

§411.402

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be made for inpatient hospital care, posthospital SNF care, or home health services furnished after the earlier of the following:

(i) The day on which the beneficiary has been determined, under §411.404, to have knowledge, actual or imputed, that the services were excluded from coverage by reason of §411.15(g) or §411.15(k).

(ii) The day on which the provider has been determined, under §411.406 to have knowledge, actual or imputed, that the services are excluded from coverage by reason of §411.15(g) or §411.15(k).

(2) *Exception.* Payment may be made for services furnished during the first day after the limit established in paragraph (b)(1) of this section, if the QIO or the intermediary determines that the additional period of one day is necessary for planning post-discharge care. If the QIO or the intermediary determines that yet another day is necessary for planning post-discharge care, payment may be made for services furnished during the second day after the limit established in paragraph (b)(1) of this section.

§411.402 Indemnification of beneficiary.

(a) *Conditions for indemnification.* If Medicare payment is precluded because the conditions of §411.400(a)(2) are not met. Medicare indemnifies the beneficiary (and recovers from the provider, practitioner, or supplier), if the following conditions are met:

(1) The beneficiary paid the provider, practitioner, or supplier some or all of the charges for the excluded services.

(2) The beneficiary did not know and could not reasonably have been expected to know that the services were not covered.

(3) The provider, practitioner, or supplier knew, or could reasonably have been expected to know that the services were not covered.

(4) The beneficiary files a proper request for indemnification before the end of the sixth month after whichever of the following is later:

(i) The month in which the beneficiary paid the provider, practitioner, or supplier.

(ii) The month in which the intermediary or carrier notified the beneficiary (or someone on his or her behalf) that the beneficiary would not be liable for the services.

For good cause shown by the beneficiary, the 6-month period may be extended.

(b) *Amount of indemnification.*¹ The amount of indemnification is the total that the beneficiary paid the provider, practitioner, or supplier.

(c) *Effect of indemnification.* The amount of indemnification is considered an overpayment to the provider, practitioner, or supplier, and as such is recoverable under this part or in accordance with other applicable provisions of law.

§411.404 Criteria for determining that a beneficiary knew that services were excluded from coverage as custodial care or as not reasonable and necessary.

(a) *Basic rule.* A beneficiary who receives services that constitute custodial care under §411.15(g) or that are not reasonable and necessary under §411.15(k), is considered to have known that the services were not covered if the criteria of paragraphs (b) and (c) of this section are met.

(b) *Written notice.* (1) Written notice is given to the beneficiary, or to someone acting on his or her behalf, that the services were not covered because they did not meet Medicare coverage guidelines.

(2) A notice concerning similar or reasonably comparable services furnished on a previous occasion also meets this criterion.

(3) After a beneficiary is notified that there is no Medicare payment for a service that is not covered by Medicare, he or she is presumed to know that there is no Medicare payment for any form of subsequent treatment for the non-covered condition.

(c) *Source of notice.* The notice was given by one of the following:

(1) The QIO, intermediary, or carrier.

¹For services furnished before 1988, the indemnification amount was reduced by any deductible or coinsurance amounts that would have been applied if the services had been covered.

(2) The group or committee responsible for utilization review for the provider that furnished the services.

(3) The provider, practitioner, or supplier that furnished the service.

[54 FR 41734, Oct. 11, 1989, as amended at 69 FR 66423, Nov. 15, 2004]

§ 411.406 Criteria for determining that a provider, practitioner, or supplier knew that services were excluded from coverage as custodial care or as not reasonable and necessary.

(a) *Basic rule.* A provider, practitioner, or supplier that furnished services which constitute custodial care under § 411.15(g) or that are not reasonable and necessary under § 411.15(k) is considered to have known that the services were not covered if any one of the conditions specified in paragraphs (b) through (e) of this section is met.

(b) *Notice from the QIO, intermediary or carrier.* The QIO, intermediary, or carrier had informed the provider, practitioner, or supplier that the services furnished were not covered, or that similar or reasonably comparable services were not covered.

(c) *Notice from the utilization review committee or the beneficiary's attending physician.* The utilization review group or committee for the provider or the beneficiary's attending physician had informed the provider that these services were not covered.

(d) *Notice from the provider, practitioner, or supplier to the beneficiary.* Before the services were furnished, the provider, practitioner or supplier informed the beneficiary that—

(1) The services were not covered; or

(2) The beneficiary no longer needed covered services.

(e) *Knowledge based on experience, actual notice, or constructive notice.* It is clear that the provider, practitioner, or supplier could have been expected to have known that the services were excluded from coverage on the basis of the following:

(1) Its receipt of CMS notices, including manual issuances, bulletins, or other written guides or directives from intermediaries, carriers, or QIOs, including notification of QIO screening criteria specific to the condition of the beneficiary for whom the furnished services are at issue and of medical

procedures subject to preadmission review by a QIO.

(2) FEDERAL REGISTER publications containing notice of national coverage decisions or of other specifications regarding noncoverage of an item or service.

(3) Its knowledge of what are considered acceptable standards of practice by the local medical community.

[54 FR 41734, Oct. 11, 1989, as amended at 60 FR 48425, Sept. 19, 1995]

§ 411.408 Refunds of amounts collected for physician services not reasonable and necessary, payment not accepted on an assignment-related basis.

(a) *Basic rule.* Except as provided in paragraph (d) of this section, a physician who furnishes a beneficiary services for which the physician does not undertake to claim payment on an assignment-related basis must refund any amounts collected from the beneficiary for services otherwise covered if Medicare payment is denied because the services are found to be not reasonable and necessary under § 411.15(k).

(b) *Time limits for making refunds.* A timely refund of any incorrectly collected amounts of money must be made to the beneficiary to whom the services were furnished. A refund is timely if—

(1) A physician who does not request a review within 30 days after receipt of the denial notice makes the refund within that time period; or

(2) A physician who files a request for review within 30 days after receipt of the denial notice makes the refund within 15 days after receiving notice of an initial adverse review determination, whether or not the physician further appeals the initial adverse review determination.

(c) *Notices and appeals.* If payment is denied for nonassignment-related claims because the services are found to be not reasonable and necessary, a notice of denial will be sent to both the physician and the beneficiary. The physician who does not accept assignment will have the same rights as a physician who submits claims on an assignment-related basis, as detailed in subpart H of part 405 and subpart B of part 473, to appeal the determination, and