

(b) *Independent Diagnostic Testing Facilities*. The effective date for billing privileges for IDTFs is specified in § 410.33(i) of this chapter.

(c) *DMEPOS suppliers*. The effective date for billing privileges for DMEPOS suppliers is specified in § 424.57(b) of this subpart and section 1834(j)(1)(A) of the Act.

(d) *Additional provider and supplier types*. (1) The effective date of billing privileges for the provider and supplier types identified in paragraph (d)(2) of this section is the later of—

(i) The date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or

(ii) The date that the provider or supplier first began furnishing services at a new practice location.

(2) The provider and supplier types to which paragraph (d)(1) of this section applies are as follows:

- (i) Physicians.
- (ii) Non-physician practitioners.
- (iii) Physician organizations.
- (iv) Non-physician practitioner organizations.
- (v) Ambulance suppliers.
- (vi) Opioid treatment programs.
- (vii) Part B hospital departments.
- (viii) Clinical Laboratory Improvement Amendment labs.
- (ix) Intensive cardiac rehabilitation facilities.
- (x) Mammography centers.
- (xi) Mass immunizers/pharmacies.
- (xii) Radiation therapy centers.
- (xiii) Home infusion therapy suppliers.
- (xiv) Physical therapists.
- (xv) Occupational therapists.
- (xvi) Speech language pathologists.

[73 FR 69940, Nov. 19, 2008, as amended at 75 FR 50418, Aug. 16, 2010; 79 FR 72531, Dec. 5, 2014; 84 FR 63203, Nov. 15, 2019; 85 FR 70355, Nov. 4, 2020; 86 FR 62419, Nov. 9, 2021]

§ 424.521 Request for payment by certain provider and supplier types.

(a) *Request for payment by certain provider and supplier types*. (1) The providers and suppliers identified in paragraph (a)(2) of this section may retrospectively bill for services when the provider or supplier has met all program requirements (including State licensure requirements), and services

were provided at the enrolled practice location for up to—

(i) Thirty days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries; or

(ii) Ninety days prior to their effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121–5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

(2) The provider and supplier types to which paragraph (a)(1) of this section applies are as follows:

- (i) Physicians.
- (ii) Non-physician practitioners.
- (iii) Physician organizations.
- (iv) Non-physician practitioner organizations.
- (v) Ambulance suppliers.
- (vi) Opioid treatment programs.
- (vii) Part B hospital departments.
- (viii) Clinical Laboratory Improvement Amendment labs.
- (ix) Intensive cardiac rehabilitation facilities.
- (x) Mammography centers.
- (xi) Mass immunizers/pharmacies.
- (xii) Radiation therapy centers.
- (xiii) Home infusion therapy suppliers.
- (xiv) Physical therapists.
- (xv) Occupational therapists.
- (xvi) Speech language pathologists.
- (b) [Reserved]

[79 FR 72531, Dec. 5, 2014, as amended at 84 FR 63203, Nov. 15, 2019; 85 FR 70355, Nov. 4, 2020; 86 FR 62419, Nov. 9, 2021]

§ 424.522 Additional effective dates.

(a) *Reassignments*. A reassignment of benefits under § 424.80 is effective beginning 30 days before the Form CMS–855R is submitted if all applicable requirements during that period were otherwise met.

(b) *Form CMS–855O enrollment*. The effective date of a Form CMS–855O enrollment is the date on which the Medicare contractor received the Form CMS–855O application if all other requirements are met.

[86 FR 62419, Nov. 9, 2021]

§ 424.525 Rejection of a provider's or supplier's application for Medicare enrollment.

(a) *Reasons for rejection.* CMS may reject a provider's or supplier's enrollment application for any of the following reasons:

(1) The provider or supplier fails to furnish complete information on the provider/supplier enrollment application within 30 calendar days from the date of the Medicare contractor's request for the missing information. This includes the following situations:

(i) The application is missing data required by CMS or the Medicare contractor to process the application (such as, but not limited to, names, Social Security Number, contact information, and practice location information).

(ii) The application is unsigned or undated.

(iii) The application contains a copied or stamped signature.

(iv) The application is signed more than 120 days prior to the date on which the Medicare contractor received the application.

(v) The application is signed by a person unauthorized to do so under this subpart.

(vi) For paper applications, the required certification statement is missing.

(vii) The paper application is completed in pencil.

(viii) The application is submitted via fax or e-mail when the provider or supplier was not otherwise permitted to do so.

(ix) The provider or supplier failed to submit all of the forms needed to process a Form CMS-855 reassignment package within 30 days of receipt.

(x) The provider or supplier submitted the incorrect Form CMS-855 application.

(2) The provider or supplier fails to furnish all required supporting documentation within 30 calendar days of submitting the enrollment application.

(3) The Prospective institutional provider or supplier does not submit the application fee in the designated amount or a hardship waiver request with the Medicare enrollment application at the time of filing.

(b) *Extension of 30-day period.* CMS, at its discretion, may choose to extend

the 30 day period if CMS determines that the provider or supplier is actively working with CMS to resolve any outstanding issues.

(c) *Resubmission after rejection.* To enroll in Medicare and obtain Medicare billing privileges after notification of a rejected enrollment application, the provider or supplier must complete and submit a new enrollment application and submit all supporting documentation for CMS review and approval.

(d) *Additional review.* Enrollment applications that are rejected are not afforded appeal rights.

(e) *Applicability.* Except as otherwise specified in the applicable reason for rejection under paragraph (a) of this section, this section applies to all CMS Medicare provider enrollment application submissions, including, but not limited to, the following:

(1) Form CMS-855 initial applications, change of information requests, changes of ownership, revalidations, and reactivations.

(2) Form CMS-588 (Electronic Funds Transfer (EFT) Authorization Agreement) submissions.

(3) Form CMS-20134 (Medicare Enrollment Application; Medicare Diabetes Prevention Program (MDPP) Suppliers) submissions.

(4) Any electronic or successor versions of the forms identified in paragraphs (e)(1) through (3) of this section.

[71 FR 20776, Apr. 21, 2006, as amended at 73 FR 36461, June 27, 2008; 76 FR 5964, Feb. 2, 2011; 86 FR 62419, Nov. 9, 2021]

EDITOR'S NOTE: At 86 FR 62419, Nov. 9, 2021, paragraph (a)(3) was amended by removing the phrase "prospective provider" and adding the word "provider" in its place; however, the phrase does not exist.

§ 424.526 Return of a provider's or supplier's enrollment application.

(a) *Reasons for return.* CMS may return a provider's or supplier's enrollment application for any of the following reasons:

(1) The provider or supplier sent its paper Form CMS-855, Form CMS-588, or Form CMS-20134 application to the incorrect Medicare contractor for processing.

(2) The Medicare contractor received the application more than 60 days prior