

(vi) For revocations based on termination from a Federal health care program other than Medicare (for example, Medicaid), the date of the termination.

(vii) For revocations based on termination of a provider agreement under part 489 of this chapter, and as applicable to the type of provider involved, the later of the following:

(A) The date of the provider agreement termination; or

(B) The date that CMS establishes under § 489.55.

(viii) For revocations based on § 424.535(a)(23), the effective dates are as follows:

(A) If the standard or condition violation involves the suspension, revocation, or termination (or surrender in lieu of further disciplinary action) of the provider's or supplier's Federal or State license, certification, accreditation, or MDPP recognition, the effective date is the date of the license, certification, accreditation, or MDPP recognition suspension, revocation, termination, or surrender.

(B) If the standard or condition violation involves a non-operational practice location, the effective date is the date the non-operational status began.

(C) If the standard violation involves a felony conviction of an individual or entity described in § 424.67(b)(6)(i), the effective date is the date of the felony conviction.

(D) For all standard violations not addressed in paragraphs (A) through (C), the effective date in paragraph (g)(1) applies if the effective date in paragraph (g)(3) does not.

(3) If the action that resulted in the revocation occurred prior to the effective date of the provider's or supplier's enrollment, the effective date of the revocation is the same as the effective date of enrollment.

(h) *Submission of claims for services furnished before revocation.* (1)(i) Except for HHAs as described in paragraph (h)(1)(ii) of this section, a revoked provider or supplier must, within 60 calendar days after the effective date of revocation, submit all claims for items and services furnished before the date of the revocation letter.

(ii) A revoked HHA must submit all claims for items and services within 60 days after the later of the following:

(A) The effective date of the revocation.

(B) The date that the HHA's last payable episode ends.

(2) Nothing in this paragraph (h) impacts the requirements of § 424.44 regarding the timely filing of claims.

(i) *Extension of revocation.* (1) If a provider's or supplier's Medicare enrollment is revoked under paragraph (a) of this section, CMS may revoke any and all of the provider's or supplier's Medicare enrollments, including those under different names, numerical identifiers or business identities and those under different types.

(2) In determining whether to revoke a provider's or supplier's other enrollments under this paragraph (i), CMS considers the following factors:

(i) The reason for the revocation and the facts of the case.

(ii) Whether any final adverse actions have been imposed against the provider or supplier regarding its other enrollments.

(iii) The number and type(s) of other enrollments.

(iv) Any other information that CMS deems relevant to its determination.

(j) *Voluntary termination.* (1) CMS may revoke a provider's or supplier's Medicare enrollment if CMS determines that the provider or supplier voluntarily terminated its Medicare enrollment in order to avoid a revocation under paragraph (a) of this section that CMS would have imposed had the provider or supplier remained enrolled in Medicare. In making its determination, CMS considers the following factors:

(i) Whether there is evidence to suggest that the provider knew or should have known that it was or would be out of compliance with Medicare requirements.

(ii) Whether there is evidence to suggest that the provider knew or should have known that its Medicare enrollment would be revoked.

(iii) Whether there is evidence to suggest that the provider voluntarily terminated its Medicare enrollment in order to circumvent such revocation.

(iv) Any other evidence or information that CMS deems relevant to its determination.

(2) A revocation under paragraph (j)(1) of this section is effective the day before the Medicare contractor receives the provider's or supplier's Form CMS-855 voluntary termination application.

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

(a) *Reasons for deactivation.* CMS may deactivate the Medicare billing privileges of a provider or supplier for any of the following reasons:

(1) The provider or supplier does not submit any Medicare claims for 6 consecutive calendar months. The 6 month period will begin the 1st day of the 1st month without a claims submission through the last day of the 6th month without a submitted claim.

(2) The provider or supplier does not report a change to the information supplied on the enrollment application within the applicable time period required under this title.

(3) The provider or supplier does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information.

(4) The provider or supplier is not in compliance with all enrollment requirements in this title.

(5) The provider's or supplier's practice location is non-operational or otherwise invalid.

(6) The provider or supplier is deceased.

(7) The provider or supplier is voluntarily withdrawing from Medicare.

(8) The provider is the seller in an HHA change of ownership under § 424.550(b)(1).

(b) *Reactivation of billing privileges.*

(1) In order for a deactivated provider or supplier to reactivate its Medicare billing privileges, the provider or supplier must recertify that its enrollment information currently on file with Medicare is correct, furnish any missing information as appropriate, and be in compliance with all applicable enrollment requirements in this title.

(2) Notwithstanding paragraph (b)(1) of this section, CMS may, for any reason, require a deactivated provider or supplier to, as a prerequisite for reactivating its billing privileges, submit a complete Form CMS-855 application.

(3) Except as provided in paragraph (b)(3)(i) of this section, reactivation of Medicare billing privileges does not require a new certification of the provider or supplier by the State survey agency or the establishment of a new provider agreement.

(i) An HHA whose Medicare billing privileges are deactivated under the provisions found at paragraph (a) of this section must obtain an initial State survey or accreditation by an approved accreditation organization before its Medicare billing privileges can be reactivated.

(ii) [Reserved]

(c) *Effect of deactivation.* The deactivation of Medicare billing privileges does not have any effect on a provider's or supplier's participation agreement or any conditions of participation.

(d) *Effective dates.* (1)(i) Except as provided in paragraph (d)(1)(ii) of this section, the effective date of a deactivation is the date on which the deactivation is imposed under this section.

(ii) A retroactive deactivation effective date (based on the date that the provider's or supplier's action or non-compliance occurred or commenced (as applicable)) may be imposed in the following instances:

(A) For the deactivation reasons in paragraphs (a)(2) through (4) of this section, the effective date is the date on which the provider or supplier became non-compliant.

(B) For the deactivation reason in paragraph (a)(5) of this section, the effective date is the date on which the provider's or supplier's practice location became non-operational or otherwise invalid.