

must be signed by both the authorized official currently on file with Medicare and the person(s) being delegated as an official of the organization. The signature of the delegated official will bind the organization both legally and financially, as if the signature was that of the authorized official. Once the delegation of authority is established, the signatures of the authorized official or the assigned delegated official(s) will be the only acceptable signature(s) on correspondence to report updates or changes to the enrollment information.

As proposed in § 424.510(b), we would verify initial compliance with Medicare statutes and regulations before providers and suppliers are granted billing privileges, as well as on a continuing basis. The verifications would be based on information submitted by providers and suppliers on the CMS 855.

We are proposing in § 424.510(c) that providers and suppliers, including those that are deemed to meet Medicare health and safety requirements by virtue of their accreditation by a national accrediting body, must attest via signature on the CMS 855 that they have met all the requirements set forth in this regulation before they are granted billing privileges. Those providers for which certification is required must meet the provisions of 42 CFR Part 488 concerning mandatory State survey and certification requirements. Providers also must have completed a provider agreement in accordance with 42 CFR Part 489, which specifies the requirements for provider agreements. In addition, in paragraphs (d) and (e) in proposed § 424.510, we are requiring that providers and suppliers must be operational as defined in § 424.502 and must meet additional requirements that apply to both enrolling and currently enrolled providers and suppliers before receiving a Medicare billing number and becoming eligible for Medicare payments.

In recognition of the effectiveness of site visits, we are proposing, at § 424.510(f), a plan for integrating site visits as part of our enrollment validation process and general program oversight activities. We are reserving the right to perform on-site inspections of the provider or supplier when we deem necessary to ensure compliance with Medicare enrollment requirements. For certain providers and suppliers this practice has always been the case (for example, Hospitals, Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs)), but we are extending this to all providers and suppliers when deemed necessary based on questionable enrollment information.

Site visits for enrollment purposes will not affect those site visits performed for establishing conditions of participation. Our proposed site visits and on-site inspections to ensure compliance with Medicare enrollment requirements are unrelated to the compliance-related site visits already being conducted by the OIG. After a provider or supplier enters into a corporate integrity agreement with the OIG, usually as the result of a Federal False Claims Act settlement, the OIG may conduct a site visit as part of its work in monitoring the provider or supplier's compliance with the terms of the corporate integrity agreement. Upon the provider or supplier's successful completion of the enrollment process, including State survey and certification, accreditation, and approval of the CMS 855, we will grant Medicare billing privileges and issue a billing number if one has not already been issued. The effective date for reimbursement of Medicare covered services will continue to be determined based on current Medicare regulations and policy based on the type of provider or supplier submitting claims. Currently, the effective dates for reimbursement can be found at § 489.13 for providers and suppliers requiring State survey or certification or accreditation, §§ 424.5 and 424.44 for non-surveyed or certified/accredited suppliers, and § 424.57 and section 1834(j)(1)(A) of the Act for DMEPOS suppliers. For those providers and suppliers seeking accreditation from a CMS approved accreditation organization, the effective date for reimbursement will be the later of the date accreditation was received or the final approval of the CMS 855. Based on the regulations cited above, CMS will not issue Medicare billing numbers or grant Medicare billing privileges retroactive to the date that the provider or supplier received final approval of their enrollment application (CMS 855). We are proposing to use this process because we believe there is a relationship between fulfilling the requirements stipulated in the Medicare program statutes and related laws, the integrity of the provider and supplier, the quality of care furnished to Medicare beneficiaries, and the confidence of the public in the Medicare program.

In the future there will be universal provider and supplier numbers, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for uniquely identifying a provider or supplier and for purposes of billing all health plans, including Medicare and Medicaid. When this universal number is in place, it will still

be necessary for providers and suppliers to apply for enrollment as a Medicare provider or supplier and be granted Medicare billing privileges.

#### D. Requirements for Reporting Changes and Updates To, and the Periodic Revalidation of, Medicare Enrollment Information

We propose that, under new § 424.515, a provider or supplier must update its enrollment information, and re-certify as to its accuracy when any changes are made. We will also periodically require revalidation of the enrollment information by all providers and suppliers when enrollment information has aged over three years. The revalidation process will ensure that we have complete and current information on all Medicare providers and suppliers and ensure continued compliance with Medicare requirements. In addition, this process further ensures that Medicare beneficiaries are receiving services furnished only by legitimate providers and suppliers, and strengthens our ability to protect the Medicare trust fund.

The accuracy of the data describing the individuals or organizations with whom we do business is essential to efficient and effective operation of the Medicare program. For this reason, we are proposing at § 424.520(b), that individuals and organizations are responsible for updating their CMS 855 information to reflect any changes in a timely manner. We define timely as meaning within 90 days, with the exception of a change in ownership or control of the provider or supplier which must be reported within 30 days. Failure to do so may result in deactivation or even revocation of their billing privileges.

We will determine, upon receipt of any changes, if continued enrollment in the Medicare program is proper. We expect that in the vast majority of cases, updates or changes will not affect the status of the provider or supplier. Where it does, we will follow the revocation procedures outlined later in this rule.

When no such changes or updates have been reported or submitted for a period of time, we believe that it is prudent to take steps to confirm the continued validity of the information that was previously submitted. We believe that this revalidation of enrollment information should be accomplished in a way that minimizes the reporting burden to the provider or supplier, but also mitigates the risk to the program of maintaining incomplete or inaccurate information that materially affects the relationship of the program to the provider or supplier. For