

investigation warranting continuation of the suspension.

(3) Good cause not to continue to suspend payments to an individual or entity against which there are credible allegations of fraud must be deemed to exist if a payment suspension has been in effect for 18 months and there has not been a resolution of the investigation, except CMS may extend a payment suspension beyond that point if—

(i) The case has been referred to, and is being considered by, the OIG for administrative action (for example, civil money penalties); or such administrative action is pending or

(ii) The Department of Justice submits a written request to CMS that the suspension of payments be continued based on the ongoing investigation and anticipated filing of criminal or civil action or both or based on a pending criminal or civil action or both. At a minimum, the request must include the following:

(A) Identification of the entity under suspension.

(B) The amount of time needed for continued suspension in order to conclude the criminal or civil proceeding or both.

(C) A statement of why or how criminal or civil action or both may be affected if the requested extension is not granted.

(c) *Steps necessary for suspension of payment, offset, and recoupment.* (1) Except as provided in paragraphs (d) and (e) of this section, CMS or the Medicare contractor suspends payments only after it has complied with the procedural requirements set forth at § 405.372.

(2) The Medicare contractor offsets or recoups payments only after it has complied with the procedural requirements set forth at § 405.373.

(d) *Suspension of payment in the case of unfiled cost reports.* (1) If a provider has failed to timely file an acceptable cost report, payment to the provider is immediately suspended in whole or in part until a cost report is filed and determined by the Medicare contractor to be acceptable.

(2) In the case of an unfiled cost report, the provisions of § 405.372 do not apply. (See § 405.372(a)(2) concerning failure to furnish other information.)

(e) *Suspension of payment in the case of unfiled hospice cap determination reports.*

(1) If a provider has failed to timely file an acceptable hospice cap determination report, payment to the provider is immediately suspended in whole or in part until a cap determination report is filed and determined by the Medicare contractor to be acceptable.

(2) In the case of an unfiled hospice cap determination report, the provisions of § 405.372 do not apply. (See § 405.372(a)(2) concerning failure to furnish other information.)

[76 FR 5961, Feb. 2, 2011, as amended at 79 FR 50509, Aug. 22, 2014; 84 FR 47852, Sept. 10, 2019]j

#### § 405.372 Proceeding for suspension of payment.

(a) *Notice of intention to suspend—*(1) *General rule.* Except as provided in paragraphs (a)(2) through (a)(4) of this section, if the Medicare contractor, or CMS has determined that a suspension of payments under § 405.371(a)(1) should be put into effect, the Medicare contractor must notify the provider or supplier of the intention to suspend payments, in whole or in part, and the reasons for making the suspension.

(2) *Failure to furnish information.* The notice requirement of paragraph (a)(1) of this section does not apply if the Medicare contractor suspends payments to a provider or supplier in accordance with section 1815(a) or section 1833(e) of the Act, respectively, because the provider or supplier has failed to submit information requested by the Medicare contractor that is needed to determine the amounts due the provider or supplier. (See § 405.371(c) concerning failure to file timely acceptable cost reports.)

(3) *Harm to trust funds.* A suspension of payment may be imposed without prior notice if CMS, the intermediary, or carrier determines that the Medicare Trust Funds would be harmed by giving prior notice. CMS may base its determination on an intermediary's or carrier's belief that giving prior notice would hinder the possibility of recovering the money.

(4) *Fraud.* If the intended suspension of payment involves credible allegations of fraud under § 405.371(a)(2), CMS—

(i) In consultation with OIG and, as appropriate, the Department of Justice, determines whether to impose the suspension and if prior notice is appropriate;

(ii) Directs the Medicare contractor as to the timing and content of the notification to the provider or supplier; and

(iii) Is the real party in interest and is responsible for the decision.

(b) *Rebuttal*—(1) *If prior notice is required.* If prior notice is required under paragraph (a) of this section, the Medicare contractor must give the provider or supplier an opportunity for rebuttal in accordance with § 405.374. If a rebuttal statement is received within the specified time period, the suspension of payment goes into effect on the date stated in the notice, and the procedures and provisions set forth in § 405.375 apply. If by the end of the period specified in the notice no statement has been received, the suspension goes into effect automatically, and the procedures set forth in paragraph (c) of this section are followed.

(2) *If prior notice is not required.* If, under the provisions of paragraphs (a)(2) through (a)(4) of this section, a suspension of payment is put into effect without prior notice to the provider or supplier, the Medicare contractor must, once the suspension is in effect, give the provider or supplier an opportunity to submit a rebuttal statement as to why the suspension should be removed.

(c) *Subsequent action.* (1) If a suspension of payment is put into effect under § 405.371(a)(1), CMS or the Medicare contractor takes timely action after the suspension to obtain the additional information it may need to make a determination as to whether an overpayment exists or the payments may be made.

(i) CMS or the Medicare contractor makes all reasonable efforts to expedite the determination.

(ii) As soon as the determination is made, CMS or the Medicare contractor informs the provider or supplier and, if appropriate, the suspension is rescinded or any existing recoupment or offset is adjusted to take into account the determination.

(2)(i) If a suspension of payment is based upon credible allegations of fraud in accordance with § 405.371(a)(2), subsequent action must be taken by CMS or the Medicare contractor to make a determination as to whether an overpayment exists.

(ii) The rescission of the suspension and the issuance of a final overpayment determination to the provider or supplier may be delayed until resolution of the investigation.

(d) *Duration of suspension of payment*—(1) *General rule.* Except as provided in paragraphs (d)(2) and (d)(3) of this section, a suspension of payment is limited to 180 days, starting with the date the suspension begins.

(2) *180-day extension.* (i) An intermediary, a carrier, or, in cases of fraud and misrepresentation, OIG or a law enforcement agency, may request a one-time only extension of the suspension period for up to 180 additional days if it is unable to complete its examination of the information or investigation, as appropriate, within the 180-day time limit. The request must be submitted in writing to CMS.

(ii) Upon receipt of a request for an extension, CMS notifies the provider or supplier of the requested extension. CMS then either extends the suspension of payment for up to an additional 180 days or determines that the suspended payments are to be released to the provider or supplier.

(3) *Exceptions to the time limits.* (i) The time limits specified in paragraphs (d)(1) and (d)(2) of this section do not apply if the suspension of payments is based upon credible allegations of fraud under § 405.371(a)(2).

(ii) Although the time limits specified in paragraphs (d)(1) and (d)(2) of this section do not apply to suspensions based on credible allegations of fraud, all suspensions of payment in accordance with § 405.371(a)(2) will be temporary and will not continue after the resolution of an investigation, unless a suspension is warranted because of reliable evidence of an overpayment or that the payments to be made may not be correct, as specified in § 405.371(a)(1).

(e) *Disposition of suspended payments.* Payments suspended under the authority of § 405.371(a) are first applied to reduce or eliminate any overpayments determined by the Medicare contractor, or CMS, including any interest assessed under the provisions of § 405.378, and then applied to reduce any other obligation to CMS or to HHS. In the absence of a legal requirement that the excess be paid to another entity, the excess is released to the provider or supplier.

[61 FR 63746, Dec. 2, 1996, as amended at 76 FR 5962, Feb. 2, 2011]

**§ 405.373 Proceeding for offset or recoupment.**

(a) *General rule.* Except as specified in paragraphs (b) and (f) of this section, if the Medicare Administrative Contractor or CMS has determined that an offset or recoupment of payments under § 405.371(a)(3) should be put into effect, the Medicare Administrative Contractor must—

(1) Notify the provider or supplier of its intention to offset or recoup payment, in whole or in part, and the reasons for making the offset or recoupment; and

(2) Give the provider or supplier an opportunity for rebuttal in accordance with § 405.374.

(b) *Exception to recouping payment.* Paragraph (a) of this section does not apply if the Medicare Administrative Contractor, after furnishing a provider a written notice of the amount of program reimbursement in accordance with § 405.1803, recoups payment under paragraph (c) of § 405.1803. (For provider rights in this circumstance, see §§ 405.1809, 405.1811, 405.1815, 405.1835, and 405.1843.)

(c) *Actions following receipt of rebuttal statement.* If a provider or supplier submits, in accordance with § 405.374, a statement as to why an offset or recoupment should not be put into effect on the date specified in the notice, the Medicare contractor must comply with the time limits and notification requirements of § 405.375.

(d) *No rebuttal statement received.* If, by the end of the time period specified in the notice, no statement has been received, the recoupment or offset goes into effect automatically.

(e) *Duration of recoupment or offset.* Except as provided in § 405.379, if a recoupment or offset is put into effect, it remains in effect until the earliest of the following:

(1) The overpayment and any assessed interest are liquidated.

(2) The Medicare contractor obtains a satisfactory agreement from the provider or supplier for liquidation of the overpayment.

(3) The Medicare contractor, on the basis of subsequently acquired evidence or otherwise, determines that there is no overpayment.

(f) *Exception to offset or recoupment of payments for shared Taxpayer Identification Number.* Paragraph (a) of this section does not apply in instances where the Medicare Administrative Contractor intends to offset or recoup payments to the applicable provider of services or supplier to satisfy an amount due from an obligated provider of services or supplier when the applicable and obligated provider of services or supplier share the same Taxpayer Identification Number.

[61 FR 63747, Dec. 2, 1996, as amended at 74 FR 47468, Sept. 16, 2009; 81 FR 80551, Nov. 15, 2016]

**§ 405.374 Opportunity for rebuttal.**

(a) *General rule.* If prior notice of the suspension of payment, offset, or recoupment is given under § 405.372 or § 405.373, the Medicare contractor must give the provider or supplier an opportunity, before the suspension, offset, or recoupment takes effect, to submit any statement (to include any pertinent information) as to why it should not be put into effect on the date specified in the notice. Except as provided in paragraph (b) of this section, the provider or supplier has at least 15 days following the date of notification to submit the statement.

(b) *Exception.* The Medicare contractor may for cause—

(1) Impose a shorter period for rebuttal; or

(2) Extend the time within which the statement must be submitted.

[61 FR 63747, Dec. 2, 1996]