

## § 424.350

services furnished as in-kind beneficiary engagement incentives that exceed \$25 in retail value.

(1) The documentation must be established contemporaneous with the furnishing of the in-kind items and services and must include at least the following:

(i) The date the item or service is furnished.

(ii) The identity of the MDPP beneficiary to whom the item or service is furnished.

(iii) The agent of the MDPP supplier that furnished the item or service, if applicable.

(iv) A description of the item or service.

(v) The retail value of the item or service.

(vi) Documentation establishing that the item or service was furnished to the MDPP beneficiary during the engagement incentive period.

(2) Documentation regarding items or services that are furnished to the MDPP beneficiary for use on an ongoing basis during the engagement incentive period, including items involving technology exceeding \$100 in retail value, must also include contemporaneous documentation establishing that the MDPP beneficiary is in the engagement incentive period throughout the time period that the MDPP beneficiary possesses or has access to the item or service furnished by the MDPP supplier.

(3) The documentation regarding items involving technology exceeding \$100 in retail value must also include contemporaneous documentation of any attempt to retrieve the item as required by paragraph (c)(3)(ii) of this section.

(4) The MDPP supplier must retain and provide access to the documentation required in this section in accordance with § 424.205(g).

[82 FR 53364, Nov. 15, 2017, as amended at 88 FR 79540, Nov. 16, 2023]

## Subparts J–L [Reserved]

## 42 CFR Ch. IV (10–1–24 Edition)

### Subpart M—Replacement and Reclamation of Medicare Payments

#### § 424.350 Replacement of checks that are lost, stolen, defaced, mutilated, destroyed, or paid on forged endorsements.

(a) *U.S. Government checks*—(1) *Responsibility*. The Treasury Department is responsible for the investigation and settlement of claims in connection with Treasury checks issued on behalf of CMS.

(2) *Action by CMS*. CMS forwards reports of lost, stolen, defaced, mutilated, destroyed, or forged Treasury checks to the Treasury Department disbursing center responsible for issuing checks.

(3) *Action by the Treasury Department*. The Treasury Department will replace and begin reclamation of Treasury checks in accordance with Treasury Department regulations (31 CFR parts 235, 240, and 245).

(b) *Intermediary and carrier benefit checks*. Checks issued by intermediaries and carriers are drawn on commercial banks and are not subject to the Federal laws and Treasury Department regulations that govern Treasury checks. Replacement procedures are carried out in accordance with § 424.352 under applicable State law (including any Federal banking laws or regulations that may affect the relevant State proceedings).

[58 FR 65129, Dec. 13, 1993]

#### § 424.352 Intermediary and carrier checks that are lost, stolen, defaced, mutilated, destroyed or paid on forged endorsements.

(a) When an intermediary or carrier is notified by a payee that a check has been lost, stolen, defaced, mutilated, destroyed, or paid on forged endorsement, the intermediary or carrier contacts the commercial bank on whose paper the check was drawn and determines whether the check has been negotiated.

(b) If the check has been negotiated—

(1) The intermediary or carrier provides the payee with a copy of the check and other pertinent information (such as a claim form, affidavit or questionnaire to be completed by the

payee) required to pursue his or her claim in accordance with State law and commercial banking regulations.

(2) To pursue the claim, the payee must examine the check and certify (by completing the claim form, questionnaire or affidavit) that the endorsement is not the payee's.

(3) The claim form and other pertinent information is sent to the intermediary or carrier for review and processing of the claim.

(4) The intermediary or carrier reviews the payee's claim. If the intermediary or carrier determines that the claim appears to be valid, it forwards the claim and a copy of the check to the issuing bank. The intermediary or carrier takes further action to recover the proceeds of the check in accordance with the State law and regulations.

(5) Once the intermediary or carrier recovers the proceeds of the initial check, the intermediary or carrier issues a replacement check to the payee.

(6) If the bank of first deposit refuses to settle on the check for good cause, the payee must pursue the claim on his or her own and the intermediary or carrier will not reissue the check to the payee.

(c) If the check has not been negotiated—

(1) The intermediary or carrier arranges with the bank to stop payment on the check; and

(2) Except as provided in paragraph (d), the intermediary or carrier reissues the check to the payee.

(d) No check may be reissued under (c)(2) unless the claim for a replacement check is received by the intermediary or carrier no later than 1 year from the date of issuance of the original check, unless State law (including any applicable Federal banking laws or regulations that may affect the relevant State proceeding) provides a longer period which will control.

[58 FR 65130, Dec. 13, 1993]

## Subparts N–O [Reserved]

## Subpart P—Requirements for Establishing and Maintaining Medicare Billing Privileges

SOURCE: 71 FR 20776, Apr. 21, 2006, unless otherwise noted.

### § 424.500 Scope.

The provisions of this subpart contain the requirements for enrollment, periodic resubmission and certification of enrollment information for revalidation, and timely reporting of updates and changes to enrollment information. These requirements apply to all providers and suppliers except for physicians and practitioners who have entered into a private contract with a beneficiary as described in part 405, subpart D of this chapter. Providers and suppliers must meet and maintain these enrollment requirements to bill either the Medicare program or its beneficiaries for Medicare covered services or supplies.

### § 424.502 Definitions.

As used in this subpart, unless the context indicates otherwise—

*Additional disclosable party* means, with respect to a skilled nursing facility defined at section 1819(a) of the Act, any person or entity who does any of the following:

(1)(i) Exercises operational, financial, or managerial control over the facility or a part thereof;

(ii) Provides policies or procedures for any of the operations of the facility; or

(iii) Provides financial or cash management services to the facility.

(2)(i) Leases or subleases real property to the facility; or

(ii) Owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property.

(3) Provides—

(i) Management or administrative services;

(ii) Management or clinical consulting services; or

(iii) Accounting or financial services to the facility.

*Affiliation* means, for purposes of applying § 424.519, any of the following:

(1) A 5 percent or greater direct or indirect ownership interest that an individual or entity has in another organization.

(2) A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization.

(3) An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization (including, for purposes of this paragraph (3), sole proprietorships), either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W-2 employee of the organization.

(4) An interest in which an individual is acting as an officer or director of a corporation.

(5) Any reassignment relationship under § 424.80.

*Approve/Approval* means the enrolling provider or supplier has been determined to be eligible under Medicare rules and regulations to receive a Medicare billing number and be granted Medicare billing privileges.

*Authorized official* means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program. For purposes of this definition only, the term "organization" means the enrolling entity as identified by its legal business name and tax identification number.

*Change in majority ownership* occurs when an individual or organization acquires more than a 50 percent direct ownership interest in an HHA or hospice during the 36 months following the HHA's or hospice's initial enrollment into the Medicare program or the 36 months following the HHA's or hospice's most recent change in majority ownership (including asset sale, stock transfer, merger, and consolidation). This includes an individual or organi-

zation that acquires majority ownership in an HHA or hospice through the cumulative effect of asset sales, stock transfers, consolidations, or mergers during the 36-month period after Medicare billing privileges are conveyed or the 36-month period following the HHA's or hospice's most recent change in majority ownership.

*Deactivate* means that the provider or supplier's billing privileges were stopped, but can be restored upon the submission of updated information.

*Delegated official* means an individual who is delegated by the "Authorized Official," the authority to report changes and updates to the enrollment record. The delegated official must be an individual with ownership or control interest in, or be a W-2 managing employee of the provider or supplier.

*Deny/Denial* means the enrolling provider or supplier has been determined to be ineligible to receive Medicare billing privileges for Medicare covered items or services provided to Medicare beneficiaries.

*Director* means a director of a corporation, regardless of whether the provider or supplier is a non-profit entity. This includes any member of the corporation's governing body irrespective of the precise title of either the board or the member.

*Disclosable event* means, for purposes of § 424.519, any of the following:

(1) Currently has an uncollected debt to Medicare, Medicaid, or CHIP, regardless of—

- (i) The amount of the debt;
- (ii) Whether the debt is currently being repaid (for example, as part of a repayment plan); or
- (iii) Whether the debt is currently being appealed;

(2) Has been or is subject to a payment suspension under a federal health care program (as that latter term is defined in section 1128B(f) of the Act), regardless of when the payment suspension occurred or was imposed;

(3) Has been or is excluded by the OIG from participation in Medicare, Medicaid, or CHIP, regardless of whether the exclusion is currently being appealed or when the exclusion occurred or was imposed; or

(4) Has had its Medicare, Medicaid, or CHIP enrollment denied, revoked, or terminated, regardless of—

(i) The reason for the denial, revocation, or termination;

(ii) Whether the denial, revocation, or termination is currently being appealed; or

(iii) When the denial, revocation, or termination occurred or was imposed.

*Enroll/Enrollment* means the process that Medicare uses to establish eligibility to submit claims for Medicare-covered items and services, and the process that Medicare uses to establish eligibility to order or certify Medicare-covered items and services. The process includes—

(1) Identification of a provider or supplier;

(2) Except for those suppliers that complete the CMS-855O form, CMS-identified equivalent, successor form or process for the sole purpose of obtaining eligibility to order or certify Medicare-covered items and services, validating the provider or supplier's eligibility to provide items or services to Medicare beneficiaries;

(3) Identification and confirmation of the provider or supplier's practice location(s) and owner(s); and

(4) Except for those suppliers that complete the CMS-855O form, CMS-identified equivalent, successor form or process for the sole purpose of obtaining eligibility to order or certify Medicare-covered items and services, granting the Medicare provider or supplier Medicare billing privileges.

*Enrollment application* means a CMS-approved paper enrollment application or an electronic Medicare enrollment process approved by OMB.

*Final adverse action* means one or more of the following actions:

(1) A Medicare-imposed revocation of any Medicare billing privileges;

(2) Suspension or revocation of a license to provide health care by any State licensing authority;

(3) Revocation or suspension by an accreditation organization;

(4) A conviction of a Federal or State felony offense (as defined in § 424.535(a)(3)(i)) within the last 10 years preceding enrollment, revalidation, or re-enrollment; or

(5) An exclusion or debarment from participation in a Federal or State health care program.

*Indirect ownership interest* means as follows:

(1)(i) Any ownership interest in an entity that has an ownership interest in the enrolling or enrolled provider or supplier.

(ii) Any ownership interest in an indirect owner of the enrolling or enrolled provider or supplier.

(2) The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation that owns 80 percent of the provider or supplier, A's interest equates to an 8 percent indirect ownership interest in the provider or supplier and must be reported on the enrollment application. Conversely, if B owns 80 percent of the stock of a corporation that owns 5 percent of the stock of the provider or supplier, B's interest equates to a 4 percent indirect ownership interest in the provider or supplier and need not be reported.

*Institutional provider* means any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (not including physician and nonphysician practitioner organizations), CMS-855S, or an associated internet-based PECOS enrollment application.

*Managing employee* means—

(1) A general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the provider or supplier. For purposes of this definition, this includes, but is not limited to, a hospice or skilled nursing facility administrator and a hospice or skilled nursing facility medical director.

(2) With respect to the additional requirements at § 424.516(g) for a skilled nursing facility defined at section 1819(a) of the Act, an individual, including a general manager, business manager, administrator, director, or

consultant, who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

*Managing organization* means an entity that exercises operational or managerial control over, or that directly or indirectly conducts, the day-to-day operations of the provider or supplier, either under contract or through some other arrangement.

*NPI* stands for National Provider Identifier.

*Officer* means an officer of a corporation, regardless of whether the provider or supplier is a non-profit entity.

*Operational* means the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered), to furnish these items or services.

*Organizational structure* means, with respect to a skilled nursing facility defined at section 1819(a) of the Act, in the case of any of the following:

(1) *A corporation.* The officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent.

(2) *A limited liability company.* The members and managers of the limited liability company including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company.

(3) *A general partnership.* The partners of the general partnership.

(4) *A limited partnership.* The general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent.

(5) *A trust.* The trustees of the trust.

(6) *An individual.* Contact information for the individual.

*Owner* means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of the provider or

supplier as defined in sections 1124 and 1124A(A) of the Act.

*PECOS* stands for Internet-based Provider Enrollment, Chain, and Ownership System.

*Physician or nonphysician practitioner organization* means any physician or nonphysician practitioner entity that enrolls in the Medicare program as a sole proprietorship or organizational entity.

*Private equity company* means, for purposes of this subpart only, a publicly traded or non-publicly traded company that collects capital investments from individuals or entities and purchases a direct or indirect ownership share of a provider.

*Real estate investment trust* means, for purposes of this subpart only, a real estate investment trust as defined in 26 U.S.C. 856.

*Reject/Rejected* means that the provider or supplier's enrollment application was not processed due to incomplete information, or that additional information or corrected information was not received from the provider or supplier in a timely manner.

*Revoke/Revocation* means that the provider or supplier's billing privileges are terminated.

*State oversight board* means, for purposes of §§ 424.530(a)(15) and 424.535(a)(22) only, any State administrative body or organization, such as (but not limited to) a medical board, licensing agency, or accreditation body, that directly or indirectly oversees or regulates the provision of health care within the State.

*Supplier* means, for purposes of this subpart, all of the following:

(1) The individuals and entities that qualify as suppliers under § 400.202.

(2) Physical therapists in private practice.

(3) Occupational therapists in private practice.

(4) Speech-language pathologists.

*Voluntary termination* means that a provider or supplier, including an individual physician or nonphysician practitioner, submits written confirmation