

§ 411.387

obtain a binding advisory opinion on the subject of a physician's referrals, as described in § 411.370. CMS has not and does not issue a binding advisory opinion on the subject matter in § 411.370, in either oral or written form, except through written opinions it issues in accordance with this subpart.

[63 FR 1658, Jan. 9, 1998]

§ 411.387 Parties affected by advisory opinions.

An advisory opinion issued by CMS does not apply in any way to any individual or entity that does not join in the request for the opinion. Individuals or entities other than the requestor(s) may not rely on an advisory opinion.

[63 FR 1658, Jan. 9, 1998]

§ 411.388 When advisory opinions are not admissible evidence.

The failure of a party to seek or to receive an advisory opinion may not be introduced into evidence to prove that 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 CMS'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, CMS's advisory opinion cannot be read to indicate CMS's views on the legal or factual issues that may be raised before that agency.

(b) An advisory opinion that CMS 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]

42 CFR Ch. IV (10-1-02 Edition)

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:

(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.