

Centers for Medicare & Medicaid Services, HHS

§ 424.1

- 424.514 Application fee.
- 424.515 Requirements for reporting changes and updates to, and the periodic revalidation of Medicare enrollment information.
- 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare program.
- 424.517 Onsite review.
- 424.518 Screening levels for Medicare providers and suppliers.
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- 424.522 Additional effective dates.
- 424.525 Rejection of a provider's or supplier's application for Medicare enrollment.
- 424.526 Return of a provider's or supplier's enrollment application.
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- 424.530 Denial of enrollment in the Medicare program.
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- 424.540 Deactivation of Medicare billing privileges.
- 424.541 Stay of enrollment.
- 424.542 Prohibition on ordering, certifying, referring, or prescribing based on felony conviction.
- 424.545 Provider and supplier appeal rights.
- 424.546 Deactivation rebuttals.
- 424.550 Prohibitions on the sale or transfer of billing privileges.
- 424.555 Payment liability.
- 424.565 Overpayment.
- 424.570 Moratoria on newly enrolling Medicare providers and suppliers.
- 424.575 Rural emergency hospitals.

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

SOURCE: 53 FR 6634, Mar. 2, 1988, unless otherwise noted.

Subpart A—General Provisions

§ 424.1 Basis and scope.

(a) *Statutory basis.* (1) This part is based on the indicated provisions of the following sections of the Act:

1814—Basic conditions for, and limitations on, Medicare payments for Part A services.

1815—Payment to providers for Part A services.

1820—Conditions for designating certain hospitals as critical access hospitals.

1833(e)—Requirement to furnish information to determine payment.

1834(a)—Payment for durable medical equipment.

1834(j)—Requirements for suppliers of medical equipment and supplies.

1835—Procedures for payment to providers for Part B services.

1842(b)(3)(B)(ii)—Assignment of Part B Medicare claims.

1842(b)(6)—Payment to entities other than the supplier.

1848—Payment for physician services.

1870(e) and (f)—Settlement of claims after death of the beneficiary.

(2) Section 424.444(c) is also based on section 216(j) of the Act.

(b) *Scope.* This part sets forth certain specific conditions and limitations applicable to Medicare payments and cites other conditions and limitations set forth elsewhere in this chapter. This subpart A provides a general overview. Other subparts deal specifically with—

(1) The requirement that the need for services be certified and that a physician establish a plan of treatment (subpart B);

(2) The procedures and time limits for filing claims (subpart C);

(3) The individuals or entities to whom payment may be made (subparts D and E);

(4) The limitations on assignment and reassignment of claims (subpart F);

(5) Special requirements that apply to services furnished by nonparticipating U.S. hospitals and foreign hospitals (subparts G and H); and

(6) The replacement and reclamation of Medicare payment checks (subpart M).

(c) *Other applicable rules.* Except for § 424.40(c)(3), this part does not deal with the conditions for payment of rural health clinic (RHC) services, Federally qualified health center (FQHC) services, or ambulatory surgical center (ASC) services. Those conditions are set forth in part 405, subpart X, and part 481 subpart A of this chapter for RHC and FQHC services; and in part 416 of this chapter, for ASC services. The rules for physician certification of terminal illness, required in connection with hospice care, are set forth in § 418.22 of this chapter.

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