

from the day following the due date of the report (plus a single extension of time not to exceed 30 days if granted for good cause, as specified in § 413.24(f) of this chapter, to the time the cost report is filed.

(4) If an intermediary or a carrier makes a final determination that an underpayment exists, interest to the provider or the supplier will accrue from the date of notification of the underpayment.

(f) *Waiver of interest charges.* (1) When an intermediary or a carrier makes a final determination that an overpayment or underpayment exists, as specified in paragraphs (e)(1), (e)(2)(ii), and (e)(4)—

(i) Interest charges will be waived if the overpayment or underpayment is completely liquidated within 30 days from the date of the final determination.

(ii) CMS may waive interest charges if it determines that the administrative cost of collecting them exceeds the interest charges.

(2) Interest will not be waived for that period of time during which the cost report was due but remained unfiled for more than 30 days, as specified in paragraph (e)(3) of this section.

(g) *Rules applicable to partial payments.* If an overpayment is repaid in installments or recouped by withholding from several payments due the provider or supplier of services—

(1) Each payment or recoupment will be applied first to accrued interest and then to the principal; and

(2) After each payment or recoupment, interest will accrue on the remaining unpaid balance.

(h) *Exceptions to applicability.* (1) The provisions of this section do not apply to the time period for which interest is payable under § 413.64(j) of this chapter because the provider seeks judicial review of a decision of the Provider Reimbursement Review Board, or a subsequent reversal, affirmance, or modification of that decision by the Administrator. Prior to that time, until the provider seeks judicial review, interest 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; 69 FR 45607, July 30, 2004]

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; doctor of osteopathy; doctor of dental surgery or of dental medicine; doctor of podiatric medicine; or doctor of optometry who is legally authorized to practice medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, or optometry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions.

Practitioner means a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical psychologist, clinical social worker, registered dietitian or nutrition professional, 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.