

(b) When a physician or practitioner who has not been excluded under sections 1128, 1156, or 1892 of the Social Security Act furnishes emergency care services or urgent care services to a Medicare beneficiary with whom the physician or practitioner has not previously entered into a private contract, he or she:

(1) Must submit a claim to Medicare in accordance with both 42 CFR part 424 and Medicare instructions (including but not limited to complying with proper coding of emergency or urgent care services furnished by physicians and practitioners who have opted-out of Medicare).

(2) May collect no more than—

(i) The Medicare limiting charge, in the case of a physician; or

(ii) The deductible and coinsurance, in the case of a practitioner.

(c) Emergency care services or urgent care services furnished to a Medicare beneficiary with whom the physician or practitioner has previously entered into a private contract (that is, entered into before the onset of the emergency medical condition or urgent medical condition), are furnished under the terms of the private contract.

(d) Medicare may make payment for emergency care services or urgent care services furnished by a physician or practitioner who has properly opted-out when the services are furnished and the claim for services is made in accordance with this section. A physician or practitioner who has been excluded must comply with the regulations at §1001.1901 (Scope and effect of exclusion) of this title when he or she furnishes emergency services to beneficiaries and may not bill and be paid for urgent care services.

§ 405.445 Cancellation of opt-out and early termination of opt-out.

(a) A physician or practitioner may cancel opt-out by submitting a written notice to each Medicare Administrative Contractor to which he or she would file claims absent the opt-out, not later than 30 days before the end of the current 2-year opt-out period, indicating that the physician or practitioner does not want to extend the application of the opt-out affidavit for a subsequent 2-year period.

(b) To properly terminate opt-out a physician or practitioner must:

(1) Not have previously opted out of Medicare.

(2) Notify all Medicare Administrative Contractors, with which he or she filed an affidavit, of the termination of the opt-out no later than 90 days after the effective date of the initial 2-year period.

(3) Refund to each beneficiary with whom he or she has privately contracted all payment collected in excess of:

(i) The Medicare limiting charge (in the case of physicians); or

(ii) The deductible and coinsurance (in the case of practitioners).

(4) Notify all beneficiaries with whom the physician or practitioner entered into private contracts of the physician's or practitioner's decision to terminate opt-out and of the beneficiaries' right to have claims filed on their behalf with Medicare for the services furnished during the period between the effective date of the opt-out and the effective date of the termination of the opt-out period.

(c) When the physician or practitioner properly terminates opt-out in accordance with paragraph (b), he or she will be reinstated in Medicare as if there had been no opt-out, and the provision of § 405.425 shall not apply unless the physician or practitioner subsequently properly opts out.

(d) A physician or practitioner who has completed opt-out on or before January 1, 1999 may terminate opt-out during the 90 days following January 1, 1999 if he or she notifies all carriers to whom he or she would otherwise submit claims of the intent to terminate opt-out and complies with paragraphs (b)(3) and (4) of this section. Paragraph (c) of this section applies in these cases.

[63 FR 58901, Nov. 2, 1998, as amended at 80 FR 71371, Nov. 16, 2015]

§ 405.450 Appeals.

(a) A determination by CMS that a physician or practitioner has failed to properly opt out, failed to maintain opt-out, failed to timely renew opt-out, failed to privately contract, failed to properly terminate opt-out, or failed to

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properly cancel opt-out is an initial determination for purposes of § 498.3(b) of this chapter.

(b) A determination by CMS that no payment can be made to a beneficiary for the services of a physician who has opted-out is an initial determination for purposes of § 405.924.

[63 FR 58901, Nov. 2, 1998, as amended at 79 FR 68001, Nov. 13, 2014; 80 FR 71371, Nov. 16, 2015]

§ 405.455 Application to Medicare Advantage contracts.

An organization that has a contract with CMS to provide one or more Medicare Advantage (M + C) plans to beneficiaries (part 422 of this chapter):

(a) Must acquire and maintain information from Medicare carriers on physicians and practitioners who have opted-out of Medicare.

(b) Must make no payment directly or indirectly for Medicare covered services furnished to a Medicare beneficiary by a physician or practitioner who has opted-out of Medicare.

(c) May make payment to a physician or practitioner who furnishes emergency or urgent care services to a beneficiary who has not previously entered into a private contract with the physician or practitioner in accordance with § 405.440.

[63 FR 58901, Nov. 2, 1998, as amended at 79 FR 68001, Nov. 13, 2014]

Subpart E—Criteria for Determining Reasonable Charges

AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

SOURCE: 32 FR 12599, Aug. 31, 1967, unless otherwise noted. Redesignated at 42 FR 52826, Sept. 30, 1977.

§ 405.500 Basis.

Subpart E is based on the provisions of the following sections of the Act: Section 1814(b) provides for Part A payment on the basis of the lesser of a provider's reasonable costs or customary charges. Section 1832 establishes the scope of benefits provided under the Part B supplementary medical insurance program. Section 1833(a) sets forth the amounts of payment for supplementary medical insurance services

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on the basis of the lesser of a provider's reasonable costs or customary charges. Section 1834(a) specifies how payments are made for the purchase or rental of new and used durable medical equipment for Medicare beneficiaries. Section 1834(b) provides for payment for radiologist services on a fee schedule basis. Section 1834(c) provides for payments and standards for screening mammography. Section 1842(b) sets forth the provisions for a carrier to enter into a contract with the Secretary and to make determinations with respect to Part B claims. Section 1842(h) sets forth the requirements for a physician or supplier to voluntarily enter into an agreement with the Secretary to become a participating physician or supplier. Section 1842(i) sets forth the provisions for the payment of Part B claims. Section 1848 establishes a fee schedule for payment of physician services. Section 1861(b) sets forth the inpatient hospital services covered by the Medicare program. Section 1861(s) sets forth medical and other health services covered by the Medicare program. Section 1861(v) sets forth the general authority under which CMS may establish limits on provider costs recognized as reasonable in determining Medicare program payments. Section 1861(aa) sets forth the rural health clinic services and Federally qualified health center services covered by the Medicare program. Section 1861(jj) defines the term “covered osteoporosis drug.” Section 1862(a)(14) lists services that are excluded from coverage. Section 1866(a) specifies the terms for provider agreements. Section 1881 authorizes special rules for the coverage of and payment for services furnished to patients with end-stage renal disease. Section 1886 sets forth the requirements for payment to hospitals for inpatient hospital services. Section 1887 sets forth requirements for payment of provider-based physicians and payment under certain percentage arrangements. Section 1889 provides for Medicare and Medigap information by telephone.

[60 FR 63175, Dec. 8, 1995]