

as part of a scheduled re-certification survey, or as a result of a complaint or other information received that would directly affect the provider's or supplier's business relationship with the Medicare program or indicate non-compliance of this regulation, we will review and re-verify the continued adherence to our requirements. The initial certification and subsequent re-certification ensure that Medicare requirements are met and continue to be met, and promote the appropriate spending of the Medicare trust fund by helping to ensure that unqualified providers and suppliers are not granted billing privileges with the Medicare program.

Historically, a provider or supplier wishing to receive payment from Medicare or its beneficiaries would contact a fiscal intermediary (FI), State Survey Agency, or carrier. In compliance with sections 1816 or 1842 of the Act, as stipulated in 42 CFR Part 421, we contract with FIs and carriers to administer payment for services and to carry out other administrative responsibilities that the law imposes. Our Regional Offices, State Survey Agencies, carriers and FIs use statutes, regulations, and operating instructions as guidance when assigning appropriate identification numbers and determining whether to grant billing privileges in the Medicare program to providers and suppliers.

As Medicare program expenditures have grown, increasing attention has been focused on strategies to curb improper Medicare payments by implementing business processes and standards that safeguard the Medicare program and its beneficiaries, while ensuring that well qualified individuals and health care organization serve beneficiaries as promptly as possible.

#### *B. Specific Authority to Collect Enrollment Information*

1. Various sections of the Act and the Code of Federal Regulations require providers and suppliers to furnish information concerning the amounts due and the identification of individuals or entities who furnish medical services to beneficiaries before payment can be made.

Sections 1102 and 1871 of the Act allow general authority for the Secretary to prescribe regulations for the efficient administration of the Medicare program. Under the above authority, this proposed regulation will require the collection of information from providers and suppliers for the purpose of enrolling in the Medicare program and granting privileges to bill the program

for health care services rendered to Medicare beneficiaries.

Sections 1814(a), 1815(a), and 1833(e) of the Act require the submission of information necessary to determine the amounts due to a provider or other person.

Section 1842(r) of the Act requires us to establish a system for furnishing a unique identifier for each physician who furnishes services for which payment may be made. To do so, we need to collect information unique to that physician.

Section 1862(e)(1) of the Act states that no payment may be made when an item or service was at the medical direction of an individual or entity that has been excluded in accordance with sections 1128, 1128A, 1156, or 1842(j)(2) of the Act.

Section 1834(j) of the Act states that no payment may be made for items furnished by a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) unless that supplier obtains, and renews at such intervals as we may require, a billing number.

The Balanced Budget Act of 1997 (BBA) (Public Law 105–33), section 4313, amended sections 1124(a)(1) and 1124A of the Act to require disclosure of both the Employer Identification Number (EIN) and Social Security Number (SSN) of each provider or supplier, each person with ownership or control interest in the provider or supplier, any subcontractor in which the provider or supplier directly or indirectly has a five percent or more ownership interest, and any managing employees. The Secretary of Health and Human Services (the Secretary) signed and sent to the Congress a “Report to Congress on Steps Taken to Assure Confidentiality of Social Security Account Numbers as Required by the Balanced Budget Act” on January 26, 1999, with mandatory collection of SSNs and EINs effective on or about April 26, 1999.

2. Section 31001(i)(1) of the Debt Collection Improvement Act of 1996 (DCIA) (Public Law 104–134) amended 31 U.S.C. section 7701 by adding paragraph (c) to require that any person or entity doing business with the Federal Government must provide their Tax Identification Number (TIN).

3. We are authorized to collect information on the Form CMS 855 (Office of Management and Budget (OMB) approval number 0938–0685) to ensure that correct payments are made to providers and suppliers under the Medicare program as established by Title XVIII of the Act.

## **II. Current Enrollment Initiatives**

For a number of years, concern about easy entry into the Medicare program by unqualified or even fraudulent providers or suppliers has led us to step up our efforts on a number of fronts to establish more stringent controls on provider and supplier entry into the Medicare system. For example, in 1993 we established the National Supplier Clearinghouse (NSC), our contractor for enrolling suppliers of DMEPOS in Medicare. We instituted new procedures to use validation software to certify the existence of the listed business address for suppliers of DMEPOS. The NSC also checked the DMEPOS supplier telephone numbers against a national directory. This initial effort resulted in the revocation of about 1,500 supplier billing numbers and an estimated savings of \$7 million per month to the Medicare trust fund.

In fiscal year 1998, we required site visits for all new DMEPOS suppliers. The DMEPOS visits resulted in:

- 156 denials of new applicants, out of 159 visits; and
- 656 revocations of existing suppliers, out of 2,091 visits.

In fiscal years 1998 and 1999, our carriers and FIs submitted proposals to conduct site visits for those provider or supplier types that they believed would yield the greatest benefit in their regions. After reviewing the submitted proposals, we funded 320 site visits to various enrolling and currently enrolled Independent Diagnostic Testing Facilities (IDTFs), skilled nursing facilities (SNFs), home health agencies (HHAs), rural health clinics, comprehensive outpatient rehabilitation facilities, physician groups, clinical psychologists, and ambulance companies. The project provided useful information for making appropriate determinations for the eligibility to bill Medicare. In the course of these reviews—

- 219 provider numbers were authorized or maintained;
- 30 provider numbers were deactivated;
- 37 provider applications were denied; and
- 34 providers were referred to contractor fraud units.

These site visits proved valuable to some providers by helping them to enroll in the Medicare program properly. The site visits were also helpful to us in ensuring that we only conduct business with legitimate providers. We believe that site visits are an important component of successful provider enrollment. As past experience has demonstrated, in many cases site