

then to reduce or eliminate the principal balance of the overpayment subject to the following:

(i) If the redetermination results in a reversal, the amount recouped may be applied to any other debt, including interest, owed by the provider or supplier before any excess is released to the provider.

(ii) If the redetermination results in a partial reversal and the decision reduces the overpayment plus assessed interest below the amount already recouped, the excess may be applied to any other debt, including interest, owed by the provider or supplier before any excess is released to the provider or supplier.

(iii) If the redetermination results in an affirmation and the provider or supplier subsequently requests a reconsideration, the Medicare contractor may retain the amount recouped and apply the funds first to accrued interest and then to outstanding principal pending action by the QIC on the reconsideration request.

(2) If the Medicare contractor also recouped funds in accordance with paragraph (e) of this section, the amount recouped may be retained by the Medicare contractor and applied first to accrued interest and then to reduce or eliminate the outstanding principal balance pending action by the QIC on the reconsideration request.

(3) If the action by the QIC is a dismissal, receipt of a withdrawal, a notice that the reconsideration is being escalated to an ALJ, or a reconsideration which affirms in whole the overpayment determination, including the redetermination, in question, the amount recouped is applied to interest first, then to reduce the outstanding principal balance and recoupment may be resumed as provided under paragraph (f) of this section.

(4) If the action by the QIC is a reconsideration, which reverses in whole the overpayment determination, including the redetermination, in question, the amount recouped may be applied to any other debt, including interest, owed by the provider or supplier to CMS or to HHS before any excess is released to the provider or supplier.

(5) If the action by the QIC is a reconsideration which results in a partial re-

versal and the decision reduces the overpayment plus assessed interest below the amount already recouped, the excess may be applied to any other debt, including interest, owed by the provider or supplier to CMS or to HHS before any excess is released to the provider or supplier.

(h) *Relationship to extended repayment schedules.* Notwithstanding § 401.607 (c)(2)(v) of this chapter regarding an extended repayment schedule (ERS), a provider or supplier will not be deemed in default if recoupment of an overpayment is not effectuated or stopped in accordance with this section, and the following conditions are met:

(1) The provider or supplier has been granted an ERS under § 401.607(c) of this chapter.

(2) The ERS has been granted for an overpayment that is listed in paragraph (b) of this section.

(3) The provider or supplier has submitted a valid and timely request to the Medicare contractor for a redetermination of the overpayment in accordance with §§ 405.940 through 405.958 or reconsideration of the overpayment in accordance with §§ 405.960 through 405.978.

[74 FR 47469, Sept. 16, 2009]

#### 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;

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(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 inpatient or outpatient hospital services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services.

*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, with respect to an affidavit that meets the requirements of § 405.420, a 2-year period beginning on the date the affidavit is signed, as specified by § 405.410(c)(1) or (2) as applicable, and each successive 2-year period unless the physician or practitioner properly cancels opt-out in accordance with § 405.445.

*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.