until the following has occurred if the denial:

(1) Was not appealed, the provider or supplier may reapply after its appeal rights have lapsed.

(2) Was appealed, the provider or supplier may reapply after notification that the determination was upheld.

(c) *Reversal of denial.* If the denial was due to adverse activity (sanction, exclusion, debt, felony) of an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier furnishing Medicare reimbursable services, the denial may be reversed if the provider or supplier terminates and submits proof that it has terminated its business relationship with that individual or organization within 30 days of the denial notification.

(d) *Additional review.* When a provider or supplier is denied enrollment in Medicare, CMS automatically reviews all other related Medicare enrollment files that the denied provider or supplier has an association with (for example, as an owner or managing employee) to determine if the denial warrants an adverse action of the associated Medicare provider or supplier.

(e) *Effective date of denial.* Denial becomes effective within 30 days of the initial denial notification.

[71 FR 20776, Apr. 21, 2006, as amended at 73 FR 69940, Nov. 19, 2008; 75 FR 70464, Nov. 17, 2010; 76 FR 5964, Feb. 2, 2011]

§ 424.535 Revocation of enrollment and billing privileges in the Medicare program.

(a) *Reasons for revocation.* CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:

(1) *Noncompliance.* The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section, or in the enrollment application applicable for its provider or supplier type, and has not submitted a plan of corrective action as outlined in part 488 of this chapter. The provider or supplier may also be determined not to be in compliance if it has failed to pay any user fees as assessed under part 488 of this chapter. All providers and suppliers are granted an opportunity to correct the deficient compliance requirement before a final determination to revoke billing privileges, except for those imposed under paragraphs (a)(2), (a)(3), or (a)(5) of this section.

(i) CMS may request additional documentation from the provider or supplier to determine compliance if adverse information is received or otherwise found concerning the provider or supplier.

(ii) Requested additional documentation must be submitted within 60 calendar days of request.

(2) *Provider or supplier conduct.* The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier is—

(i) Excluded from the Medicare, Medicaid, and any other Federal health care program, as defined in §1001.2 of this chapter, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Act.

(ii) Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity in accordance with the FASA implementing regulations and the Department of Health and Human Services nonprocurement common rule at 45 CFR part 76.

(3) *Felonies.* The provider, supplier, or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries.

(i) Offenses include—

(A) Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was

convicted, including guilty pleas and adjudicated pretrial diversions.

(C) Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

(D) Any felonies that would result in mandatory exclusion under section 1128(a) of the Act.

(ii) Denials based on felony convictions are for a period to be determined by the Secretary, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses.

(4) *False or misleading information.* The provider or supplier certified as ''true'' misleading or false information on the enrollment application to be enrolled or maintain enrollment in the Medicare program. (Offenders may be subject to either fines or imprisonment, or both, in accordance with current law and regulations.)

(5) *On-site review.* CMS determines, upon on-site review, that the provider or supplier is no longer operational to furnish Medicare covered items or services, or is not meeting Medicare enrollment requirements under statute or regulation to supervise treatment of, or to provide Medicare covered items or services for, Medicare patients. Upon on-site review, CMS determines that—

(i) A Medicare Part A provider is no longer operational to furnish Medicare covered items or services, or the provider fails to satisfy any of the Medicare enrollment requirements.

(ii) A Medicare Part B supplier is no longer operational to furnish Medicare covered items or services, or the supplier has failed to satisfy any or all of the Medicare enrollment requirements, or has failed to furnish Medicare covered items or services as required by the statute or regulations.

(6) *Grounds related to provider and supplier screening requirements.* (i)(A) An institutional provider does not submit an application fee or hardship exception request that meets the requirements set forth in §424.514 with the Medicare revalidation application; or

(B) The hardship exception is not granted and the institutional provider does not submit the applicable application form or application fee within 30 days of being notified that the hardship exception request was denied.

(ii)(A) Either of the following occurs:

(*1*) CMS is not able to deposit the full application amount into a government-owned account.

(*2*) The funds are not able to be credited to the U.S. Treasury.

(B) The provider or supplier lacks sufficient funds in the account at the banking institution whose name is imprinted on the check or other banking instrument to pay the application fee; or

(C) There is any other reason why CMS or its Medicare contractor is unable to deposit the application fee into a government-owned account.

(7) *Misuse of billing number.* The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers who enter into a valid reassignment of benefits as specified in §424.80 or a change of ownership as outlined in §489.18 of this chapter.

(8) *Abuse of billing privileges.* The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to situations where the beneficiary is deceased, the directing physician or beneficiary is not in the State or country when services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.

(9) *Failure to report.* The provider or supplier did not comply with the reporting requirements specified in §424.516(d)(1)(ii) and (iii) of this subpart.

(10) *Failure to document or provide CMS access to documentation.* (i) The provider or supplier did not comply with the documentation or CMS access requirements specified in §424.516(f) of this subpart.

(ii) A provider or supplier that meets the revocation criteria specified in paragraph (a)(10)(i) of this section, is subject to revocation for a period of not more than 1 year for each act of noncompliance.

(11) *Initial reserve operating funds.* CMS or its designated Medicare contractor may revoke the Medicare billing privileges of an HHA and the corresponding provider agreement if, within 30 days of a CMS or Medicare contractor request, the HHA cannot furnish supporting documentation verifying that the HHA meets the initial reserve operating funds requirement found in 42 CFR 489.28(a).

(12) *Medicaid termination.* (i) Medicaid billing privileges are terminated or revoked by a State Medicaid Agency.

(ii) Medicare may not terminate unless and until a provider or supplier has exhausted all applicable appeal rights.

(b) *Effect of revocation on provider agreements.* When a provider's or supplier's billing privilege is revoked, any provider agreement in effect at the time of revocation is terminated effective with the date of revocation.

(c) *Reapplying after revocation.* After a provider, supplier, delegated official, or authorizing official has had their billing privileges revoked, they are barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar. The re-enrollment bar is a minimum of 1 year, but not greater than 3 years, depending on the severity of the basis for revocation. The re-enrollment bar does not apply in the event a revocation of Medicare billing privileges is imposed under paragraph (a)(1) of this section based upon a provider or supplier's failure to respond timely to a revalidation request or other request for information.

(d) *Re-enrollment after revocation.* If a provider or supplier seeks to re-establish enrollment in the Medicare program after notification that its billing privileges is revoked (either after the appeals process is exhausted or in place of the appeals process), the following conditions apply:

(1) The provider or supplier must reenroll in the Medicare program through the completion and submission of a new applicable enrollment application and applicable documentation, as a new provider or supplier, for validation by CMS.

(2) Providers must be resurveyed and recertified by the State survey agency as a new provider and must establish a new provider agreement with CMS's Regional Office.

(e) *Reversal of revocation.* If the revocation was due to adverse activity (sanction, exclusion, or felony) against an owner, managing employee, or an authorized or delegated official; or a medical director, supervising physician, or other personnel of the provider or supplier furnishing Medicare reimbursable services, the revocation may be reversed if the provider or supplier terminates and submits proof that it has terminated its business relationship with that individual within 30 days of the revocation notification.

(f) *Additional review.* When a provider or supplier is revoked from the Medicare program, CMS automatically reviews all other related Medicare enrollment files that the revoked provider or supplier has an association with (for example, as an owner or managing employee) to determine if the revocation warrants an adverse action of the associated Medicare provider or supplier.

(g) *Effective date of revocation.* Revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier, except if the revocation is based on Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational. When a revocation is based on a Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational, the revocation is effective with the date of exclusion or debarment, felony conviction, license suspension or revocation or the date that CMS or its contractor determined that the provider or supplier was no longer operational.

(h) *Submission of claims for services furnished before revocation.* A physician organization, physician, nonphysician practitioner or independent diagnostic testing facility must submit all claims for items and services furnished within

60 calendar days of the effective date of revocation.

[71 FR 20776, Apr. 21, 2006, as amended at 72 FR 53648, Sept. 19, 2007; 73 FR 36461, June 27, 2008; 73 FR 69940, Nov. 19, 2008; 75 FR 24449, May 5, 2010; 75 FR 70465, Nov. 17, 2010; 76 FR 5964, Feb. 2, 2011; 77 FR 25318, Apr. 27, 2012; 77 FR 29030, May 16, 2012]

§ 424.540 Deactivation of Medicare billing privileges.

(a) *Reasons for deactivation.* CMS may deactivate the Medicare billing privileges of a provider or supplier for any of the following reasons:

(1) The provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. The 12 month period will begin the 1st day of the 1st month without a claims submission through the last day of the 12th month without a submitted claim.

(2) The provider or supplier does not report a change to the information supplied on the enrollment application within 90 calendar days of when the change occurred. Changes that must be reported include, but are not limited to, a change in practice location, a change of any managing employee, and a change in billing services. A change in ownership or control must be reported within 30 calendar days as specified in §§ 424.520(b) and 424.550(b).

(3) The provider or supplier does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information.

(b) *Reactivation of billing privileges.* (1) When deactivated for any reason other than nonsubmission of a claim, the provider or supplier must complete and submit a new enrollment application to reactivate its Medicare billing privileges or, when deemed appropriate, at a minimum, recertify that the enrollment information currently on file with Medicare is correct.

(2) Providers and suppliers deactivated for nonsubmission of a claim are required to recertify that the enrollment information currently on file with Medicare is correct and furnish any missing information as appropriate. The provider or supplier must meet all current Medicare requirements in place at the time of reactivation, and be prepared to submit a valid Medicare claim.

(3) Except as provided in paragraph (b)(3)(i) of this section, reactivation of Medicare billing privileges does not require a new certification of the provider or supplier by the State survey agency or the establishment of a new provider agreement.

(i) An HHA whose Medicare billing privileges are deactivated under the provisions found at paragraph (a) of this section must obtain an initial State survey or accreditation by an approved accreditation organization before its Medicare billing privileges can be reactivated.

(ii) [Reserved]

(c) *Effect of deactivation.* Deactivation of Medicare billing privileges is considered an action to protect the provider or supplier from misuse of its billing number and to protect the Medicare Trust Funds from unnecessary overpayments. The deactivation of Medicare billing privileges does not have any effect on a provider or supplier's participation agreement or any conditions of participation.

[71 FR 20776, Apr. 21, 2006, as amended at 74 FR 58134, Nov. 10, 2009; 77 FR 29030, May 16, 2012]

§ 424.545 Provider and supplier appeal rights.

(a) *General.* A prospective provider or supplier that is denied enrollment in the Medicare program, or a provider or supplier whose Medicare enrollment has been revoked may appeal CMS' decision in accordance with part 498, subpart A of this chapter.

(1) *Appeals resulting in the termination of a provider agreement.* (i) When revocation of billing privileges also results in the termination of a corresponding provider agreement, the provider may appeal CMS' decision in accordance with part 498 of this chapter with the final decision of the appeal applying to both the billing privileges and the provider agreement.

(ii) When a provider appeals the revocation of billing privileges and the termination of its provider agreement, there will be one appeals process which