that the prospective 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.

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

§424.530 Denial of enrollment in the Medicare program.

(a) *Reasons for denial.* CMS may deny a provider's or supplier's enrollment in the Medicare program for the following reasons:

(1) *Compliance.* The provider or supplier at any time is found not to be in compliance with the Medicare enrollment requirements described in this section or on the applicable enrollment application to the type of provider or supplier enrolling, and has not submitted a plan of corrective action as outlined in part 488 of this chapter.

(2) *Provider or supplier conduct.* A provider, supplier, an owner, managing employee, an authorized or delegated official, medical director, supervising physician, or other health care personnel furnishing Medicare reimbursable services who is required to be reported on the enrollment application, in accordance with section 1862(e)(1) of the Act, is—

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

(ii) Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement activity in accordance with section 2455 of the Federal Acquisition Streamlining Act (FASA).

(3) *Felonies.* If within the 10 years preceding enrollment or revalidation of enrollment, the provider, supplier, or any owner of the provider or supplier, 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. CMS considers the severity of the underlying offense.

(i) Offenses include—

(A) Felony crimes against persons, such as murder, rape, or 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 outlined in section 1128 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 has submitted false or misleading information on the enrollment application to gain enrollment in the Medicare program. (Offenders may be referred to the Office of Inspector General for investigation and possible criminal, civil, or administrative sanctions.)

(5) *On-site review.* Upon on-site review or other reliable evidence, we determine that the provider or supplier is not operational, or is not meeting Medicare enrollment requirements to furnish Medicare covered items or services. 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) *Overpayment.* The current owner (as defined in § 424.502), physician or nonphysician practitioner has an existing overpayment at the time of filing of an enrollment application.

(7) *Payment suspension.* The current owner (as defined in § 424.502), physician or nonphysician practitioner has been placed under a Medicare payment suspension as defined in § 405.370 through § 405.372 of this subchapter.

(8) *Initial Reserve Operating Funds.* (i) CMS or its designated Medicare contractor may deny Medicare billing privileges if, within 30 days of a CMS or Medicare contractor request, a home health agency (HHA) cannot furnish supporting documentation which verifies that the HHA meets the initial reserve operating funds requirement found in § 489.28(a) of this title.

(ii) CMS may deny Medicare billing privileges upon an HHA applicant's failure to satisfy the initial reserve operating funds requirement found in 42 CFR 489.28(a).

(9) *Application fee/hardship exception.* An institutional provider's or supplier's hardship exception request is not granted, and the provider or supplier does not submit the application fee within 30 days of notification that the hardship exception request was not approved.

(10) *Temporary moratorium.* A provider or supplier submits an enrollment application for a practice location in a geographic area where CMS has imposed a temporary moratorium.

(11) *Prescribing authority.* (i) A physician or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration to dispense a controlled substance is currently suspended or revoked; or

(ii) The applicable licensing or administrative body for any State in which a physician or eligible professional practices has suspended or revoked the physician or eligible professional's ability to prescribe drugs, and such suspension or revocation is in effect on the date the physician or eligible professional submits his or her enrollment application to the Medicare contractor.

(b) *Resubmission after denial.* A provider or supplier that is denied enrollment in the Medicare program cannot submit a new enrollment application 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; 79 FR 29968, May 23, 2014]

§ 424.535 Revocation of enrollment 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