CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 684	**Date: November 1, 2016**
	Change Request 9628

Transmittal 666, dated August 5, 2016, is being rescinded and replaced by Transmittal 684, dated, November 1, 2016 to clarify the Medicare Administrative Contractors (MACs) required actions when deactivating a provider or supplier for non-response to revalidation. Changes have been made to the manual instruction in Pub. 100-08, 15.29.4.5 and business requirement 9628.11. All other information remains the same.

SUBJECT: Incorporation of Cycle 2 Revalidation Policies

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to incorporate various existing revalidation policies into Pub. 100-08, Program Integrity Manual (PIM), chapter 15.

EFFECTIVE DATE: December 2, 2106
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 2, 2106

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

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N	15.24.5.7 – Model Return Revalidation Letter
R	15.29.1 – Revalidation Lists
R	15.29.2 –Mailing Revalidation Letters
R	15.29.3.1 – Phone Calls
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R	15.29.4.1 – Revalidation Received and Development Required
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N	15.29.4.5 – Reassignment Applications Received After Revalidation Letter Mailed
R	15.29.5 – Revalidating Providers Involved in a Change of Ownership (CHOW)
R	15.29.7 – Large Group Revalidation Coordination

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15.29.8 – Finalizing the Revalidation Application
R	15.29.9 – Revalidation Reporting
R	15.29.10 - Revalidation Files Available Online
R	15.29.11/Revalidation Extension Requests

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-08	Transmittal: 684	Date: November 1, 2016	Change Request: 9628

Transmittal 666, dated August 5, 2016, is being rescinded and replaced by Transmittal 684, dated, November 1, 2016 to clarify the Medicare Administrative Contractors (MACs) required actions when deactivating a provider or supplier for non-response to revalidation. Changes have been made to the manual instruction in Pub. 100-08, 15.29.4.5 and business requirement 9628.11. All other information remains the same.

SUBJECT: Incorporation of Cycle 2 Revalidation Policies

EFFECTIVE DATE: 30 days from issuance
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: 30 days from issuance

I. GENERAL INFORMATION

A. Background: This CR is intended to formally incorporate into Pub. 100-08, PIM, chapter 15 various revalidation policies currently in effect. As these policies were previously established via business requirements, said business requirements are not being repeated in this CR.

B. Policy: This CR incorporates various existing revalidation policies into Pub. 100-08, PIM, chapter 15.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9628.1	MACs shall adhere to definitions of '*processed,*' '*receipt,*' '*reject/rejected*' in accordance with Pub. 100-08, chapter 15, section 15.1.1 for the purposes for inventory and timeliness reporting.	X	X	X						
9628.2	Revalidation Timeliness and Accuracy - The MACs shall process all revalidation applications in accordance with the timeliness and accuracy standards found in Pub. 100-08, chapter 15, section 15.6. Initial and revalidation timeliness shall be reported together. Likewise, initial and revalidation accuracy shall be reported together.	X	X	X						
9628.3	MACs shall return all revalidation applications received more than 6 months prior to the provider/suppliers established due date in accordance with the reasons for return found in Pub. 100-08,	X	X	X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	chapter 15, section 15.8.1. MACs shall also return any application fee submitted along with an unsolicited revalidation.									
9628.3.1	MACs shall not be required to return the application or supporting documentation. If the MAC chooses not to return the application or supporting documentation, the MAC shall update the return letter accordingly.	X	X	X						
9628.4	MACs shall use the revalidation letter templates in accordance with Pub. 100-08, chapter 15, section 15.24.5.	X	X	X						
9628.5	MACs shall adhere to revalidation policies in accordance with Pub. 100-08, chapter 15, section 15.29.	X	X	X						
9628.6	The initial revalidation letter may include a generic provider enrollment signature; however, all other letters (development, payment hold, deactivation, etc.) shall include a provider enrollment analyst's name and phone number for provider/supplier contacts.	X	X	X						
9628.7	When issuing revalidation notices to individual group members, MACs shall provide on the revalidation notice identifying information of the organization (s) (i.e., Legal Business Name (LBN), Doing Business As (DBA) name, Tax Identification Number) that the provider reassigns benefits in lieu of including the provider's Provider Transaction Numbers (PTANs). Individual group members may be more familiar with the LBN or DBA name of the organizations they are associated versus the PTANs. This should eliminate MACs developing for PTANs not included on the revalidation application.	X	X	X						
9628.8	MACs shall follow the processing instruction as follows; Any subunit that has a separate provider agreement (e.g., home health agency (HHA) subunits) must revalidate on a separate Form CMS-855A. It cannot revalidate via the main provider's Form CMS-855A. If the subunit has a separate CMS Certification Number (CCN) but not a separate provider agreement (e.g., hospital psychiatric unit, HHA branch), the revalidation can be disclosed on the main provider's Form CMS-855A. This is because the subunit is a practice location of the main provider and not a	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	separately enrolled entity. Separate fees are not required.									
9628.9	If the provider/supplier requests to collapse its PTANs as a result of revalidation, the MAC shall process those requests, if appropriate (based on payment localities, etc.).	X	X	X						
9628.10	The MAC shall accept a full 855I or sections 1, 2, 4, & 15 of the 855I to report the missing reassignments anytime prior to their revalidation due date, even post revalidation application approval.		X							
9628.11	If the revalidation due date has been posted (6 months prior to revalidation due date) and a reassignment and/or employment arrangement application has been received within that 6 month timeframe, MACs shall process the reassignment and/or employment arrangement application. The newly established reassignment/employment arrangement is not required to be reported on the revalidation application and MACs shall not develop for the missing information, since they were established after the revalidation notice was issued. MACs shall however, maintain the reassignment/employment arrangement information in the enrollment record when processing the revalidation application and this information shall not be overridden. In the instance where the provider or supplier fails to respond to the revalidation request, all reassignments/employment arrangements shall be end dated, including the newly established reassignment/employment arrangement.		X	X						
9628.12	In scenarios where a revalidation response is received for a single reassignment within an enrollment record that has multiple reassignments, the MAC shall develop to the contact person (or the individual provider if a contact is not listed), for the remaining reassignments not accounted for. If no response is received within 30 days, the MAC shall revalidate the single reassignment and deactivate the reassignments within the enrollment record that was not revalidated. The deactivation date shall be consistent with the latter of: (1) the revalidation due date, or (2) the date deactivation action is taken due to non-response or incomplete response to a development request.		X							

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
9628.12.1	The deactivation date shall be consistent with (1) the revalidation due date, or (2) the date deactivation action is taken due to non-response or incomplete response to a development request for all provider and supplier business structures (i.e. organizations, sole proprietors, sole owners, etc.)	X	X	X						
9628.13	MACs shall only accept extension requests from a provider or supplier that was not given the full six months advance notice prior to their revalidation due date as a result of the due date list being untimely posted to the CMS website. MACs shall no longer accept extension requests from the providers or suppliers for any other reason. If there is a delay in posting the above referenced list, which impacts a provider or supplier receiving the full six month advance notice, the MAC shall accept the provider or supplier's extension request and grant the provider or supplier an extension up to the full six month period from the date of the list being posted with no impacts to their effective date. MACs shall accept these type of extension requests from the provider or supplier and the requests may be made by the provider or supplier in writing (fax/email permissible) or via phone requested by the individual provider, Authorized/Delegated Official or contact person.	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Joseph Schultz, 410-786-2656 or Joseph.Schultz@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Program Integrity Manual
Chapter 15 - Medicare Enrollment

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15.1.1 – Definitions

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

Below is a list of terms commonly used in the Medicare enrollment process:

Accredited provider/supplier means a supplier that has been accredited by a CMS-designated accreditation organization.

Advanced diagnostic imaging service means any of the following diagnostic services:

(i) Magnetic Resonance Imaging (MRI).
(ii) Computed Tomography (CT).
(iii)Nuclear Medicine.
(iv)Positron Emission Tomography (PET).

Applicant means the individual (practitioner/supplier) or organization who is seeking enrollment into the Medicare program.

Approve/Approval means the enrolling provider or supplier has been determined to be eligible under Medicare rules and regulations to receive a Medicare billing number and be granted Medicare billing privileges.

Authorized official means an appointed official (e.g., chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

Billing agency means an entity that furnishes billing and collection services on behalf of a provider or supplier. A billing agency is not enrolled in the Medicare program. A billing agency submits claims to Medicare in the name and billing number of the provider or supplier that furnished the service or services. In order to receive payment directly from Medicare on behalf of a provider or supplier, a billing agency must meet the conditions described in § 1842(b)(6)(D) of the Social Security Act. (For further information, see CMS Publication 100-04, chapter 1, section 30.2.4.)

Change in majority ownership occurs when an individual or organization acquires more than a 50 percent direct ownership interest in a home health agency (HHA) during the 36 months following the HHA's initial enrollment into the Medicare program or the 36 months following the HHA's most recent change in majority ownership (including asset sales, stock transfers, mergers, or consolidations). This includes an individual or organization that acquires majority ownership in an HHA through the cumulative effect of asset sales, stock transfers, consolidations, or mergers during the 36-month period after Medicare billing privileges are conveyed or the 36-month period following the HHA's most recent change in majority ownership.

Change of ownership (CHOW) is defined in 42 CFR §489.18 (a) and generally means, 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. In the case of a corporation, the term generally means 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. The transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership.

CMS-approved accreditation organization means an accreditation organization designated by CMS to perform the accreditation functions specified.

Deactivate means that the provider or supplier's billing privileges were stopped, but can be restored upon the submission of updated information.

Delegated official means an individual who is delegated by the "Authorized Official" the authority to report changes and updates to the provider/supplier's enrollment record. The delegated official must be an individual with an ownership or control interest in (as that term is defined in section 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of, the provider or supplier.

Deny/Denial means the enrolling provider or supplier has been determined to be ineligible to receive Medicare billing privileges.

Enroll/Enrollment means the process that Medicare uses to establish eligibility to submit claims for Medicare-covered items and services, and the process that Medicare uses to establish eligibility to order or certify Medicare-covered items and services.

Enrollment application means a paper CMS-855 enrollment application or the equivalent electronic enrollment process approved by the Office of Management and Budget (OMB).

Final adverse action means one or more of the following actions:

(i) A Medicare-imposed revocation of any Medicare billing privileges;

(ii) Suspension or revocation of a license to provide health care by any State licensing authority;

(iii) Revocation or suspension by an accreditation organization;

(iv) A conviction of a Federal or State felony offense (as defined in §424.535(a)(3)(i)) within the last 10 years preceding enrollment, revalidation, or re-enrollment; or

(v) An exclusion or debarment from participation in a Federal or State health care program.

Immediate family member or member of a physician's immediate family means – under 42 CFR § 411.351 - a husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

Institutional provider means – for purposes of the Medicare application fee only - any provider or supplier that submits a paper Medicare enrollment application using the Form CMS–855A, Form CMS–855B (not including physician and non-physician practitioner organizations), Form CMS–855S or associated Internet-based Provider Enrollment, Chain and Ownership System (PECOS) enrollment application.

Legal business name is the name that is reported to the Internal Revenue Service (IRS).

Managing employee means a general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the provider or supplier.

Medicare identification number - For Part A providers, the Medicare Identification Number (MIN) is the CMS Certification Number (CCN). For Part B suppliers other than suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), the MIN is the Provider Identification Number (PIN). For DMEPOS suppliers, the MIN is the number issued to the supplier by the NSC. (Note that for Part B and DMEPOS suppliers, the Medicare Identification Number may sometimes be referred to as the Provider Transaction Access Number (PTAN).)

National Provider Identifier is the standard unique health identifier for health care providers (including Medicare suppliers) and is assigned by the National Plan and Provider Enumeration System (NPPES).

Operational – under 42 CFR §424.502 – means that the provider or supplier has a qualified physical practice location; is open to the public for the purpose of providing health care related services; is prepared to submit valid Medicare claims; and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered) to furnish these items or services.

Owner means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of, the provider or supplier as defined in sections 1124 and 1124(A) of the Social Security Act.

Ownership or investment interest – under 42 CFR § 411.354(b) – means an ownership or investment interest in the entity that may be through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in any entity that furnishes designated health services.

Physician means a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor, as defined in section 1861(r) of the Social Security Act.

Physician-owned hospital – under 42 CFR § 489.3 – means any participating hospital in which a physician, or an immediate family member of a physician, has a direct or indirect ownership or investment interest, regardless of the percentage of that interest.

Physician owner or investor – under 42 CFR § 411.362(a) – means a physician (or an immediate family member) with a direct or an indirect ownership or investment interest in the hospital.

Processed (application) - means that a provider or supplier's enrollment application was received by a Medicare Administrative Contractor (MAC) and the MAC has made a final determination on the application submission. Finalized outcomes include; rejected, approved, approval pending RO review, and denied. Regardless of whether or not an application is a part of a submission package or submitted alone each application is counted as a separate submission for the purpose of inventory and timeliness reporting.

Prospective provider means any entity specified in the definition of "provider" in 42 CFR §498.2 that seeks to be approved for coverage of its services by Medicare.

Prospective supplier means any entity specified in the definition of "supplier" in 42 CFR §405.802 that seeks to be approved for coverage of its services under Medicare.

Provider is defined at 42 CFR §400.202 and generally means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency or hospice, that has in effect an agreement to participate in Medicare; or a clinic, rehabilitation agency, or public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services; or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.

Reassignment means that an individual physician, non-physician practitioner, or other supplier has granted a Medicare-enrolled provider or supplier the right to receive payment for the physician's, non-physician practitioner's or other supplier's services. (For further information, see § 1842(b)(6) of the Social Security Act, the Medicare regulations at 42 CFR §§424.70 - 424.90, and CMS Publication 100-04, chapter 1, sections 30.2 – 30.2.16.)

Receipt (application) - Regardless of whether or not an application is a part of a submission package or submitted alone each application is counted as a separate submission for the purpose of inventory and timeliness reporting.

Reject/Rejected means that the provider or supplier's enrollment application was not *approved* due to incomplete information or that additional information or corrected information was not received from the provider or supplier in a timely manner.

Revoke/Revocation means that the provider or supplier's billing privileges are terminated.

Supplier is defined in 42 CFR § 400.202 and means a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare.

Tax identification number means the number (either the Social Security Number (SSN) or Employer Identification Number (EIN)) that the individual or organization uses to report tax information to the IRS.

15.6 - Timeliness and Accuracy Standards

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

Sections 15.6.1 through 15.6.3 of this chapter address the timeliness and accuracy standards applicable to the processing of Form CMS-855 applications. Even though the provisions of 42 CFR §405.818 contain processing timeframes that differ than those in sections 15.6.1 through 15.6.3, the contractor shall adhere to the standards specified in sections 15.6.1 through 15.6.3.

The processing of an application generally includes, but is not limited to, the following activities:

- Receipt of the application in the contractor's mailroom and forwarding it to the appropriate office for review.

- Prescreening the application.

- Creating a logging and tracking (L & T) record and an enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS).

- Ensuring that the information on the application is verified.

- Requesting and receiving clarifying information.

- Site visit (if necessary).

- Formal notification to the SA and/or RO of the contractor's approval, denial or recommendation for approval of the application.

15.6.1 – Standards for Initial *and Revalidation* Applications

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

For purposes of sections 15.6.1.1 through 15.6.1.4 of this chapter, the term "initial applications" also includes:

1. Form CMS-855 change of ownership, acquisition/merger, and consolidation applications submitted by the new owner.

2. “Complete” Form CMS-855 applications submitted by enrolled providers: (a) voluntarily, (b) as part of any change request if the provider does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS), (c) as a Form CMS-855 reactivation, or (d) as a revalidation.

3. Reactivation certification packages (as described in sections 15.27.1.2.1 and 15.27.1.2.2 of this chapter).

Initial and revalidation application timeliness standards shall be reported together. Likewise, initial and revalidation accuracy shall be reported together.

15.6.1.1.1 – Form *CMS-855* Applications That Require *a* Site Visit

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

The contractor shall process 80 percent of all Form CMS-855 initial *and revalidation* applications that require a site visit within 80 calendar days of receipt, process 90 percent of all Form CMS-855 initial *and revalidation* applications that require a site visit within 150 calendar days of receipt, and process 95 percent of all Form CMS-855 initial *and revalidation* applications that require a site visit within 210 calendar days of receipt.

15.6.1.1.2 – Form *CMS-855* Applications That Do Not Require *a* Site Visit

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

The contractor shall process 80 percent of all Form CMS-855 initial *and revalidation* applications that do not require a site visit within 60 calendar days of receipt, process 90 percent of all Form CMS-855 initial *and revalidation* applications that do not require a site visit within 120 calendar days of receipt, and process 95 percent of all Form CMS-855 initial *and revalidation* applications that do not require a site visit within 180 calendar days of receipt.

15.6.1.3.1 – Web-Based Applications That Require *a* Site Visit

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

The contractor shall process 80 percent of all Form CMS-855 Web-based initial *and revalidation* applications that require a site visit within 80 calendar days of receipt, process 90 percent of all Form CMS-855 Web-based initial *and revalidation* applications that require a site visit within 90 calendar days of receipt, and process 95 percent of all Form CMS-855 Web-based initial *and revalidation* applications that require a site visit within 120 calendar days of receipt. This process generally includes, but is not limited to:

- Receipt of the provider’s certification statement in the contractor’s mailroom and forwarding it to the appropriate office for review.

- Verification of the application in accordance with existing instructions.

- Requesting and receiving clarifying information in accordance with existing instructions.

- Supplier site visit.

15.6.1.3.2 – Web-Based Applications That Do Not Require *a* Site Visit

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

The contractor shall process 80 percent of all Form CMS-855 Web-based initial *and revalidation* applications that do not require a site visit within 45 calendar days of receipt, process 90 percent of all Form CMS-855 Web-based initial *and revalidation* applications that do not require a site visit within 60 calendar days of receipt, and process 95 percent of all Form CMS-855 Web-based initial *and revalidation* applications that do not require a site visit within 90 calendar days of receipt. This process generally includes, but is not limited to:

- Receipt of the provider's certification statement in the contractor's mailroom and forwarding it to the appropriate office for review.

- Verification of the application in accordance with existing instructions.

- Requesting and receiving clarifying information in accordance with existing instructions.

15.6.1.2 - Paper Applications – Accuracy

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

The contractor shall process 98 percent of paper CMS-855 initial *and revalidation* applications in full accordance with all of the instructions in this chapter (with the exception of the timeliness standards identified in sections 15.6.1.1.1 through 15.6.1.1.4 of this chapter) and all other applicable CMS directives.

15.6.1.3 - Web-Based Applications - Timeliness

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

The contractor shall process 90 percent of Form CMS-855 Web-based initial *and revalidation* applications within 45 calendar days of receipt, process 95 percent of Form CMS-855 Web-based initial *and revalidation* applications within 60 calendar days of receipt, and process 99 percent of Form CMS-855 Web-based initial *and revalidation* applications within 90 calendar days of receipt. This process generally includes, but is not limited to:

- Receipt of the provider's certification statement in the contractor's mailroom and forwarding it to the appropriate office for review.

- Verification of the application in accordance with existing instructions.

- Requesting and receiving clarifying information in accordance with existing instructions.

- Supplier site visit (if required).

15.6.1.4 - Web-Based Applications - Accuracy

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

The contractor shall process 98 percent of Form CMS-855 Web-based initial *and revalidation* applications in full accordance with all of the instructions in this chapter (with the exception of the timeliness standards identified in section 15.6.1.3 above) and all other applicable CMS directives.

15.8.1 – Returns

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

A. Reasons for Return

Unless stated otherwise in this chapter or in another CMS directive, the contractor (including the National Supplier Clearinghouse) may immediately return the enrollment application to the provider or supplier only in the instances described below. This policy – again, unless stated otherwise in this chapter or in another CMS directive - applies to all applications identified in this chapter (e.g., initial applications, change requests, Form CMS-855O applications, Form CMS-588 submissions, change of ownership (CHOW) applications, revalidations, reactivations):

- The applicant sent its paper Form CMS-855 to the wrong contractor (e.g., the application was sent to Contractor X instead of Contractor Y).

- The contractor received the application more than 60 days prior to the effective date listed on the application. (This does not apply to: (1) providers and suppliers submitting a Form CMS-855A application, (2) ambulatory surgical centers (ASCs), or (3) portable x-ray suppliers (PXRSs).

- The contractor received an initial application from (1) a provider or supplier submitting a Form CMS-855A application, (2) an ASC, or (3) a PXRS, more than 180 days prior to the effective date listed on the application.

- An old owner or new owner in a CHOW submitted its application more than 90 days prior to the anticipated date of the sale. (This only applies to Form CMS-855A applications.)

- The contractor can confirm that the provider or supplier submitted an initial enrollment application prior to the expiration of the time period in which it is entitled to appeal the denial of its previously submitted application.

- The provider or supplier submitted an initial application prior to the expiration of a re-enrollment bar.

- The application is to be returned per the instructions in section 15.7.7.1.4 of this chapter.

- The application is not needed for the transaction in question. Two common examples include:

    - An enrolled physician wants to change his/her reassignment of benefits from one group to another group and submits a Form CMS-855I and a Form CMS-855R. As only the Form CMS-855R is needed, the Form CMS-855I shall be returned.

    - A physician who is already enrolled in Medicare submits a Form CMS-855O application, thinking that he must do so in order to refer services for Medicare beneficiaries. The Form CMS-855O can be returned, as the physician is already enrolled via the Form CMS-855I.

- *The provider or supplier submitted a revalidation application more than six months prior to their revalidation due date.*

The contractor need not request additional information in any of these scenarios. For instance, if the application is not necessary for the particular transaction, the contractor can return the application immediately. If an application fee has already been submitted, the contractor shall follow existing instructions regarding the return of the fee.

The difference between a "rejected" application and a "returned" application is that the former is typically based on the provider's failure to respond to the contractor's request for missing or clarifying information. A "returned" application is effectively considered a non-application.

B. Procedures for Returning the Application

If the contractor returns the application:

- It shall notify the provider via letter (sent by mail or e-mail) that the application is being returned, the reason(s) for the return, and how to reapply.

- It shall not enter the application into PECOS. No logging & tracking (L & T) record shall be created.

- Any application resubmission must contain a brand new certification statement page containing a signature and date. The provider cannot simply add its signature to the original certification statement it submitted. (This does not apply to e-signature situations.)

It *may* return all paper documents submitted with the paper or Internet-based PECOS application (e.g., Form CMS-588, Form CMS-460). The contractor shall, however, make and keep a photocopy or scanned version of the paper application (if applicable) and any paper documents (regardless of whether the application was submitted via paper or electronically) prior to returning them. *MACs are not required to return the application or supporting documentation. If the MAC chooses not to return the application or supporting documentation, the MAC shall update the return letter accordingly.*

C. Other Impacts of a Return

1. Changes of Information and Changes of Ownership (CHOWs)

a. Expiration of Timeframe for Reporting Changes - If the contractor returns a change of information or CHOW submission per this section 15.8.1 and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to its *CMS* Provider Enrollment *& Oversight* Group Business Function Lead (PEOG BFL) notifying him or her of the return. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR § 424.540(a)(2) or revoked under 42 CFR § 424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

b. Timeframe Not Yet Expired - If the contractor returns a change of information or CHOW submission and the applicable 90-day or 30-day period for reporting the change has not yet expired, the contractor shall send the e-mail referred to in (1)(a) above after the expiration of said time period unless the provider has resubmitted the change request/CHOW.

c. Second Return, Rejection, or Denial – If, per (1)(b), the provider resubmits the change of information or CHOW application and the contractor either returns it again, rejects it per section 15.8.2 of this chapter, or denies it, the contractor shall send the e-mail referred to in (1)(a) above regardless of whether the applicable timeframe has expired. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR § 424.540(a)(2) or revoked under 42 CFR § 424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

2. Reactivations – If the contractor returns a reactivation application, the provider's Medicare billing privileges shall remain deactivated.

15.24.5 – Model Revalidation Letter

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

REVALIDATION

[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

Dear [Provider/Supplier Name],

Every five years, CMS requires you to revalidate your Medicare enrollment record. You need to update or confirm all the information in your record, including your practice locations and reassignments.

*We need this from you by **[Due date, as Month dd yyyy].** If we don't receive your response by then, we may stop your Medicare billing privileges.*

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating by [Due date, as Month dd yyyy]

*[Name] | **NPI** [NPI] | **PTAN** [PTAN]*
Reassignments: <Only include this title if the record has any reassignments>
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at go.cms.gov/MedicareRevalidation.

What you need to do

***Revalidate your Medicare enrollment record**, through PECOS.cms.hhs.gov, or form CMS-855.*

- ***Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.*
- ***Paper:** Download the right version of form CMS-855 for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].*

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification. For more on fees and exceptions, search cms.gov for "CR 7350" or "Fee Matrix".

If you need help

Visit go.cms.gov/MedicareRevalidation
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name], [Title]

15.24.5.2 – Model Large Group Revalidation Notification Letter

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

[Month Day & Year]

PROVIDER/SUPPLIER GROUP NAME
ADDRESS 1, ADDRESS 2
CITY STATE ZIP CODE

NPI:
PTAN:

Dear Provider/Supplier Group Name:

THIS IS **NOT** A PROVIDER ENROLLMENT REVALIDATION REQUEST

This is to inform you that a number of physicians and/or non-physician practitioners reassigning all or some of their benefits to your group have been selected for revalidation. For your convenience, a list of those individuals is attached. A revalidation notice will be sent to the physician or non-physician practitioner within *the next 6 months. They will need to respond by the revalidation due date provided for each provider.* It is the responsibility of the physician *and*/or non-physician practitioner to revalidate all *their* Medicare enrollment information and not *just* that associated with the reassignment to your group practice.

In accordance with Section 6401 (a) of the Patient Protection and Affordable Care Act, all new and existing providers must be reevaluated under the new screening guidelines. Medicare requires all enrolled providers and suppliers to revalidate their enrollment information every five years (reference 42 CFR §424.515). To ensure compliance with these requirements, existing regulations at 42 CFR §424.515(d) provide that the Centers for Medicare & Medicaid Services (CMS) is permitted to conduct off-cycle revalidations for certain program integrity purposes.

Physicians and non-physician practitioners can revalidate by using either Internet-based PECOS or submitting a paper CMS-855 enrollment application. Failure to submit a complete revalidation application and all supporting documentation within 60 calendar days may result in the physician or non-physician practitioner's Medicare billing privileges being deactivated. As such, your group will no longer be reimbursed for services rendered by the physician or non-physician practitioner.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the revalidation process.

Sincerely,

[Your Name]
[Title]

15.24.5.3 – Model Revalidation Pend Letter

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

PAYMENT HOLD

[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

Dear [Provider/Supplier Name],

We are holding all payments on your Medicare claims, because you haven't revalidated your enrollment record with us. This does not affect your Medicare participation agreement, or any of its conditions.

Every five years, CMS requires you to revalidate your Medicare enrollment record information. You need to update or confirm all the information in your record, including your practice locations and reassignments.

Failure to respond to this notice will result in a possible deactivation of your Medicare enrollment. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

What record needs revalidating

*[Name] | **NPI** [NPI] | **PTAN** [PTAN]*
Reassignments:

[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at ***go.cms.gov/MedicareRevalidation****.*

How to resume your payments

Revalidate your Medicare enrollment record*, through PECOS.cms.hhs.gov, or form CMS-855.*

- ***Online:*** *PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.*
- ***Paper:*** *Download the right version of form CMS-855 for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].*

If you have a fee due, use PECOS to pay. If you feel you qualify for a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

If you need help

Visit ***go.cms.gov/MedicareRevalidation***
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name], [Title]

15.24.5.4 – Model Revalidation Deactivation Letter

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

STOPPING BILLING PRIVILEGES

[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

Dear [Provider/Supplier Name],

We have stopped your Medicare billing privileges *on [deactivation date], because you haven't revalidated your enrollment record with us, or you didn't respond to our requests for more information. We will not pay any claims after this date.*

Every five years, CMS requires you to revalidate your Medicare enrollment record.

What record needs revalidating

[Name] | ***NPI*** *[NPI] |* ***PTAN*** *[PTAN]*
Reassignments:
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at ***go.cms.gov/MedicareRevalidation****.*

How to recover your billing privileges

Revalidate your Medicare enrollment record*, through PECOS.cms.hhs.gov, or form CMS-855.*

- ***Online:*** *PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.*
- ***Paper:*** *Download the right version of form CMS-855 for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].*

If you have a fee due, use PECOS to pay. If you feel you deserve a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If you need help

Visit ***go.cms.gov/MedicareRevalidation***
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name], [Title]

15.24.5.5 – Model Revalidation Past-Due Group Member Letter

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

REVALIDATION | Past-Due Group Member

[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

Dear [Provider/Supplier Name],

Every five years, CMS requires providers to revalidate their Medicare enrollment records. You have not revalidated by the requested due date of [revalidation due date].

You need to update or confirm all the information in your record, including your practice locations and reassignments. If you are a non-certified provider or supplier, and your enrollment is deactivated, you will maintain your original PTAN, however will not be paid for services rendered during the period of deactivation. This will cause a gap in your reimbursement.

If multiple records below need to be revalidated, please coordinate with the appropriate parties to provide only one response.

What record needs revalidating

[Name] | ***NPI*** *[NPI] |* ***PTAN*** *[PTAN]*
Reassignments: <Only include this title if the record has any reassignments>
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

CMS lists the records that need revalidating at ***go.cms.gov/MedicareRevalidation****.*

What your group member needs to do

Revalidate their Medicare enrollment record*, through PECOS.cms.hhs.gov, or form CMS-855.*

- ***Online:*** *PECOS is the fastest option. If they don't know their username or password, PECOS offers ways to retrieve them. Our customer service can also help by phone at 866-484-8049.*
- ***Paper:*** *Download the right version of form CMS-855 for their situation at cms.gov. We recommend getting proof of receipt for this mailing. Mail to [contractor address].*

If your group member needs help

Visit ***go.cms.gov/MedicareRevalidation***

Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name], [Title]

15.24.5.6 – Model Deactivation Letter due to Inactive Provider/Supplier Letter
(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

STOPPING BILLING PRIVILEGES | Inactive Provider/Supplier

[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

Dear [Provider/Supplier Name],

***We have stopped your Medicare billing privileges** on [deactivation date], due to inactivity. We will not pay any claims after this date.*

What record has been deactivated

*[Name] | **NPI** [NPI] | **PTAN** [PTAN]*
Reassignments:
[Legal Business Name] | [dba Name] | Tax ID [Tax ID, mask all but last 4 digits]
<Repeat for other reassignments>

How to recover your billing privileges

***Reactivate your Medicare enrollment record**, through PECOS.cms.hhs.gov, or form CMS-855.*

- ***Online:** PECOS is the fastest option. If you don't know your username or password, PECOS offers ways to retrieve them. Our customer service can also help you by phone at 866-484-8049.*
- ***Paper:** Download the right version of form CMS-855 for your situation at cms.gov. We recommend getting proof of receipt for your mailing. Mail to [contractor address].*

If you have a fee due, use PECOS to pay. If you feel you deserve a hardship waiver, mail us a request on practice letterhead with financial statements, application form, and certification.

If you need help

*Visit **go.cms.gov/MedicareRevalidation***
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name], [Title]

15.24.5.7 – Model Return Revalidation Letter
(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

RETURN REVALIDATION

[Month dd, yyyy]

[PROVIDER/SUPPLIER NAME | ADDRESS 1, ADDRESS 2 CITY, ST ZIP]

Dear [Provider/Supplier Name],

Your Medicare enrollment application(s) was received on [date]. We are closing this request and returning your application(s) for the following reason(s):

- *The CMS-855 application received by [PROVIDER/SUPPLIER NAME] was unsolicited.*
    - *An unsolicited revalidation is one that is received more than 6 months prior to the provider/suppliers due date. Due dates are established around 5 years from the provider/suppliers last successful revalidation or their initial enrollment.*
    - *To find the provider/suppliers revalidation due date, please go to http://go.cms.gov/MedicareRevalidation.*
    - *If you are not due for revalidation in the current six month period, you will find that your due date is listed as "TBD" (or To Be Determined). This means that you do not yet have a due date for revalidation within the current six month period. This list with be updated monthly.*

- *If your intention is to change information on your Medicare enrollment file, you must complete a new Medicare enrollment application(s) and mark 'change' in section 1 of the CMS-855.*

- *Please address the above issues as well as sign and date the new certification statement page on your resubmitted application(s).*

Providers and suppliers can apply to enroll in the Medicare program using one of the following two methods:

1. Internet-based Provider Enrollment, Chain and Organization System (PECOS). Go to: http://www.cms.hhs.gov/MedicareProviderSupEnroll.

2. Paper application process: Download and complete the Medicare enrollment application(s) at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html. DMEPOS suppliers should send the completed application to the National Supplier Clearinghouse (NSC).

If you need help
Visit http://go.cms.gov/MedicareRevalidation, or
Call [contractor phone #] or visit [contractorsite.com] for more options.

Sincerely,
[Name], [Title]

15.29.1 – Revalidation Lists
(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

CMS will identify the providers and suppliers required to revalidate during each cycle. CMS will communicate when new lists become available through the appropriate channels, at which time the contractor shall obtain the list from the CGI Share Point Ensemble website.

The list will contain a suggested revalidation due date, consisting of a month and day of the year, to assist MACs in staggering their workload and distributing the e-mails or mailings evenly. MACs shall review the list and may alter a provider/ suppliers' due date month based on staffing levels and workload. However, the day that the revalidation is due shall always remain as the last day of each month (i.e., June 30th, July 31st, or August 31st). When distributing the workload, MACs shall ensure that the revalidation due dates are divided equally over a 6 month period and accounts for fifty percent of the MAC's list (i.e., 50 percent of the revalidation due dates are defined in the first 6 months, and the remaining 50 percent in the last 6 months). MACs shall also ensure that the due dates selected do not go beyond the current year.

Once the MAC confirmed lists are received by CMS, a final list will be generated capturing the provider/supplier's due date and timeframes for each revalidation action (i.e., e-mail or mail date, pend,

deactivation). The list will be posted to the CGI Share Point Ensemble site and will be refreshed with updated enrollment data every 60 days to account for providers/suppliers who have been deactivated or have had changes in the provider/supplier's enrollment information. MACs shall use the most current list available to conduct their e-mails or mailings and shall allow sufficient time for the provider/supplier to meet their deadline (between 75 to 90 days prior to the revalidation due date).

This list will also be made available on *https://data.cms.gov/revalidation*so that providers and suppliers are aware of who has been selected to revalidate.

15.29.2 – Mailing Revalidation Letters

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

Based on the due date identified on the list, MACs shall send a revalidation notice between 75 to 90 days prior to the revalidation due date using the sample letter provided in Pub. 100-08, chapter 15, section 15.24.5. The initial revalidation letter may include a generic provider enrollment signature; however, development letters shall include a provider enrollment analyst's name and phone number for provider/supplier contacts. MACs may send revalidation notices via email if this option is in line with the MAC's security requirements and capabilities. Email addresses will be provided as part of the CMS list (derived from Section 2 and 13 of PECOS). When sending revalidation notices via email, MACs shall indicate "URGENT: Medicare Provider Enrollment Revalidation Request" in the subject line to differentiate this from other emails. The sample letter provided in Pub. 100-08, chapter 15, section 15.24.5 should be included in the body of the email and should not be included as an attachment to the email or require a password be sent to the provider/supplier to view the email content. MACs are not required to send a paper copy of the revalidation notice if sent via email. If the notice is sent to multiple email addresses but one is returned as undeliverable, MACs are not required to mail a revalidation notice as long as one email is delivered successfully.

If all of the emails are returned as undeliverable, paper revalidation notices shall be mailed to the provider/supplier's correspondence and special payment addresses, within the 75 to 90 day timeframe prior to the revalidation due date. If the correspondence and special payment address is the same, MACs shall send the second letter to the provider/supplier's practice location address. If the correspondence, practice and special payments address are the same, only one letter shall be sent.

If no email addresses exist in the enrollment record or the MAC chooses the mail option, MACs shall mail two revalidation notices to the provider/supplier's correspondence and special payment address and/or practice location address using the instructions outlined above.

When issuing revalidation notices to individual group members, MACs shall provide on the revalidation notice identifying information of the organization (s) (i.e., Legal Business Name (LBN), Doing Business As (DBA) name, Tax Identification Number) that the provider reassigns benefits in lieu of including the provider's PTANs. Individual group members may be more familiar with the LBN or DBA name of the organizations they are associated versus the PTANs. This should eliminate MACs developing for PTANs not included on the revalidation application.

If one of the locations is found to be incorrect or the letter gets returned as undeliverable, the contractor shall re-send the returned letter to an address not used for the initial mailing. If it is determined that all locations are the same and the contractor has exhausted all reasonable means of contacting the provider/supplier, the contractor shall deactivate the provider/supplier's enrollment in either MCS/FISS or PECOS, whenever possible.

15.29.3.1 – Phone Calls

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

MACs may continue to contact providers/suppliers via telephone or email to communicate non-receipt of revalidation applications; however, these contacts are not required.

If telephone or email contacts are made, MACs shall continue to document all communications with the providers/suppliers.

15.29.3.2 – Pend Status

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

MACs shall apply the payment hold (pend flag) in PECOS if the provider/supplier fails to respond to the revalidation request. MACs shall perform this action within 25 days after the revalidation due date. MACs may, but are not required to notify the provider/supplier of the payment hold.

Since there is no way to assign a payment hold to an individual group member without it preventing payment to the entire group, MACs shall issue a letter to the individual group members in lieu of the payment hold within 25 days after the revalidation due date using the sample letter provided in Pub. 100-08, chapter 15, section 15.24.5 (Revalidation Past Due Group Member Sample Letter). MACs may send the payment hold notice via email if this option is in line with the MAC's security requirements and capabilities. Email addresses will be provided as part of the CMS list (derived from Section 2 and 13 of the Provider Enrollment Chain and Ownership System (PECOS).When sending payment hold notices via email, MACs shall indicate "URGENT: Revalidation Past Due" in the subject line to differentiate this from other emails. The letter should be included in the body of the email and should not be included as an attachment to the email or require a password be sent to the provider/supplier to view the email content. MACs are not required to send a paper copy of the payment hold notice if sent via email. If the notice is sent to multiple email addresses but one is returned as undeliverable, MACs are not required to mail a payment hold notice as long as one email is delivered successfully.

If all of the emails are returned as undeliverable, paper payment hold notices shall be mailed to the provider/supplier's correspondence and special payment addresses. If the correspondence and special payment address is the same, MACs shall send the second letter to the provider/supplier's practice location address. If the correspondence, practice and special payments address are the same, only one letter shall be sent.

If no email addresses exist in the enrollment record or the MAC chooses the mail option, MACs shall mail the two payment hold notices to the provider/supplier's correspondence and special payment address and/or the practice location address using the instructions outlined above.

This requirement shall only apply to individual group members who are reassigned to a group and/or providers who have employment arrangements

15.29.3.3 – Deactivation Actions

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

MACs shall deactivate a provider/supplier's enrollment record for failure to respond to the revalidation request between days 60 – 75 after the revalidation due date and notify the provider/supplier using the sample letter provided in Pub. 100-08, chapter 15, section 15.24.5 (Stopping Billing Privileges Sample Letter).

The MAC shall establish the effective date of deactivation as the same date the action is being taken.

If an individual provider is deactivated for failure to respond to a revalidation request, the contractor shall search the provider's associate record to determine if the provider is identified as a supervising physician on any independent diagnostic testing facility (IDTF) enrollments. If so, the provider shall be disassociated as the supervising physician for that entity. If the deactivated provider is the only supervising physician on file for the IDTF, the contractor shall develop for an active supervising physician to bring the IDTF into

compliance. The contractor shall give the IDTF 30 days to respond. Failure to provide an active supervising physician in the designated timeframe shall result in revocation of the IDTF's billing privileges for non-compliance with the IDTF standards.

15.29.4 – Receipt of Revalidation Application

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

MACs shall return all unsolicited applications. Unsolicited applications are: (1) revalidation applications received more than 6 months prior to the provider/suppliers established due date and/or (2) Providers and suppliers identified as TBD (To Be Determined) on the revalidation look up tool. MACs shall return these applications using the sample return letter template provided in Pub. 100-08, chapter 15, section 15.24.5, within 20 business days of receipt. MACs shall also submit a request to CMS to have the application fee returned to the provider. Revalidation applications submitted within 6 months of their due date shall be accepted and processed by the MAC. The submission date of a revalidation application for providers/suppliers who are on the CMS posted list will not alter their future revalidation due date.

The contractor may only accept revalidation applications signed by the individual provider or the authorized official (AO) or delegated official (DO) of the provider/supplier organization.

If a provider/supplier wishes to voluntary withdrawal from Medicare (including deactivating all active PTANs), the contractor shall accept this request via phone, U.S. mail or fax from the individual provider or the AO/DO (on letterhead); the contractor shall not require the provider/supplier to complete a CMS-855 application. If the request is made via telephone, the contractor shall document the telephone conversation (in accordance with section 15.7.3 of this chapter) and take the appropriate action in PECOS.

Any subunit that has a separate provider agreement (e.g., home health agency (HHA) subunits) it must revalidate on a separate Form CMS-855A. It cannot revalidate via the main provider's Form CMS-855A. If the subunit has a separate CMS Certification Number (CCN) but not a separate provider agreement (e.g., hospital psychiatric unit, HHA branch), the revalidation can be disclosed on the main provider's Form CMS-855A. This is because the subunit is a practice location of the main provider and not a separately enrolled entity. Separate fees are not required.

If the provider/supplier requests to collapse its PTANs as a result of revalidation, the MAC shall process those requests, if appropriate (based on payment localities, etc.).

15.29.4.1 – Revalidation *Application* Received and Development Required

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

If the revalidation application is received but requires development (i.e., missing application fee, hardship request, *reassignments and/or employment arrangements*, documentation, signature*, etc.*), the *MAC* shall notify the provider or supplier via mail, phone, fax or email. *MACs shall develop for all of the missing information in one development request.* Providers and suppliers shall be given 30 days to respond to the *MAC*'s request and may submit the missing information via mail, fax, or e-mail containing scanned documentation (this includes missing signatures and dates). *The provider may submit a full 855I or sections 1, 2, 4, & 15 of the 855I to report the missing reassignments and/or employment arrangements any time prior to their revalidation due date, even post revalidation application approval*.

If licensure and/or educational requirements (i.e., non-physician practitioner's degree or diploma) can be verified online, the *MAC* shall not require the provider/supplier to submit this documentation. *If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again with their revalidation application. The MAC may utilize the existing documentation for verification.* Residency information shall also not be required as part of revalidation. The *MAC* shall not require further development for data that is missing on the provider/supplier's revalidation

application if the information is disclosed (1) elsewhere on the application, or (2) in the supporting documentation submitted with the application with the exception of the following items:

- Adverse legal action data
- Legal business name (LBN)
- Tax identification number (TIN)
- NPI-legacy number combinations
- Supplier/Practitioner type
- "Doing business as" name
- Effective dates of sale/transfer/consolidation or indication of acceptance of assets/liabilities

MACs shall not require providers/suppliers to include the PTAN(s) in section 2 or 4 on the revalidation application, provided they have included the necessary information (NPI, TIN, LBN, DBA, etc.) for the MACs to appropriately make the association. If the PTAN is not submitted but is needed to make the connection, MACs shall use the shared systems, PECOS or their provider files as a resource before developing back to the provider/supplier.

MACs shall not develop for the EFT form if the provider/supplier has either the 05/2010 or 09/13 version of CMS 588 (EFT) on file. If an EFT form is submitted along with a bank letter or voided check, MACs may verify that the LBN matches and develop to process the application accordingly.

In scenarios where a revalidation response is received for a single reassignment within an enrollment record that has multiple reassignments and/or employment arrangements, the MAC shall develop to the contact person (or the individual provider if a contact is not listed), for the remaining reassignments and/or employment arrangements not accounted for. If no response is received within 30 days, the MAC shall revalidate the single reassignment and deactivate the reassignments and/or employment arrangements within the enrollment records that were not revalidated.

The deactivation date shall be consistent with the latter of: (1) the revalidation due date, or (2) the date deactivation action is taken due to non-response or incomplete response to a development request for all provider and supplier business structures (i.e. organizations, sole proprietors, sole owners, etc).

To illustrate, *in scenario #1 the MAC issues a revalidation notice to the provider and includes reassignments and/or employment arrangements for Groups A, B & C. The provider submits the revalidation application to the MAC but only addresses the reassignment for Group A. The MAC develops to the contact person for the missing reassignments and/or employment arrangements for Groups B & C. The provider responds with the reassignment information for Groups B & C prior to the development due date. Since the revalidation application is still considered in progress, the provider may submit a full 855I or sections 1, 2, 4, & 15 of the 855I to report the missing reassignment information, even post revalidation application approval. The revalidation application is processed to completion and the provider experiences no break in billing.*

In scenario #2 the MAC issues a revalidation notice to the provider and includes reassignments and/or employment arrangements for Groups A, B & C. The provider submits the revalidation application to the MAC but only addresses the reassignment for Group A. The MAC develops to the contact person for the missing reassignments and/or employment arrangements for Groups B & C. No response is received within 30 days and the revalidation due date has passed. Group A's reassignment is revalidated. Group B & C's reassignments and/or employment arrangements are deactivated effective with the date deactivation action is taken due to non-response or incomplete response to a development request. The approval letter issued by the MAC will identify the reassignments and/or employment arrangements that were revalidated and those terminated with the effective date of the reassignment or termination. The provider is required to submit a full application (CMS-855R) to reactivate the reassignment. The effective date for the reactivation is based on the receipt date of the CMS-855R. In this scenario the provider does experience a break in billing.

In *this* scenario, the entire enrollment *shall* not be deactivated; only the non-response *reassignments and/or employment arrangements shall* be *deactivated* and the other *reassignments and/or employment arrangements revalidated*.)

If other missing information is not received within 30 days, MACs shall deactivate the provider/supplier within 25 days after the development due date and notify the provider/supplier of the deactivation using the sample letter provided in Pub. 100-08, chapter 15, section 15.24.5. After deactivation, the provider shall be required to submit an entirely new application in order to reactivate their PTANs. Supporting documentation received may be used, if needed, for subsequent application submissions.

15.29.4.2 – Revalidation Received after a Pend is Applied

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

The contractor shall remove the pend within 15 business days of receiving the revalidation application, even though the submitted application has not been processed to completion. This will release all held paper checks, SPRs, and EFT payments.

The contractor shall process the revalidation application using current processing instructions and mail, fax, or email a decision letter to the provider or supplier to notify it that the revalidation application has been processed.

15.29.4.3 – Revalidation Received After a Deactivation Occurs

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

MACs shall require the provider/supplier to submit a new full application to reactivate their enrollment record after they have been deactivated. The MAC shall process the application as a reactivation and establish an effective date based on the receipt date of the application. The provider/supplier shall maintain their original PTAN but the MAC shall reflect a gap in coverage (between the deactivation and reactivation of billing privileges) on the existing PTAN using Action Reason (A/R) codes in the Multi-Carrier Claims System (MCS) based on the receipt date of the application. The provider will not be reimbursed for dates of service in which they were not in compliance with Medicare requirements (deactivated for non-response to revalidation). This requirement also applies to group members whose reassignment association was terminated when the group was deactivated.

Since the issuance of PTANs and effective dates for Part A certified providers/suppliers, including ASC's and Portable X-Ray, are determined by the RO and the deactivation action does not terminate their provider agreement, MACs shall allow the provider/supplier to maintain its original PTAN and effective date when the reactivation application is processed.

When processing the revalidation application after a deactivation occurs, the contractor shall not:

- Require any provider/supplier whose PTAN(s) have been deactivated to obtain a new State survey or accreditation as a condition of revalidation

- Collect a 2nd application fee if a fee was previously submitted with the initial revalidation application

15.29.4.4 – Change of Information Received Prior to Revalidation Letter Mailed

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

If a change of information (COI) application is received from the provider/supplier prior to the contractor having mailed the revalidation letter, the contractor shall process the COI as normal and proceed with mailing the revalidation notice.

If the provider/supplier submits an application marked as a revalidation but only includes enough information to be considered a COI, the contractor shall (1) develop for a complete application containing the missing data elements, and (2) treat it as a revalidation.

15.29.4.5 – Reassignments and/or Employment Arrangement Applications Received After Revalidation Letter Mailed

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

If the revalidation due date has been posted (6 months prior to revalidation due date) and a reassignment and/or employment arrangement application has been received within that 6 month timeframe, MACs shall process the reassignment and/or employment arrangement application. The newly established reassignment/employment arrangement is not required to be reported on the revalidation application and MACs shall not develop for the missing information, since they were established after the revalidation notice was issued. MACs shall however, maintain the reassignment/employment arrangement information in the enrollment record when processing the revalidation application and this information shall not be overridden. In the instance where the provider or supplier fails to respond to the revalidation request, all reassignments/employment arrangements shall be end dated, including the newly established reassignment/employment arrangement.

To illustrate, Dr. Doe submits a CMS-855R application to his MAC to add a new reassignment to Browns Medical Center. Soon after he checks https://data.cms.gov/revalidation and notices that he is due for revalidation in the next 6 months. He submits his revalidation application to his MAC but does not include the reassignment for Browns Medical Center since it is in progress and an approval notification has not been issued. The MAC finalizes the reassignment changes and then proceeds with processing the revalidation application. The MAC shall not develop for the new reassignment to Browns Medical Center and shall maintain the reassignment in the provider's enrollment record when processing the revalidation application.

If a revalidation and change of information application is received concurrently, the MACs shall merge the two applications and process accordingly.

15.29.5 – Revalidating Providers Involved in a Change of Ownership (CHOW)

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

MACs shall not take revalidation actions on providers or suppliers that are undergoing a CHOW that is currently in process by the MAC or pending review by the State/RO. MACs shall notify their BFL if a seller enrollment record is up for revalidation and the CHOW application is currently in process by the MAC. MACs shall include the seller and buyer enrollment record ID in their email notification to their BFL.

15.29.7 – Large Group Revalidation Coordination

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

In addition to providing the finalized revalidation list with MAC confirmed due dates, CMS will provide a list of large groups affected by this notification, including the individual providers reassigning benefits to their group that appear on the 6 month list. MACs may stagger the large group mailings however they see fit to ensure the group receives notification that providers within their group will be receiving a request to revalidate in the next 6 months. MACs shall send the notification letter to the Authorized/Delegated Official

or the enrollment contact person. MACs may send the group notices via email utilizing the email addresses provided as part of the CMS list (derived from Section 2 and 13 of PECOS).

MACs shall indicate ***"IMPORTANT: Group Notification of Upcoming Provider Enrollment Revalidation Request"*** *in the subject line to differentiate this from other emails. MACs shall use the sample letter provided in Pub. 100-08, chapter 15, section 15.24.5 to notify the large groups by attaching the letter in the body of the email. The letter should not be included as an attachment to the email or require a password be sent to the provider/supplier to view the email content. MACs are not required to send a paper copy of the group notice if sent via email. If all of the emails the notice is sent to are returned as undeliverable, paper revalidation notices shall be mailed to the provider/supplier's correspondence and special payment addresses, within the 75 to 90 day timeframe. MACs do not need to mail a notification if one or a few of the emails are returned as undeliverable, but one or more have been delivered successfully. If the correspondence and special payment address is the same, MACs shall send the second letter to the provider/supplier's practice location address. If the correspondence, practice and special payments address are the same, only one letter shall be sent.*

If no email addresses exist in the enrollment record, then MACs shall mail the notice to the group's correspondence address.

MACs shall include with the notification letter a spreadsheet identifying the individual providers that will be revalidated. The spreadsheet shall contain the Provider's Name, National Provider Identifier (NPI) and Specialty. This information will be provided as part of the list supplied by CMS.

The large group list will contain only those large groups consisting of 200 or more reassignments. Groups with less than 200 reassignments will not appear on the list and are not required to be emailed or mailed a group notification letter; however, all reassignment information will be available at https://data.cms.gov/revalidation for providers and suppliers to view.

MACs shall designate an enrollment analyst for each of the large groups to coordinate revalidation activities. The designated enrollment analyst shall be identified on the group notification letter. The enrollment analysts shall work directly with the group's enrollment contact person or the Authorized/Delegated Official on file.

MACs shall allow large groups to submit a spreadsheet identifying those providers that are no longer practicing at their group in lieu of submitting CMS-855R termination applications. The spreadsheet shall be accompanied by a letter signed by the Authorized/Delegated Official of the group. This process is only acceptable for large groups who are completing their revalidation and coordinating directly with the MAC.

15.29.8 – Finalizing the Revalidation Application

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

Prior to processing the revalidation application to completion, the contractor shall ensure that:

- A site visit (if applicable to the provider/supplier in question) is requested to be conducted by the National Site Visit Contractor (NSVC)

- The provider/supplier meets all applicable federal regulatory requirements regarding licensure, certification and/or educational requirements, as listed in the Code of Federal Regulations (CFR) and as described in CMS Publication 100-02 for his or her supplier type.

- The provider/supplier's information is revalidated based on the information in PECOS.

- Practice locations continue to be verified; however, there is no need to contact each and every location separately. Verification shall be done with the contact person listed on the application and noted accordingly in the contractor's verification documentation per section 15.7.3 of this chapter.

- The appropriate logging & tracking (L&T) record type and finalization status are identified in PECOS.

- An enrollment record is not marked as revalidated in PECOS if responses have been received for some PTANs yet not all PTANs have been addressed (meaning that no action has been taken on the non-response PTANs, i.e., end-dated). If all PTANs have been addressed (i.e., revalidated, end-dated), the enrollment can be marked as revalidated.

- PECOS and the claims systems remain in sync. The contractor shall not directly update the shared systems without first updating PECOS when processing a revalidation unless instructed otherwise in another CMS directive.

- *When processing of the revalidation application is complete, MACs shall issue an approval letter to the contact person or the provider/supplier if a contact person is not listed, via mail, fax, or email. If the provider/supplier has reassignments that were terminated due to non-response, the approval letter shall contain the reassignments that were terminated due to non-response and the effective date of termination (i.e., the revalidation due date or the development due date).*

15.29.9 – Revalidation Reporting

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

MACs are no longer required to submit reports on the 5th and 20th of each month for Cycle 2. However, MACs shall maintain internally the method of delivery for the provider/supplier revalidation notices and the date the email or letter was sent. CMS may periodically request ad hoc reporting of this data. The data elements for ad-hoc reporting shall include, but is not limited to the following; revalidation notification delivery date, delivery method, delivery address, deactivation date, provider response date, reactivation date, application finalization date, etc.

15.29.10 - Revalidation Files *Available Online*

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

The revalidation due dates are available at https://data.cms.gov/revalidation via the Revalidation look up tool. The tool includes all enrolled providers/suppliers. Those due for revalidation will display a revalidation due date, all other providers/suppliers not up for revalidation will display a "TBD" (To Be Determined) in the due date field. In addition, a crosswalk to the organizations that the individual provider reassigns benefits will also be available at https://data.cms.gov/revalidation on the CMS website.

15.29.11 – Revalidation Extension Requests

(Rev. 684, Issued: 11-01-16, Effective: 12-02-16, Implementation: 12-02-16)

MACs shall only accept extension requests from a provider or supplier that was not given the full six months advance notice prior to their revalidation due date as a result of the due date list being untimely posted to the CMS website. MACs shall no longer accept extension requests from the providers or suppliers for any other reason.

If there is a delay in posting the above referenced list, which impacts a provider or supplier receiving the full six month advance notice, the MAC shall accept the provider or supplier's extension request and grant the provider or supplier an extension up to the full six month period from the date of the list being posted with no impacts to their effective date. MACs shall accept these type of extension requests from the provider or supplier and the requests may be made by the provider or supplier in writing (fax/email permissible) or via phone requested by the individual provider, Authorized/Delegated Official or contact person.