(i) Length of the relationship.
(ii) Type of relationship.
(iii) Degree of affiliation.
(4) If the affiliation has ended, the reason for the termination.

(d) *Mechanism.* The information required to be disclosed under paragraphs (b) and (c) of this section must be furnished to CMS or its contractors via the Form CMS–855 application (paper or the internet-based PECOS enrollment process).

(e) *Denial or revocation.* The failure of the provider or supplier to fully and completely disclose the information specified in paragraphs (b) and (c) of this section when the provider or supplier knew or should reasonably have known of this information may result in either of the following:

(1) The denial of the provider's or supplier's initial enrollment application under §424.530(a)(1) and, if applicable, §424.530(a)(4).

(2) The revocation of the provider's or supplier's Medicare enrollment under §424.535(a)(1) and, if applicable, §424.535(a)(4).

(f) *Undue risk.* Upon receiving the information described in paragraphs (b) and (c) of this section, CMS determines whether any of the disclosed affiliations poses an undue risk of fraud, waste, or abuse by considering the following factors:

(1) The duration of the affiliation.
(2) Whether the affiliation still exists and, if not, how long ago it ended.
(3) The degree and extent of the affiliation.
(4) If applicable, the reason for the termination of the affiliation.
(5) Regarding the affiliated provider's or supplier's disclosable event under paragraph (b) of this section:
(i) The type of disclosable event.
(ii) When the disclosable event occurred or was imposed.
(iii) Whether the affiliation existed when the disclosable event occurred or was imposed.
(iv) If the disclosable event is an uncollected debt:
(A) The amount of the debt.
(B) Whether the affiliated provider or supplier is repaying the debt.
(C) To whom the debt is owed.
(v) If a denial, revocation, termination, exclusion, or payment suspension is involved, the reason for the disclosable event.
(6) Any other evidence that CMS deems relevant to its determination.

(g) *Determination of undue risk.* A determination by CMS that a particular affiliation poses an undue risk of fraud, waste, or abuse will result in, as applicable, the denial of the provider's or supplier's initial enrollment application under §424.530(a)(13) or the revocation of the provider's or supplier's Medicare enrollment under §424.535(a)(19).

(h) *Duplicate data.* A provider or supplier is not required to report affiliation data in that portion of the Form CMS–855 application that collects affiliation information if the same data is being reported in the ''owning or managing control'' (or its successor) section of the Form CMS–855 application.

(i) *Undisclosed affiliations.* CMS may apply §424.530(a)(13) or §424.535(a)(19) to situations where a disclosable affiliation (as described in §424.519(b) and (c)) poses an undue risk of fraud, waste or abuse, but the provider or supplier has not yet reported or is not required at that time to report the affiliation to CMS.

[84 FR 47853, Sept. 10, 2019]

§424.520 Effective date of Medicare billing privileges.

(a) *Surveyed, certified or accredited providers and suppliers.* The effective date for billing privileges for providers and suppliers requiring State survey, certification or accreditation is specified in §489.13 of this chapter. If a provider or supplier is seeking accreditation from a CMS-approved accreditation organization, the effective date is specified in §489.13.

(b) *Independent Diagnostic Testing Facilities.* The effective date for billing privileges for IDTFs is specified in §410.33(i) of this chapter.

(c) *DMEPOS suppliers.* The effective date for billing privileges for DMEPOS suppliers is specified in §424.57(b) of this subpart and section 1834(j)(1)(A) of the Act.

(d) *Physicians, non-physician practitioners, physician and non-physician practitioner organizations, ambulance suppliers, and opioid treatment programs.*

The effective date for billing privileges for physicians, non-physician practitioners, physician and non-physician practitioner organizations, ambulance suppliers, and opioid treatment programs is the later of—

(1) The date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or

(2) The date that the supplier first began furnishing services at a new practice location.

[73 FR 69940, Nov. 19, 2008, as amended at 75 FR 50418, Aug. 16, 2010; 79 FR 72531, Dec. 5, 2014; 84 FR 63203, Nov. 15, 2019]

§ 424.521 Request for payment by physicians, non-physician practitioners, physician and non-physician organizations, ambulance suppliers, and opioid treatment programs.

(a) Physicians, non-physician practitioners, physician and non-physician practitioner organizations, ambulance suppliers, and opioid treatment programs may retrospectively bill for services when the physician, non-physician practitioner, physician or non-physician organization, ambulance supplier, or opioid treatment program has met all program requirements, including State licensure requirements, and services were provided at the enrolled practice location for up to—

(1) Thirty days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries; or

(2) Ninety days prior to their effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121–5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

(b) [Reserved]

[79 FR 72531, Dec. 5, 2014, as amended at 84 FR 63203, Nov. 15, 2019]

§ 424.525 Rejection of a provider or supplier's enrollment application for Medicare enrollment.

(a) *Reasons for rejection.* CMS may reject a provider's or supplier's enrollment application for any of the following reasons:

(1) The prospective provider or supplier fails to furnish complete information on the provider/supplier enrollment application within 30 calendar days from the date of the contractor request for the missing information.

(2) The prospective provider or supplier fails to furnish all required supporting documentation within 30 calendar days of submitting the enrollment application.

(3) The prospective institutional provider or supplier does not submit the application fee in the designated amount or a hardship waiver request with the Medicare enrollment application at the time of filing.

(b) *Extension of 30-day period.* CMS, at its discretion, may choose to extend the 30 day period if CMS determines 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) *Noncompliance.* The provider or supplier is determined to not be in compliance with the enrollment requirements in this subpart P 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.

(2) *Provider or supplier conduct.* A provider, supplier, an owner, managing employee, an authorized or delegated official, medical director, supervising