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) 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.

[61 FR 63745, Dec. 2, 1996, as amended at 74 FR 47468, Sept. 16, 2009; 76 FR 5961, Feb. 2, 2011; 86 FR 6093, Jan. 19, 2021]

§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

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]i

§ 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—