

## § 421.126

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

[59 FR 682, Jan. 6, 1994]

### § 421.126 Termination of agreements.

(a) *Termination by intermediary.* An intermediary may terminate its agreement at any time by—

(1) Giving written notice of its intention to CMS and to the providers it services at least 180 days before its intended termination date; and

(2) Giving public notice of its intention by publishing a statement of the effective date of termination at least 60 days before that date. Publication must be in a newspaper of general circulation in each community served by the intermediary.

(b) *Termination by the Secretary, and right of appeal.* (1) The Secretary may terminate an agreement if—

(i) The intermediary fails to comply with the requirements of this subpart;

(ii) The intermediary fails to meet the criteria or standards specified in §§ 421.120 and 421.122; or

(iii) CMS has reassigned, under § 421.114 or § 421.116, all of the providers assigned to the intermediary.

(2) If the Secretary decides to terminate an agreement, he or she will offer the intermediary an opportunity for a hearing, in accordance with § 421.128.

(3) If the intermediary does not request a hearing, or if the hearing decision affirms the Secretary's decision, the Secretary will provide reasonable notice of the effective date of termination to—

(i) The intermediary;

(ii) The providers served by the intermediary; and

(iii) The general public.

(4) The providers served by the intermediary will be given the opportunity to nominate another intermediary, in accordance with § 421.104.

### § 421.128 Intermediary's opportunity for hearing and right to judicial review.

(a) *Basis for appeal.* An intermediary adversely affected by any of the following actions shall be granted an opportunity for a hearing:

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(1) Assignment or reassignment of providers to another intermediary.

(2) Designation of a national or regional intermediary to serve a class of providers.

(3) Termination of the agreement.

(b) *Request for hearing.* The intermediary shall file the request with CMS within 20 days from the date on the notice of intended action.

(c) *Hearing procedures.* The hearing officer shall be a representative of the Secretary and not otherwise a party to the initial administrative decision. The intermediary may be represented by counsel and may present evidence and examine witnesses. A complete recording of the proceedings at the hearing will be made and transcribed.

(d) *Judicial review.* An adverse hearing decision concerning action under paragraph (a)(1) or (a)(2) of this section is subject to judicial review in accordance with 5 U.S.C. chapter 7.

(e) As specified in § 421.118, contracts awarded under the experimental authority of CMS are not subject to the provisions of this section.

(f) *Exception.* An intermediary adversely affected by the designation of a regional intermediary or an alternative regional intermediary for HHAs, or an intermediary for hospices, under § 421.117 of this subpart is not entitled to a hearing or judicial review concerning adverse effects caused by the designation of an intermediary.

[45 FR 42179, June 23, 1980, as amended at 47 FR 38540, Sept. 1, 1982; 49 FR 3660, Jan. 30, 1984; 53 FR 17945, May 19, 1988]

## Subpart C—Carriers

### § 421.200 Carrier functions.

A contract between CMS and a carrier, other than a regional DMEPOS carrier, specifies the functions to be performed by the carrier which must include, but are not necessarily limited to, the following:

(a) *Coverage.* (1) The carrier ensures that payment is made only for services that are:

(i) Furnished to Medicare beneficiaries;

(ii) Covered under Medicare; and

(iii) In accordance with QIO determinations when they are services for

which the QIO has assumed review responsibility under its contract with CMS.

(2) The carrier takes appropriate action to reject or adjust the claim if—

(i) The carrier or the QIO determines that the services furnished or proposed to be furnished were not reasonable, not medically necessary, or not furnished in the most appropriate setting;

(ii) The carrier determines that the claim does not properly reflect the kind and amount of services furnished.

(b) *Payment on a cost basis.* If payment is on a cost basis, the carrier must assure that payments are based on reasonable costs, as determined under part 413 of this chapter.

(c) *Payment on a charge basis.* If payment is on a charge basis, under part 405, subpart E of this chapter, the carrier must ensure that—

(1) Charges are reasonable and not higher than the charge for a comparable service furnished under comparable circumstances to the carrier's policy holders and subscribers; and

(2) The payment is based on one of the following—

(i) An itemized bill.

(ii) An assignment under the terms of which the reasonable charge is the full charge for the service, as specified in § 424.55 of this chapter.

(iii) If the beneficiary has died, the procedures set forth in §§ 424.62 and 424.64 of this chapter.

(d) *Fiscal management.* The carrier must receive, disburse, and account for funds in making payments under Medicare.

(e) *Provider audits.* The carrier must audit the records of providers to whom it makes Medicare Part B payments to assure that payments are made properly.

(f) *Utilization patterns.* (1) The carrier must have methods and procedures for identifying utilization patterns that deviate from professionally established norms and bring the deviant patterns to the attention of appropriate professional groups.

(2) The carrier must assist providers and other persons who furnish Medicare Part B services to—

(i) Develop procedures relating to utilization practices;

(ii) Make studies of the effectiveness of those procedures and devise methods to improve them;

(iii) Apply safeguards against unnecessary utilization of services; and

(iv) Develop procedures for utilization review, and establish groups to perform such reviews of providers to whom it makes Medicare Part B payments.

(g) *Information and reports.* The carrier must furnish to CMS any information and reports that CMS requests in order to carry out CMS's responsibilities in the administration of the Medicare program. The carrier must be responsive to requests for information from the public.

(h) *Maintenance and availability of records.* The carrier must maintain and make available to CMS the records necessary for verification of payments and for other related purposes.

(i) *Hearings to Part B beneficiaries.* (1) The carrier must provide an opportunity for a fair hearing if it denies the beneficiary's request for payment, does not act upon the request with reasonable promptness, or pays less than the amount claimed.

(2) The hearing procedures must be in accordance with part 405, subpart H, of this chapter (Review and Hearing Under the Supplementary Medical Insurance Program).

(j) *Other terms and conditions.* The carrier must comply with any other terms and conditions included in its contract.

[45 FR 42183, Jun. 23, 1980; 45 FR 64913, Oct. 1, 1980, as amended at 49 FR 3660, Jan. 30, 1984; 49 FR 9174, Mar. 12, 1984; 51 FR 34833, Sept. 30, 1986; 51 FR 41350, Nov. 14, 1986; 51 FR 43198, Dec. 1, 1986; 52 FR 4499, Feb. 12, 1987; 53 FR 6648, Mar. 2, 1988; 54 FR 4027, Jan. 27, 1989; 57 FR 27307, June 18, 1992]

#### § 421.201 Performance criteria and standards.

(a) *Application of performance criteria and standards.* As part of the carrier evaluations mandated by section 1842(b)(2) of the Act, CMS periodically assesses the performance of carriers in their Medicare operations using performance criteria and standards.

(1) The criteria measure and evaluate carrier performance of functional responsibilities such as—