

amount of payment has been made, notice of the provisions of section 1870(c) of the Act regarding waiver of adjustment or recovery shall be sent to the overpaid individual and to any other individual against whom adjustment or recovery of the overpayment is to be effected (see § 405.358).

[61 FR 49271, Sept. 19, 1996]

**§ 405.358 When waiver of adjustment or recovery may be applied.**

Section 1870(c) of the Act provides that there shall be no adjustment or recovery in any case where an incorrect payment under title XVIII (hospital and supplementary medical insurance benefits) has been made (including a payment under section 1814(e) of the Act with respect to an individual:

- (a) Who is without fault, and
- (b) Adjustment or recovery would either:
  - (1) Defeat the purposes of title II or title XVIII of the Act, or
  - (2) Be against equity and good conscience.

[61 FR 49271, Sept. 19, 1996]

**§ 405.359 Liability of certifying or disbursing officer.**

No certifying or disbursing officer shall be held liable for any amount certified or paid by him to any provider of services or other person:

- (a) Where the adjustment or recovery of such amount is waived (see § 405.355), or
- (b) Where adjustment (see § 405.352) or recovery is not completed prior to the death of all persons against whose benefits such adjustment is authorized.

**SUSPENSION AND RECOUPMENT OF PAYMENT TO PROVIDERS AND SUPPLIERS AND COLLECTION AND COMPROMISE OF OVERPAYMENTS**

**§ 405.370 Definitions.**

(a) For purposes of this subpart, the following definitions apply:

*Credible allegation of fraud.* A credible allegation of fraud is an allegation from any source, including but not limited to the following:

- (1) Fraud hotline tips verified by further evidence
- (2) Claims data mining.

(3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability.

*Fraud hotline tip.* A complaint or other communications that are submitted through a fraud reporting phone number or a website intended for the same purpose, such as the Federal Government's HHS OIG Hotline or a health plan's fraud hotline.

*Medicare contractor.* Unless the context otherwise requires, includes, but is not limited to the any of following:

- (1) A fiscal intermediary.
- (2) A carrier.
- (3) Program safeguard contractor.
- (4) Zone program integrity contractor.
- (5) Part A/Part B Medicare administrative contractor.

*Offset.* The recovery by Medicare of a non-Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness. (Examples are Public Health Service debts or Medicaid debts recovered by CMS).

*Recoupment.* The recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness.

*Resolution of an investigation.* An investigation of credible allegations of fraud will be considered resolved when legal action is terminated by settlement, judgment, or dismissal, or when the case is closed or dropped because of insufficient evidence to support the allegations of fraud.

*Suspension of payment.* The withholding of payment by a Medicare contractor from a provider or supplier of an approved Medicare payment amount before a determination of the amount of the overpayment exists, or until the resolution of an investigation of a credible allegation of fraud.

(b) For purposes of §§ 405.378 and 405.379, the following terms apply:

*Appellant* means the beneficiary, assignee or other person or entity that has filed and pursued an appeal concerning a particular initial determination. Designation as an appellant does

not in itself convey standing to appeal the determination in question.

*Fiscal intermediary* means an organization that has entered into a contract with CMS in accordance with section 1816 of the Act and is authorized to make determinations and payments for Part A of title XVIII of the Act, and Part B provider services as specified in § 421.5(c) of this chapter.

*Medicare Appeals Council* means the council within the Departmental Appeals Board of the U.S. Department of Health and Human Services.

*Medicare contractor*, unless the context otherwise requires, includes, but is not limited to, a fiscal intermediary, carrier, recovery audit contractor, and Medicare administrative contractor.

*Party* means an individual or entity listed in § 405.906 that has standing to appeal an initial determination and/or a subsequent administrative appeal determination.

*Qualified Independent Contractor (QIC)* means an entity which contracts with the Secretary in accordance with section 1869 of the Act to perform reconsiderations under § 405.960 through § 405.978.

*Remand* means to vacate a lower level appeal decision, or a portion of the decision, and return the case, or a portion of the case, to that level for a new decision.

*Vacate* means to set aside a previous action.

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**§ 405.371 Suspension, offset, and recoupment of Medicare payments to providers and suppliers of services.**

(a) *General rules*—Medicare payments to providers and suppliers, as authorized under this subchapter (excluding payments to beneficiaries), may be one of the following:

(1) Suspended, in whole or in part, by CMS or a Medicare contractor if CMS or the Medicare contractor possesses reliable information that an overpayment exists or that the payments to be made may not be correct, although additional information may be needed for a determination.

(2) In cases of suspected fraud, suspended, in whole or in part, by CMS or a Medicare contractor if CMS or the Medicare contractor has consulted with the OIG, and, as appropriate, the Department of Justice, and determined that a credible allegation of fraud exists against a provider or supplier, unless there is good cause not to suspend payments.

(3) Offset or recouped, in whole or in part, by a Medicare contractor if the Medicare contractor or CMS has determined that the provider or supplier to whom payments are to be made has been overpaid.

(4) Suspended, in whole or in part, by CMS or a Medicare contractor if the provider or supplier has been subject to a Medicaid payment suspension under § 455.23(a)(1) of this chapter.

(b) *Good cause exceptions applicable to payment suspensions.* (1) CMS may find that good cause exists not to suspend payments or not to continue to suspend payments to an individual or entity against which there are credible allegations of fraud if—

(i) OIG or other law enforcement agency has specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation;

(ii) It is determined that beneficiary access to items or services would be so jeopardized by a payment suspension in whole or part as to cause a danger to life or health;

(iii) It is determined that other available remedies implemented by CMS or a Medicare contractor more effectively or quickly protect Medicare funds than would implementing a payment suspension; or

(iv) CMS determines that a payment suspension or a continuation of a payment suspension is not in the best interests of the Medicare program.

(2) Every 180 days after the initiation of a suspension of payments based on credible allegations of fraud, CMS will—

(i) Evaluate whether there is good cause to not continue such suspension under this section; and

(ii) Request a certification from the OIG or other law enforcement agency that the matter continues to be under