(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;

(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