payment under the plan, including the information described in § 422.202(a)(1).

(3) The information was provided in a manner that was reasonably designed to effect informed agreement and met the requirements of paragraphs (g) and (h) of this section.

(g) *Enrollment information.* Enrollment information was provided by one of the following methods or a similar method:

(1) Presentation of an enrollment card or other document attesting to enrollment.

(2) Notice of enrollment from CMS, a Medicare intermediary or carrier, or the MA organization itself.

(h) *Information on payment terms and conditions.* Information on payment terms and conditions was made available through either of the following methods:

(1) The MA organization used postal service, electronic mail, FAX, or telephone to communicate the information to one of the following:

(i) The provider.

(ii) The employer or billing agent of the provider.

(iii) A partnership of which the provider is a member.

(iv) Any party to which the provider makes assignment or reassigns benefits.

(2) The MA organization has in effect a procedure under which—

(i) Any provider furnishing services to an enrollee in an MA private fee-for-service plan, and who has not previously entered into a contract or agreement to furnish services under the plan, can receive instructions on how to request the payment information;

(ii) The organization responds to the request before the entity furnishes the service; and

(iii) The information the organization provides includes the following:

(A) Billing procedures.

(B) The amount the organization will pay towards the service.

(C) The amount the provider is permitted to collect from the enrollee.

(D) The information described in § 422.202(a)(1).

(3) Announcements in newspapers, journals, or magazines or on radio or television are not considered communication of the terms and conditions of payment.

(i) *Provider credential requirements.* Contracts with providers must provide that, in order to be paid to provide services to plan enrollees, providers must meet the requirements specified in §§ 422.204(b)(1)(i) and (b)(3).

[63 FR 35085, June 26, 1998, as amended at 65 FR 40325, June 29, 2000; 70 FR 52056, Sept. 1, 2005; 70 FR 47490, Aug. 12, 2005; 70 FR 76197, Dec. 23, 2005; 73 FR 54250, Sept. 18, 2008; 77 FR 22167, Apr. 12, 2012]

§ 422.220 Exclusion of payment for basic benefits furnished under a private contract.

(a) Unless otherwise authorized in paragraph (b) or (c) of this section, an MA organization may not pay, directly or indirectly, on any basis, for basic benefits furnished to a Medicare enrollee by a physician (as defined in paragraphs (1), (2), (3), and (4) of section 1861(r) of the Act) or other practitioner (as defined in section 1842(b)(18)(C) of the Act) who has filed with the Medicare contractor an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts under section 1802(b) of the Act with the beneficiaries.

(b) An MA organization must pay for emergency or urgently needed services furnished by a physician or practitioner described in paragraph (a) of this section who has not signed a private contract with the beneficiary.

(c) An MA organization may make payment to a physician or practitioner described in paragraph (a) of this section for services that are not basic benefits but are provided to a beneficiary as a supplemental benefit consistent with § 422.102.

[86 FR 6098, Jan. 19, 2021]

§ 422.222 Preclusion list for contracted and non-contracted individuals and entities.

(a)(1)(i) Except as provided in paragraph (a)(1)(ii) of this section, an MA organization must not make payment for a health care item, service, or drug that is furnished, ordered, or prescribed by an individual or entity that is included on the preclusion list, defined in § 422.2.