

§ 421.205

which must be incurred by an efficiently and economically operated carrier, those high costs may also be grounds for adverse action.

[59 FR 682, Jan. 6, 1994]

§ 421.205 Termination by the Secretary.

(a) *Cause for termination.* The Secretary may terminate a contract with a carrier at any time if he or she determines that the carrier has failed substantially to carry out any material terms of the contract or has performed its function in a manner inconsistent with the effective and efficient administration of the Medicare Part B program.

(b) *Notice and opportunity for hearing.* Upon notification of the Secretary's intent to terminate the contract, the carrier may request a hearing within 20 days after the date on the notice of intent to terminate.

(c) *Hearing procedures.* The hearing procedures will be those specified in § 421.128(c).

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

(a) *Basis.* This section is based on sections 1834(a)(12) and 1834(h) of the Act, which authorize the Secretary to designate one carrier for one or more entire regions to process claims for durable medical equipment, prosthetic devices, prosthetics, orthotics, and other supplies (DMEPOS). This authority has been delegated to CMS.

(b) *Types of claims.* Claims for the following, except for items incident to a physician's professional service as defined in § 410.26, incident to a physician's service in a rural health clinic as defined in § 405.2413, or bundled into payment to a provider, ambulatory surgical center, or other facility, are processed by the designated carrier for its designated region and not by other carriers—

(1) Durable medical equipment (and related supplies) as defined in section 1861(n) of the Act;

(2) Prosthetic devices (and related supplies) as described in section 1861(s)(8) of the Act, (including intra-ocular lenses and parenteral and en-

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teral nutrients, supplies, and equipment, when furnished under the prosthetic device benefit);

(3) Orthotics and prosthetics (and related supplies) as described in section 1861(s)(9);

(4) Home dialysis supplies and equipment as described in section 1861(s)(2)(F);

(5) Surgical dressings and other devices as described in section 1861(s)(5);

(6) Immunosuppressive drugs as described in section 1861(s)(2)(J); and

(7) Other items or services which are designated by CMS.

(c) *Region designation.* (1) The boundaries of the initial four regions for processing claims described in paragraph (b) of this section contain the following States and territories:

(i) Region A: Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, New York, New Jersey, Pennsylvania, and Delaware.

(ii) Region B: Maryland, the District of Columbia, Virginia, West Virginia, Ohio, Michigan, Indiana, Illinois, Wisconsin, and Minnesota.

(iii) Region C: North Carolina, South Carolina, Kentucky, Tennessee, Georgia, Florida, Alabama, Mississippi, Louisiana, Texas, Arkansas, Oklahoma, New Mexico, Colorado, Puerto Rico, and the Virgin Islands.

(iv) Region D: Alaska, Hawaii, American Samoa, Guam, the Northern Mariana Islands, California, Nevada, Arizona, Washington, Oregon, Montana, Idaho, Utah, Wyoming, North Dakota, South Dakota, Nebraska, Kansas, Iowa, and Missouri.

(2) CMS has the option to modify the number and boundaries of the regions established in paragraph (c)(1) of this section based on appropriate criteria and considerations, including the effect of the change on beneficiaries and DMEPOS suppliers. To announce changes, CMS publishes a notice in the FEDERAL REGISTER that delineates the regional boundary or boundaries changed, the States and territories affected, and supporting criteria or considerations.

(d) *Criteria for designating regional carriers.* CMS designates regional carriers

to achieve a greater degree of effectiveness and efficiency in the administration of the Medicare program. In making this designation, CMS will award regional carrier contracts in accordance with applicable law and will consider some or all of the following criteria—

- (1) Timeliness of claim processing;
- (2) Cost per claim;
- (3) Claim processing quality;
- (4) Experience in claim processing, and in establishing local medical review policy; and
- (5) Other criteria that CMS believes to be pertinent.

(e) *Carrier designation.* (1) Each carrier designated a regional carrier must process claims for items listed in paragraph (b) of this section for beneficiaries whose permanent residence is within that carrier's region as designated under paragraph (c) of this section. When processing the claims, the carrier must use the payment rates applicable for the State of residence of the beneficiary, including a qualified Railroad Retirement beneficiary. A beneficiary's permanent residence is the address at which he or she intends to spend 6 months or more of the calendar year.

(2) CMS notifies affected Medicare beneficiaries and suppliers when it designates a regional carrier (in accordance with paragraph (d) of this section) to process DMEPOS claims (as defined in paragraph (b) of this section) for all Medicare beneficiaries residing in their respective regions (as designated under paragraph (c) of this section).

(3) CMS may contract for the performance of National Supplier Clearinghouse functions through a contract amendment to one of the DME regional carrier contracts or through a contract amendment to any Medicare carrier contract under § 421.200.

(4) CMS periodically recompetes the contracts for the DME regional carriers. CMS also periodically recompetes the National Supplier Clearinghouse function.

(f) *Collecting information of ownership.* Carriers designated as regional claims processors must obtain from each supplier of items listed in paragraph (b) of this section information concerning ownership and control as required by

section 1124A of the Act and part 420 of this chapter, and certifications that supplier standards are met as required by part 424 of this chapter.

[57 FR 27307, June 18, 1992, as amended at 58 FR 60796, Nov. 18, 1993; 70 FR 9239, Feb. 25, 2005]

§ 421.212 Railroad Retirement Board contracts.

In accordance with this subpart C, the Railroad Retirement Board contracts with DMEPOS regional carriers designated by CMS, as set forth in § 421.210(e)(2), for processing claims for Medicare-eligible Railroad Retirement beneficiaries, for the same contract period as the contracts entered into between CMS and the DMEPOS regional carriers.

[58 FR 60797, Nov. 18, 1993]

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

(a) *Scope and applicability.* This section provides for the following:

(1) Sets forth requirements and procedures for the issuance and recovery of advance payments to suppliers of Part B services and the rights and responsibilities of suppliers under the payment and recovery process.

(2) Does not limit CMS's right to recover unadjusted advance payment balances.

(3) Does not affect suppliers' appeal rights under part 405, subpart H of this chapter relating to substantive determinations on suppliers' claims.

(4) Does not apply to claims for Part B services furnished by suppliers that have in effect provider agreements under section 1866 of the Act and part 489 of this chapter, and are paid by intermediaries.

(b) *Definition.* As used in this section, *advance payment* means a conditional partial payment made by the contractor in response to a claim that it is unable to process within established time limits except as provided in paragraph (j) of this section.

(c) *When advance payments may be made.* Unless otherwise qualified under paragraph (j) of this section, an advance payment may be made if all of the following conditions are met:

(1) The carrier is unable to process the claim timely.

(2) CMS determines that the prompt payment interest provision specified in section 1842(c) of the Act is insufficient to make a claimant whole.

(3) CMS approves, in writing to the carrier, the making of an advance payment by the carrier.

(d) *When advance payments are not made.* Advance payments are not made to any supplier that meets any of the following conditions:

(1) Is delinquent in repaying a Medicare overpayment.

(2) Has been advised of being under active medical review or program integrity investigation.

(3) Has not submitted any claims.

(4) Has not accepted claims' assignments within the most recent 180-day period preceding the system malfunction.

(5) Is in bankruptcy.

(e) *Requirements for suppliers.* (1) Except as provided for in paragraph (g)(1) of this section, a supplier must request, in writing to the carrier, an advance payment for Part B services it furnished.

(2) A supplier must accept an advance payment as a conditional payment subject to adjustment, recoupment, or both, based on an eventual determination of the actual amount due on the claim and subject to the provisions of this section.

(f) *Requirements for carriers.* (1) A carrier must notify a supplier as soon as it is determined that payment will not be made in a timely manner, and an advance payment option is to be offered to the supplier.

(i) Unless otherwise qualified under paragraph (j) of this section, a contractor must calculate an advance payment for a particular claim at no more than 80 percent of the anticipated payment for that claim based upon the historical assigned claims payment data as defined in paragraph (f)(1)(ii) of this section for claims paid to the supplier. For suppliers qualifying and approved for advance payments under paragraph (j) of this section, a contractor may calculate an advance payment for a particular claim at up to 100 percent of the anticipated payment for that claim based upon the historical assigned

claims payment data as defined in paragraph (f)(1)(ii) of this section for claims paid to the supplier.

(ii) "Historical data" are defined as a representative 90-day assigned claims payment trend within the most recent 180-day experience before the system malfunction.

(iii) Based on this amount and the number of claims pending for the supplier, the carrier must determine and issue advance payments.

(iv) If historical data are not available or if backlogged claims cannot be identified, the carrier must determine and issue advance payments based on some other methodology approved by CMS.

(v) Advance payments can be made no more frequently than once every 2 weeks to a supplier.

(2) Generally, a supplier will not receive advance payments for more assigned claims than were paid, on a daily average, for the 90-day period before the system malfunction.

(3) A carrier must recover an advance payment by applying it against the amount due on the claim on which the advance was made. If the advance payment exceeds the Medicare payment amount, the carrier must apply the unadjusted balance of the advance payment against future Medicare payments due the supplier.

(4) In accordance with CMS instructions, a carrier must maintain a financial system of data in accordance with the Statement of Federal Financial Accounting Standards for tracking each advance payment and its recoupment.

(g) *Requirements for CMS.* (1) In accordance with the provisions of this section, CMS may determine that circumstances warrant the issuance of advance payments to all affected suppliers furnishing Part B services. CMS may waive the requirement in paragraph (e)(1) of this section as part of that determination.

(2) If adjusting Medicare payments fails to recover an advance payment, CMS may authorize the use of any other recoupment method available (for example, lump sum repayment or an extended repayment schedule) including, upon written notice from the carrier to the supplier, converting any unpaid balances of advance payments