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§ 890.904 Determination of FEHB benefit payment.

(a) The FEHB plan's benefit payment for inpatient hospital services under this subpart is the amount calculated by the FEHB plan, using information and instructions provided by the Department of Health and Human Services (HHS) and guidelines specified by OPM, as equivalent to the Medicare Part A payment under the DRG-based PPS (this is, the amount payable before the Medicare deductible, coinsurance and lifetime limits are applied), reduced by any FEHB plan deductible, coinsurance, copayment, or preadmission certification penalty that is the responsibility of the retired enrolled individual.

(b) The FEHB plan's benefit payment for physician services under this subpart is determined by taking the lower of the following amounts:

(1) The amount determined by the FEHB plan, which is equivalent to the Medicare part B payment under the Medicare Participating Physician Fee Schedule for Medicare participating physicians and the Medicare Nonparticipating Physician Fee Schedule for Medicare nonparticipating physicians (the amount payable before the Medicare deductible and coinsurance are applied); or

(2) The actual billed charges; and

(3) Reducing the lower amount by any FEHB plan deductible, coinsurance, or copayment that is the responsibility of the retired enrolled individual.

[58 FR 38663, July 20, 1993, as amended at 60 FR 26668, May 18, 1995]

§ 890.905 Limits on inpatient hospital and physician charges.

(a) Hospitals may not collect from FEHB plans and retired enrolled individuals for inpatient hospital services more than the amount determined to be equivalent to the Medicare part A payment under the DRG-based PPS.

(b) Medicare participating providers may not collect from FEHB plans and retired enrolled individuals for physician services more than the amount determined to be equivalent to the Medicare part B payment under the Medicare Participating Physician Fee Schedule.

(c) Medicare nonparticipating providers may not collect from FEHB plans and retired enrolled individuals for physician services more than the amount determined to be equivalent to the Medicare limiting charge amount.

[60 FR 26668, May 18, 1995; 60 FR 28019, May 26, 1995]

§ 890.906 Retired enrolled individuals coinsurance payments.

(a) A retired enrolled individual's coinsurance responsibility for inpatient hospital services is calculated in accordance with the plan's contractual benefit structure and is based on the amount determined to be equivalent to the Medicare part A payment under the DRG-based PPS.

(b) A retired enrolled individual's coinsurance responsibility for physician services is calculated in accordance with the plan's contractual benefit structure and is based on the lower of the actual charges or the amount determined to be equivalent to the Medicare part B payment under the Medicare Participating Physician Fee Schedule for Medicare participating physicians and the Medicare Nonparticipating Physician Fee Schedule for Medicare nonparticipating physicians.

[60 FR 26668, May 18, 1995]

§ 890.907 Effective dates.

(a) The limitation specified in this subpart applies to inpatient hospital admissions commencing on or after January 1, 1992.

(b) The limitation specified in this subpart applies to physician services supplied on or after January 1, 1995.

[60 FR 26668, May 18, 1995]

§ 890.908 Notification of HHS.

An FEHB plan, under the oversight of OPM, will notify the Secretary of HHS, or the Secretary's designee, if the plan finds that:

(a) A hospital knowingly and willfully collects, on a repeated basis, more than the amount determined to be equivalent to the Medicare part A payment under the DRG-based PPS.

(b) A Medicare participating physician or supplier knowingly and willfully collects, on a repeated basis, more

than the amount determined to be equivalent to the Medicare part B payment under the Medicare Participating Physician Fee Schedule.

(c) A Medicare nonparticipating physician or supplier knowingly and willfully charges, on a repeated basis, more than the amount determined to be equivalent to the Medicare limiting charge amount.

[60 FR 26668, May 18, 1995]

§ 890.909 End-of-year settlements.

Neither OPM, nor the FEHB plans, will perform end-of-year settlements with, or make retroactive adjustments as a result of retroactive changes in the Medicare payment calculation information to, hospital providers who have received FEHB benefit payments under this subpart.

[57 FR 10610, Mar. 27, 1992. Redesignated at 60 FR 26668, May 18, 1995]

§ 890.910 Provider information.

The hospital provider information used to calculate the amount equivalent to the Medicare part A payment will be updated on an annual basis.

[57 FR 10610, Mar. 27, 1992. Redesignated at 60 FR 26668, May 18, 1995]

Subpart J—Administrative Sanctions Imposed Against Health Care Providers

AUTHORITY: 5 U.S.C. 8902a.

SOURCE: 68 FR 5475, Feb. 3, 2003, unless otherwise noted.

GENERAL PROVISIONS AND DEFINITIONS

§ 890.1001 Scope and purpose.

(a) *Scope.* This subpart implements 5 U.S.C. 8902a, as amended by Public Law 105–266 (October 19, 1998). It establishes a system of administrative sanctions that OPM may, or in some cases, must apply to health care providers who have committed certain violations. The sanctions include debarment, suspension, civil monetary penalties, and financial assessments.

(b) *Purpose.* OPM uses the authorities in this subpart to protect the health and safety of the persons who obtain their health insurance coverage through the FEHBP and to assure the financial and programmatic integrity of FEHBP transactions.

§ 890.1002 Use of terminology.

Unless otherwise indicated, within this subpart the words ''health care provider,'' ''provider,'' and ''he'' mean a health care provider(s) of either gender or as a business entity, in either the singular or plural. The acronym ''OPM'' and the pronoun ''it'' connote the U.S. Office of Personnel Management.

§ 890.1003 Definitions.

In this subpart:

Carrier means an entity responsible for operating a health benefits plan described by 5 U.S.C. 8903 or 8903a.

Community means a geographically-defined area in which a provider furnishes health care services or supplies and for which he may request a limited waiver of debarment in accordance with this subpart. *Defined service area* has the same meaning as community.

Contest means a health care provider's request for the debarring or suspending official to reconsider a proposed sanction or the length or amount of a proposed sanction.

Control interest means that a health care provider:

(1) Has a direct and/or indirect ownership interest of 5 percent or more in an entity;

(2) Owns a whole or part interest in a mortgage, deed of trust, note, or other obligation secured by the entity or the entity's property or assets, equating to a direct interest of 5 percent or more of the total property or assets of the entity;

(3) Serves as an officer or director of the entity, if the entity is organized as a corporation;

(4) Is a partner in the entity, if the entity is organized as a partnership;

(5) Serves as a managing employee of the entity, including but not limited to employment as a general manager, business manager, administrator, or other position exercising, either directly or through other employees, operational or managerial control over the activities of the entity or any portion of the entity;