

level screening required under § 424.518(b).

(2) CMS may revoke an OTP's enrollment on any of the following grounds:

(i) The provider does not have a current, valid certification by SAMHSA as required under paragraph (b)(4)(i) of this section or fails to meet any other applicable requirement or standard in this section, including, but not limited to, the OTP standards in paragraphs (b)(6) and (e)(1) of this section.

(ii) Any of the revocation reasons in § 424.535 applies.

(3) An OTP may appeal the revocation of its enrollment under part 498 of this title.

(f) *Claim payment.* For an OTP to receive payment for furnished drugs:

(1) The prescribing or medication ordering physician's or other eligible professional's National Provider Identifier must be listed on Field 17 of the Form CMS-1500; and

(2) All other applicable requirements of this section, this part, and part 8 of this title must be met.

(g) *Relation to part 8 of this title.* Nothing in this section shall be construed as:

(1) Supplanting any of the provisions in part 8 of this title; or

(2) Eliminating an OTP's obligation to maintain compliance with all applicable provisions in part 8 of this title.

[84 FR 63202, Nov. 15, 2019, as amended at 85 FR 85038, Dec. 28, 2020]

**§ 424.68 Enrollment requirements for home infusion therapy suppliers.**

(a) *Definition.* For purposes of this section, a home infusion therapy supplier means a supplier of home infusion therapy that meets all of the following requirements:

(1) Furnishes infusion therapy to individuals with acute or chronic conditions requiring administration of home infusion drugs.

(2) Ensures the safe and effective provision and administration of home infusion therapy on a 7-day-a-week, 24-hour-a-day basis.

(3) Is accredited by an organization designated by the Secretary in accordance with section 1834(u)(5) of the Act.

(4) Is enrolled in Medicare as a home infusion therapy supplier consistent

with the provisions of this section and subpart P of this part.

(b) *General requirement.* For a supplier to receive Medicare payment for the provision of home infusion therapy supplier services, the supplier must qualify as a home infusion therapy supplier (as defined in this section) and be in compliance with all applicable provisions of this section and of subpart P of this part.

(c) *Specific requirements for enrollment.* To enroll in the Medicare program as a home infusion therapy supplier, a home infusion therapy supplier must meet all of the following requirements:

(1)(i) Fully complete and submit the Form CMS-855B application (or its electronic or successor application) to its applicable Medicare contractor.

(ii) Certify via the Form CMS-855B that the home infusion therapy supplier meets and will continue to meet the specific requirements and standards for enrollment described in this section and in subpart P of this part.

(2) Comply with the application fee requirements in § 424.514.

(3) Be currently and validly accredited as a home infusion therapy supplier by a CMS-recognized home infusion therapy supplier accreditation organization.

(4) Comply with § 414.1515 of this chapter and all provisions of part 486, subpart I of this chapter.

(5) Successfully complete the limited categorical risk level of screening under § 424.518.

(d) *Denial of enrollment.* (1) Enrollment denial by CMS. CMS may deny a supplier's enrollment application as a home infusion therapy supplier on either of the following grounds:

(i) The supplier does not meet all of the requirements for enrollment outlined in § 424.68 and in subpart P of this part.

(ii) Any of the applicable denial reasons in § 424.530.

(2) Appeal of an enrollment denial. A supplier may appeal the denial of its enrollment application as a home infusion therapy supplier under part 498 of this chapter.

(e) *Continued compliance, standards, and reasons for revocation.* (1) Upon and after enrollment, a home infusion therapy supplier—

(i) Must remain currently and validly accredited as described in paragraph (c)(3) of this section.

(ii) Remains subject to, and must remain in full compliance with, all of the provisions of—

- (A) This section;
- (B) Subpart P of this part;
- (C) Section 414.1515 of this chapter; and
- (D) Part 486, subpart I of this chapter.

(2) CMS may revoke a home infusion therapy supplier's enrollment on any of the following grounds:

(i) The supplier does not meet the accreditation requirements as described in paragraph (c)(3) of this section.

(ii) The supplier does not comply with all of the provisions of—

- (A) This section;
- (B) Subpart P of this part;
- (C) Section 414.1515 of this chapter; and
- (D) Part 486, subpart I of this chapter; or

(iii) Any of the revocation reasons in § 424.535 applies.

(3) A home infusion therapy supplier may appeal the revocation of its enrollment under part 498 of this chapter.

[85 FR 70355, Nov. 4, 2020]

## Subpart F—Limitations on Assignment and Reassignment of Claims

### § 424.70 Basis and scope.

(a) *Statutory basis.* This subpart implements sections 1815(c) and 1842(b)(6) of the Act, which establish limitations on who may receive payments due a provider or supplier of services or a beneficiary.

(b) *Scope.* This subpart—

(1) Prohibits the assignment, reassignment, or other transfer of the right to Medicare payments except under specified conditions;

(2) Sets forth the sanctions that CMS may impose on a provider or supplier that violates this prohibition, or on a supplier that violates the conditions to which it agreed in accepting assignment from the individual; and

(3) Specifies the conditions for payment under court-ordered assignments or reassignments.

### § 424.71 Definitions.

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

*Court of competent jurisdiction* means a court that has jurisdiction over the subject matter and the parties before it.

*Facility* means a hospital or other institution that furnishes health care services to inpatients.

*Entity* means a person, group, or facility that is enrolled in the Medicare program.

*Power of attorney* means any written documents by which a principal authorizes an agent to—

(1) Receive, in the agent's name, any payments due the principal;

(2) Negotiate checks payable to the principal; or

(3) Receive, in any other manner, direct payment of amounts due the principal.

[53 FR 6634, Mar. 2, 1988, as amended at 69 FR 66426, Nov. 15, 2004]

### § 424.73 Prohibition of assignment of claims by providers.

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

(b) *Exceptions to the prohibition—*(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 the provider.

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

(3) *Payment to an agent.* Medicare may pay an agent who furnishes billing and collection services to the provider if the following conditions are met:

(i) The agent receives the payment under an agency agreement with the provider;

(ii) The agent's compensation is not related in any way to the dollar amounts billed or collected;

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(iii) The agent's compensation is not dependent upon the actual collection of payment;

(iv) The agent acts under payment disposition instructions that the provider may modify or revoke at any time; and

(v) The agent, in receiving the payment, acts only on behalf of the provider.

Payment to an agent will always be made in the name of the provider.

#### § 424.74 Termination of provider agreement.

CMS may terminate a provider agreement, in accordance with § 489.53(a)(1) of this chapter, if the provider—

(a) Executes or continues a power of attorney, or enters into or continues any other arrangement, that authorizes or permits payment contrary to the provisions of this subpart; or

(b) Fails to furnish, upon request by CMS or the intermediary, evidence necessary to establish compliance with the requirements of this subpart.

#### § 424.80 Prohibition of reassignment of claims by suppliers.

(a) *Basic prohibition.* Except as specified in paragraph (b) of this section, Medicare does not pay amounts that are due a supplier under an assignment to any other person under reassignment, power of attorney, or any other direct arrangement. Nothing in this section alters a party's obligations under the anti-kickback statute (section 1128B(b) of the Act), the physician self-referral prohibition (section 1877 of the Act), the rules regarding physician billing for purchased diagnostic tests (§414.50 of this chapter), the rules regarding payment for services and supplies incident to a physician's professional services (§410.26 of this chapter), or any other applicable Medicare laws, rules, or regulations.

(b) *Exceptions to the basic rule—(1) Payment to employer.* Medicare may pay the supplier's employer if the supplier is required, as a condition of employment, to turn over to the employer the fees for his or her services.

(2) *Payment to an entity under a contractual arrangement.* Medicare may pay an entity enrolled in the Medicare pro-

gram if there is a contractual arrangement between the entity and the supplier under which the entity bills for the supplier's services, subject to the provisions of paragraph (d) of this section.

(3) *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 a reassignment by the supplier.

(4) *Payment under a reassignment established by court order.* Medicare may pay under a reassignment established by, or in accordance with, the order of a court competent jurisdiction, if the reassignment meets the conditions set forth in §424.90.

(5) *Payment to an agent.* Medicare may pay an agent who furnishes billing and collection services to the supplier, or to the employer, facility, or system specified in paragraphs (b) (1), (2) and (3) of this section, if the conditions of §424.73(b)(3) for payment to a provider's agent are met by the agent of the supplier or of the employer, facility, or system. Payment to an agent will always be made in the name of the supplier or the employer, facility, or system.

(c) *Rules applicable to an employer or entity.* An employer or entity that may receive payment under paragraph (b)(1) or (b)(2) of this section is considered the supplier of those services for purposes of subparts C, D, and E of this part, subject to the provisions of paragraph (d) of this section.

(d) *Reassignment to an entity under an employer-employee relationship or under a contractual arrangement: Conditions and limitations—(1) Liability of the parties.* An entity enrolled in the Medicare program that receives payment under a contractual arrangement under paragraph (b)(2) of this section and the supplier that otherwise receives payment are jointly and severally responsible for any Medicare overpayment to that entity.

(2) *Access to records.* The supplier who furnishes the service has unrestricted

access to claims submitted by an entity for services provided by that supplier. This paragraph applies irrespective of whether the supplier is an employee or whether the service is provided under a contractual arrangement. If an entity refuses to provide, upon request, the billing information to the supplier performing the service, the entity's right to receive reassigned benefits may be revoked under § 424.82(c)(3).

(3) *Reassignment of the technical or professional component of a diagnostic test.* If a physician or other supplier bills for the technical or professional component of a diagnostic test covered under section 1861(s)(3) of the Act and paid for under part 414 of this chapter (other than clinical diagnostic laboratory tests paid under section 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 notice, 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

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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 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.

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(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.

(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.