Subpart K—Payment for Certain Excluded Services

§411.400 Payment for custodial care and services not reasonable and necessary.

(a) *Conditions for payment.* Notwithstanding the exclusions set forth in §411.15 (g) and (k). Medicare pays for ''custodial care'' and ''services not reasonable and necessary'' if the following conditions are met:

(1) The services were funished by a provider or by a practitioner or supplier that had accepted assignment of benefits for those services.

(2) Neither the beneficiary nor the provider, practitioner, or supplier knew, or could reasonably have been expected to know, that the services were excluded from coverage under §411.15 (g) or (k).

(b) *Time limits on payment*—(1) *Basic rule.* Except as provided in paragraph (b)(2) of this section, payment may not be made for inpatient hospital care, posthospital SNF care, or home health services furnished after the earlier of the following:

(i) The day on which the beneficiary has been determined, under §411.404, to have knowledge, actual or imputed, that the services were excluded from coverage by reason of §411.15(g) or §411.15(k).

(ii) The day on which the provider has been determined, under §411.406 to have knowledge, actual or imputed, that the services are excluded from coverage by reason of §411.15(g) or §411.15(k).

(2) *Exception.* Payment may be made for services furnished during the first day after the limit established in paragraph (b)(1) of this section, if the QIO or the intermediary determines that the additional period of one day is necessary for planning post-discharge care. It the QIO or the intermediary determines that yet another day is necessary for planning post-discharge care, payment may be made for services furnished during the second day after the limit established in paragraph (b)(1) of this section.

§411.402 Indemnification of beneficiary.

(a) *Conditions for indemnification.* If Medicare payment is precluded because the conditions of §411.400(a)(2) are not met. Medicare indemnifies the beneficiary (and recovers from the provider, practitioner, or supplier), if the following conditions are met:

(1) The beneficiary paid the provider, practitioner, or supplier some or all of the charges for the excluded services.

(2) The beneficiary did not know and could not reasonably have been expected to know that the services were not covered.

(3) The provider, practitioner, or supplier knew, or could reasonably have been expected to know that the services were not covered.

(4) The beneficiary files a proper request for indemnification before the end of the sixth month after whichever of the following is later:

(i) The month is which the beneficiary paid the provider, practitioner, or supplier.

(ii) The month in which the intermediary or carrier notified the beneficiary (or someone on his or her behalf) that the beneficiary would not be liable for the services.

For good cause shown by the beneficiary, the 6-month period may be extended.

(b) *Amount of indemnification.*[1] The amount of indemnification is the total that the beneficiary paid the provider, practitioner, or supplier.

(c) *Effect of indemnification.* The amount of indemnification is considered an overpayment to the provider, practitioner, or supplier, and as such is recoverable under this part or in accordance with other applicable provisions of law.

[1] For services furnished before 1988, the indemnification amount was reduced by any deductible or coinsurance amounts that would have been applied if the services had been covered.