

claiming payment under the Medicare program.

- Within the last 10 years or more preceding enrollment or revalidation of enrollment, 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.

- Any felonies referred to in section 1128 of the Act.

Under section 1128(a) of the Act, the Secretary must exclude individuals or entities convicted of certain crimes, such as program-related crimes, crimes related to patient abuse or neglect, and conviction of a felony related to health care fraud or controlled substances. In addition, the Secretary has authority to exclude individuals and entities for other adverse actions including when an individual or entity is owned or controlled by a sanctioned or convicted individual, in accordance with section 1128(b)(8) of the Act.

In cases where the provider or supplier is not a convicted individual but, rather, has an ownership or management relationship with a convicted or excluded individual, that provider or supplier may also be subject to civil monetary penalties (section 1128A(a)(6) of the Act). In addition, we may deny or revoke billing privileges if such a relationship exists. However, the denial may be reversed if, within 30 days of the denial notification, the provider or supplier terminates its ownership or management relationship with the convicted or excluded individual or organization. We specifically invite further comments on our approach to treating convicted felons, and any impact that may have on access to care for Medicare beneficiaries.

We propose in § 424.530(a)(4) that we may deny enrollment if the provider or supplier has deliberately submitted false or misleading information on their CMS 855 to gain enrollment in the Medicare program. Offenders may be subject to fines or imprisonment, or both, in accordance with current law and regulation.

In § 424.530(a)(5) we propose possible denial of enrollment where there are repeated instances in which, upon onsite review or other reliable evidence, we do not find present those licensed medical professionals required under the Medicare statute or regulations to supervise treatment or provide Medicare covered services for Medicare patients; or we determine that the provider or supplier is not operational to furnish Medicare covered services or supplies.

As outlined in proposed § 424.530(b), if the denied provider or supplier

appeals the decision, and the denial is upheld, that provider or supplier may submit a new CMS 855 after we notify it that the original determination has been upheld. If the provider or supplier did not appeal the determination, it may submit a new CMS 855 when the time frame for appeal rights has lapsed. We are proposing this latter requirement to prevent administrative difficulties that might result in processing two enrollment forms if a new one is submitted during the time period when the provider or supplier may appeal an initial denial.

Medicare enrollment denials will impact the provider or supplier on a national scale. In proposed § 424.530(c), we state that when a provider or supplier is denied enrollment in Medicare, we will review 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.

H. Revocation of Enrollment and Billing Privileges from the Medicare Program

Revocation occurs when an enrolled provider or supplier's billing privileges are terminated. In proposed § 424.535, we outline the causes for revocation and what a provider or supplier would need to do to re-enroll in the Medicare program after revocation. In considering whether to revoke enrollment and billing privileges in the Medicare program, we would consider the severity of the offenses, mitigating circumstances, program and beneficiary risk if enrollment continued, possibility of corrective action plans, beneficiary access to care, and any other pertinent factors.

In general, we propose revocation criteria that are similar to our reasons for denial of initial Medicare program enrollment. In § 424.535(a)(1) we propose that a provider or supplier's enrollment and billing privileges may be revoked if, at any time, it is determined to be out of compliance with the Medicare enrollment requirements outlined in subpart P including failure to report changes to enrollment information timely or failure to adhere to corrective action plans, and has not corrected the problem within 30 days of notice of non-compliance or submitted a plan of corrective action as cited earlier. We are providing that we 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. If requested

documentation as required by CMS under this or other statutory or regulatory authority is not submitted within 30 calendar days of our request, we would immediately begin revocation proceedings. If the documentation is received timely, we would review and verify the information to determine if we should proceed with the revocation. Providers requiring State survey and certification would continue to receive payment during the data verification review under current regulations found at Part 488 and under section 1819(h)(2)(c) of the Act. Providers and suppliers not subject to State survey and certification may have its payments suspended during the data review.

We are also proposing that we may revoke a provider or supplier's billing privileges if the provider or supplier establishes:

- Repeated instances in which, upon onsite review or other reliable evidence, we do not find present those licensed medical professionals required under the Medicare statute or regulation to supervise treatment of, or to provide Medicare covered service for, Medicare patients. Additional proposed reasons that may result in the revocation of billing privileges in § 424.535(a) include the following:

- In accordance with section 1862(e)(1) and (2) of the Act, the provider or supplier, any owner, managing employee, authorized or delegated official, supervising physician or other health care personnel who must be reported on the CMS 855 (for example, ambulance crew member), of the provider or supplier, becomes excluded from the Medicare, Medicaid or any other Federal health care programs, as defined in § 1001.2, in accordance with section 1128 or 1156 of the Act, or is debarred, suspended or otherwise by any Federal health care program or agency.

- The provider or supplier, or any owner of the provider or supplier, is convicted of a Federal or State felony offense that we determine to be detrimental to the best interests of the program as outlined in "Denial of Enrollment" above.

- The provider or supplier certified as "true" deliberately submitted false or misleading information on the CMS 855 in order to enroll or maintain enrollment in the Medicare program. (Offenders may be subject to criminal or civil prosecution, in accordance with current laws and regulations).

- Upon onsite review, we determine that the provider or supplier is no longer operational to furnish Medicare covered services or supplies.