(i) The type of disclosable event.

(ii) When the disclosable event occurred or was imposed.

(iii) Whether the affiliation existed when the disclosable event occurred or was imposed.

(iv) If the disclosable event is an uncollected debt:

(A) The amount of the debt.

(B) Whether the affiliated provider or supplier is repaying the debt.

(C) To whom the debt is owed.

(v) If a denial, revocation, termination, exclusion, or payment suspension is involved, the reason for the disclosable event.

(6) Any other evidence that CMS deems relevant to its determination.

(g) *Determination of undue risk.* A determination by CMS that a particular affiliation poses an undue risk of fraud, waste, or abuse will result in, as applicable, the denial of the provider's or supplier's initial enrollment application under § 424.530(a)(13) or the revocation of the provider's or supplier's Medicare enrollment under § 424.535(a)(19).

(h) *Duplicate data.* A provider or supplier is not required to report affiliation data in that portion of the Form CMS–855 application that collects affiliation information if the same data is being reported in the ''owning or managing control'' (or its successor) section of the Form CMS–855 application.

(i) *Undisclosed affiliations.* CMS may apply § 424.530(a)(13) or § 424.535(a)(19) to situations where a disclosable affiliation (as described in § 424.519(b) and (c)) poses an undue risk of fraud, waste or abuse, but the provider or supplier has not yet reported or is not required at that time to report the affiliation to CMS.

[84 FR 47853, Sept. 10, 2019]

§ 424.520 Effective date of Medicare billing privileges.

(a) *Surveyed, certified or accredited providers and suppliers.* The effective date for billing privileges for providers and suppliers requiring State survey, certification or accreditation is specified in § 489.13 of this chapter. If a provider or supplier is seeking accreditation from a CMS-approved accreditation organization, the effective date is specified in § 489.13.

(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