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FACT SHEET

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Period of Enhanced Oversight for New Hospices in Arizona, California, Nevada, & Texas

CMS is placing **newly enrolling** hospices located in Arizona, California, Nevada, and Texas in a provisional period of enhanced oversight. Over the last 12 months, we've received numerous reports of hospice fraud, waste, and abuse. The number of enrolled hospices has also increased significantly in these states, raising serious concerns about market oversaturation.

What's the Goal?

The goal of enhanced oversight is to reduce hospice fraud, waste, and abuse.

Am I Considered a New Hospice?

For the period of enhanced oversight, new hospices include those:

- Newly enrolling in the Medicare Program (starting July 13, 2023)
- Submitting a change of ownership (CHOW) that meets all the regulatory requirements under 42 CFR 489.18
- Undergoing a 100% ownership change that doesn't fall under 42 CFR 489.18

Does This Affect Me?

You may be affected if you:

- Got final approval for Medicare enrollment on or after July 13, 2023
- Started the enrollment or certification process before July 13, 2023, but haven't received a final approval letter from your Medicare Administrative Contractor (MAC)
- Got approval on a change of ownership request on or after July 13, 2023

What Type of Enhanced Oversight Will You Perform?

The provisional period of enhanced oversight will include medical review such as prepayment review.

How Will You Notify Me?

If we're placing you in a period of enhanced oversight, we'll mail a letter to the correspondence address on file in PECOS. It will include:

- Effective date of the enhanced oversight period.
- Duration of the enhanced oversight period.
- Notice that we may do a medical review of all your claims. If you don't respond to our requests, we may deny claims or revoke your Medicare enrollment.

When Does the Period of Enhanced Oversight Start?

The period of enhanced oversight is effective starting July 13, 2023.

Will Every Hospice in the Period of Enhanced Oversight Have the Same Start Date?

No. Each hospice will have an individual effective date—on or after July 13, 2023—in their final approval letter related to their recent enrollment application.

How Long Will a Hospice Stay in the Period of Enhanced Oversight?

The period of enhanced oversight can be 30 days – 1 year.

Can You Perform Medical Review on a Hospice That's No Longer in the Period of Enhanced Oversight?

Yes. We can conduct medical review after the provisional period of enhanced oversight has ended under Section 1833(e) of the Social Security Act.

Where Can I Get More Information?

If you have questions, email ProvisionalPeriod@cms.hhs.gov.

For more information on the policy, visit:

- Revocation of Enrollment in the Medicare Program
- Section1866(j)(3) Social Security Act

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This content is from the eCFR and is authoritative but unofficial.

Title 42 —Public Health

Chapter IV —Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter G —Standards and Certification

Part 489 —Provider Agreements and Supplier Approval

Subpart A —General Provisions

Authority: 42 U.S.C. 1302, 1395i–3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh.

Source: 45 FR 22937, Apr. 4, 1980, unless otherwise noted.

§ 489.18 Change of ownership or leasing: Effect on provider agreement.

(a) *What constitutes change of ownership* —

(1) *Partnership.* In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law, constitutes change of ownership.

(2) *Unincorporated sole proprietorship.* Transfer of title and property to another party constitutes change of ownership.

(3) *Corporation.* The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation constitutes change of ownership. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change of ownership.

(4) *Leasing.* The lease of all or part of a provider facility constitutes change of ownership of the leased portion.

(b) *Notice to CMS.* A provider who is contemplating or negotiating a change of ownership must notify CMS.

(c) *Assignment of agreement.* When there is a change of ownership as specified in paragraph (a) of this section, the existing provider agreement will automatically be assigned to the new owner.

(d) *Conditions that apply to assigned agreements.* An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued including, but not limited to, the following:

(1) Any existing plan of correction.

(2) Compliance with applicable health and safety standards.

(3) Compliance with the ownership and financial interest disclosure requirements of part 420, subpart C, of this chapter.

(4) Compliance with civil rights requirements set forth in 45 CFR parts 80, 84, and 90.

(e) *Effect of leasing.* The provider agreement will be assigned to the lessee only to the extent of the leased portion of the facility.

[45 FR 22937, Apr. 4, 1980, as amended at 59 FR 56251, Nov. 10, 1994]

This content is from the eCFR and is authoritative but unofficial.

Title 42 —Public Health
Chapter IV —Centers for Medicare & Medicaid Services, Department of Health and Human Services
Subchapter B —Medicare Program
Part 424 —Conditions for Medicare Payment
Subpart P —Requirements for Establishing and Maintaining Medicare Billing Privileges

Source: 71 FR 20776, Apr. 21, 2006, unless otherwise noted.
Authority: 42 U.S.C. 1302 and 1395hh.
Source: 53 FR 6634, Mar. 2, 1988, unless otherwise noted.

§ 424.535 Revocation of enrollment in the Medicare program.

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

(1) ***Noncompliance.*** The provider or supplier is determined to not be in compliance with the enrollment requirements described 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. The provider or supplier may also be determined not to be in compliance if it has failed to pay any user fees as assessed under part 488 of this chapter.

(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.

(ii) Requested additional documentation must be submitted within 60 calendar days of request.

(2) ***Provider or supplier conduct.***

(i) The provider or supplier, or any owner, managing employee, managing organization, officer, director, authorized or delegated official, medical director, supervising physician, or other health care or administrative or management services personnel furnishing services payable by a Federal health care program, of the provider or supplier is—

(A) Excluded from the Medicare, Medicaid, and any other Federal health care program, as defined in § 1001.2 of this chapter, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Act.

(B) Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement activity in accordance with the FASA implementing regulations and the Department of Health and Human Services nonprocurement common rule at 45 CFR part 76.

(ii) The individuals and organizations identified in paragraph (a)(2)(i) of this section include, but are not limited to, W–2 employees and contracted individuals and organizations of the provider or supplier.

(3) ***Felonies.***

(i) The provider, supplier, or any owner, managing employee, managing organization, officer, or director of the provider or supplier was, within the preceding 10 years, convicted (as that term is defined in 42 CFR 1001.2) of a Federal or State felony offense that CMS determines is detrimental to the best interests of the Medicare program and its beneficiaries.

(ii) Offenses include, but are not limited in scope or severity to—

(A) Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial 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 pretrial 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 that would result in mandatory exclusion under section 1128(a) of the Act.

(iii) Revocations 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.

(iv) The individuals and organizations identified in paragraph (a)(3) of this section include, but are not limited to, W–2 employees and contracted individuals and organizations of the provider or supplier.

(4) ***False or misleading information.*** The provider or supplier certified as "true" misleading or false information on the enrollment application 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) ***On-site review.*** Upon on-site review or other reliable evidence, CMS determines that the provider or supplier is either of the following:

(i) No longer operational to furnish Medicare-covered items or services.

(ii) Otherwise fails to satisfy any Medicare enrollment requirement.

(6) ***Grounds related to provider and supplier screening requirements.***

(i)

(A) An institutional provider does not submit an application fee or hardship exception request that meets the requirements set forth in § 424.514 with the Medicare revalidation application; or

(B) The hardship exception is not granted and the institutional provider does not submit the applicable application form or application fee within 30 days of being notified that the hardship exception request was denied.

(ii)

(A) Either of the following occurs:

(*1*) CMS is not able to deposit the full application amount into a government-owned account.

(*2*) The funds are not able to be credited to the U.S. Treasury.

(B) The provider or supplier lacks sufficient funds in the account at the banking institution whose name is imprinted on the check or other banking instrument to pay the application fee; or

(C) There is any other reason why CMS or its Medicare contractor is unable to deposit the application fee into a government-owned account.

(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 specified in § 424.80 or a change of ownership as outlined in § 489.18 of this chapter.

(8) ***Abuse of billing privileges.*** Abuse of billing privileges includes either of the following:

(i) The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to the following situations:

(A) Where the beneficiary is deceased.

(B) The directing physician or beneficiary is not in the state or country when services were furnished.

(C) When the equipment necessary for testing is not present where the testing is said to have occurred.

(ii) CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements. In making this determination, CMS considers, as appropriate or applicable, the following:

(A) The percentage of submitted claims that were denied during the period under consideration.

(B) Whether the provider or supplier has any history of final adverse actions and the nature of any such actions.

(C) The type of billing non-compliance and the specific facts surrounding said non-compliance (to the extent this can be determined).

(D) Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination.

(9) ***Failure to report.*** The provider or supplier did not comply with the reporting requirements specified in § 424.516(d) or (e), § 410.33(g)(2) of this chapter, or § 424.57(c)(2). In determining whether a revocation under this paragraph (a)(9) is appropriate, CMS considers the following factors:

(i) Whether the data in question was reported.

(ii) If the data was reported, how belatedly.

(iii) The materiality of the data in question.

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

(10) ***Failure to document or provide CMS access to documentation.***

(i) The provider or supplier did not comply with the documentation or CMS access requirements specified in § 424.516(f) of this subpart.

(ii) A provider or supplier that meets the revocation criteria specified in paragraph (a)(10)(i) of this section, is subject to revocation for a period of not more than 1 year for each act of noncompliance.

(11) ***Initial reserve operating funds.*** CMS or its designated Medicare contractor may revoke the Medicare billing privileges of an HHA and the corresponding provider agreement if, within 30 days of a CMS or Medicare contractor request, the HHA cannot furnish supporting documentation verifying that the HHA meets the initial reserve operating funds requirement found in 42 CFR 489.28(a).

(12) ***Other program termination.***

(i) The provider or supplier is terminated, revoked or otherwise barred from participation in a State Medicaid program or any other federal health care program. In determining whether a revocation under this paragraph (a)(12) is appropriate, CMS considers the following factors:

(A) The reason(s) for the termination or revocation.

(B) Whether the provider or supplier is currently terminated, revoked or otherwise barred from more than one program (for example, more than one State's Medicaid program) or has been subject to any other sanctions during its participation in other programs.

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

(ii) Medicare may not revoke unless and until a provider or supplier has exhausted all applicable appeal rights or the timeframe for filing an appeal has expired without the provider or supplier filing an appeal.

(iii) CMS may apply paragraph (a)(12)(i) of this section to the provider or supplier under any of its current or former names, numerical identifiers or business identities.

(13) ***Prescribing authority.***

(i) A physician or other eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration to dispense a controlled substance is currently suspended or revoked or is surrendered in response to an order to show cause;

(ii) The applicable licensing or administrative body for any state in which the physician or eligible professional practices suspends or revokes the physician or eligible professional's ability to prescribe drugs.

(14) ***Improper prescribing practices.*** CMS determines that the physician or eligible professional has a pattern or practice of prescribing Part B or D drugs that falls into one of the following categories:

(i) The pattern or practice is abusive or represents a threat to the health and safety of Medicare beneficiaries or both. In making this determination, CMS considers the following factors:

(A) Whether there are diagnoses to support the indications for which the drugs were prescribed.

(B) Whether there are instances when the necessary evaluation of the patient for whom the drug was prescribed could not have occurred (for example, the patient was deceased or out of state at the time of the alleged office visit).

(C) Whether the physician or eligible professional has prescribed controlled substances in excessive dosages that are linked to patient overdoses.

(D) The number and type(s) of disciplinary actions taken against the physician or eligible professional by the licensing body or medical board for the State or States in which he or she practices, and the reason(s) for the action(s).

(E) Whether the physician or eligible professional has any history of "final adverse actions" (as that term is defined in § 424.502).

(F) The number and type(s) of malpractice suits that have been filed against the physician or eligible professional related to prescribing that have resulted in a final judgment against the physician or eligible professional or in which the physician or eligible professional has paid a settlement to the plaintiff(s) (to the extent this can be determined).

(G) Whether any State Medicaid program or any other public or private health insurance program has restricted, suspended, revoked, or terminated the physician or eligible professional's ability to prescribe medications, and the reason(s) for any such restriction, suspension, revocation, or termination.

(H) Any other relevant information provided to CMS.

(ii) The pattern or practice of prescribing fails to meet Medicare requirements. In making this determination, CMS considers the following factors:

(A) Whether the physician or eligible professional has a pattern or practice of prescribing without valid prescribing authority.

(B) Whether the physician or eligible professional has a pattern or practice of prescribing for controlled substances outside the scope of the prescriber's DEA registration.

(C) Whether the physician or eligible professional has a pattern or practice of prescribing drugs for indications that were not medically accepted—that is, for indications neither approved by the FDA nor medically accepted under section 1860D–2(e)(4) of the Act—and whether there is evidence that the physician or eligible professional acted in reckless disregard for the health and safety of the patient.

(15)–(16) [Reserved]

(17) ***Debt referred to the United States Department of Treasury.*** The provider or supplier has an existing debt that CMS appropriately refers to the United States Department of Treasury. In determining whether a revocation under this paragraph (a)(17) is appropriate, CMS considers the following factors:

(i) The reason(s) for the failure to fully repay the debt (to the extent this can be determined).

(ii) Whether the provider or supplier has attempted to repay the debt (to the extent this can be determined).

(iii) Whether the provider or supplier has responded to CMS' requests for payment (to the extent this can be determined).

(iv) Whether the provider or supplier has any history of final adverse actions or Medicare or Medicaid payment suspensions.

(v) The amount of the debt.

(vi) Any other evidence that CMS deems relevant to its determination.

(18) ***Revoked under different name, numerical identifier or business identity.*** The provider or supplier is currently revoked under a different name, numerical identifier, or business identity, and the applicable reenrollment bar period has not expired. In determining whether a provider or supplier is a currently revoked provider or supplier under a different name, numerical identifier, or business identity, CMS investigates the degree of commonality by considering the following factors:

(i) Owning and managing employees and organizations (regardless of whether they have been disclosed on the Form CMS–855 application).

(ii) Geographic location.

(iii) Provider or supplier type.

(iv) Business structure.

(v) Any evidence indicating that the two parties are similar or that the provider or supplier was created to circumvent the revocation or reenrollment bar.

(19) ***Affiliation that poses an undue risk.*** CMS determines that the provider or supplier has or has had an affiliation under § 424.519 that poses an undue risk of fraud, waste, or abuse to the Medicare program.

(20) ***Billing from non-compliant location.*** CMS may revoke a provider's or supplier's Medicare enrollment or enrollments, even if all of the practice locations associated with a particular enrollment comply with Medicare enrollment requirements, if the provider or supplier billed for services performed at or items furnished from a location that it knew or should have known did not comply with Medicare enrollment requirements. In determining whether and how many of the provider's or supplier's enrollments, involving the non-compliant location or other locations, should be revoked, CMS considers the following factors:

(i) The reason(s) for and the specific facts behind the location's non-compliance.

(ii) The number of additional locations involved.

(iii) Whether the provider or supplier has any history of final adverse actions or Medicare or Medicaid payment suspensions.

(iv) The degree of risk that the location's continuance poses to the Medicare Trust Funds.

(v) The length of time that the non-compliant location was non-compliant.

(vi) The amount that was billed for services performed at or items furnished from the non-compliant location.

(vii) Any other evidence that CMS deems relevant to its determination.

(21) ***Abusive ordering, certifying, referring, or prescribing of Part A or B services, items or drugs.*** The physician or eligible professional has a pattern or practice of ordering, certifying, referring, or prescribing Medicare Part A or B services, items, or drugs that is abusive, represents a threat to the

health and safety of Medicare beneficiaries, or otherwise fails to meet Medicare requirements. In making its determination as to whether such a pattern or practice exists, CMS considers the following factors:

(i) Whether the physician's or eligible professional's diagnoses support the orders, certifications, referrals or prescriptions in question.

(ii) Whether there are instances where the necessary evaluation of the patient for whom the service, item or drug was ordered, certified, referred, or prescribed could not have occurred (for example, the patient was deceased or out of state at the time of the alleged office visit).

(iii) The number and type(s) of disciplinary actions taken against the physician or eligible professional by the licensing body or medical board for the state or states in which he or she practices, and the reason(s) for the action(s).

(iv) Whether the physician or eligible professional has any history of final adverse actions (as that term is defined in § 424.502).

(v) The length of time over which the pattern or practice has continued.

(vi) How long the physician or eligible professional has been enrolled in Medicare.

(vii) The number and type(s) of malpractice suits that have been filed against the physician or eligible professional related to ordering, certifying, referring or prescribing that have resulted in a final judgment against the physician or eligible professional or in which the physician or eligible professional has paid a settlement to the plaintiff(s) (to the extent this can be determined).

(viii) Whether any State Medicaid program or any other public or private health insurance program has restricted, suspended, revoked, or terminated the physician's or eligible professional's ability to practice medicine, and the reason(s) for any such restriction, suspension, revocation, or termination.

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

(22) ***Patient harm.***

(i) The physician or other eligible professional (as that term is defined in 1848(k)(3)(B) of the Act) has been subject to prior action from a State oversight board, Federal or State health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care with underlying facts reflecting improper physician or other eligible professional conduct that led to patient harm. In determining whether a revocation is appropriate, CMS considers the following factors:

(A) The nature of the patient harm.

(B) The nature of the physician's or other eligible professional's conduct.

(C) The number and type(s) of sanctions or disciplinary actions that have been imposed against the physician or other eligible professional by the State oversight board, IRO, Federal or State health care program, or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care. Such actions include, but are not limited to in scope or degree:

(*1*) License restriction(s) pertaining to certain procedures or practices.

(*2*) Required compliance appearances before State medical board members.

(*3*) License restriction(s) regarding the ability to treat certain types of patients (for example, cannot be alone with members of a different gender after a sexual offense charge).

(*4*) Administrative or monetary penalties.

(*5*) Formal reprimand(s).

(D) If applicable, the nature of the IRO determination(s).

(E) The number of patients impacted by the physician's or other eligible professional's conduct and the degree of harm thereto or impact upon.

(ii) Paragraph (a)(22)(i) of this section does not apply to actions or orders pertaining exclusively to either of the following:

(A) Required participation in rehabilitation or mental/behavioral health programs; or

(B) Required abstinence from drugs or alcohol and random drug testing.

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

(c) ***Reapplying after revocation.***

(1) After a provider or supplier has had their enrollment revoked, they are barred from participating in the Medicare program from the effective date of the revocation until the end of the reenrollment bar. The reenrollment bar—

(i) Begins 30 days after CMS or its contractor mails notice of the revocation and lasts a minimum of 1 year, but not greater than 10 years (except for the situations described in paragraphs (c)(2) and (3) of this section), depending on the severity of the basis for revocation.

(ii) Does not apply in the event a revocation of Medicare enrollment is imposed under paragraph (a)(1) of this section based upon a provider's or supplier's failure to respond timely to a revalidation request or other request for information.

(2)

(i) CMS may add up to 3 more years to the provider's or supplier's reenrollment bar (even if such period exceeds the 10-year period identified in paragraph (c)(1) of this section) if it determines that the provider or supplier is attempting to circumvent its existing reenrollment bar by enrolling in Medicare under a different name, numerical identifier or business identity.

(ii) A provider's or supplier's appeal rights regarding paragraph (c)(2)(i) of this section—

(A) Are governed by part 498 of this chapter; and

(B) Do not extend to the imposition of the original reenrollment bar under paragraph (c)(1) of this section; and

(C) Are limited to any additional years imposed under paragraph (c)(2)(i) of this section.

(3) CMS may impose a reenrollment bar of up to 20 years on a provider or supplier if the provider or supplier is being revoked from Medicare for the second time. In determining the length of the reenrollment bar under this paragraph (c)(3), CMS considers the following factors:

(i) The reasons for the revocations.

(ii) The length of time between the revocations.

(iii) Whether the provider or supplier has any history of final adverse actions (other than Medicare revocations) or Medicare or Medicaid payment suspensions.

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

(4) A reenrollment bar applies to a provider or supplier under any of its current, former or future names, numerical identifiers or business identities.

(d) ***Re-enrollment after revocation.*** If a provider or supplier seeks to re-establish enrollment in the Medicare program after notification that its billing privileges is 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 enrollment application and applicable documentation, as a new provider or supplier, for validation by CMS.

(2) Providers must be resurveyed and recertified by the State survey agency as a new provider and must establish a new provider agreement with CMS's Regional Office.

(e) ***Reversal of revocation.*** If the revocation was due to adverse activity (sanction, exclusion, or felony) against the provider's or supplier's owner, managing employee, managing organization, officer, director, authorized or delegated official, medical director, supervising physician, or other health care or administrative or management services personnel furnishing services payable by a Federal health care program, 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.

(f) ***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.

(g) ***Effective date of revocation.*** Revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier, except if the revocation is based on Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational. When a revocation is based on a Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational, the revocation is effective with the date of exclusion or debarment, felony conviction, license suspension or revocation or the date that CMS or its contractor determined that the provider or supplier was no longer operational.

(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.

[71 FR 20776, Apr. 21, 2006, as amended at 72 FR 53648, Sept. 19, 2007; 73 FR 36461, June 27, 2008; 73 FR 69940, Nov. 19, 2008; 75 FR 24449, May 5, 2010; 75 FR 70465, Nov. 17, 2010; 76 FR 5964, Feb. 2, 2011; 77 FR 25318, Apr. 27, 2012; 77 FR 29030, May 16, 2012; 79 FR 29968, May 23, 2014; 79 FR 72532, Dec. 5, 2014; 84 FR 47854, Sept. 10, 2019; 84 FR 63204, Nov. 15, 2019; 86 FR 65682, Nov. 19, 2021; 87 FR 70232, Nov. 18, 2022]