CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 782	**Date: March 30, 2018**
	Change Request 10443

SUBJECT: Update to Chapter 15 of Publication 100-08 - Medicare Enrollment Deactivation Policies

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to update the Medicare Enrollment Deactivation Policies in Chapter 15 of Publication 100-08.

EFFECTIVE DATE: April 2, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 30, 2018

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.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	15/15.24/15.24.15/Model Deactivation Letter
R	15/15.27/15.27.1/15.27.1.1/Deactivations
R	15/15.29/15.29.1/Revalidation Lists
R	15/15.29/15.29.2/Mailing Revalidation Letters
R	15/15.29/15.29.7/Large Group Revalidation Coordination

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: 782	Date: March 30, 2018	Change Request: 10443

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I. GENERAL INFORMATION

A. Background: This CR updates the Medicare Enrollment Deactivation Policies in Chapter 15 of Pub. 100-08. These updates to the manual will align Medicare enrollment policies with 42 CFR 424.540 - Deactivation of Medicare billing privileges.

Deactivation of Medicare billing privileges

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

(1) The provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. The 12 month period will begin the 1st day of the 1st month without a claims submission through the last day of the 12th month without a submitted claim.

(2) The provider or supplier does not report a change to the information supplied on the enrollment application within 90 calendar days of when the change occurred. Changes that must be reported include, but are not limited to, a change in practice location, a change of any managing employee, and a change in billing services. A change in ownership or control must be reported within 30 calendar days as specified in §§ 424.520(b) and 424.550(b).

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

(b)*Reactivation of billing privileges.*

(1) When deactivated for any reason other than nonsubmission of a claim, the provider or supplier must complete and submit a new enrollment application to reactivate its Medicare billing privileges or, when deemed appropriate, at a minimum, recertify that the enrollment information currently on file with Medicare is correct.

(2) Providers and suppliers deactivated for nonsubmission of a claim are required to recertify that the enrollment information currently on file with Medicare is correct and furnish any missing information as appropriate. The provider or supplier must meet all current Medicare requirements in place at the time of reactivation, and be prepared to submit a valid Medicare claim.

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

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

(ii) [Reserved]

(c)*Effect of deactivation.* Deactivation of Medicare billing privileges is considered an action to protect the provider or supplier from misuse of its billing number and to protect the Medicare Trust Funds from unnecessary overpayments. The deactivation of Medicare billing privileges does not have any effect on a provider or supplier's participation agreement or any conditions of participation.

B. Policy: 42 CFR 424.540

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	
10443.1	Medicare Administrative Contractors (MACs) shall end-date all reassignment and employment relationship Provider Transaction Numbers (PTANs) linked to an organization's enrollment record that is -- 1) deactivated; 2) revoked; or 3) voluntarily withdraws, within fourteen (14) calendar days of the organization's related enrollment action in the Provider Enrollment Chain and Ownership System (PECOS).		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10443.1.1	MACs shall not deactivate the group member or physician assistant enrollment records at the time of the organizations action regardless of whether or not the group member PTAN is the only PTAN on the individual's enrollment record.		X							
10443.1.2	MACs shall issue-- 1) deactivation; 2) revocation; or 3) voluntary withdraw letter to the deactivated or revoked Part B organization that includes the following language; *Please notify all Physician Assistants and/or Group Members who reassign benefits to your organization that in accordance with 42 CFR §424.540(a)(2) their Medicare enrollment status may be deactivated if they fail to update their*		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	enrollment record within 90 calendar days.									
10443.1.3	MACs shall access the 'Group Member Enrollments without Reassignment Aging Report' in PECOS to identify providers that have been in an approved status with no active reassignments or practice locations for 90 days. Note: Physician Assistants not included.		X							
10443.1.3.1	MACs shall deactivate group member's enrollment record in PECOS within fourteen (14) calendar days of reaching the 90 day mark if an application is not submitted to report a new practice location or reassignment.		X							
10443.1.3.1.1	If a provider does submit an application to report a new practice location or reassignment and that application is subsequently rejected or		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	denied, the MAC shall deactivate the provider in accordance with 42 CFR §424.540(a)(2) after the 90 day period has lapsed.									
10443.1.4	MACs shall issue a deactivation letter to the individual provider at the correspondence address in PECOS that cites 42 CFR 424.540(a)(2) the same day as the PECOS deactivation. MACs shall use the attached model letter.		X							
10443.2	MACs shall send a revalidation notice between 90 to 105 days prior to the revalidation due date using the sample letter provided in Pub. 100-08, chapter 15, section 15.24.5.	X	X	X						
10443.3	MAC shall be aware that the effective date limitations outlined in Pub. 100-08, chapter 15, section 15.27.1.2 – Reactivations, are only applicable if a		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	provider or supplier is deactivated for failure to respond to a revalidation request or a provider or supplier fails to respond timely to a revalidation development request. In all other situations a 30 day retrospective billing date is allowable.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	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

Table of Contents
(Rev.782, Issued: 03-30-18)

Transmittals for Chapter 15

15.24.15 – Model Deactivation Letter for an Individual Provider
(Rev.782; Issued: 03-30-18; Effective: 04-02-18; Implementation: 04-30-18)

[month] [day], [year]

[Provider/Supplier Name]
[Address]
[City] ST [Zip]

Reference # (Contractor Control Number or NPI)

Dear [Provider/Supplier Name]:

Your enrollment record is being deactivated effective [month] [day], [year}, for the following reason:

xx CFR §xxx.(x) [heading]

[Specific reason]

If you have any questions, please contact our office at [phone number] between the hours of [x:00 AM/PM] and [x:00 AM/PM].
.
Sincerely,

[Name]
[Title]
[Company]

15.27.1.1 – Deactivations
(Rev.782; Issued: 03-30-18; Effective: 04-02-18; Implementation: 04-30-18)

A. Reasons

Unless indicated otherwise in this chapter or in another CMS instruction or directive, the contractor *shall* – with*out* prior approval from its CMS Provider Enrollment Business Function Lead (PEBFL) - deactivate a *provider or supplier's entire enrollment record and Medicare billing privileges when*:

- *A provider or supplier fails to respond to a revalidation request;*
- *A provider or supplier fails to respond timely to a revalidation development request, or;*
- *A provider is enrolled in an approved status without an active reassignment or practice location for 90 days or longer.*

The contractor shall not take deactivation actions unless specified in this chapter or other CMS directives.

The effective date limitations outlined in chapter 15.27.1.2 – Reactivations, are only applicable if a provider or supplier is deactivated for failure to respond to a revalidation

request or a provider or supplier fails to respond timely to a revalidation development request. In all other situations a 30 day retrospective billing date is allowable.

B. Regulations

- *Per §424.540(a)(1), a provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. The 12 month period begins on the 1st day of the 1st month without a claims submission through the last day of the 12th month without a submitted claim;*

- *Per §424.540(a)(2), a provider or supplier fails to report a change to the information supplied on the enrollment application within 90 calendar days of when the change occurred. Changes that must be reported include, but are not limited to, a change in practice location, a change of any managing employee, and a change in billing services; a provider or supplier fails to report a change in ownership or control within 30 calendar days.*

- *Per §424.540(a)(3), a provider or supplier does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information.*

C. Effective Dates

The effective dates of a deactivation are as follows:

1. Non-Billing §424.540(a)(1) – The effective date is the date the action is taken unless stated otherwise in this chapter or another CMS directive.

2. Failure to Report or Furnish Information §424.540(a)(2) and (3), – The effective date is the date the action is taken unless stated otherwise in this chapter or another CMS directive.

3. The "36-Month Rule" for HHAs – CMS' provider enrollment staff will determine the effective date during its review of the case.

D. Appeals Rights

The Medicare contractor shall not afford a provider or supplier appeal rights when a deactivation determination is made.

E. Miscellaneous

1. The deactivation of Medicare billing privileges does not affect a supplier's participation agreement (CMS-460).

2. Prior to deactivating an HHA's billing privileges for any reason (including under the "36-month rule"), the contractor shall refer the matter to its PEBFL for review and approval. The only exception for PEBFL review and approval is deactivations due to failure to comply with a revalidation request.

15.29.1 – Revalidation Lists

(Rev.782; Issued: 03-30-18; Effective: 04-02-18; Implementation: 04-30-18)

The 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 *90 to 105* 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.782; Issued: 03-30-18; Effective: 04-02-18; Implementation: 04-30-18)

Based on the due date identified on the list, MACs shall send a revalidation notice between *90 to 105* 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 *90 to 105* 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.

15.29.7 – Large Group Revalidation Coordination

(Rev.782; Issued: 03-30-18; Effective: 04-02-18; Implementation: 04-30-18)

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 *90 to 105* 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.