

## § 420.400

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 CMS 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.

### **Subpart E—Rewards for Information Relating to Medicare Fraud and Abuse, and Establishment of a Program to Collect Suggestions for Improving Medicare Program Efficiency and to Reward Suggesters for Monetary Savings**

SOURCE: 63 FR 31128, June 8, 1998, unless otherwise noted.

#### **§ 420.400 Basis and scope.**

This subpart implements sections 203(b) and (c) of Public Law 104-191, which require the establishment of programs to encourage individuals to report suspected cases of fraud and abuse and submit suggestions on methods to improve the efficiency of the Medicare program. Sections 203(b) and (c) of Public Law 104-191 also provide the authority for CMS to reward individuals for

## 42 CFR Ch. IV (10-1-23 Edition)

reporting fraud and abuse and for submitting suggestions that could improve the efficiency of the Medicare program. This subpart sets forth procedures for rewarding individuals.

[64 FR 66401, Nov. 26, 1999]

#### **§ 420.405 Rewards for information relating to Medicare fraud and abuse.**

(a) *General rule.* CMS pays a monetary reward for information that leads to the recovery of at least \$100 of Medicare funds from individuals and entities that are engaging in, or have engaged in, acts or omissions that constitute grounds for the imposition of a sanction under section 1128, section 1128A, or section 1128B of the Act or that have otherwise engaged in sanctionable fraud and abuse against the Medicare program. The determination of whether an individual meets the criteria for an award, and the amount of the award, is at the discretion of CMS. CMS pays rewards only if a reward is not otherwise provided for by law. When CMS applies the criteria specified in paragraphs (b), (c), and (e) of this section to determine the eligibility and the amount of the reward, it notifies the beneficiary as specified in paragraph (d) of this section.

(b) *Information eligible for reward.* (1) In order for an individual to be eligible to receive a reward, the information he or she supplied must relate to the activities of a specific individual or entity and must specify the time period of the alleged activities.

(2) CMS does not give a reward for information relating to an individual or entity that, at the time the information is provided, is already the subject of a review or investigation by CMS or its contractors, or the OIG, the Department of Justice, the Federal Bureau of Investigation, or any other Federal, State, or local law enforcement agency.

(c) *Persons eligible to receive a reward—*(1) *General rule.* Any person (other than one excluded under paragraph (c)(2) of this section) is eligible to receive a reward under this section if the person submits the information in the manner set forth in paragraph (f) of this section.

(2) *Excluded individuals.* (i) An individual who was, or is an immediate

family member of, an officer or employee of HHS or its contractors, the SSA, the OIG, a State Medicaid Agency, or the Department of Justice, the Federal Bureau of Investigation, or any other Federal, State, or local law enforcement agency at the time he or she came into possession of, or divulged, information leading to a recovery of Medicare funds is not eligible to receive a reward under this section.

(ii) Any other Federal or State employee or contractor or an HHS grantee is not eligible for a reward under this section if the information submitted came to his or her knowledge in the course of his or her official duties.

(iii) An individual who illegally obtained the information he or she submitted is excluded from receiving a reward under this section.

(iv) An individual who participated in the sanctionable offense with respect to which payment would be made is excluded from receiving a reward under this section.

(d) *Notification of eligibility*—(1) *General rule.* After all Medicare funds have been recovered and CMS has determined a participant eligible to receive a reward under the provisions of this section, it notifies the informant of his or her eligibility, by mail, at the most recent address supplied by the individual. It is the individual's responsibility to ensure that the reward program has been notified of any change in his or her address or other relevant personal information (for example, change of name, phone number).

(2) *Special circumstances.* (i) If the individual has relocated to an unknown address, the individual or his or her legal representative may claim the reward by contacting CMS within 1 year from the date on which CMS first attempted to notify the individual about a reward. CMS does not consider the individual or his or her legal representative eligible for a reward more than 1 year after the date on which it first attempted to give notice. CMS does not pay interest on rewards that are not immediately claimed.

(ii) If the individual has become incapacitated or has died, an executor, administrator, or other legal representative may claim the reward on behalf of the individual or the individual's es-

tate. The claimant must submit certified copies of the letters testamentary, letters of administration, or other similar evidence to show his or her authority to claim the reward. The claim must be filed within 1 year from the date on which CMS first gave or attempted to give notice of the reward.

(e) *Amount and payment of reward.* (1) In determining whether it will pay a reward and, if so, the amount of the reward, CMS takes into account all relevant factors, including the significance of the information furnished in relation to the ultimate resolution of the case and the recovery of Medicare funds.

(2) The amount of a reward represents what CMS considers to be adequate compensation in the particular case, not to exceed 10 percent of the overpayments recovered in the case or \$1,000, whichever is less.

(3) If more than one person is eligible to receive a reward in a particular case, CMS allocates the total reward amount (not to exceed 10 percent of the overpayments recovered in that case or \$1,000, whichever is less) among the participants.

(4) CMS bases rewards only on recovered Medicare payments and not on amounts collected as penalties or fines.

(5) CMS makes payments as promptly as the circumstances of the case permit, but not until it has collected all Medicare overpayments, fines, and penalties.

(6) No person may make any offer or promise or otherwise bind CMS or HHS with respect to the payment of any reward under this section or the amount of the reward.

(f) *Submission of information.* (1) An individual may submit information on persons or entities engaging in, or that have engaged in, fraud and abuse against the Medicare program to the Office of the Inspector General, or to the Medicare intermediary or carrier that has jurisdiction over the suspected fraudulent provider or supplier.

(2) A participant interested in receiving a reward must provide his or her name, address, telephone number, and any other requested identifying information so that he or she may be contacted, if necessary, for additional information and, when applicable, for the

## § 420.410

## 42 CFR Ch. IV (10–1–23 Edition)

payment of a reward upon resolution of the case.

(g) *Confidentiality.* CMS does not reveal a participant's identity to any person, except as required by law.

(h) *Finding of ineligibility after reward is accepted.* If, after a reward is accepted, CMS finds that the awardee was ineligible to receive the reward, the Government is not liable for the reward and the awardee must refund all monies received.

### **§ 420.410 Establishment of a program to collect suggestions for improving Medicare program efficiency and to reward suggesters for monetary savings.**

(a) *Definitions.* As used in this section, the following definitions apply:

*Payment* means a monetary award given to a suggester in recognition of, and as a reward for, a suggestion adopted by CMS that improves the efficiency of, and results in monetary savings to, the Medicare program.

*Savings* means the monetary value of the net benefits the Medicare program derives from implementing the suggestion.

*Suggester* means an individual, a group of individuals, or a legal entity such as a corporation, partnership, or professional association, not otherwise excluded under § 420.410(d), who submits a suggestion under this section.

*Suggestion* means an original idea submitted in writing.

*Suggestion program* means the specific procedures and requirements established by CMS for receiving suggestions from the suggester on methods to improve the efficiency of the Medicare program, evaluating the suggestions and, if appropriate, paying a reward to the suggester for adopted suggestions that result in improved efficiency and produce monetary savings to the Medicare program.

(b) *General rule.* CMS may make payment for adopted suggestions that increase the efficiency of the Medicare program and result in monetary savings. CMS only makes payment for suggestions in instances in which a reward is not otherwise provided by law. The determination to adopt a suggestion, to reward the suggester, and the method of calculating a reward are at the sole discretion of CMS.

(c) *Eligibility.* Except as specified in paragraph (d) of this section, any individual, group of individuals or legal entity, such as a corporation, partnership or professional association, is eligible to submit a suggestion and be considered for a reward under this suggestion program if the suggestion is submitted to CMS in the manner set forth in paragraph (e) of this section.

(d) *Exclusions.* Medicare contractors, their officers and employees, individuals who work for Federal agencies under a contract, employees of Federally-sponsored research and demonstration projects, Federal officers and employees, and immediate family members of these individuals, are excluded from receiving payment under the suggestion program. If, after the suggester receives a reward payment, CMS determines that the suggester was ineligible to receive the reward, CMS is not liable for the reward payment and the suggester must refund all monies received.

(e) *Requirements for submitting suggestions*—(1) To be considered, the suggestion must be in writing, mailed to CMS, and must include the following information:

(i) A description of an existing problem or need;

(ii) A suggested method for solving the problem or filling the need; and

(iii) If known, an estimate of the savings potential that could result from implementing the suggestion.

(2) Suggestions must be mailed to: Centers for Medicare & Medicaid Services Suggestion Program, 7500 Security Blvd., Baltimore, Maryland 21244-1850.

(3) Any suggesters interested in receiving a reward must provide CMS with the following information: An individual suggester must provide his or her name, a group of suggesters must provide the names of all the group members, and a legal entity must provide its name and the name of its representative. All suggesters must provide an address, telephone number, and any other identifying information that CMS needs to contact the suggester for additional information and, where applicable, to mail the reward.

(f) *Evaluation process*—(1) *Relevant factors.* CMS evaluates all suggestions on the basis of the following factors:

(i) Originality of suggestion.

(ii) An estimate of potential monetary savings to the Medicare program.

(iii) The extent to which Medicare program efficiency would be improved if CMS adopts the suggestion.

(iv) Accuracy of the information reflected in the suggestion.

(v) Feasibility of implementation.

(vi) Nature and complexity of the suggestion.

(vii) Any other factors that appear to be relevant.

(2) *Evaluation time limit.* CMS concludes the evaluation process in a reasonable amount of time, not to exceed 2 years from the receipt date, taking into consideration the complexity of the suggestion, the number of possible implementation strategies, and CMS's current workload.

(g) *Basis for reward payment*—(1) *General rule.* If CMS determines that it is appropriate to make a reward payment for a suggestion adopted in whole or in part, that results in improved efficiency and monetary savings to the Medicare program, the payment is based on—

(i) The actual first-year net savings to the Medicare program, or

(ii) The average annual net savings to the Medicare program expected to be realized over a period of not more than 3 years if—

(A) An improvement is expected to yield monetary savings for more than 1 year and implementation involves substantial costs; or

(B) Monetary savings are negligible in the first year but are expected to substantially increase in subsequent years.

(2) *Reward payment amount.* CMS determines the amount of a reward payment using the following formula:

(i) Net savings from \$1,000 to \$10,000—10 percent of the savings, with a minimum award amount of \$100;

(ii) Net savings of \$10,001 to \$100,000—\$1,000 for the first \$10,000 of savings, plus 3 percent of the net savings over \$10,000;

(iii) Net savings of more than \$100,000—\$3,700 for the first \$100,000 of savings, plus 0.5 percent of savings over \$100,000, with a maximum award amount of \$25,000.

(h) *Adoption of suggestion and issuance of reward payment*—(1) *Adoption.* Upon

completing its evaluation, CMS decides whether to adopt a suggestion. If CMS receives the same or an overlapping suggestion from two or more unrelated parties, CMS will consider a reward only for the suggestion CMS received first, if the suggestion or overlapping part of the suggestion are identical, and CMS has adopted that part. If the suggestions are not identical, CMS will consider rewarding the suggestion received first, if it is feasible and CMS is able to adopt and implement the suggestion. If the first suggestion cannot be implemented, CMS may consider rewarding the suggestion received next, even if it is similar, provided CMS can adopt and implement the suggestion.

(2) *Issuance of reward payment.* After the reward payment amount is determined, as described in paragraph (g) of this section, CMS mails payment to the suggester (or to the legal representatives referenced in paragraph (k) of this section) only after the suggestion has been in operation for 1 year.

(i) *Group suggestions.* When CMS deems that a reward payment is appropriate for a suggestion submitted by a group of individuals, CMS pays an equal share of the reward to each of the individuals identified in the group. If an organization such as a corporation, partnership, or professional association submits a suggestion, CMS makes a single reward payment to that organization.

(j) *Change in name or address.* It is the suggester's responsibility to notify CMS of any change of address or other relevant information. If the suggester fails to update CMS on any change in this information, and the reward payment mailed to the suggester is returned to CMS, the suggester must claim the reward payment by contacting CMS within 1 year from the date CMS first mailed the reward payment to the suggester. CMS does not pay interest on rewards that, for any reason, are delayed or are not immediately claimed.

(k) *Incapacitated or deceased suggester.* If the suggester is incapacitated or has died, an executor, administrator, or other legal representative may claim the reward on behalf of the suggester or the suggester's estate. The claimant

## **Pt. 421**

must submit certified copies of the letters testamentary, letters of administration, or other similar evidence to CMS showing his or her authority to claim the reward. The claim must be filed within 1 year from the date on which CMS first attempted to pay the reward to the individual who submitted the suggestion.

(1) *Maintenance of records*—(1) CMS retains records related to the administration of the suggestion program in accordance with 36 CFR part 1228 (the regulations for the National Archives and Records Administration).

(2) CMS does not disclose information submitted under the suggestion program, except as required by law.

[64 FR 66401, Nov. 26, 1999]

## **PART 421—MEDICARE CONTRACTING**

### **Subpart A—Scope, Definitions, and General Provisions**

Sec.

421.1 Basis, applicability, and scope.

421.3 Definitions.

421.5 General provisions.

### **Subpart B—Intermediaries**

421.100 Intermediary functions.

421.103 Payment to providers.

421.104 Assignment of providers of services to intermediaries during transition to Medicare Administrative Contractors (MACs).

421.110 Requirements for approval of an agreement.

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

421.114 Assignment and reassignment of providers by CMS.

421.120 Performance criteria.

421.122 Performance standards.

421.124 Intermediary's failure to perform efficiently and effectively.

421.126 Termination of agreements.

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

### **Subpart C—Carriers**

421.200 Carrier functions.

421.201 Performance criteria and standards.

421.202 Requirements and conditions.

421.203 Carrier's failure to perform efficiently and effectively.

421.205 Termination by the Secretary.

## **42 CFR Ch. IV (10–1–23 Edition)**

421.210 Designations of regional carriers to process claims for durable medical equipment, prosthetics, orthotics and supplies.

421.212 Railroad Retirement Board contracts.

421.214 Advance payments to suppliers furnishing items or services under Part B.

### **Subpart D—Medicare Integrity Program Contractors**

421.300 Basis, applicability, and scope.

421.302 Eligibility requirements for Medicare integrity program contractors.

421.304 Medicare integrity program contractor functions.

421.306 Awarding of a contract.

421.308 Renewal of a contract.

421.310 Conflict of interest requirements.

421.312 Conflict of interest resolution.

421.316 Limitation on Medicare integrity program contractor liability.

### **Subpart E—Medicare Administrative Contractors (MACs)**

421.400 Statutory basis and scope.

421.401 Definitions.

421.404 Assignment of providers and suppliers to MACs.

### **Subpart F [Reserved]**

AUTHORITY: 42 U.S.C. 1302 and 1395hh.

SOURCE: 45 FR 42179, June 23, 1980, unless otherwise noted.

### **Subpart A—Scope, Definitions, and General Provisions**

#### **§ 421.1 Basis, applicability, and scope.**

(a) *Basis*. This part is based on the provisions of the following sections of the Act:

Section 1124—Requirements for disclosure of certain information.

Sections 1816 and 1842—Provisions relating to the administration of Parts A and B.

Section 1893—Requirements for protecting the integrity of the Medicare program.

(b) *Applicability*. The provisions of this part apply to agreements with Part A (Hospital Insurance) fiscal intermediaries that received awards under sections 1816 or 1842 of the Act prior to October 1, 2005, contracts with Part B (Supplementary Medical Insurance) carriers that received awards under sections 1816 or 1842 of the Act prior to October 1, 2005, and contracts