

1833(a)(2)(D) of the Act, which are subject to the special rules set forth in section 1833(h)(5)(A) of the Act) following a reassignment from a physician or other supplier who performed the technical or professional component, the amount payable to the billing physician or other supplier may be subject to the limits specified in § 414.50 of this chapter.

[53 FR 6634, Mar. 2, 1988, as amended at 54 FR 4027, Jan. 27, 1989; 69 FR 66426, Nov. 15, 2004; 70 FR 16722, Apr. 1, 2005; 71 FR 69788, Dec. 1, 2006; 72 FR 66406, Nov. 27, 2007]

**§ 424.82 Revocation of right to receive assigned benefits.**

(a) *Scope.* This section sets forth the conditions and procedures for revocation of the right of a supplier or other party to receive Medicare payments.

(b) *Definition.* As used in this section, *other party* means an employer, facility, or health care delivery system to which Medicare may make payment under § 424.80(b) (1), (2), or (3).

(c) *Basis for revocation.* CMS may revoke the right of a supplier or other party to receive Medicare payments if the supplier or other party, after warning by CMS or the carrier—

(1) Violates the terms of assignment in § 424.55(b).

(2) Continues collection efforts or fails to refund moneys incorrectly collected, in violation of the terms of assignment in § 424.55(b).

(3) Executes or continues in effect a reassignment or power of attorney or any other arrangement that seeks to obtain payment contrary to the provisions of § 424.80; or

(4) Fails to furnish evidence necessary to establish its compliance with the requirements of § 424.80.

(d) *Proposed revocation: Notice and opportunity for review.* If CMS proposes to revoke the right to payment in accordance with paragraph (c) of this section, it will send the supplier or other party a written notice that—

(1) States the reasons for the proposed revocation; and

(2) Provides an opportunity for the supplier or other party to submit written argument and evidence against the proposed revocation. CMS usually allows 15 days from the date on the no-

tice, but may extend or reduce the time as circumstances require.

(e) *Actual revocation: Timing, notice, and opportunity for hearing—*(1) *Timing.* CMS determines whether to revoke after considering any written argument or evidence submitted by the supplier or other party or, if none is submitted, at the expiration of the period specified in the notice of proposed revocation.

(2) *Notice and opportunity for hearing.* The notice of revocation specifies—

(i) The reasons for the revocation;

(ii) That the revocation is effective as of the date on the notice;

(iii) That the supplier or other party may, within 60 days from the date on the notice (or a longer period if the notice so specifies), request an administrative hearing and may be represented by counsel or other qualified representative.

(iv) That the carrier will withhold payment on any claims submitted by the supplier or other party until the period for requesting a hearing expires or, if a hearing is requested, until the hearing officer issues a decision;

(v) That if the hearing decision reverses the revocation, the carrier will pay the supplier's or other party's claims; and

(vi) That if a hearing is not requested or the hearing decision upholds the revocation, payment will be made to the beneficiary or to another person or agency authorized to receive payment on his or her behalf.

[53 FR 6644, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988]

**§ 424.83 Hearings on revocation of right to receive assigned benefits.**

If the supplier or other party requests a hearing under § 424.82(e)(2)—

(a) The hearing is conducted—

(1) By a CMS hearing official who was not involved in the decision to revoke; and

(2) In accordance with the procedures set forth in §§ 405.824 through 405.833 (but excepting § 405.832(d)) and 405.860 through 405.872 of this chapter. In applying those procedures, “CMS” is substituted for “carrier”; and “hearing official”, for “hearing officer”.

(b) As soon as practicable after the close of the hearing, the official who

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conducted it issues a hearing decision that—

(1) Is based on all the evidence presented at the hearing and included in the hearing record; and

(2) Contains findings of fact and a statement of reasons.

#### § 424.84 Final determination on revocation of right to receive assigned benefits.

(a) *Basis of final determination*—(1) *Final determination without a hearing.* If the supplier or other party does not request a hearing, CMS's revocation determination becomes final at the end of the period specified in the notice of revocation.

(2) *Final determination following a hearing.* If there is a hearing, the hearing decision constitutes CMS's final determination.

(b) *Notice of final determination.* CMS sends the supplier or other party a written notice of the final determination and, if there was a hearing, includes a copy of the hearing decision.

(c) *Application of the final determination*—(1) A final determination not to revoke is the final administrative decision by CMS on the matter.

(2) A final determination to revoke remains in effect until CMS finds that the reason for the revocation has been removed and that there is reasonable assurance that it will not recur.

(d) *Effect of revocation when supplier or other party has a financial interest in another entity.* Revocation of the party's right to accept assignment also applies to any corporation, partnership, or other entity in which the party, directly or indirectly, has or acquires all or all but a nominal part of the financial interest.

[53 FR 6644, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988]

#### § 424.86 Prohibition of assignment of claims by beneficiaries.

(a) *Basic prohibition.* Except as specified in paragraph (b) of this section, Medicare does not pay amounts that are due a beneficiary under § 424.53 to any other person under assignment, power of attorney, or any other direct payment arrangement.

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(b) *Exceptions*—(1) *Payment to a government agency or entity.* Subject to the requirements of the Assignment of Claims Act (31 U.S.C. 3727), Medicare may pay a government agency or entity under an assignment by a beneficiary (or by the beneficiary's legal guardian or representative payee).

(2) *Payment under an assignment established by court order.* Medicare may pay under an assignment established by, or in accordance with, a court order if the assignment meets the conditions set forth in § 424.90.

#### § 424.90 Court ordered assignments: Conditions and limitations.

(a) *Conditions for acceptance.* An assignment or reassignment established by or in accordance with a court order is effective for Medicare payments only if—

(1) Someone files a certified copy of the court order and of the executed assignment or reassignment (if it was necessary to execute one) with the intermediary or carrier responsible for processing the claim; and

(2) The assignment or reassignment—

(i) Applies to all Medicare benefits payable to a particular person or entity during a specified or indefinite time period; or

(ii) Specifies a particular amount of money, payable to a particular person or entity by a particular intermediary or carrier.

(b) *Retention of authority to reduce interim payments to providers.* A court-ordered assignment does not preclude the intermediary or carrier from reducing interim payments, as set forth in § 413.64(i) of this chapter, if the provider or assignee is in imminent danger of insolvency or bankruptcy.

(c) *Liability of the parties.* The party that receives payments under a court-ordered assignment or reassignment that meets the conditions of paragraph (a) of this section and the party that would have received payment if the court order had not been issued are jointly and severally responsible for any Medicare overpayment to the former.