

Proposed Rules

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This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 420, 424, 489, and 498

[CMS-6002-P]

RIN 0938-AH73

Medicare Program; Requirements for Establishing and Maintaining Medicare Billing Privileges

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would require that all providers and suppliers (other than physicians who have elected to "opt-out" of the Medicare program) complete an enrollment form and submit specified information to us, and periodically update and certify to the accuracy of the enrollment information, to receive and maintain billing privileges in the Medicare program. The information must clearly identify the provider or supplier and its place of business, provide documentation that it is qualified to perform the services for which it is billing, ensure that it is not currently excluded from the Medicare program, and meets any other applicable Medicare requirements. If we determine the information submitted is incomplete, invalid, or insufficient to meet Medicare requirements, we would have the discretion to reject, deny, deactivate, or revoke billing privileges.

This proposed rule would implement provisions in the Medicare statute that require the Secretary to ensure that all Medicare providers and suppliers are qualified to provide the appropriate health care services. These statutory provisions include requirements meant to protect beneficiaries and the Medicare trust fund by preventing unqualified, fraudulent, or excluded providers and suppliers from providing services to Medicare beneficiaries or

billing the Medicare program or its beneficiaries.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on June 24, 2003.

ADDRESSES: In commenting, please refer to file code CMS-6002-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Mail written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-6002-P, P.O. Box 8013, Baltimore, MD 21244-8013.

Please allow sufficient time for us to receive mailed comments on time in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) to one of the following addresses:

Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5-14-03, 7500 Security Boulevard, Baltimore, MD 21244-8013.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available if you wish to retain proof of filing by stamping in and retaining an extra copy of the comments being filed).

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Michael C. Collett, (410) 786-6121.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an

appointment to view public comments, phone (410) 786-7197.

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I. Background

A. General

The Medicare program, Title XVIII of the Social Security Act (the Act), is currently the principal payer for health care for 39.2 million enrolled beneficiaries. Under section 1802 of the Act, a beneficiary may obtain health services from any institution, agency, or person qualified to participate in the Medicare program. Qualifications to participate are specified in statute and in regulations. See, for example, sections 1814, 1815, 1819, 1833, 1834, 1842, 1861, 1866, and 1891 of the Act; and 42 CFR Chapter IV, Subchapter E, which concerns standards and certification requirements.

Providers and suppliers furnishing services must comply with the Medicare requirements stipulated in the Act and in our regulations. These requirements are meant to ensure compliance with applicable statutes, as well as to promote the furnishing of high quality care. We and/or State Survey and Certification Agencies inspect facilities when required, for compliance with regulatory and operational requirements before we allow them to participate in the Medicare program. Thereafter, either