

provider or supplier does not have independent authority to sell or transfer any billing number issued or the billing privileges granted with the billing number assigned.

We propose this policy because only we and our agents have the authority to issue Medicare billing numbers and grant Medicare billing privileges. These numbers are issued only after the information about the provider or supplier collected on the CMS 855 is verified. Because it is used to uniquely identify a provider or supplier, the Medicare billing number we issue is solely for use by the specific provider or supplier to whom it was issued.

In the case of a provider or supplier undergoing a change of ownership as described in part 489 subpart A, we would require at § 424.550(b) that a CMS 855 be completed and submitted by both the current owner and the new owner before the completion of the ownership change. Failure of the current owner to submit the CMS 855 prior to the change of ownership may result in sanctions and/or penalties, after the date of ownership change, in accordance with §§ 424.520, 424.540, and 489.53. Failure of the new owner to submit the CMS 855 prior to the change of ownership may result in the deactivation of the Medicare billing number until the CMS 855 has been submitted.

We may deactivate a Medicare billing number at any time before final transference of the provider agreement to the new owner. This may occur as a result of the submission of a CMS 855 with material omissions, or preliminary information received or determined by us that makes us question whether the new owner will ultimately be granted a final transference of the provider agreement. This allows us the right to ensure that billing privileges are given only to a new owner for which we have adequate information to, at a minimum, determine that the new owner should have billing privileges prior to the complete validation of their CMS 855 and the transfer of the provider agreement.

We understand that not all enrollment information is available before the change of ownership. We will work with the new owner(s) to ensure a seamless transition, but it is the provider's or supplier's responsibility to report this and any other changes to us to prevent us from imposing any adverse action against it.

For those providers and supplier not covered by Part 489, any change in the ownership or control of the provider or supplier must be reported on the CMS 855 within 90 days of the change as

noted in § 424.540(a)(2). Generally, a change of ownership that also changes the tax identification number will require a new CMS 855 from the new owner.

L. Payment Liability

In new § 424.555, we propose that any expenses for services furnished to a Medicare beneficiary by those categories of suppliers covered by section 1834 of the Act (that is, suppliers of DMEPOS) are the responsibility of that supplier if the supplier has been denied Medicare billing privileges. We further propose that no payment may be made for covered services furnished to a Medicare beneficiary by a provider or supplier whose billing privileges have been deactivated or revoked. The Medicare beneficiary will have no financial responsibility for this type of expense, and the provider or supplier must refund on a timely basis any amounts collected from the beneficiary for those covered services.

We are proposing these provisions because a provider or supplier who fails to provide valid enrollment information, or who is not a valid provider or supplier type under the Medicare program, cannot be verified as a legitimate provider or supplier for purposes of this rule. Claims or bills submitted for covered Medicare services must have an active Medicare billing number. Claims or bills submitted by a provider or supplier who is not properly enrolled, and does not have an active Medicare billing number, would be considered incomplete and would be returned. The provider or supplier would then be in violation of the mandatory claims submission requirements and could be fined for each occurrence. An incomplete claim returned for this reason would not be afforded appeal rights for the provider or supplier. However, as described earlier, a provider or supplier may appeal a denial or revocation of enrollment in accordance with regulations elsewhere in this subpart.

Sections 1802(b), 1834(j), 1866, and 1870 of the Act, provide Medicare beneficiaries with certain protections against liabilities imposed by providers and suppliers. In section 1834(j)(4), for example, the statute protects the beneficiary against demands for payment for covered Medicare services by certain categories of suppliers that have not been granted Medicare billing privileges. Section 1866 of the Act prohibits providers that have entered into agreements described in that section from charging the beneficiary for covered items or services that are not paid by Medicare because the provider

has failed to comply with certain requirements. Furthermore, section 1802(b) of the Act, which sets forth a variety of criteria under which physicians and practitioners may enter into private contracts with Medicare beneficiaries, provides for additional beneficiary protection. Section 1870 provides that, except under certain circumstances, any payment to a provider of services with respect to items or services furnished shall be considered a payment to the individual, but that the individual will not be liable for overpayment to the provider where the individual is without fault.

In addition, section 1128A(a)(6) of the Act provides for criminal penalties for providers and suppliers having knowledge of events affecting the right to benefit or payment, and concealing or failing to disclose such an event with an intent to fraudulently secure benefit or payment when it is not authorized.

IV. Data Requested on the CMS 855 and Its Iterations

Because we are intending to use the CMS 855 series of forms as the principal information collection instrument, we are providing the following information about the data requested on the CMS 855 forms. In addition to the legal authority already cited in this preamble, the following additional provisions of the statute grant us the authority to collect the information required to complete the CMS 855:

- Section 1814(a) of the Act states that payment for services furnished to an individual may only be made to providers eligible under section 1866 and only if a written request is filed in such a form and manner as the Secretary may prescribe.

- Sections 1815(a) and 1833(e) of the Act authorize the Secretary to withhold Medicare payments until the provider or supplier furnishes such information as may be necessary to determine amounts due.

- Section 1866(a)(1) of the Act establishes provider agreement requirements; including a requirement not to charge the beneficiary (except as provided in section 1866(a)(2)) for items or services for which the beneficiary would have been entitled to have payment had the provider complied with procedural requirements.

A. Information Collection on the CMS 855

Since its inception in April 1996, the CMS 855 has been revised three times, in May 1997, January 1998, and in November 2001. A new proposed revision of the CMS 855 series is being submitted with this proposed rule for