

§ 411.389

the party either intended or did not intend to violate the provisions of sections 1128, 1128A or 1128B of the Act.

[63 FR 1658, Jan. 9, 1998]

§ 411.389 Range of the advisory opinion.

(a) An advisory opinion states only HCFA's opinion regarding the subject matter of the request. If the subject of an advisory opinion is an arrangement that must be approved by or is regulated by any other agency, HCFA's advisory opinion cannot be read to indicate HCFA's views on the legal or factual issues that may be raised before that agency.

(b) An advisory opinion that HCFA issues under this part does not bind or obligate any agency other than the Department. It does not affect the requestor's, or anyone else's, obligations to any other agency, or under any statutory or regulatory provision other than that which is the specific subject matter of the advisory opinion.

[63 FR 1658, Jan. 9, 1998]

Subpart K—Payment for Certain Excluded Services

§ 411.400 Payment for custodial care and services not reasonable and necessary.

(a) *Conditions for payment.* Notwithstanding the exclusions set forth in § 411.15 (g) and (k). Medicare pays for "custodial care" and "services not reasonable and necessary" if the following conditions are met:

(1) The services were furnished by a provider or by a practitioner or supplier that had accepted assignment of benefits for those services.

(2) Neither the beneficiary nor the provider, practitioner, or supplier knew, or could reasonably have been expected to know, that the services were excluded from coverage under § 411.15 (g) or (k).

(b) *Time limits on payment.* (1) *Basic rule.* Except as provided in paragraph (b)(2) of this section, payment may not be made for inpatient hospital care, posthospital SNF care, or home health services furnished after the earlier of the following:

42 CFR Ch. IV (10–1–00 Edition)

(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 PRO or the intermediary determines that the additional period of one day is necessary for planning post-discharge care. If the PRO 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.* Written notice has been 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. A notice concerning similar or reasonably comparable services furnished on a previous occasion also meets this criterion. For example, program payment may not be made for the treatment of obesity, no matter what form the treatment may take. After the beneficiary who is treated for obesity with dietary control is informed in writing that Medicare will not pay for treatment of obesity, he or she will be presumed to know that there will be no Medicare payment for any form of subsequent treatment of this condition, including use of a combination of exercise, machine treatment, diet, and medication.

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

(1) The PRO, 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.

§ 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 PRO, intermediary or carrier.* The PRO, 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 HCFA notices, including manual issuances, bulletins, or other written guides or directives from intermediaries, carriers, or PROs, including notification of PRO 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 PRO.