

§ 424.500

check, the intermediary or carrier issues a replacement check to the payee.

(6) If the bank of first deposit refuses to settle on the check for good cause, the payee must pursue the claim on his or her own and the intermediary or carrier will not reissue the check to the payee.

(c) If the check has not been negotiated—

(1) The intermediary or carrier arranges with the bank to stop payment on the check; and

(2) Except as provided in paragraph (d), the intermediary or carrier reissues the check to the payee.

(d) No check may be reissued under (c)(2) unless the claim for a replacement check is received by the intermediary or carrier no later than 1 year from the date of issuance of the original check, unless State law (including any applicable Federal banking laws or regulations that may affect the relevant State proceeding) provides a longer period which will control.

[58 FR 65130, Dec. 13, 1993]

Subparts N–O [Reserved]

Subpart P—Requirements for Establishing and Maintaining Medicare Billing Privileges

SOURCE: 71 FR 20776, Apr. 21, 2006, unless otherwise noted.

§ 424.500 Scope.

The provisions of this subpart contain the requirements for enrollment, periodic resubmission and certification of enrollment information for revalidation, and timely reporting of updates and changes to enrollment information. These requirements apply to all providers and suppliers except for physicians and practitioners who have entered into a private contract with a beneficiary as described in part 405, subpart D of this chapter. Providers and suppliers must meet and maintain these enrollment requirements to bill either the Medicare program or its beneficiaries for Medicare covered services or supplies.

42 CFR Ch. IV (10–1–16 Edition)

§ 424.502 Definitions.

As used in this subpart, unless the context indicates otherwise—

Approve/Approval means the enrolling provider or supplier has been determined to be eligible under Medicare rules and regulations to receive a Medicare billing number and be granted Medicare billing privileges.

Authorized official means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

Change in majority ownership occurs when an individual or organization acquires more than a 50 percent direct ownership interest in an HHA during the 36 months following the HHA's initial enrollment into the Medicare program or the 36 months following the HHA's most recent change in majority ownership (including asset sale, stock transfer, merger, and consolidation). This includes an individual or organization that acquires majority ownership in an HHA through the cumulative effect of asset sales, stock transfers, consolidations, or mergers during the 36-month period after Medicare billing privileges are conveyed or the 36-month period following the HHA's most recent change in majority ownership.

Deactivate means that the provider or supplier's billing privileges were stopped, but can be restored upon the submission of updated information.

Delegated official means an individual who is delegated by the "Authorized Official," the authority to report changes and updates to the enrollment record. The delegated official must be an individual with ownership or control interest in, or be a W-2 managing employee of the provider or supplier.

Deny/Denial means the enrolling provider or supplier has been determined to be ineligible to receive Medicare billing privileges for Medicare covered

items or services provided to Medicare beneficiaries.

Enroll/Enrollment means the process that Medicare uses to establish eligibility to submit claims for Medicare-covered items and services, and the process that Medicare uses to establish eligibility to order or certify Medicare-covered items and services. The process includes—

(1) Identification of a provider or supplier;

(2) Except for those suppliers that complete the CMS-855O form, CMS-identified equivalent, successor form or process for the sole purpose of obtaining eligibility to order or certify Medicare-covered items and services, validating the provider or supplier's eligibility to provide items or services to Medicare beneficiaries;

(3) Identification and confirmation of the provider or supplier's practice location(s) and owner(s); and

(4) Except for those suppliers that complete the CMS-855O form, CMS-identified equivalent, successor form or process for the sole purpose of obtaining eligibility to order or certify Medicare-covered items and services, granting the Medicare provider or supplier Medicare billing privileges.

Enrollment application means a CMS-approved paper enrollment application or an electronic Medicare enrollment process approved by OMB.

Final adverse action means one or more of the following actions:

(1) A Medicare-imposed revocation of any Medicare billing privileges;

(2) Suspension or revocation of a license to provide health care by any State licensing authority;

(3) Revocation or suspension by an accreditation organization;

(4) A conviction of a Federal or State felony offense (as defined in § 424.535(a)(3)(i)) within the last 10 years preceding enrollment, revalidation, or re-enrollment; or

(5) An exclusion or debarment from participation in a Federal or State health care program.

Institutional provider means any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (not including physician and nonphysician practitioner organizations), CMS-855S or as-

sociated Internet-based PECOS enrollment application.

Managing employee means a general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the provider or supplier.

Operational means the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered), to furnish these items or services.

Owner means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of the provider or supplier as defined in sections 1124 and 1124A(A) of the Act.

Physician or nonphysician practitioner organization means any physician or nonphysician practitioner entity that enrolls in the Medicare program as a sole proprietorship or organizational entity.

Reject/Rejected means that the provider or supplier's enrollment application was not processed due to incomplete information, or that additional information or corrected information was not received from the provider or supplier in a timely manner.

Revoke/Revocation means that the provider or supplier's billing privileges are terminated.

Voluntary termination means that a provider or supplier, including an individual physician or nonphysician practitioner, submits written confirmation to CMS of its decision to discontinue enrollment in the Medicare program.

[71 FR 20776, Apr. 21, 2006, as amended at 73 FR 69939, Nov. 19, 2008; 75 FR 70464, Nov. 17, 2010; 75 FR 73628, Nov. 29, 2010; 76 FR 5962, Feb. 2, 2011; 79 FR 72531, Dec. 5, 2014]