

§ 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.

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.

§ 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 QIO, intermediary, or carrier.

(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 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 physi-

cian 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 will be subject to the same time limitations.

(d) *When a refund is not required.* A refund of any amounts collected for services not reasonable and necessary is not required if—

(1) The physician did not know, and could not reasonably have been expected to know, that Medicare would not pay for the service; or

(2) Before the service was provided—

(i) The physician informed the beneficiary, or someone acting on the beneficiary's behalf, in writing that the physician believed Medicare was likely to deny payment for the specific service; and

(ii) The beneficiary (or someone eligible to sign for the beneficiary under § 424.36(b) of this chapter) signed a