

when it is determined that an overpayment was made.

(3) Furnishing to CMS timely information and reports that CMS requests in order to carry out its responsibilities in the administration of the Medicare program.

(4) Establishing and maintaining procedures as approved by CMS for the re-determination of payment determinations.

(5) Maintaining records and making available to CMS the records necessary for verification of payments and for other related purposes.

(6) Upon inquiry, assisting individuals for matters pertaining to an intermediary agreement.

(7) Serving as a channel of communication to and from CMS of information, instructions, and other material as necessary for the effective and efficient performance of an intermediary agreement.

(8) Undertaking other functions as mutually agreed to by CMS and the intermediary.

(c) *Dual intermediary responsibilities.* Regarding the responsibility for service to provider-based HHAs and provider-based hospices, where the HHA or the hospice and its parent provider will be served by different intermediaries, the designated regional intermediary will process bills, make coverage determinations, and make payments to the HHAs and the hospices. The intermediary or Medicare integrity program contractor serving the parent provider will perform all fiscal functions, including audits and settlement of the Medicare cost reports and the HHA and hospice supplement worksheets.

[72 FR 48886, Aug. 24, 2007]

§ 421.103 Payment to providers.

Providers are assigned to intermediaries in accordance with § 421.104. As the Medicare Administrative Contractors (MACs) are implemented, providers are reassigned from intermediaries to MACs in accordance with § 412.404 of this chapter.

[71 FR 68228, Nov. 24, 2006]

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

(a) Beginning October 1, 2005, CMS assigns providers of services and other entities that may bill Part A benefits to intermediaries in a manner that will best support the transition to Medicare Administrative Contractors (MACs) under section 1874A of the Act in accordance with subpart E of this part.

(b) These providers of services and other entities must continue to bill the intermediary that they were billing prior to October 1, 2005, until one of the following events occurs:

(1) The intermediary's agreement with CMS ends, and the provider or entity is directed by CMS to bill another CMS contractor.

(2) The provider or entity is assigned to a MAC that has begun to administer claims within the geographic locale of the provider or entity.

(3) CMS directs the provider or entity to begin billing another CMS contractor in order to support the implementation of MACs under section 1874A of the Act and subpart E of this part.

(c) New providers of services and new entities will be assigned to the intermediary serving their geographic locale if no MAC has begun to administer Medicare claims in the locale. These providers or entities must continue to bill the intermediary until one of the events in paragraph (b) of this section occurs.

(d) Providers or entities will only be granted exceptions to the provisions of paragraphs (b) or (c) of this section if CMS deems the exception to be in the compelling interest of the Medicare program.

(e) CMS will notify the provider or entity, the outgoing intermediary, and the newly assigned intermediary of assignment or reassignment decisions.

[71 FR 68228, Nov. 24, 2006]

§ 421.110 Requirements for approval of an agreement.

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

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

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(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. CMS 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, the Secretary may make determinations with respect to the termination of an intermediary

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agreement, and CMS may make determinations with respect to renewal of an intermediary agreement under § 421.110.

(b) When taking the actions specified in paragraph (a) of this section, the Secretary or CMS will consider the performance of the individual intermediary in its Medicare operations using the factors contained in the performance criteria specified in § 421.120 and the performance standards specified in § 421.122.

(c) In addition, when taking the actions listed in paragraph (a) of this section, the Secretary or CMS 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.

[45 FR 42179, June 23, 1980, as amended at 59 FR 682, Jan. 6, 1994; 71 FR 68229, Nov. 24, 2006]

§ 421.114 Assignment and reassignment of providers by CMS.

CMS may assign or reassign any provider to any intermediary if it determines that the assignment or reassignment will be in the best interests of the Medicare program.

[71 FR 68229, Nov. 24, 2006]

§ 421.120 Performance criteria.

(a) *Application of performance criteria.* As part of the intermediary evaluations authorized by section 1816(f) of