that meets the criteria specified in § 405.415.

Properly opt-out means to complete, without defect, the requirements for opt-out as specified in § 405.410.

Properly terminate opt-out means to complete, without defect, the requirements for terminating opt-out as specified in § 405.445.

Urgent care services means services furnished to an individual who requires services to be furnished within 12 hours in order to avoid the likely onset of an emergency medical condition.

§ 405.405 General rules.

(a) A physician or practitioner may enter into one or more private contracts with Medicare beneficiaries for the purpose of furnishing items or services that would otherwise be covered by Medicare, provided the conditions of this subpart are met.

(b) A physician or practitioner who enters into at least one private contract with a Medicare beneficiary under the conditions of this subpart, and who submits one or more affidavits in accordance with this subpart, opt-out of Medicare for a 2-year period unless the opt-out is terminated early according to § 405.445. The physician’s or practitioner’s opt-out may be renewed for subsequent 2-year periods.

(c) Both the private contracts described in paragraph (a) of this section and the physician’s or practitioner’s opt-out described in paragraph (b) of this section are null and void if the physician or practitioner fails to properly opt-out in accordance with the conditions of this subpart.

(d) Both the private contracts described in paragraph (a) of this section and the physician’s or practitioner’s opt-out described in paragraph (b) of this section are null and void if the remainder of the opt-out period if the physician or practitioner fails to remain in compliance with the conditions of this subpart during the opt-out period.

(e) Services furnished under private contracts meeting the requirements of this subpart are not covered services under Medicare, and no Medicare payment will be made for such services either directly or indirectly, except as permitted in accordance with § 405.435(c).

§ 405.410 Conditions for properly opting-out of Medicare.

The following conditions must be met for a physician or practitioner to properly opt-out of Medicare:

(a) Each private contract between a physician or a practitioner and a Medicare beneficiary that is entered into prior to the submission of the affidavit described in paragraph (b) of this section must meet the specifications of § 405.415.