

may deactivate the Medicare billing number. If an incomplete enrollment application is submitted, CMS may also deactivate the Medicare billing number based upon material omissions on the submitted enrollment application, or based on preliminary information received or determined by CMS that makes CMS question whether the new owner is ultimately granted a final transference of the provider agreement.

(1) Unless an exception in paragraph (b)(2) of this section applies, if there is a change in majority ownership of a home health agency (HHA) or hospice by sale (including asset sales, stock transfers, mergers, and consolidations) within 36 months after the effective date of the HHA's or hospice's initial enrollment in Medicare or within 36 months after the HHA's or hospice's most recent change in majority ownership, the provider agreement and Medicare billing privileges do not convey to the new owner. The prospective provider/owner of the HHA or hospice must instead do both of the following:

(i) Enroll in the Medicare program as a new (initial) HHA or hospice under the provisions of § 424.510 of this subpart.

(ii) Obtain a State survey or an accreditation from an approved accreditation organization.

(2)(i) The HHA or hospice submitted 2 consecutive years of full cost reports since initial enrollment or the last change in majority ownership, whichever is later. For purposes of the exception in this paragraph (b)(2)(i), low utilization or no utilization cost reports do not qualify as full cost reports.

(ii) An HHA's or hospice's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation.

(iii) The owners of an existing HHA or hospice are changing the HHA's or hospice's existing business structure (for example, from a corporation to a partnership (general or limited); from an LLC to a corporation; from a partnership (general or limited) to an LLC) and the owners remain the same.

(iv) An individual owner of an HHA or hospice dies.

(c) *Suppliers not covered by part 489 of this chapter.* For those suppliers not covered by part 489 of this chapter, any

change in the ownership or control of that supplier must be reported on the enrollment application within 30 days of the change as noted in § 424.540(a)(2). Generally, a change of ownership that also changes the tax identification number requires the completion and submission of a new enrollment application from the new owner.

[71 FR 20776, Apr. 21, 2006, as amended at 74 FR 58134, Nov. 10, 2009; 75 FR 70465, Nov. 17, 2010; 75 FR 76293, Dec. 8, 2010; 86 FR 62421, Nov. 9, 2021; 88 FR 77878, Nov. 13, 2023]

#### § 424.555 Payment liability.

(a) No payment may be made for otherwise Medicare covered items or services furnished to a Medicare beneficiary by suppliers of durable medical equipment, prosthetics, orthotics, and other supplies unless the supplier obtains (and renews, as set forth in section 1834(j) of the Act) Medicare billing privileges.

(b) No payment may be made for otherwise Medicare covered items or services furnished to a Medicare beneficiary by a provider or supplier if the billing privileges of the provider or supplier are deactivated, denied, or revoked, or if the provider or supplier is currently under a stay of enrollment (except as stated in § 424.541(a)(2)(ii)(B)). The Medicare beneficiary has no financial responsibility for expenses, and the provider or supplier must refund on a timely basis to the Medicare beneficiary any amounts collected from the Medicare beneficiary for these otherwise Medicare covered items or services.

(c) If any provider or supplier furnishes an otherwise Medicare covered item or service for which payment may not be made by reason of paragraph (b) of this section, any expense incurred for such otherwise Medicare covered item or service shall be the responsibility of the provider or supplier. The provider or supplier may also be criminally liable for pursuing payments that may not be made by reason of paragraph (b) of this section, in accordance with section 1128B(a)(3) of the Act.

[71 FR 20776, Apr. 21, 2006, as amended at 88 FR 79543, Nov. 16, 2023]

**§ 424.565 Overpayment.**

A physician or nonphysician practitioner organization, physician or nonphysician practitioner that does not comply with the reporting requirements specified in § 424.516(d)(1)(ii) and (iii) of this subpart is assessed an overpayment back to the date of the final adverse action or change in practice location. Overpayments are processed in accordance with part 405 subpart C of this chapter.

[73 FR 69941, Nov. 19, 2008]

**§ 424.570 Moratoria on newly enrolling Medicare providers and suppliers.**

(a) *Temporary moratoria*—(1) *General rules.* (i) CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area.

(ii) CMS will announce the temporary enrollment moratorium in a FEDERAL REGISTER document that includes the rationale for imposition of the temporary enrollment moratorium.

(iii) The temporary moratorium does not apply to any of the following:

(A) Changes in practice location (except if the location is changing from a location outside the moratorium area to a location inside the moratorium area).

(B) Changes in provider or supplier information, such as phone numbers.

(C) Changes in ownership (except changes in ownership of home health agencies that would require an initial enrollment).

(iv) A temporary moratorium does not apply to any enrollment application that has been received by the Medicare contractor prior to the date the moratorium is imposed.

(2) *Imposition of a temporary moratoria.* CMS may impose the temporary moratorium if—

(i) CMS determines that there is a significant potential for fraud, waste or abuse with respect to a particular provider or supplier type or particular geographic area or both. CMS's determination is based on its review of existing data, and without limitation, identifies a trend that appears to be as-

sociated with a high risk of fraud, waste or abuse, such as a—

(A) Highly disproportionate number of providers or suppliers in a category relative to the number of beneficiaries; or

(B) Rapid increase in enrollment applications within a category;

(ii) A State Medicaid program has imposed a moratorium on a group of Medicaid providers or suppliers that are also eligible to enroll in the Medicare program;

(iii) A State has imposed a moratorium on enrollment in a particular geographic area or on a particular provider or supplier type or both; or

(iv) CMS, in consultation the HHS OIG or the Department of Justice or both and with the approval of the CMS Administrator identifies either or both of the following as having a significant potential for fraud, waste or abuse in the Medicare program:

(A) A particular provider or supplier type.

(B) Any particular geographic area.

(b) *Duration of moratoria.* A moratorium under this section may be imposed for a period of 6 months and, if deemed necessary by CMS, may be extended in 6-month increments. CMS will publish a document in the FEDERAL REGISTER when it extends a moratorium.

(c) *Denial of enrollment: Moratoria.* A Medicare contractor denies the enrollment application of a provider or supplier if the provider or supplier is subject to a moratorium as specified in paragraph (a) of this section.

(d) *Lifting moratoria.* CMS will publish a document in the FEDERAL REGISTER when a moratorium is lifted. CMS may lift a temporary moratorium at any time after imposition of the moratorium if one of the following occur:

(1) The President declares an area a disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121–5206 (Stafford Act).

(2) Circumstances warranting the imposition of a moratorium have abated or CMS has implemented program safeguards to address the program vulnerability.

(3) The Secretary has declared a public health emergency under section 319