

the provider concerning the overpayment, including any reduction or suspension of Medicaid payments made with respect to that overpayment.

(7) A copy of the provider's agreement with the agency under § 431.107 of this chapter.

(d) *Notification to terminate withholding.* (1) If an agency has requested withholding under this section, it must notify HCFA if any of the following occurs:

(i) The Medicaid provider makes an agreement satisfactory to the agency to repay the overpayment;

(ii) The Medicaid overpayment is completely recovered; or

(iii) The agency determines that there is no overpayment, based on newly acquired evidence or subsequent audit.

(2) Upon receipt of notification from the State agency, HCFA will terminate withholding.

(e) *Accounting for returned overpayment.* The agency must treat as a recovered overpayment the amounts received from HCFA to offset Medicaid overpayments.

(f) *Procedures for restoring excess withholding.* The agency must establish procedures satisfactory to HCFA to assure the return to the provider of amounts withheld under this section that are ultimately determined to be in excess of overpayments. Those procedures are subject to HCFA review.

[50 FR 19689, May 10, 1985, as amended at 61 FR 63749, Dec. 2, 1996]

§ 447.40 Payments for reserving beds in institutions.

(a) The Medicaid agency may make payments to reserve a bed during a recipient's temporary absence from an inpatient facility, if—

(1) The State plan provides for such payments and specifies any limitations on the policy; and

(2) Absences for purposes other than required hospitalization (which cannot be anticipated and planned) are included in the patient's plan of care.

(b) An agency that pays for reserved beds in an inpatient facility may pay less for a reserved bed than an occupied bed if there is a cost differential be-

tween the two beds. (Section 1102 of the Act.)

[43 FR 45253, Sept. 29, 1978, as amended at 51 FR 24491, July 3, 1986]

§ 447.45 Timely claims payment.

(a) *Basis and purpose.* This section implements section 1902(a)(37) of the Act by specifying—

(1) State plan requirements for—

(i) Timely processing of claims for payment;

(ii) Prepayment and postpayment claims reviews; and

(2) Conditions under which the Administrator may grant waivers of the time requirements.

(b) *Definitions.* *Claim* means (1) a bill for services, (2) a line item of service, or (3) all services for one recipient within a bill.

Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

A shared health facility means any arrangement in which—

(1) Two or more health care practitioners practice their professions at a common physical location;

(2) The practitioners share common waiting areas, examining rooms, treatment rooms, or other space, the services of supporting staff, or equipment;

(3) The practitioners have a person (who may himself be a practitioner)—

(i) Who is in charge of, controls, manages, or supervises substantial aspects of the arrangement or operation for the delivery of health or medical services at the common physical location other than the direct furnishing of professional health care services by the practitioners to their patients; or

(ii) Who makes available to the practitioners the services of supporting staff who are not employees of the practitioners; and

(iii) Who is compensated in whole or in part, for the use of the common physical location or related support services, on a basis related to amounts charged or collected for the services