§ 420.304 Procedures for obtaining access to books, documents, and records.

(a) Contents of the request. Requests for access will be in writing and contain the following elements:

1. Reasonable identification of the books, documents, and records to which access is being requested.
2. Identification of the contract or subcontract in which costs are being questioned as excessive or inappropriate.
3. The reason that the appropriateness of the costs or value of the services of the subcontractor in question cannot be adequately or efficiently determined without access to the subcontractor’s books and records.
4. The authority in the statute and regulations for the access requested.
5. To the extent possible, the identification of those individuals who will be visiting the subcontractor to obtain access to the books, documents, and records.
6. The time and date of the scheduled visit.
7. The name of the duly authorized representative of HHS to contact if there are any questions.

(b) Subcontractor response to a request for access to books, documents, and records. (1) The subcontractor will have 30 days from the date of a written request for access to books, documents, and records to make them available in accordance with the request.

2. If the subcontractor believes the request is inadequate because it does not fully meet one or more of the required elements in paragraph (a) of this section, the subcontractor must advise the requesting organization of the additional information needed.

(i) The subcontractor must notify the requesting organization within 20 days of the date of the request that it was improperly completed.

(ii) The subcontractor must make the books, documents, and records available within 20 days after the date of the requesting organization’s response.

3. If the subcontractor believes, for good cause, that the requested books, documents, and records cannot be made available as requested with the 30-day period under paragraph (b)(1) of this section, the subcontractor may request an extension of time within which to comply with the request from the requesting organization. The requesting organization may, at its discretion, grant the request for an extension, in whole or in part, for good cause shown.

4. The subcontractor must make the books, documents, and records available during its regular business hours for inspection, audit, and reproduction.

5. If HHS asks the subcontractor to reproduce books, documents, and records, HHS will pay the reasonable cost of reproduction. However, if the subcontractor reproduces books, documents, and records as a means of making them available, the subcontractor must bear the cost of the reproduction and no Medicare reimbursement will be made for that purpose.

6. HHS reserves the right to examine the originals of any requested contracts, books, documents, and records, if they exist.

(c) Refusal by subcontractor to furnish access to records. If HCFA determines that the books, documents, and records are necessary for the reimbursement determination and the subcontractor refuses to make them available, HHS may initiate legal action against the subcontractor.

PART 421—INTERMEDIARIES AND CARRIERS

Subpart A—Scope, Definitions, and General Provisions

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Subpart B—Intermediaries

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§ 421.5 General provisions.

(a) Competitive bidding not required for carriers. HCFA may enter into contracts with carriers, or with intermediaries to act as carriers in certain circumstances, without regard to section 3709 of the U.S. Revised Statutes or any other provision of law that requires competitive bidding.

(b) Indemnification of intermediaries and carriers. Intermediaries and carriers act on behalf of HCFA in carrying out its Medicare-related responsibilities. HCFA is responsible for the performance of these functions and for any resulting liabilities. Intermediaries and carriers must be indemnified for any damages resulting from the performance of these functions.

§ 421.3 Definitions.

Intermediary means an entity that has a contract with HCFA to determine and make Medicare payments for Part A or Part B benefits payable on a cost basis (or under the Prospective Payment System for hospitals) and to perform other related functions. For purposes of designating regional or alternative regional intermediaries for home health agencies and of designating intermediaries for hospices under §421.117 as well as for applying the performance criteria in §421.120 and the performance standards in §421.122 and any adverse action resulting from such application, the term intermediary also means a Blue Cross Plan which has entered into a subcontract approved by HCFA with the Blue Cross and Blue Shield Association to perform intermediary functions.

[59 FR 681, Jan. 6, 1994]
§ 421.100 Intermediary functions.

An agreement between HCFA and an intermediary specifies the functions to be performed by the intermediary, which must include, but are not necessarily limited to, the following:

(a) Coverage. (1) The intermediary ensures that it makes payments only for services that are:

(i) Furnished to Medicare beneficiaries;

(ii) Covered under Medicare; and

(iii) In accordance with PRO determinations when they are services for which the PRO has assumed review responsibility under its contract with HCFA.

(2) The intermediary takes appropriate action to reject or adjust the claim if—

(i) The intermediary or the PRO determines that the services furnished or proposed to be furnished were not reasonable, not medically necessary, or not furnished in the most appropriate setting; or

(ii) The intermediary determines that the claim does not properly reflect the kind and amount of services furnished.

(b) Fiscal management. The intermediary must receive, disburse, and account for funds in making Medicare payments.

(c) Provider audits. The intermediary must audit the records of providers of services as necessary to assure proper payment.

(d) Utilization patterns. The intermediary must assist providers to—

(1) Develop procedures relating to utilization practices;

(2) Make studies of the effectiveness of those procedures and recommend methods to improve them;

(3) Evaluate the results of utilization review activity; and

(4) Assist in the application of safeguards against unnecessary utilization of services.

(e) Resolution of cost report disputes. The intermediary must establish and maintain procedures approved by HCFA to consider and resolve any disputes that may result from provider dissatisfaction with an intermediary’s determinations concerning provider cost reports.

(f) Reconsideration of determinations. The intermediary must establish and maintain procedures approved by HCFA for the reconsideration of its determinations to deny payments to an individual or to the provider that furnished services to the individual. The PRO performs reconsideration of cases in which it made a determination subject to reconsideration.

(g) Information and reports. The intermediary must furnish to HCFA any information and reports that HCFA requests in order to carry out its responsibilities in the administration of the Medicare program.
§ 421.105 Notification of action on nomination.

(a) HCFA will send, to each member of a nominating association or group, written notice of a decision to enter into or not enter into an agreement with the nominated organization or agency.

(b) Any member of a group or association having more than one nominated intermediary approved by HCFA to act on its behalf must withdraw its nomination.
§ 421.106 Change to another intermediary or to direct payment.

(a) Any provider may request a change of intermediary, or except for a hospice, that it be paid directly by HCFA, by—

(1) Giving HCFA written notice of its desire at least 120 days before the end of its current fiscal year; and

(2) Concurrently giving written notice to its intermediary.

(b) If HCFA finds the change is consistent with effective and efficient administration of the program and approves the request under paragraph (a) of this section, it will notify the provider, the outgoing intermediary, and the newly-elected intermediary (if any) that the change will be effective on the first day following the close of the fiscal year in which the request was filed.

§ 421.110 Requirements for approval of an agreement.

Before entering into or renewing an intermediary agreement, HCFA will—

(a) Determine that to do so is consistent with the effective and efficient administration of the Medicare program;

(b) Review the performance of the intermediary as measured by the criteria (§421.120) and standards (§421.122); and

(c) Determine that the intermediary or prospective intermediary—

(1) Is willing and able to assist providers in the application of safeguards against unnecessary utilization of services;

(2) Meets all solvency and financial responsibility requirements imposed by the statutes and regulatory authorities of the State or States in which it, or any subcontractor performing some or all of its functions, would serve;

(3) Has the overall resources and experience to administer its responsibilities under the Medicare program and has an existing operational, statistical, and recordkeeping capacity to carry out the additional program responsibilities it proposes to assume. HCFA will presume that an intermediary or prospective intermediary meets this requirement if it has at least 5 years experience in paying for or reimbursing the cost of health services;

(4) Will serve a sufficient number of providers to permit a finding of effective and efficient administration. Under this criterion no intermediary or prospective intermediary shall be found to be not efficient or effective solely on the grounds that it serves only providers located in a single State;

(5) Has acted in good faith to achieve effective cooperation with the providers it will service and with the physicians and medical societies in the area;

(6) Has established a record of integrity and satisfactory service to the public; and

(7) Has an affirmative equal employment opportunity program that complies with the fair employment provisions of the Civil Rights Act of 1964 and Executive Order 11246, as amended.

§ 421.112 Considerations relating to the effective and efficient administration of the program.

(a) In order to accomplish the most effective and efficient administration of the Medicare program, determinations may be made by the Secretary with respect to the termination of an intermediary agreement, or by HCFA with respect to the—

(1) Renewal of an intermediary agreement (§421.110);

(2) Assignment or reassignment of providers to an intermediary (§421.114); or

(3) Designation of a regional or national intermediary to serve a class of providers (§421.116).

(b) When taking the actions listed in paragraph (a), the Secretary or HCFA will consider the performance of the individual intermediary in its Medicare operations using the factors contained in the performance criteria (§421.120) and performance standards (§421.122).
§ 421.117 Designation of regional and alternative designated regional intermediaries for home health agencies and hospices.

(a) This section is based on section 1816(e)(4) of the Social Security Act, which requires the Secretary to designate regional intermediaries for home health agencies (HHAs) other than hospital-based HHAs but permits him or her to designate regional intermediaries for hospital-based HHAs only if the designation meets promulgated criteria concerning administrative efficiency and effectiveness; on section 1816(e)(5) of the Social Security Act, which requires the Secretary to designate intermediaries for hospices; and on section 1874 of the Act, which permits HCFA to contract with any organization for the purpose of making payments to any provider that elects to receive payment directly from HCFA.

(b) HCFA applies the following criteria to determine whether the assignment of hospital-based HHAs to designated regional intermediaries will result in the more effective and efficient administration of the Medicare program:

(c) In addition, when taking the actions listed in paragraph (a) of this section, the Secretary or HCFA may consider factors relating to—

(1) Consistency in the administration of program policy;
(2) Development of intermediary expertise in difficult areas of program administration;
(3) Individual capacity of available intermediaries to serve providers as it is affected by such considerations as—
   (i) Program emphasis on the number or type of providers to be served; or
   (ii) Changes in data processing technology;
(4) Overdependence of the program on the capacity of an intermediary to an extent that services could be interrupted;
(5) Economy in the delivery of intermediary services;
(6) Timeliness in the delivery of intermediary services;
(7) Duplication in the availability of intermediaries;
(8) Conflict of interest between an intermediary and provider; and
(9) Any additional pertinent factors.

§ 421.118  
(1) Uniform interpretation of Medicare rules;  
(2) Expertise in bill processing;  
(3) Control of administrative costs;  
(4) Ease of communication of program policy and issues to affected providers;  
(5) Ease of data collection;  
(6) Ease of HCFA’s monitoring of intermediary performance; and  
(7) Other criteria as the Secretary believes to be pertinent.  
(c) Except as provided in paragraphs (e), (f), and (g) of this section, an HHA must receive payment through a regional intermediary designated by HCFA.  
(d) Except as provided in paragraphs (f) through (h) of this section, a hospice must receive payment for covered services furnished to Medicare beneficiaries through an intermediary designated by HCFA.  
(e) An HHA chain not desiring to receive payment from designated regional intermediaries may request service by one lead intermediary with the assistance of a local designated regional intermediary. Alternatively, the chain may request to be serviced by a single intermediary. A lead, local, or a single intermediary must be an organization that is a designated regional intermediary. Any request made under this paragraph is evaluated by HCFA in accordance with the criteria contained at §421.106 of this subpart.  
(f) An HHA or hospice not wishing to receive payment from a regional intermediary designated under paragraph (c) or (d) of this section may submit a request to the HCFA Regional Office to receive payment through an alternative regional intermediary designated by HCFA.  
(g) Except as provided in paragraph (h) of this section, any request that an HHA or hospice may make to change from a designated regional intermediary to an alternative designated regional intermediary, in accordance with paragraph (f) of this section, is evaluated by HCFA in accordance with the criteria set forth at §421.106(b) of this subpart and must be filed within the timeframe established at §421.106(a) of this subpart.  
(h) Exception: An HHA or a hospice that, as of June 20, 1988 is receiving payment from a designated regional intermediary may, without regard to the limitations contained in §421.106 of this subpart, continue to receive payment from that intermediary. It may do so even if that intermediary is not the designated regional intermediary or the alternative designated regional intermediary for the particular State in which the HHA or hospice is located.  
[53 FR 17944, May 19, 1988]  
§ 421.118 Awarding of experimental contracts.  
Notwithstanding the provisions of §§421.103 and 421.104, HCFA may award a fixed price or performance incentive contract under the experimental authority contained in 42 U.S.C. 1395b–1 for performance of any of the functions specified in §421.100. Action taken by HCFA under this paragraph is not subject to—  
(a) The administrative and judicial review which would otherwise be available under §421.128; or  
(b) Performance criteria and performance standards review as provided for in §§421.120 and 421.122.  
[45 FR 42179, June 23, 1980, as amended at 59 FR 682, Jan. 6, 1994]  
§ 421.120 Performance criteria.  
(a) Application of performance criteria. As part of the intermediary evaluations authorized by section 1816(f) of the Act, HCFA periodically assesses the performance of intermediaries in their Medicare operations using performance criteria. The criteria measure and evaluate intermediary performance of functional responsibilities such as—  
(1) Correct coverage and payment determinations;  
(2) Responsiveness to beneficiary concerns; and  
(3) Proper management of administrative funds.  
(b) Basis for criteria. HCFA will base the performance criteria on—  
(1) Nationwide intermediary experience;  
(2) Changes in intermediary operations due to fiscal constraints; and  
(3) HCFA’s objectives in achieving better performance.  
42 CFR Ch. IV (10-1-96 Edition)
§ 421.126 Termination of agreements.

(a) Termination by intermediary. An intermediary may terminate its agreement at any time by—

(1) Giving written notice of its intention to HCFA and to the providers it services at least 180 days before its intended termination date; and

(2) Giving public notice of its intention by publishing a statement of the effective date of termination at least 60 days before that date. Publication must be in a newspaper of general circulation in each community served by the intermediary.

(b) Termination by the Secretary, and right of appeal. (1) The Secretary may terminate an agreement if—

(i) The intermediary fails to comply with the requirements of this subpart;
(ii) The intermediary fails to meet the criteria or standards specified in §§421.120 and 421.122; or
(iii) HCFA has reassigned, under §421.114 or §421.116, all of the providers assigned to the intermediary.
(2) If the Secretary decides to terminate an agreement, he or she will offer the intermediary an opportunity for a hearing, in accordance with §421.128.
(3) If the intermediary does not request a hearing, or if the hearing decision affirms the Secretary's decision, the Secretary will provide reasonable notice of the effective date of termination to—
(i) The intermediary;
(ii) The providers served by the intermediary; and
(iii) The general public.
(4) The providers served by the intermediary will be given the opportunity to nominate another intermediary, in accordance with §421.104.

§421.128 Intermediary's opportunity for hearing and right to judicial review.

(a) Basis for appeal. An intermediary adversely affected by any of the following actions shall be granted an opportunity for a hearing:
(1) Assignment or reassignment of providers to another intermediary.
(2) Designation of a national or regional intermediary to serve a class of providers.
(3) Termination of the agreement.
(b) Request for hearing. The intermediary shall file the request with HCFA within 20 days from the date on the notice of intended action.
(c) Hearing procedures. The hearing officer shall be a representative of the Secretary and not otherwise a party to the initial administrative decision. The intermediary may be represented by counsel and may present evidence and examine witnesses. A complete recording of the proceedings at the hearing will be made and transcribed.
(d) Judicial review. An adverse hearing decision concerning action under paragraph (a)(1) or (a)(2) of this section is subject to judicial review in accordance with 5 U.S.C. chapter 7.

§421.200 Carrier functions.

A contract between HCFA and a carrier, other than a regional DMEPOS carrier, specifies the functions to be performed by the carrier which must include, but are not necessarily limited to, the following:
(a) Coverage. (1) The carrier ensures that payment is made only for services that are:
(i) Furnished to Medicare beneficiaries;
(ii) Covered under Medicare; and
(iii) In accordance with PRO determinations when they are services for which the PRO has assumed review responsibility under its contract with HCFA.
(2) The carrier takes appropriate action to reject or adjust the claim if—
(i) The carrier or the PRO determines that the services furnished or proposed to be furnished were not reasonable, not medically necessary, or not furnished in the most appropriate setting;
(ii) The carrier determines that the claim does not properly reflect the kind and amount of services furnished.
(b) Payment on a cost basis. If payment is on a cost basis, the carrier shall assure that payments are based on reasonable costs, as determined under part 413 of this chapter.
(c) Payment on a charge basis. If payment is on a charge basis, under part 405, subpart E of this chapter, the carrier must assure that payments are based on reasonable costs, as determined under part 413 of this chapter.

Subpart C—Carriers

§421.200 Carrier functions.

A contract between HCFA and a carrier, other than a regional DMEPOS carrier, specifies the functions to be performed by the carrier which must include, but are not necessarily limited to, the following:
(a) Coverage. (1) The carrier ensures that payment is made only for services that are:
(i) Furnished to Medicare beneficiaries;
(ii) Covered under Medicare; and
(iii) In accordance with PRO determinations when they are services for which the PRO has assumed review responsibility under its contract with HCFA.
(2) The carrier takes appropriate action to reject or adjust the claim if—
(i) The carrier or the PRO determines that the services furnished or proposed to be furnished were not reasonable, not medically necessary, or not furnished in the most appropriate setting;
(ii) The carrier determines that the claim does not properly reflect the kind and amount of services furnished.
(b) Payment on a cost basis. If payment is on a cost basis, the carrier shall assure that payments are based on reasonable costs, as determined under part 413 of this chapter.
(c) Payment on a charge basis. If payment is on a charge basis, under part 405, subpart E of this chapter, the carrier must assure that—
(1) Charges are reasonable and not higher than the charge for a comparable service furnished under comparable circumstances to the carrier's policy holders and subscribers; and
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(2) The payment is based on one of the following—
   (i) An itemized bill.
   (ii) An assignment under the terms of which the reasonable charge is the full charge for the service, as specified in § 424.55 of this chapter.
   (iii) If the beneficiary has died, the procedures set forth in §§ 424.62 and 424.64 of this chapter.

(d) Fiscal management. The carrier must receive, disburse, and account for funds in making payments under Medicare.

(e) Provider audits. The carrier must audit the records of providers to whom it makes Medicare Part B payments to assure that payments are made properly.

(f) Utilization patterns. (1) The carrier must have methods and procedures for identifying utilization patterns that deviate from professionally established norms and bring the deviant patterns to the attention of appropriate professional groups.

   (2) The carrier must assist providers and other persons who furnish Medicare Part B services to—
      (i) Develop procedures relating to utilization practices;
      (ii) Make studies of the effectiveness of those procedures and devise methods to improve them;
      (iii) Apply safeguards against unnecessary utilization of services; and
      (iv) Develop procedures for utilization review, and establish groups to perform such reviews of providers to whom it makes Medicare Part B payments.

(g) Information and reports. The carrier must furnish to HCFA any information and reports that HCFA requests in order to carry out HCFA’s responsibilities in the administration of the Medicare program. The carrier must be responsive to requests for information from the public.

(h) Maintenance and availability of records. The carrier must maintain and make available to HCFA the records necessary for verification of payments and for other related purposes.

(i) Hearings to Part B beneficiaries. (1) The carrier must provide an opportunity for a fair hearing if it denies the beneficiary’s request for payment, does not act upon the request with reasonable promptness, or pays less than the amount claimed.

(2) The hearing procedures must be in accordance with part 405, subpart H, of this chapter (Review and Hearing Under the Supplementary Medical Insurance Program).

(j) Other terms and conditions. The carrier must comply with any other terms and conditions included in its contract.


§ 421.201 Performance criteria and standards.

(a) Application of performance criteria and standards. As part of the carrier evaluations mandated by section 1842(b)(2) of the Act, HCFA periodically assesses the performance of carriers in their Medicare operations using performance criteria and standards.

   (1) The criteria measure and evaluate carrier performance of functional responsibilities such as—
      (i) Accurate and timely payment determinations;
      (ii) Responsiveness to beneficiary, physician, and supplier concerns; and
      (iii) Proper management of administrative funds.

   (2) The standards evaluate the specific requirements of each functional responsibility or criterion.

(b) Basis for criteria and standards. HCFA bases the performance criteria and standards on—

   (1) Nationwide carrier experience;
   (2) Changes in carrier operations due to fiscal constraints; and
   (3) HCFA’s objectives in achieving better performance.

(c) Publication of criteria and standards. Before the beginning of each evaluation period, which usually coincides with the Federal fiscal year period of October 1-September 30, HCFA publishes the performance criteria and standards as a notice in the Federal Register. HCFA may not necessarily publish the criteria and standards every year. HCFA interprets the statutory phrase “before the beginning of each evaluation period” as allowing
§ 421.202 Requirements and conditions.
Before entering into or renewing a carrier contract, HCFA determines that the carrier—
(a) Has the capacity to perform its contractual responsibilities effectively and efficiently;
(b) Has the financial responsibility and legal authority necessary to carry out its responsibilities; and
(c) Will be able to meet any other requirements HCFA considers pertinent, and, if designated a regional DMEPOS carrier, any special requirements for regional carriers under §421.210 of this subpart.

[45 FR 42179, June 23, 1980, as amended at 57 FR 27307, June 18, 1992]

§ 421.203 Carrier's failure to perform efficiently and effectively.
(a) Failure by a carrier to meet, or demonstrate the capacity to meet, the criteria and standards specified in §421.201 may be grounds for adverse action by the Secretary, such as contract termination or non-renewal.
(b) Notwithstanding whether or not a carrier meets the criteria and standards specified in §421.201, if the cost incurred by the carrier to meet its contractual requirements exceeds the amount that HCFA finds to be reasonable and adequate to meet the cost which must be incurred by an efficiently and economically operated carrier, those high costs may also be grounds for adverse action.

[59 FR 682, Jan. 6, 1994]

§ 421.205 Termination by the Secretary.
(a) Cause for termination. The Secretary may terminate a contract with a carrier at any time if he or she determines that the carrier has failed substantially to carry out any material term of the contract or has performed its function in a manner inconsistent with the effective and efficient administration of the Medicare Part B program.
(b) Notice and opportunity for hearing. Upon notification of the Secretary's intent to terminate the contract, the carrier may request a hearing within 20 days after the date on the notice of intent to terminate.
(c) Hearing procedures. The hearing procedures will be those specified in §421.128(c).

§ 421.210 Designations of regional carriers to process claims for durable medical equipment, prosthetics, orthotics and supplies.
(a) Basis. This section is based on sections 1834(a) and 1834(h) of the Act which authorize the Secretary to designate one or more carriers by specific regions to process claims for durable medical equipment, prosthetic devices, prosthetics, orthotics and other supplies (DMEPOS). This authority has been delegated to HCFA.
(b) Types of claims. Claims for the following, except for items incident to a physician's professional service as defined in §410.26, incident to a physician's service in a rural health clinic as defined in §405.2413, or bundled into payment to a provider, ambulatory surgical center, or other facility, are processed by the designated carrier for its designated region and not by other carriers—
(1) Durable medical equipment (and related supplies) as defined in section 1861(n) of the Act;
(2) Prosthetic devices (and related supplies) as described in section 1861(s)(8) of the Act, (including intraocular lenses and parenteral and enteral nutrients, supplies, and equipment, when furnished under the prosthetic device benefit);
(3) Orthotics and prosthetics (and related supplies) as described in section 1861(s)(9);
(4) Home dialysis supplies and equipment as described in section 1861(s)(2)(F);
(5) Surgical dressings and other devices as described in section 1861(s)(5);
(6) Immunosuppressive drugs as described in section 1861(s)(2)(F); and
(7) Other items or services which are designated by HCFA.
(c) Region designation. The boundaries of the four regions for processing claims described in paragraph (b) of this section coincide with the boundaries of 1 or more sectors or areas designated for the Common Working File. These four regions contain the following States and territories: Region A: Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, New York, New Jersey, Pennsylvania, and Delaware. Region B: Maryland, the District of Columbia, Virginia, West Virginia, Ohio, Michigan, Indiana, Illinois, Wisconsin and Minnesota. Region C: North Carolina, South Carolina, Kentucky, Tennessee, Georgia, Florida, Alabama, Mississippi, Louisiana, Texas, Arkansas, Oklahoma, New Mexico, Colorado, Puerto Rico and the Virgin Islands. Region D: Alaska, Hawaii, American Samoa, Guam, the Northern Mariana Islands, California, Nevada, Arizona, Washington, Oregon, Montana, Idaho, Utah, Wyoming, North Dakota, South Dakota, Nebraska, Kansas, Iowa and Missouri.

(d) Criteria for designating regional carriers. HCFA designates regional carriers to achieve a greater degree of effectiveness and efficiency in the administration of the Medicare program as measured by—

(1) Timeliness of claim processing;
(2) Cost per claim;
(3) Claim processing quality;
(4) Experience in claim processing, and in establishing local medical review policy; and
(5) Other criteria that HCFA believes to be pertinent.

(e) Carrier designation. (1) Each carrier designated a regional carrier is responsible, using the payment rates applicable for the State of residence of a beneficiary, including a qualified Railroad Retirement beneficiary, for processing claims for items listed in paragraph (b) of this section for beneficiaries whose permanent residence is within the area designated in paragraph (c) of this section. A beneficiary’s permanent residence is the address at which he or she intends to spend 6 months or more of the calendar year.

(2) The regional carriers designated to process DMEPOS claims (as defined in paragraph (b) of this section) for all Medicare beneficiaries residing in their respective regions (as designated in paragraph (c) of this section), including those entitled under the Railroad Retirement Act, are the following:

(i) The Travelers Insurance Company (Region A), which will be processing claims in Pennsylvania.
(ii) Associated Insurance Companies, Inc.—AdminaStar (Region B), which will be processing claims in Indiana.
(iii) Blue Cross and Blue Shield of South Carolina (doing business as Palmetto Governments Benefits Administrators) (Region C), which will be processing claims in South Carolina.
(iv) Connecticut General Life Insurance Co. (a CIGNA Company) (Region D), which will be processing claims in Tennessee.

(3) Blue Cross and Blue Shield of South Carolina (Palmetto Government Benefits Administrators) has been selected to serve as the National Supplier Clearinghouse and the Statistical Analysis DME regional carrier.

(4) The contracts for the four DME regional carriers will be periodically recompeted. The National Supplier Clearinghouse and Statistical Analysis DME regional carrier do not constitute separate contracts, but are contract amendments to one of the DME regional carrier contracts. The National Supplier Clearinghouse and Statistical Analysis DME regional carrier contract amendments will also be periodically recompeted.

(f) Collecting information of ownership. Carriers designated as regional carriers must obtain from each supplier of items listed in paragraph (b) of this section information concerning ownership and control as required by section 1124A of the Act and part 420 of this chapter, and certifications that supplier standards are met as required by part 424 of this chapter.

§ 421.212 Railroad Retirement Board contracts.

In accordance with this subpart C, the Railroad Retirement Board contracts with DMEPOS regional carriers designated by HCFA, as set forth in §421.210(e)(2), for processing claims for Medicare-eligible Railroad Retirement
§ 421.214 Advance payments to suppliers furnishing items or services under Part B.

(a) Scope and applicability. This section provides for the following:

(1) Sets forth requirements and procedures for the issuance and recovery of advance payments to suppliers of Part B services and the rights and responsibilities of suppliers under the payment and recovery process.

(2) Does not limit HCFA’s right to recover unadjusted advance payment balances.

(3) Does not affect suppliers’ appeal rights under part 405, subpart H of this chapter relating to substantive determinations on suppliers’ claims.

(4) Does not apply to claims for Part B services furnished by suppliers that have in effect provider agreements under section 1866 of the Act and part 489 of this chapter, and are paid by intermediaries.

(b) Definition. As used in this section, advance payment means a conditional partial payment made by the carrier in response to a claim that it is unable to process within established time limits.

(c) When advance payments may be made. An advance payment may be made if all of the following conditions are met:

(1) The carrier is unable to process the claim timely.

(2) HCFA determines that the prompt payment interest provision specified in section 1842(c) of the Act is insufficient to make a claimant whole.

(3) HCFA approves, in writing to the carrier, the making of an advance payment by the carrier.

(d) When advance payments are not made. Advance payments are not made to any supplier that meets any of the following conditions:

(1) Is delinquent in repaying a Medicare overpayment.

(2) Has been advised of being under active medical review or program integrity investigation.

(3) Has not submitted any claims.

(4) Has not accepted claims’ assignments within the most recent 180-day period preceding the system malfunction.

(e) Requirements for suppliers. (1) Except as provided for in paragraph (g)(1) of this section, a supplier must request, in writing to the carrier, an advance payment for Part B services it furnished.

(2) A supplier must accept an advance payment as a conditional payment subject to adjustment, recoupment, or both, based on an eventual determination of the actual amount due on the claim and subject to the provisions of this section.

(f) Requirements for carriers. (1) A carrier must notify a supplier as soon as it is determined that payment will not be made in a timely manner, and an advance payment option is to be offered to the supplier.

(i) A carrier must calculate an advance payment for a particular claim at no more than 80 percent of the anticipated payment for that claim based upon the historical assigned claims payment data for claims paid the supplier.

(ii) “Historical data” are defined as a representative 90-day assigned claims payment trend within the most recent 180-day experience before the system malfunction.

(iii) Based on this amount and the number of claims pending for the supplier, the carrier must determine and issue advance payments.

(iv) If historical data are not available or if backlogged claims cannot be identified, the carrier must determine and issue advance payments based on some other methodology approved by HCFA.

(v) Advance payments can be made no more frequently than once every 2 weeks to a supplier.

(2) Generally, a supplier will not receive advance payments for more assigned claims than were paid, on a daily average, for the 90-day period before the system malfunction.

(3) A carrier must recover an advance payment by applying it against the amount due on the claim on which the advance was made. If the advance payment exceeds the Medicare payment amount, the carrier must apply the
unadjusted balance of the advance payment against future Medicare payments due the supplier.

(4) In accordance with HCFA instructions, a carrier must maintain a financial system of data in accordance with the Statement of Federal Financial Accounting Standards for tracking each advance payment and its recoupment.

(g) Requirements for HCFA. (1) In accordance with the provisions of this section, HCFA may determine that circumstances warrant the issuance of advance payments to all affected suppliers furnishing Part B services. HCFA may waive the requirement in paragraph (e)(1) of this section as part of that determination.

(2) If adjusting Medicare payments fails to recover an advance payment, HCFA may authorize the use of any other recoupment method available (for example, lump sum repayment or an extended repayment schedule) including, upon written notice from the carrier to the supplier, converting any unpaid balances of advance payments to overpayments. Overpayments are recovered in accordance with part 401, subpart F of this chapter concerning claims collection and compromise and part 405, subpart C of this chapter concerning recovery of overpayments.

(h) Prompt payment interest. An advance payment is a "payment" under section 1842(c)(2)(C) of the Act for purposes of meeting the time limit for the payment of clean claims, to the extent of the advance payment.

(i) Notice, review, and appeal rights. (1) The decision to advance payments and the determination of the amount of any advance payment are committed to HCFA’s discretion and are not subject to review or appeal.

(2) The carrier must notify the supplier receiving an advance payment about the amounts advanced and recouped and how any Medicare payment amounts have been adjusted.

(3) The supplier may request an administrative review from the carrier if it believes the carrier’s reconciliation of the amounts advanced and recouped is incorrectly computed. If a review is requested, the carrier must provide a written explanation of the adjustments.

(4) The review and explanation described in paragraph (i)(3) of this section is separate from a supplier’s right to appeal the amount and computation of benefits paid on the claim, as provided at part 405, subpart H of this chapter. The carrier’s reconciliation of amounts advanced and recouped is not an initial determination as defined at §405.803 of this chapter, and any written explanation of a reconciliation is not subject to further administrative review.