

§ 424.127

(i) Meets the requirements set forth in § 424.104; and

(ii) Reflects the hospital's intent to claim for all covered services furnished during a calendar year.

(2) Claims payment in accordance with §§ 424.32 and 413.74 of this chapter; and

(3) Submits evidence requested by CMS to establish that the services meet the requirements of this subpart.

(b) *Amount of payment.* Payment is made (in accordance with § 413.74 of this chapter) on the basis of 100 percent of the hospital's customary charges, subject to the applicable deductible and coinsurance provisions set forth elsewhere in this chapter.

§ 424.127 Payment to the beneficiary.

(a) *Conditions for payment of inpatient hospital services.* Medicare pays the beneficiary if—

(1) The hospital does not have in effect an election to claim payment; and

(2) The beneficiary, or someone on his or her behalf, submits—

(i) A claim in accordance with § 424.32;

(ii) An itemized hospital bill; and

(iii) Evidence requested by CMS to establish that the services meet the requirements of this subpart.

(b) *Amount payable for inpatient hospital services.* The amount payable to the beneficiary is determined in accordance with § 424.109(b).

(c) *Conditions for payment for Part B services.* Medicare pays the beneficiary for physicians' services and ambulance services as specified in § 424.121, if an itemized bill for the services is submitted by the beneficiary or someone on his or her behalf and the conditions of § 424.126(a) (2) and (3) are met.

(d) The amount payable to the beneficiary is determined in accordance with § 410.152 of this chapter.

Subparts I-L [Reserved]

42 CFR Ch. IV (10-1-11 Edition)

Subpart M—Replacement and Reclamation of Medicare Payments

§ 424.350 Replacement of checks that are lost, stolen, defaced, mutilated, destroyed, or paid on forged endorsements.

(a) *U.S. Government checks—(1) Responsibility.* The Treasury Department is responsible for the investigation and settlement of claims in connection with Treasury checks issued on behalf of CMS.

(2) *Action by CMS.* CMS forwards reports of lost, stolen, defaced, mutilated, destroyed, or forged Treasury checks to the Treasury Department disbursing center responsible for issuing checks.

(3) *Action by the Treasury Department.* The Treasury Department will replace and begin reclamation of Treasury checks in accordance with Treasury Department regulations (31 CFR parts 235, 240, and 245).

(b) *Intermediary and carrier benefit checks.* Checks issued by intermediaries and carriers are drawn on commercial banks and are not subject to the Federal laws and Treasury Department regulations that govern Treasury checks. Replacement procedures are carried out in accordance with § 424.352 under applicable State law (including any Federal banking laws or regulations that may affect the relevant State proceedings).

[58 FR 65129, Dec. 13, 1993]

§ 424.352 Intermediary and carrier checks that are lost, stolen, defaced, mutilated, destroyed or paid on forged endorsements.

(a) When an intermediary or carrier is notified by a payee that a check has been lost, stolen, defaced, mutilated, destroyed, or paid on forged endorsement, the intermediary or carrier contacts the commercial bank on whose paper the check was drawn and determines whether the check has been negotiated.

(b) If the check has been negotiated—

(1) The intermediary or carrier provides the payee with a copy of the check and other pertinent information (such as a claim form, affidavit or questionnaire to be completed by the

payee) required to pursue his or her claim in accordance with State law and commercial banking regulations.

(2) To pursue the claim, the payee must examine the check and certify (by completing the claim form, questionnaire or affidavit) that the endorsement is not the payee's.

(3) The claim form and other pertinent information is sent to the intermediary or carrier for review and processing of the claim.

(4) The intermediary or carrier reviews the payee's claim. If the intermediary or carrier determines that the claim appears to be valid, it forwards the claim and a copy of the check to the issuing bank. The intermediary or carrier takes further action to recover the proceeds of the check in accordance with the State law and regulations.

(5) Once the intermediary or carrier recovers the proceeds of the initial 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.

§ 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).