

the HHS Common Rule at 45 CFR part 76.

(b) *Reporting requirements.* Following enrollment, a provider or supplier must report to CMS any changes to the information furnished on the CMS 855 or supporting documentation within 90 calendar days of the change, with the exception of changes in ownership or control of the provider or supplier which must be reported within 30 calendar days. Failure to do so may result in the deactivation or revocation of the provider or supplier's Medicare billing number.

§ 424.525 Rejection of a provider or supplier's CMS 855 for Medicare Enrollment

(a) *Reasons for rejection.* CMS rejects a provider or supplier's CMS 855 for the following reasons:

(1) The provider or supplier fails to furnish complete information within 60 calendar days of CMS's request for the information as required.

(2) The provider or supplier fails to furnish supporting documentation within 60 calendar days of CMS's request for the documentation as required.

(b) *Extension of 60-day period.* CMS will not reject any provider or supplier enrollment application if the provider or supplier is actively communicating with CMS to resolve any issues regardless of the length of time it takes to resolve those issues.

(c) *Resubmission after rejection.* To enroll in Medicare and obtain a Medicare billing number and billing privileges after notification of a rejected CMS 855, the provider or supplier must complete and submit a new CMS 855 and all applicable documentation for CMS review and approval.

§ 424.530 Denial of enrollment.

(a) *Reasons for denial.* CMS may deny a provider 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 the CMS 855 enrollment form applicable 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 and under section 1819(h)(2)(c) of the Act.

(2) *Provider or supplier conduct.* The provider or supplier, or any owner, managing employee, or an authorized or delegated official; or any medical director, supervising physician, or other health care personnel furnishing Medicare reimbursable services who is required to be reported on the CMS 855,

in accordance with section 1862(e)(1) of the Act,—

(i) Is excluded from the Medicare, Medicaid and any other Federal health care programs, as defined in § 1001.2 of this title, in accordance with section 1128 or 1156 of the Act; or

(ii) Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or non-procurement activity in accordance with FASA section 2455; or

(3) *Felonies.* The provider, supplier, or any owner of the provider or supplier, has been 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. The conviction must have occurred within the last 10 years or more and CMS will consider the severity of the underlying offense.

(i) Offenses include—

(A) Felony crimes against persons (such as rape, murder, or assault) and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial 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 pre-trial 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 CMS 855 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) *Onsite review.* Upon onsite review or other reliable evidence—

(i) There are repeated instances in which we do not find present or available those medical professionals required under the Medicare statute and regulations to supervise treatment of, or provide Medicare covered services for, Medicare patients; or

(ii) We determine that the provider or supplier is not operational to furnish Medicare covered services.

(b) *Resubmission after denial.* A provider or supplier that is denied enrollment in the Medicare program must not submit a new CMS 855 until the following has occurred:

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

(2) If the denial was appealed, the provider or supplier may reapply after CMS notification that the original determination has been upheld.

(c) *Reversal of denial.* If the denial was due to adverse activity (sanction, exclusion, debt, felony) of an owner, managing employee, or an authorized or delegated official; or of a 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.

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

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

(1) Non-compliance. The provider or supplier, at any time is determined not to be in compliance with the enrollment requirements described in the CMS 855 enrollment form applicable to its provider or supplier type and has not submitted a plan of corrective action as outlined in part 488 of this chapter and under section 1819(h)(2)(C) of the Act. All providers and suppliers will be granted an opportunity to correct the deficient compliance requirement prior to a final determination to revoke billing privileges.

(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.