submits the same information that it would submit for payment under Original Medicare is deemed to be seeking to be paid the amount it would be paid under Original Medicare unless the provider expressly notifies the MA organization in writing that it is billing an amount less than such amount.

(d) *Regional PPO payments in non-network areas.* An MA Regional PPO must pay non-contract providers the Original Medicare payment rate in those portions of its service area where it is providing access to services by non-network means under § 422.111(b)(3)(ii) of this part.

[63 FR 35085, June 26, 1998, as amended at 65 FR 40325, June 29, 2000; 70 FR 4724, Jan. 28, 2005; 70 FR 47490, Aug. 12, 2005; 76 FR 21564, Apr. 15, 2011]

§ 422.216 Special rules for MA private fee-for-service plans.

(a) *Payment to providers*—(1) *Payment rate.* (i) The MA organization must establish payment rates for plan covered items and services that apply to deemed providers. The MA organization may vary payment rates for providers in accordance with § 422.4(a)(3).

(ii) Providers must be reimbursed on a fee-for-service basis.

(iii) The MA organization must make information on its payment rates available to providers that furnish services that may be covered under the MA private fee-for-service plan.

(2) *Noncontract providers.* The organization pays for services of noncontract providers in accordance with § 422.100(b)(2).

(3) *Services furnished by providers of service.* Any provider of services as defined in section 1861(u) of the Act that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA private fee-for-service plan must receive, and accept as payment in full, at least the amount (less any payments under §§ 412.105(g) and 413.76 of this chapter) that it could collect if the beneficiary were enrolled in original Medicare.

(b) *Charges to enrollees*—(1) *Contract providers* (i) Contract providers and ''deemed'' contract providers may charge enrollees no more than the cost-sharing and, subject to the limit in paragraph (b)(1)(ii) of this section, balance billing amounts that are permitted under the plan, and these amounts must be the same for ''deemed'' contract providers as for those that have signed contracts in effect, unless access requirements with respect to a particular category of health care providers are met solely through § 422.114(a)(2)(ii) and the MA organization imposes higher beneficiary copayments as permitted under § 422.114(c).

(ii) The organization may permit balance billing no greater than 15 percent of the payment rate established under paragraph (a)(1) of this section.

(iii) The MA organization must specify the amount of cost-sharing and balance billing in its contracts with providers and these amounts must be the same for ''deemed'' contract providers as for those that have signed contracts in effect, unless access requirements with respect to a particular category of health care providers are met solely through § 422.114(a)(2)(ii) and the MA organization imposes higher beneficiary copayments as permitted under § 422.114(c).

(iv) The MA organization is subject to intermediate sanctions under § 422.752(a)(7), under the rules in subpart O of this part, if it fails to enforce the limit specified in paragraph (b)(1)(i) of this section.

(2) *Noncontract providers.* A noncontract provider may not collect from an enrollee more than the cost-sharing established by the MA private fee-for-service plan as specified in § 422.256(b)(3), unless the provider has opted out of Medicare as described in part 405, subpart D of this chapter.

(c) *Enforcement of limit*—(1) *Contract providers.* An MA organization that offers an MA fee-for-service plan must enforce the limit specified in paragraph (b)(1) of this section.

(2) *Noncontract providers.* An MA organization that offers an MA private fee-for-service plan must monitor the amount collected by noncontract providers to ensure that those amounts do not exceed the amounts permitted to be collected under paragraph (b)(2) of this section, unless the provider has opted out of Medicare as described in part 405, subpart D of this chapter. The

MA organization must develop and document violations specified in instructions and must forward documented cases to CMS.

(d) *Information on enrollee liability*—(1) *General information.* An MA organization that offers an MA private fee-for-service plan must provide to plan enrollees, an appropriate explanation of benefits consistent with the requirements of § 422.111(b)(12).

(2) *Advance notice for hospital services.* In its terms and conditions of payment to hospitals, the MA organization must require the hospital, if it imposes balance billing, to provide to the enrollee, before furnishing any services for which balance billing could amount to not less than $500—

(i) Notice that balance billing is permitted for those services;

(ii) A good faith estimate of the likely amount of balance billing, based on the enrollees presenting condition; and

(iii) The amount of any deductible, coinsurance, and copayment that may be due in addition to the balance billing amount.

(e) *Coverage determinations.* The MA organization must make coverage determinations in accordance with subpart M of this part.

(f) *Rules describing deemed contract providers.* Any provider furnishing health services, except for emergency services furnished in a hospital pursuant to § 489.24 of this chapter, to an enrollee in an MA private fee-for-service plan, and who has not previously entered into a contract or agreement to furnish services under the plan, is treated as having a contract in effect and is subject to the limitations of this section that apply to contract providers if the following conditions are met:

(1) The services are covered under the plan and are furnished—

(i) To an enrollee of an MA fee-for-service plan; and

(ii) Provided by a provider including a provider of services (as defined in section 1861(u) of the Act) that does not have in effect a signed contract with the MA organization.

(2) Before furnishing the services, the provider—

(i) Was informed of the individual's enrollment in the plan; and

(ii) Was informed (or given a reasonable opportunity to obtain information) about the terms and conditions of payment under the plan, including the information described in § 422.202(a)(1).

(3) The information was provided in a manner that was reasonably designed to effect informed agreement and met the requirements of paragraphs (g) and (h) of this section.

(g) *Enrollment information.* Enrollment information was provided by one of the following methods or a similar method:

(1) Presentation of an enrollment card or other document attesting to enrollment.

(2) Notice of enrollment from CMS, a Medicare intermediary or carrier, or the MA organization itself.

(h) *Information on payment terms and conditions.* Information on payment terms and conditions was made available through either of the following methods:

(1) The MA organization used postal service, electronic mail, FAX, or telephone to communicate the information to one of the following:

(i) The provider.

(ii) The employer or billing agent of the provider.

(iii) A partnership of which the provider is a member.

(iv) Any party to which the provider makes assignment or reassigns benefits.

(2) The MA organization has in effect a procedure under which—

(i) Any provider furnishing services to an enrollee in an MA private fee-for-service plan, and who has not previously entered into a contract or agreement to furnish services under the plan, can receive instructions on how to request the payment information;

(ii) The organization responds to the request before the entity furnishes the service; and

(iii) The information the organization provides includes the following:

(A) Billing procedures.

(B) The amount the organization will pay towards the service.

(C) The amount the provider is permitted to collect from the enrollee.

(D) The information described in § 422.202(a)(1).

(3) Announcements in newspapers, journals, or magazines or on radio or television are not considered communication of the terms and conditions of payment.

(i) *Provider credential requirements.* Contracts with providers must provide that, in order to be paid to provide services to plan enrollees, providers must meet the requirements specified in §§ 422.204(b)(1)(i) and (b)(3).

[63 FR 35085, June 26, 1998, as amended at 65 FR 40325, June 29, 2000; 70 FR 52056, Sept. 1, 2005; 70 FR 47490, Aug. 12, 2005; 70 FR 76197, Dec. 23, 2005; 73 FR 54250, Sept. 18, 2008; 77 FR 22167, Apr. 12, 2012]

§ 422.220 Exclusion of services furnished under a private contract.

An MA organization may not pay, directly or indirectly, on any basis, for services (other than emergency or urgently needed services as defined in § 422.2) furnished to a Medicare enrollee by a physician (as defined in section 1861(r)(1) of the Act) or other practitioner (as defined in section 1842(b)(18)(C) of the Act) who has filed with the Medicare carrier an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts under section 1802(b) of the Act with the beneficiaries. An MA organization must pay for emergency or urgently needed services furnished by a physician or practitioner who has not signed a private contract with the beneficiary.

§ 422.222 Preclusion list for contracted and non-contracted individuals and entities.

(a)(1)(i) Except as provided in paragraph (a)(1)(ii) of this section, an MA organization must not make payment for a health care item, service, or drug that is furnished, ordered, or prescribed by an individual or entity that is included on the preclusion list, defined in § 422.2.

(ii) With respect to MA providers that have been added to an updated preclusion list but are not currently excluded by the OIG, the MA organization must do all of the following:

(A) No later than 30 days after the posting of this updated preclusion list, must provide an advance written notice to any beneficiary who has received or been prescribed an MA service, item, or drug from or by the individual or entity added to the preclusion list in this update.

(B)(*1*) Subject to paragraph (a)(1)(ii)(B)(*2*) of this section, must ensure that reasonable efforts are made to notify the individual or entity described in paragraph (a)(1)(ii) of this section of a beneficiary who was sent a notice under paragraph (a)(1)(ii)(A) of this section.

(*2*) Paragraph (a)(1)(ii)(B)(*1*) of this section applies only upon receipt of a claim from a precluded provider in Medicare Part C when—

(*i*) The MA organization has enough information on file to either copy the provider on the notification previously sent to the beneficiary or send a new notice informing the provider that they may not see plan beneficiaries due to their preclusion status; and

(*ii*) The claim is received after the claim denial or reject date in the preclusion file.

(C) Must not deny payment for a service, item, or drug furnished, ordered, or prescribed by the newly added individual or entity, solely on the ground that they have been included in the updated preclusion list, in the 60-day period after the date it sent the notice described in paragraph (a)(1)(ii)(A) of this section.

(2)(i) CMS sends written notice to the individual or entity via letter of their inclusion on the preclusion list. The notice must contain the reason for the inclusion and inform the individual or entity of their appeal rights. An individual or entity may appeal their inclusion on the preclusion list, defined in § 422.2, in accordance with part 498 of this chapter.

(ii) If the individual's or entity's inclusion on the preclusion list is based on a contemporaneous Medicare revocation under § 424.535 of this chapter:

(A) The notice described in paragraph (a)(2)(i) of this section must also include notice of the revocation, the reason(s) for the revocation, and a description of the individual's or entity's appeal rights concerning the revocation.

(B) The appeals of the individual's or entity's inclusion on the preclusion list