

(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 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 nonprocurement program or activity in accordance with the Federal Acquisition Streamlining Act 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, 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 certified as “true” false or misleading information on the CMS 855 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) *Onsite review.* CMS determines, upon onsite review, that the provider or supplier is no longer operational to furnish Medicare covered services or supplies, or we do not find present or available those professionals required under Medicare statute or regulation to supervise treatment of, or to provide Medicare covered services for, Medicare patients.

(6) *Inadequate re-verification information.* The provider or supplier fails to furnish complete and accurate information and any applicable documentation within 60 calendar days of the provider or supplier's notification from CMS to resubmit and certify to the accuracy of its enrollment information.

(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 outlined in § 424.80.

(b) *Effect of revocation on provider agreements.* When a provider's or supplier's billing privilege has been revoked, any provider agreement in effect at the time of revocation will be terminated effective with the date of revocation.

(c) *Re-enrollment after revocation.* If a provider or supplier seeks to re-establish enrollment in the Medicare program after notification that its billing number and billing privileges have been 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 re-enroll in the Medicare program through the completion and submission of a new applicable CMS 855 and applicable documentation, as a new provider or supplier, for validation by CMS.

(2) Providers must be re-surveyed and/or re-certified by the State Survey Agency as a new provider and must establish a new provider agreement with CMS's Regional Office.

(d) *Reversal of revocation.* If the revocation was due to adverse activity (sanction, exclusion, debt, 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.

(e) *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.

#### **§ 424.540 Deactivation of Medicare billing privileges.**

(a) *Reasons for deactivation.* CMS deactivates a provider or supplier's Medicare billing privileges for the following reasons:

(1) The provider or supplier does not submit any Medicare claims for two consecutive calendar quarters (6 months), unless current policy or regulations specify otherwise for your provider or supplier type.

(2) The provider or supplier does not report a change to the information supplied on its CMS 855 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 stated in §§ 424.520(b) and 424.550(b).

(b) *Reactivation of billing privileges.* The provider or supplier must either complete and submit a new CMS 855 to reactivate its Medicare billing number and billing privileges or, at a minimum, re-certify that the enrollment information currently on file with Medicare is correct. 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. Reactivation of a Medicare billing number does not require a new survey and certification of the provider or supplier by the State Survey Agency or the establishment of a new provider agreement.

(c) *Effect of deactivation.* Deactivation of Medicare billing privileges is considered a temporary action to protect the provider or supplier from misuse of Medicare billing numbers and to protect the Medicare trust fund from unnecessary overpayments. The temporary deactivation of a Medicare billing number will not have any effect on a provider or supplier's participation agreement or any conditions of participation.