

(1) The person who claims payment must meet the following requirements:

(i) Submit a claim on a CMS-prescribed form and an itemized bill in accordance with the requirements of this subpart. (See paragraph (g) of this section for an exception.)

(ii) Provide evidence that the services were furnished if the intermediary or carrier requests it.

(iii) Provide evidence of payment of the bill and of the identity of the person who paid it.

(2) If a person claims payment as the legal representative of the deceased beneficiary's estate, he or she must also submit a copy of the papers showing appointment as legal representative.

(3) If a person claims payment as a survivor of the beneficiary, he or she must also submit evidence, if the intermediary or carrier requests it, that he or she is highest on the priority list of paragraph (c)(3) of this section.

(f) *Evidence of payment.* Evidence of payment may be—

(1) A receipted bill, or a properly completed "Report of Services" section of a claim form, showing who paid the bill;

(2) A cancelled check;

(3) A written statement from the provider or supplier or an authorized staff member; or

(4) Other probative evidence.

(g) *Exception: Claim submitted before beneficiary died.* If a claim and itemized bill has been submitted by or on behalf of the beneficiary before he or she died, submission of another claim form and itemized bill is not required; any written request by the person seeking payment is sufficient.

§ 424.64 Payment after beneficiary's death: Bill has not been paid.

(a) *Scope.* This section specifies whom Medicare pays, and the conditions for payment when the beneficiary has died and the bill has not been paid.

(b) *Situation.* (1) The beneficiary has received covered Part B services furnished by a physician or other supplier.

(2) The beneficiary died without making an assignment to the physician or other supplier or receiving Medicare payment.

(3) The bill has not been paid.

(c) *To whom payment is made.* In the situation described in paragraph (b) of this section, Medicare pays as follows:

(1) *Payment to the supplier.* Medicare pays the physician or other supplier if he or she—

(i) Files a claim on a CMS-prescribed form in accordance with the applicable requirements of this subpart;

(ii) Upon request from the carrier, provides evidence that the services for which it claims payment were, in fact, furnished; and

(iii) Agrees in writing to accept the reasonable charge as the full charge for the services.

(2) *Payment to a person who assumes legal obligation to pay for the services.* If the physician or other supplier does not agree to accept the reasonable charge as full charge for the service, Medicare pays any person who submits to the carrier all of the following:

(i) A statement indicating that he or she has assumed legal obligation to pay for the services.

(ii) A claim on a CMS-prescribed form in accordance with the requirements of this subpart. (If a claim had been submitted by or on behalf of the beneficiary before he or she died, submission of another claim form is not required; a written request by the person seeking payment meets the requirement for a claim.)

(iii) An itemized bill that identifies the claimant as the person to whom the physician or other supplier holds responsible for payment. (If such an itemized bill had been submitted by or on behalf of the beneficiary before he or she died, submission of another itemized bill is not required.)

(iv) If the intermediary or carrier requests it, evidence that the services were actually furnished.

[53 FR 6634, Mar. 2, 1988, as amended at 53 FR 28388, July 28, 1988]

§ 424.66 Payment to entities that provide coverage complementary to Medicare Part B.

(a) *Conditions for payment.* Medicare may pay an entity for Part B services furnished by a physician or other supplier if the entity meets all of the following requirements:

(1) Provides coverage of the service under a complementary health benefit

plan (this is, the coverage that the plan provides is complementary to Medicare benefits and covers only the amount by which the Part B payment falls short of the approved charge for the service under the plan).

(2) Has paid the person who provided the service an amount (including the amount payable under the Medicare program) that the person accepts as full payment.

(3) Has the written authorization of the beneficiary (or of a person authorized to sign claims on his behalf under § 424.36) to receive the Part B payment for the services for which the entity pays.

(4) Relieves the beneficiary of liability for payment for the service and will not seek any reimbursement from the beneficiary, his or her survivors or estate.

(5) Submits any information CMS or the carrier may request, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program.

(6) Identifies and excludes from its requests for payment all services for which Medicare is the secondary payer.

(b) *Services paid for by the entity.* An entity is not required to pay and claim reimbursement for all Part B services furnished to members of its plans. However, if it does not pay and claim reimbursement for all those services, it must establish in advance precise criteria for identifying the services for which it will pay and claim reimbursement.

[53 FR 28388, July 28, 1988; 53 FR 40231, Oct. 14, 1988]

§ 424.67 Enrollment requirements for opioid treatment programs (OTP).

(a) *General enrollment requirement.* In order for a program or eligible professional (as that term is defined in section 1848(k)(3)(B) of the Act) to receive Medicare payment for the provision of opioid use disorder treatment services, the provider must qualify as an OTP (as that term is defined in § 8.2 of this title) and enroll in the Medicare program under the provisions of this section and of subpart P of this part.

(b) *Specific requirements and standards for enrollment.* To enroll in the Medicare program, an OTP must meet all of

the following requirements and standards:

(1) Fully complete and submit, as applicable, the Form CMS–855A or Form CMS–855B application (or their successor applications) and any applicable supplement or attachment thereto to its applicable Medicare contractor. This includes, but is not limited to, the following:

(i) Maintain and submit to CMS (via the applicable supplement or attachment) a list of all physicians, other eligible professionals, and pharmacists (regardless of whether the individual is a W–2 employee of the OTP) who are legally authorized to prescribe, order, or dispense controlled substances on behalf of the OTP. The list must include the physician's, other eligible professional's, or pharmacist's:

(A) First and last name, and middle initial.

(B) Social Security Number.

(C) National Provider Identifier.

(D) License number (if applicable).

(ii) Certifying via the Form CMS–855A or Form CMS–855B (as applicable) and/or the applicable supplement or attachment thereto that the OTP meets and will continue to meet the specific requirements and standards for enrollment described in paragraphs (b) and (e) of this section.

(2) Comply with the application fee requirements in § 424.514. (This includes OTPs enrolling under the circumstances described in paragraph (c)(2) of this section.)

(3)(i) Except as stated in paragraph (b)(3)(ii) of this section, successfully complete the assigned categorical risk level screening required under, as applicable, § 424.518(b) and (c).

(ii) For currently enrolled OTPs that are changing their OTP enrollment from a Form CMS–855B enrollment to a Form CMS–855A enrollment, or vice versa, successfully complete the limited level of categorical screening under § 424.518(a) if the OTP has already completed, as applicable, the moderate or high level of categorical screening under § 424.518(b) or (c), respectively.

(4)(i) Have a current, valid certification by SAMHSA for an opioid treatment program consistent with the provisions and requirements of § 8.11 of this title.

(ii) A provisional certification under § 8.11(e) of this title does not meet the requirements of paragraph (b)(4)(i) of this section.

(5) Report on the Form CMS-855A or Form CMS-855B (as applicable) and/or any applicable supplement all OTP staff who meet the definition of “managing employee” in § 424.502. Such individuals include, but are not limited to, the following:

(i) Medical director (as described in § 8.2 of this title).

(ii) Program sponsor (as described in § 8.2 of this title).

(6)(i)(A) Must not employ or contract with a prescribing or ordering physician or eligible professional or with any individual legally authorized to dispense narcotics who, within the preceding 10 years, has been convicted (as that term is defined in 42 CFR 1001.2) of a Federal or State felony that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries based on the same categories of detrimental felonies, as well as case by case detrimental determinations, found at § 424.535(a)(3).

(B) Paragraph (b)(6)(i)(A) of this section applies regardless of whether the individual in question is:

(1) Currently dispensing narcotics at or on behalf of the OTP; or

(2) A W-2 employee of the OTP.

(ii) Must not employ or contract with any personnel (regardless of whether the individual is a W-2 employee of the OTP) who is revoked from Medicare under § 424.535 or any other applicable section in Title 42, or who is on the preclusion list under § 422.222 or § 423.120(c)(6) of this chapter.

(iii) Must not employ or contract with any personnel (regardless of whether the individual is a W-2 employee of the OTP) who has a prior adverse action by a State oversight board, including, but not limited to, a reprimand, fine, or restriction, for a case or situation involving patient harm that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries. CMS will consider the factors enumerated at § 424.535(a)(22) in each case of patient harm that potentially applies to this paragraph.

(7)(i) Sign (and adhere to the term of) a provider agreement in accordance with the provisions of part 489 of this chapter.

(ii) An OTP’s appeals under part 498 of a Medicare revocation (under § 424.535) and a provider agreement termination (under § 489.53 of this chapter) must be filed jointly and, as applicable, considered jointly by CMS under part 498 of this chapter.

(8) Comply with all other applicable requirements for enrollment specified in this section and in subpart P of this part.

(c) *Clarification of required enrollment forms.* (1) An OTP may only be enrolled as an OTP via the Form CMS-855A or Form CMS-855B but not both.

(2) If a currently enrolled OTP is changing its OTP enrollment from a Form CMS-855B enrollment to a Form CMS-855A enrollment, or vice versa, the effective date of billing that was established for the OTP’s prior enrollment under §§ 424.520(d) and 424.521(a) is applied to the OTP’s new enrollment.

(d) *Denial of enrollment.* CMS may deny an OTP’s enrollment application on any of the following grounds:

(1)(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 in this section.

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

(2) An OTP may appeal the denial of its enrollment application under part 498 of this chapter.

(e) *Continued compliance, standards, and reasons for revocation.* (1) Upon and after enrollment, an OTP—

(i) Must remain validly certified by SAMHSA as required under § 8.11 of this title.

(ii) Remains subject to, and must remain in full compliance with, the provisions of this section and of subpart P of this part. This includes, but is not limited to, the provisions of paragraph (b)(6) of this section, the revalidation provisions in § 424.515, and the deactivation and reactivation provisions in § 424.540.

(iii) Upon revalidation, successfully complete the moderate categorical risk