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.

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.

§ 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 § 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), 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 program 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...
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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 agency authorized to receive payment on his or her behalf.

§ 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.

(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 any part of the financial interest.


§ 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.

(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.

Subpart G—Special Conditions: Emergency Services Furnished by a Nonparticipating Hospital

§ 424.100 Scope.

This subpart sets forth procedures and criteria that are followed in determining whether Medicare will pay for emergency services furnished by a hospital that is located in the United States and does not have in effect a provider agreement, that is, an agreement to participate in Medicare.

§ 424.101 Definitions.

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

Emergency services means inpatient or outpatient hospital services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services.

Hospital means a facility that—

(1) Is primarily engaged in providing, by or under the supervision of doctors of medicine or osteopathy, inpatient services for the diagnosis, treatment, and care or rehabilitation of persons who are sick, injured, or disabled; 

(2) Is not primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care, as described in section 1861(j)(1)(A) of the Act; 

(3) Provides 24-hour nursing service in accordance with section 1861(e)(5) of the Act; and

(4) Is licensed, or is approved as meeting the standards for licensing, by the State or local licensing agency.

Reasonable charges means customary charges insofar as they are reasonable.

§ 424.102 Situations that do not constitute an emergency.

Without additional evidence of a threat to life or health, the following situations do not in themselves indicate a need for emergency services:

(a) Lack of care at home.

(b) Lack of transportation to a participating hospital.

(c) Death of the patient in the hospital.

§ 424.103 Conditions for payment for emergency services.

Medicare pays for emergency services furnished to a beneficiary by a nonparticipating hospital or under arrangements made by such a hospital if the conditions of this section are met.

(a) General requirements. (1) The services are of the type that Medicare would pay for if they were furnished by a participating hospital.

(2) The hospital has in effect an election to claim payment for all emergency services furnished in a calendar year in accordance with § 424.104.

(3) The need for emergency services arose while the beneficiary was not an inpatient in a hospital.

(4) In the case of inpatient hospital services, the services are furnished during a period in which the beneficiary could not be safely discharged or transferred to a participating hospital or other institution.

(5) The determination that the hospital was the most accessible hospital available and equipped to furnish the services is made in accordance with § 424.106.

(b) Medical information requirements. A physician (or, if appropriate, the hospital) submits medical information that—

(1) Describes the nature of the emergency and specifies why it required that the beneficiary be treated in the most accessible hospital; 

(2) Establishes that all the conditions in paragraph (a) of this section are met; and

(3) Indicates when the emergency ended, which, for inpatient hospital services, is the earliest date on which the beneficiary could be safely discharged or transferred to a participating hospital or other institution.

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