CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10481	**Date: November 18, 2020**
	Change Request 12058

NOTE: This Transmittal is no longer sensitive and is being re-communicated December 31, 2020. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Update to Policies on the Enrollment of Opioid Treatment Programs (OTPs)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to--

(1) Incorporate into chapter 10 in Publication (Pub.) 100-08, Program Integrity Manual (PIM) existing policies concerning the enrollment of OTPs in Medicare; and

(2) Address certain updates to OTP enrollment policies outlined in the CMS final rule titled, "Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2021".

EFFECTIVE DATE: Contractors to begin accepting new applications pursuant to our policy revisions beginning on November 16, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 20, 2020

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/10.2/10.2.7/Opioid Treatment Programs
N	10/10.2/10.2.8/Providers/Suppliers Not Eligible to Enroll

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and

immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-08	Transmittal: 10481	Date: November 18, 2020	Change Request: 12058

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EFFECTIVE DATE: Contractors to begin accepting new applications pursuant to our policy revisions beginning on November 16, 2020
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I. GENERAL INFORMATION

A. Background: On November 15, 2019, CMS published a final rule in the FR titled, "Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations" (84 FR 62567). The Final Rule, in part, established policies concerning the enrollment in Medicare of OTPs effective January 1, 2020; these policies were incorporated largely in new 42 Code of Federal Regulations (CFR) § 424.67. To facilitate the implementation of these regulatory provisions, CR 11459 was issued on November 1, 2019. This CR contained numerous detailed Business Requirements (BRs) for contractors to follow in their processing of Form CMS-855B enrollment applications submitted by new OTPs. Contractors have been adhering to these BRs and enrolling OTPs throughout CY 2020. However, not all of the CR's policies have been incorporated into chapter 10 in Pub. 100-08.

The requirement in 42 CFR § 424.67 that newly enrolling OTPs complete the Form CMS-855B application was predicated partially on the assumption that OTPs would generally submit the CMS-1500 claim form to receive payment for their services. However, some OTPs indicated to CMS in 2020 that they wished to instead bill for OTP services on an institutional claim form (specifically, the 837I). To this end, CMS published a proposed rule in the Federal Register on August 17, 2020 titled, "Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2021" (85 FR 50074). We proposed therein to permit OTPs to bill for OTP services via the 837I, which, in turn, would necessitate the OTP's enrollment via the Form CMS-855A. We finalized our proposed provisions without change in the CY 2021 Physician Fee Schedule (PFS) final rule.

The current CR serves two purposes. First, it will instruct contractors on the policies regarding OTP Form CMS-855A enrollment and how this relates to Form CMS-855B enrollment. Second, it will formally incorporate into chapter 10 in Pub. 100-08; all of the policies outlined in CR 11459 and in the above-mentioned CY 2021 Final Rule. Note that this CR will not restate all of the BRs contained in CR 11459 because contractors (as already stated) have been adhering to them. The only BRs in this CR are those specifically pertaining to the changes made in CY 2021 PFS Final Rule.

Pursuant to the CY 2021 PFS Final Rule, there are four principal policies outlined in this CR. First, OTPs may enroll (and be enrolled) in Medicare via the Form CMS-855A or the Form CMS-855B but not both. Second, currently enrolled OTPs that are changing their OTP enrollment from a Form CMS-855B to a Form CMS-855A (or vice versa) must successfully complete the limited level of categorical screening under 42 CFR § 424.518(a) if the OTP has already completed, as applicable, the moderate or high level of categorical screening under 42 CFR § 424.518(b) or (c), respectively. Third, if a Form CMS-855B-enrolled OTP changes to a Form CMS-855A enrollment (or vice versa) the effective date of billing that was established for the OTP's prior enrollment under 42 CFR §§ 424.520(d) and 424.521(a) would be applied to the OTP's new enrollment. Fourth, the application fee requirements apply to OTPs changing their enrollment from a Form CMS-855B to a Form CMS-855A (or vice versa).

B. Policy: 42 CFR §§ 424.67 and 424.518, CY 2021 PFS Final Rule.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12058.1	The contractor shall be aware of the addition to Chapter 10 in Pub. 100-08 of previously communicated and new policies concerning the processing of OTP Form CMS-855 enrollment applications.	X	X							
12058.2	The contractor shall begin accepting and processing initial Form CMS-855A applications submitted by OTPs beginning on November 16, 2020.	X								
12058.3	The contractor shall process Form CMS-855A applications submitted by OTPs consistent with the instructions in chapters 10 and 15 (as applicable) of Pub. 100-08.	X								
12058.4	Upon receipt of an initial Form CMS-	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	855A or Form CMS 855B application from an OTP, the contractor shall confirm that the OTP is not currently enrolled as such via another Form CMS-855 application type. (For example, if the contractor receives an initial Form CMS-855A from an OTP, the contractor shall verify that the OTP is not already enrolled via the Form CMS-855B.)									
12058.4.1	The contractor shall process the application normally if the contractor determines that the OTP is not already enrolled pursuant to BR 12058.4.	X	X							
12058.4.2	If the contractor determines that the OTP is already enrolled as such via a different Form CMS-855 application type, the contractor shall verify with an authorized or delegated official of the OTP (by telephone or e-mail) that the OTP is changing its enrollment type.	X	X							
12058.5	Consistent with 42 CFR 424.514 and chapters 10 and 15 (as applicable) in Pub. 100-08, the contractor shall require an application fee if a currently enrolled OTP submits an initial Form CMS-855A or	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Form CMS-855B (as applicable) to enroll as such via a different Form CMS-855 application type.									
12058.6	If an OTP seeks to change its existing OTP Form CMS-855 enrollment type, the contractor shall conduct limited-risk screening under 42 CFR § 424.518(a) if the OTP has already completed, as applicable, moderate or high-risk level screening under 42 CFR § 424.518(b) or (c).	X	X							
12058.7	If the contractor determines that the OTP's application should be approved, it shall conduct the activities described in BRs 12058.7.1 through 12058.7.4 and in section 10.2.7(C) in Chapter 10 in Pub. 100-08.	X	X							
12058.7.1	If a Form CMS-855B-enrolled OTP changes to a Form CMS-855A enrollment (or vice versa) and the contractor approves the application, the contractor shall apply the same effective date of billing that was established for the OTP’s prior enrollment.	X	X							
12058.7.2	The contractor shall, as applicable: (1) for Form CMS-855A applications only, request via	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	PEMACReports@cms.hhs.gov that CMS assign a Form CMS-855A CCN to the enrollment; (2) send the Form CMS-1561 to PEMACReports@cms.hhs.gov for CMS to execute the signature on behalf of the Secretary; (3) send a copy of the executed provider agreement to the OTP along with the enrollment approval letter; and (4) retain the original provider agreement.									
12058.7.3	If the OTP is changing its Form CMS-855 enrollment type, the contractor shall end-date/deactivate the prior enrollment effective: (1) the date following that on which the OTP submitted its last claim under its prior enrollment; or (2) the prior enrollment's effective date of billing if no claims were submitted under the prior enrollment.	X	X							
12058.7.4	If the OTP is changing its Form CMS-855 enrollment type, the contractor shall notify the OTP in the approval letter that the OTP's prior enrollment has been end-dated/deactivated and specify said end-date.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Frank Whelan, frank.whelan@cms.hhs.gov.

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Program Integrity Manual
Chapter 10 – Medicare Enrollment

Table of Contents
(Rev. 10481; Issued: 11-18-20)

Transmittals for Chapter 10

10.2.7 - *Opioid Treatment Programs*

(Rev. 10481; Issued: 11-18-20; Effective: 11-16-20; Implementation: 11-20-20)

A. Legislative and Regulatory Background

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (hereafter referenced as the "SUPPORT Act") was designed to alleviate the nationwide opioid crisis by: (1) reducing the abuse and supply of opioids; (2) helping individuals recover from opioid addiction and supporting the families of these persons; and (3) establishing innovative and long-term solutions to the crisis. Section 2005 of the SUPPORT Act attempted to fulfill these objectives, in part, by establishing a new Medicare benefit category for opioid treatment programs (OTPs).

An OTP is currently defined in 42 CFR § 8.2 as a program or practitioner engaged in opioid treatment of individuals with an opioid agonist treatment medication registered under 21 U.S.C. § 823(g)(1). There are three overarching (but not exclusive) requirements that an OTP must meet in order to bill for OTP services:

1. Accreditation

The OTP must have a current, valid accreditation by an accrediting body or other entity approved by the Substance Abuse and Mental Health Services Administration (SAMHSA), the federal agency that oversees OTPs. The accreditation process includes, but is not limited to, an accreditation survey, which involves an onsite review and evaluation of the OTP to determine compliance with applicable federal standards. There are currently six SAMHSA-approved accreditation bodies.

2. Certification

The OTP must have a current, full, valid certification by SAMHSA for such a program. The prerequisites for certification (as well as the certification process itself) are addressed in 42 CFR § 8.11 and include, but are not restricted to, the following:

- *Current and valid accreditation (described in subsection (A)(1) above)*
- *Adherence to the federal opioid treatment standards described in 42 CFR § 8.12*
- *Compliance with all pertinent state laws and regulations, as stated in § 8.11(f)(1)*

Under 42 CFR § 8.11(a)(3), certification is generally for a maximum 3-year period, though this may be extended by 1 year if an application for accreditation is pending. SAMHSA may revoke or suspend an OTP's certification if any of the applicable grounds identified in 42 CFR § 8.14(a) or (b), respectively, exist.

3. Enrollment

The SUPPORT Act also required that an OTP be enrolled in the Medicare program under section 1866(j) of the Act in order to bill and receive payment from Medicare for opioid use disorder treatment services.

*In the Calendar Year (CY) 2020 Physician Fee Schedule final rule (published in the **Federal Register** on November 15, 2019 (84 FR 62567)), CMS established a new 42 CFR § 424.67 containing requirements that OTPs must meet and continually adhere to in order to enroll (and remain enrolled) in Medicare effective January 1, 2020. Since this latter date, OTPs have enrolled in Medicare consistent with 42 CFR § 424.67 and the general provider enrollment requirements of 42 CFR Part 424, subpart P (42 CFR § 424.500-570). This section 10.2.7 outlines the specific enrollment policies associated with OTP enrollment.*

B. OTP Enrollment Process

The instructions in this section 10.2.7(B) are in addition to, and not in lieu of, those in CMS Pub. 100-08, Program Integrity Manual (PIM), chapters 10 and 15 (as applicable).

1. Applicable Form CMS-855

As of November 16, 2020, OTPs may enroll (and remain enrolled) via the Form CMS-855B or the Form CMS-855A, but not both. Some OTPs currently enrolled via the Form CMS-855B may accordingly seek to change their enrollment to a Form CMS-855A. To ensure that the OTP is at no time enrolled under both Form CMS-855 application types, the contractor shall do the following:

- *Upon receipt of an initial Form CMS-855A or Form CMS 855B from an OTP, the contractor shall confirm that the OTP is not currently enrolled as such via another Form CMS-855 application type. (For example, if the contractor receives an initial Form CMS-855A from an OTP, the contractor shall verify that the OTP is not already enrolled via the Form CMS-855B.)*

- *If the contractor determines that the OTP is not already enrolled as such, the contractor shall process the application normally.*

- *If, however, the contractor determines that the OTP is already enrolled as such via a different Form CMS-855 application type, the contractor shall verify with an authorized or delegated official of the OTP (by telephone or e-mail) that the OTP is changing its enrollment from a Form CMS-855B to a Form CMS-855A (or vice versa). The OTP in this situation is not required to submit a Form CMS-855 application to voluntarily terminate its prior enrollment.*

Regardless of which Form CMS-855 the OTP submits (and until the Form CMS-855s are updated to add "Opioid Treatment Program" as a listed provider type), the OTP shall check the "Other" box in Section 2 and state "Opioid Treatment Program." The "Other" provider type category can be used in PECOS for Form CMS-855A OTP applications if the "Opioid Treatment Program" category is unavailable.

An entity that is enrolling or is already enrolled in Medicare as another provider or supplier type may also seek enrollment as an OTP. It must, however, submit a separate Form CMS-855 application to do so; it cannot enroll or be enrolled as an OTP and another provider/supplier type via the same enrollment.

Note that the policies in this section 10.2.7 regarding an OTP's transition from a Form CMS-855B enrollment to a Form CMS-855A enrollment (or vice versa) only apply if the OTP is doing so in the same state in which it is currently enrolled as an OTP. If an OTP is enrolling under a different Form CMS-855 in a state different from that in which it is currently enrolled (e.g., a Form CMS-855B enrolled OTP in State X is enrolling via the Form CMS-855A in State Y), it is considered a brand new enrollment (and not merely a "switch" in OTP enrollment type); this would thus require, for instance, moderate or high-level screening as opposed to limited screening (as discussed further in section 10.2.7(B)(3) below).

2. Applicable Fee

An OTP is an "institutional provider" under 42 CFR § 424.502 and thus is required to pay an application fee pursuant to 42 CFR § 424.514. The contractor shall follow the application fee procedures outlined in chapter 10 or 15 (as applicable) of the PIM. A fee is

required even when the OTP is changing its enrollment from a Form CMS-855B to a Form CMS-855A, or vice versa.

3. Categorical Screening

Consistent with 42 CFR § 424.518, the contractor shall categorically screen OTP applications as follows:

a. Newly enrolling OTPs that are not changing their enrollment from a Form CMS-855B to a Form CMS-855A, or vice versa -

- *If the OTP has not been fully and continuously certified by SAMHSA since October 24, 2018, the contractor shall conduct high-risk level categorical screening.*

- *If the OTP has been fully and continuously certified by SAMHSA since October 24, 2018, the contractor shall conduct moderate-risk level categorical screening.*

b. Newly enrolling OTPs that are changing their enrollment from a Form CMS-855B to a Form CMS-855A, or vice versa - The contractor shall conduct limited-risk level categorical screening if the OTP had previously completed, as applicable, the moderate or high-risk level screening as part of its initial enrollment. Otherwise, moderate or high-risk level screening (as applicable under § 424.518) shall be conducted.

c.Revalidating OTPs – The contractor shall conduct moderate-risk level categorical screening.

4. Confirmation of Certification

When processing OTP initial applications (including those involving a change in Form CMS-855 application type) and revalidation applications, the contractor shall confirm and record in PECOS the OTP's SAMHSA certification status as follows:

a. Review the OTP directory at: https://dpt2.samhsa.gov/treatment/directory.aspx The OTP's certification must be full, current, and valid. ("Provisional" certification status is not acceptable.) The OTPs SAMHSA certificate (and the OTP's identification in the SAMHSA directory) need not be have the exact same legal business name as that on the OTP's IRS document, though the contractor shall develop for clarification if it has questions as to whether the OTP on the application and in the directory are truly the same.

b. Verify that each location listed on the Form CMS-855 is separately and uniquely certified.

c. Enter into PECOS the OTP's relevant certification data obtained from the aforementioned OTP directory. This includes: (1) the OTP number; and (2) the certification effective date (which can be obtained from the OTP's renewal letter). The certification effective date is the date on which SAMHSA acknowledged notification from the accrediting organization and can be verified by reviewing the OTP's renewal letter information in the database. (The contractor need not obtain a copy of the letter from the OTP.)

The expiration date must be obtained via the SAMHSA operating certificate for the location in question; the OTP should submit said certificate with its application.

Irrespective of whether the OTP reported the data described in (4)(c) on the Form CMS-855, the contractor shall use the information in the OTP directory for purposes of data entry.

5. OTP Managing Employees

As with all enrolling providers and suppliers, the OTP must disclose all of its managing employees in Section 6 of the Form CMS-855. Such managing employees must include the OTP's medical director and program sponsor, which the OTP must have pursuant to 42 CFR §§ 8.12(b) and §§ 424.67(b)(5). The contractor shall ensure that the medical director is a validly licensed physician or psychiatrist.

The OTP must submit a copy of the organizational diagram required under Section 5 of the Form CMS-855 even if it merely changing its enrollment type from a Form CMS-855B to a Form CMS-855A (or vice versa).

6. Provider Agreement

To enroll (and remain enrolled) in Medicare as an OTP, the OTP must sign and adhere to the terms of the Form CMS-1561 Provider Agreement. (This is the same agreement signed by certified providers such as hospitals, hospices, and home health agencies. See 42 CFR Part 489, Subparts A through E (as well as CMS Pub. 100-07, State Operational Manual) for general information on provider agreements.) Given this, the contractor shall verify that the OTP submitted a signed and dated Form CMS-1561 with its initial enrollment package. The provider agreement must be signed by an authorized or delegated official (as those terms are defined in § 424.502) of the OTP; the signature can be handwritten or digital. This form may be accepted via mail, fax, email, or document upload. The legal business name on the Form CMS-1561 must match that on the Form CMS-855.

If the OTP failed to submit the Form CMS-1561 as described in the previous paragraph, the contractor shall develop for the document (or any missing or inconsistent data thereon) consistent with the procedures outlined in chapter 10 or 15 (as applicable) of the PIM.

The requirement to submit, sign, and date a new Form CMS-1561 does not apply if the OTP meets all of the following requirements: (1) the OTP is already enrolled as such in Medicare; (2) the OTP already has a valid Form CMS-1561 agreement in effect; and (3) the OTP is newly enrolling solely to change its existing Form CMS-855B enrollment to a Form CMS-855A, or vice versa.

C. Approval

1. No State Agency or Regional Office (RO) Involvement

Unlike with many entities that complete the Form CMS-855A, there is no State Agency or CMS RO involvement with OTP Form CMS-855A enrollments. Accordingly, no recommendations for approval or other type of referral need be made to the State or RO nor will the CMS RO send any tie-in notice to the contractor. Except as otherwise stated in this section 10.2.7, the application will be reviewed and handled entirely at the contractor level

2. Process of Approval

If the contractor determines that the OTP's application should be approved, it shall undertake the following:

a. For Form CMS-855A applications only, request via PEMACReports@cms.hhs.gov that CMS assign a Form CMS-855A CCN to the enrollment.

b. As applicable, send the Form CMS-1561 to PEMACReports@cms.hhs.gov for CMS to execute the signature on behalf of the Secretary. CMS will return the executed provider agreement within 3 business days.

c. As applicable, send a copy of the executed provider agreement to the OTP along with the enrollment approval letter. (The contractor shall retain the original provider agreement.)

3. Effective Date of Billing

For newly enrolling OTPs that are not changing their enrollment from a Form CMS-855B to a Form CMS-855A (or vice versa), the contractor shall apply the effective date policies outlined in 42 CFR §§ 424.520(d) and 424.521(a) and explained in chapter 10 or 15 (as applicable) of the PIM.

For newly enrolling OTPs that are changing their enrollment from a Form CMS-855B to a Form CMS-855A (or vice versa), the contractor shall apply to the new/changed enrollment the same effective date of billing that was applied to the OTP's initial/former enrollment. (See 42 CFR § 424.67(c)(2).) To illustrate, suppose an OTP initially enrolled via the Form CMS-855B in 2020. The effective date of billing was April 1, 2020. Wishing to submit an 837I claim form for the services it has provided since April 1, 2020 the OTP elects to end its Form CMS-855B enrollment and enroll via the Form CMS-855A pursuant. It successfully does the latter in March 2021. Under § 424.67(c)(2), the billing effective date of the Form CMS-855A enrollment would be retroactive to April 1, 2020 (though the time limits for filing claims found in § 424.44 would continue to apply).

4. In cases where the OTP is changing its Form CMS-855 enrollment type, the contractor shall do the following:

a. End-date/deactivate the prior enrollment effective: (1) the date following that on which the
OTP submitted its last claim under its prior enrollment; or (2) the prior enrollment's effective date of billing if no claims were submitted under the prior enrollment.

b. Notify the OTP in the approval letter that the OTP's prior enrollment has been end-dated/deactivated and specify said end-date.

10.2.8 - Providers/Suppliers Not Eligible to Enroll

(Rev. 10481; Issued: 11-18-20; Effective: 11-16-20; Implementation: 11-20-20)

Below is a list of individuals and entities that frequently attempt to enroll in Medicare, but are not eligible to do so. This list is not an all-inclusive list. If the contractor receives an enrollment application from any of these individuals or entities, the contractor shall deny the application, with the exception of entities eligible to enroll using the Form CMS-20134, which is specific to the furnishing of MDPP services. An assisted living facility, for example, that also provides the DPP and is eligible to enroll as an MDPP supplier may enroll through the CMS-20134, however, this enrollment only pertains to the rendering of MDPP services.

- *Acupuncturist*
- *Assisted Living Facility*
- *Birthing Center*
- *Certified Alcohol and Drug Counselor*
- *Certified Social Worker*
- *Drug and Alcohol Rehabilitation Counselor*

- *Hearing Aid Center/Dealer*
- *Intern (Graduate Medical Education)*
- *Licensed Alcoholic and Drug Counselor*
- *Licensed Massage Therapist*
- *Licensed Practical Nurse*
- *Licensed Professional Counselor*
- *Marriage Family Therapist*
- *Master of Social Work*
- *Medicare Beneficiaries*
- *Mental Health Counselor*
- *National Certified Counselor*
- *Naturopath*
- *Occupational Therapist Assistant*
- *Physical Therapist Assistant*
- *Registered Nurse*
- *Speech and Hearing Center*
- *State Medicaid Agency*

  State Medicaid agencies do not have a National Provider Identifier and are not eligible to enroll in the Medicare program. If a Medicaid State agency is enrolled or seeks enrollment as a provider or supplier in the Medicare program, the contractor shall deny or revoke its Medicare billing privileges using, respectively, §424.530(a)(5) (denials) and § 424.535(a)(3) (revocations) as the basis.
- *Substance Abuse Facility*