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Centers for Medicare & Medicaid Services
Revalidation of Medicare Provider Enrollment National Provider Call

Moderator: Diane Maupai

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Contents

Introduction 2
Overview of Revalidation of Medicare Provider Enrollment 3
Improvement to the Provider Enrollment, Chain and Ownership System (PECOS) 8
Changes to the CMS-855A Form 12
Advanced Diagnostic Imaging and Accreditation 14
Note: Revalidation Applies to all Providers/Suppliers 15
Revalidation Application Fees 16
855 Forms 17

Operator: At this time, I would like to welcome everyone to the Revalidation of Medicare Provider Enrollment Conference Call. All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. Thank you for your participation. I will now turn the call over to Diane Maupai. You may begin.

Introduction

Diane Maupai: Good afternoon, everyone. This is Diane Maupai. I'm with the Provider Communications Group at the Centers for Medicare & Medicaid Services (CMS) in Baltimore. Thank you for joining us today for our call on Revalidation of Medicare Provider Enrollment.

Let me start by apologizing. There was no presentation for today's call. We did plan on having one and told you we would, so I'm sorry for those of you who searched for it. On the good news front, we will be posting the transcript and the audio recording of this call on the CMS Web site after the call.

Mark your calendars for our next call, which is Thursday, December 1st, at this same time, when we will be talking about the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) and tips for completing enrollment applications.(**POST CALL UPDATE** : *this call has been postponed.*)

I'm happy to introduce our speakers for today. We'll be starting off with Zabeen Chong, who is the Director of the Provider Enrollment Operations Group, and Mark Majestic, who is a Deputy Director. They will be talking about revalidation, which will be the bulk of the call. Then we will have some brief updates.

Zabeen will be talking about 2012 Internet-based PECOS improvements. Frank Whelan will be giving some information and updates on the 855A enrollment application form, and Tiffany Stouder will be talking about advanced diagnostic imaging. With that, I'm turning it over to you, Mark.

Overview of Revalidation of Medicare Provider Enrollment

Mark Majestic: Thank you. I'm Mark Majestic. We're going to talk a little bit today about the revalidation efforts that are now under way throughout the country. The revalidation project itself is being done as a result of provisions in the Affordable Care Act, particularly section 6401, which established a requirement that all enrolled providers and suppliers have to revalidate their enrollment information under new screening provisions. This means all providers and suppliers enrolled prior to March 25, 2011. The only providers and suppliers that would be exempt from having to go through the revalidation are those that enrolled after the March 25th date.

The March 25th date became the magical date because it is one year after the passage of the Affordable Care Act. Everything was based upon the date that the Act was actually passed.

CMS is working with contractors throughout the country to try to make this effort as smooth as possible. Due to the size of this revalidation project, we're instituting measures—or have already instituted some measures, with more going on—that will try to ease the burden as much as possible on the provider/supplier community.

We will go over some of the enhancements in the PECOS system, as well as development issues that the contractors are undertaking during the revalidation efforts, to try to make this as smooth as possible.

The first phase of the revalidation effort started a couple of weeks ago and it dealt with those providers and suppliers that had active enrollment in Medicare but were not actively enrolled in the PECOS system.

In the last week of September, contractors mailed approximately 89,000 revalidation notices out to suppliers and providers around the country. The rest of this whole project is being done as a phased approach that will allow the contractors the ability to manage their workload and to better serve the

community with questions, answers, and the ability to handle the large influx of applications coming in.
As I said, the first phase was for those just outside of PECOS. Future phases, which will commence after the first of the year, will primarily start on a smaller basis, and as the Medicare administrative contractors ramp up in staff, the mailings will increase. The key message is that we are asking everybody who is listening on this call not to do anything until you are instructed by your contractors to do so. This phased approach will allow contractors to manage the workload and ease the burden. If everybody decided to submit their applications all at once, unsolicited, it would create a bottleneck at the contractors and we don't want this revalidation effort to impact their everyday processing of new applications, changes of information, and other enrollment documents that may be required to be submitted.

The key is for providers/suppliers, particularly those large groups, to wait to be instructed by the contractors. We're moving a lot of the larger groups back into the later phases to leverage the enhancements that are being made to the Provider Enrollment, Chain and Ownership System (PECOS), which will be addressed a little bit later. I think you'll find during that conversation that some of the enhancements that will be made in January will ease the burden quite significantly on the provider community as the revalidation effort proceeds.

Another reason why this is being done in a phased approach is not only that the contractors will be able to manage their inventory better, but it will allow the contractors the ability to provide education and outreach. CMS will also be able to manage such efforts, through avenues such as this and MLN Matters and the listserv messages, and try to extend and enhance all of the ongoing communications that we have about the revalidation effort. During the revalidation process, the Medicare administrative contractors will send a revalidation notice to the providers/suppliers. We are instructing the MACs to send it in a colored envelope so it stands out among all the other correspondence that one may receive. Many of the things that we have done have been implemented through groups such as this, or by addressing smaller

groups, but we have received feedback and suggestions throughout this course.

You'll be getting a letter that will provide specific instructions on what you will need to do. Such as, you have 60 days after the date of the letter to send your revalidation notices to the contractor. As long as you submit those documents within 60 days, there is no interruption to your billing privileges. No matter how long it takes the MAC to process that revalidation, during that processing time there will be no interruption.

Another avenue also being explored to ease the burden on the provider community is the submission of certain documents to the Medicare contractors. In the past, one may have had to submit documents, such as EFT agreements or tax documents, which may have already been on file with the contractors. However, under past procedures the contractors were to request the same document again. That process has changed. Now, as long as your information is correct and the documents are at the MAC, you will not be required to resubmit something that they already have on file and can verify.

One of the questions that came up early on in focus groups, and in many of the questions that we received prior to this call, was "How do I know I am getting a letter?" "How do I know one wasn't sent to me?" CMS is seeing that we have all of the identifying information on the 89,000 letters that went out earlier and we are in the process of posting that to www.cms.gov. This will give the business name and the NPI of each of the entities or individuals that were sent letters. Throughout this whole process of revalidation, we hope to update that list on a recurring basis—we are not sure specifically if it's going to be done every other week or monthly, but we're going to find the best solution—so everybody will be able to go to one spot and see if, in fact, they were mailed a letter. (Post Call Update: List now available as a download on the Medicare Provider Supplier Enrollment Revalidation Page.)

Several questions that we received previously or in the written questions were: "Where are the letters going?" "What addresses are they using?" Well, if you weren't in PECOS, they are going to your Special Payments or your practice address. Obviously, if you have already received a letter, it hit the right

address. Historically we have sent the letter to one address. In this case, we're actually sending them out to two different addresses to make every effort to ensure that providers actually get notified of this action. They are going to use the Special Payments and the Correspondence addresses simultaneously <u>for providers in PECOS</u>. (Underlined text is post call clarification). The letters will go out to both of those addresses at the same time. If both of those addresses happen to be the same, then the second letter will go out to the practice location.

As I said before, the letter will be in a different color envelope so it stands out from all the others. The letter itself is in a different type of format from other CMS letters. In bold print at the beginning of the letter is a statement within a block saying that this is a revalidation notice. The letter will describe basically what actions one must take—who to mail things to, and if you have issues, numbers to call, and things of that nature. If one waits to receive the notice and follows the instructions on the notice and adheres to that timeline it will help this process go through.

Our goal in using this phased approach is to leverage enhancements that are being made to PECOS in a way that would encourage the provider community to use PECOS as the means to revalidate. Zabeen will be talking about these enhancements to PECOS here in a few minutes. During the subsequent release, after the January release, the submission of revalidations will be much simpler than submitting the paper 855s, and it will ease the burden on the MACs as well. It's really just a couple-of-steps process and then revalidation via PECOS will be complete.

After you have been mailed the letter, you have 60 days to respond to that revalidation notice.

Another point about this process: Right now the regulations require that failure to respond to a revalidation notice means your provider number would be revoked.

Due to the magnitude of this effort, we don't want to take any undue administrative action unless required. So, instead of revoking the provider

number, we have opted to deactivate the provider number and allow the provider the avenue—once they know their number has been deactivated—of submitting the revalidation documents. Then, their provider number would be reinstated provided the revalidation documents are received within 120 days of the postmark of the original revalidation request. (Underlined text is post call clarification.)

Prior to that happening though, to ensure that every effort has been made to notify you of the revalidation attempt (in addition to the letter prior to that 60-day timeline), CMS has instructed the contractors to make at least two telephone calls to the phone numbers that are in PECOS to try to reach somebody to let them know that the revalidation letter was mailed, that you have not responded, and that you have to respond. We are trying to reach out in every way that we can to make sure that contact is made and to ensure that you are made aware that the revalidation is for you, and you are required to submit it.

Particularly for the larger groups, we have instructed the contractors to reach out and move those revalidation efforts later on in the process. We are doing that to leverage those enhancements in PECOS. This will allow the MACs to work very closely with the large provider groups and facilitate the flow of information to them, because we understand the complexities involved in that type of arrangement and we want to make sure that all of the enhancements in PECOS are operational. Once again, we are trying to ease the burden as much as possible on that group.

We will be continuing education and outreach efforts throughout this whole process, as I said, through MLN Matters, listserv messages, and addressing forums such as this. We are also posting Frequently Asked Questions that people have submitted. Based upon the submission of questions prior to this Open Door Forum, many of those will be incorporated as well. They will be published very soon. And certainly, as we go through this process we understand that keeping the lines of communication open and undertaking these educational activities are paramount to the success of this operation.

Because of the changes that may result, we think we will continue with outreach efforts throughout this whole process. At this time I will turn it over to Zabeen, who will talk about some of those enhancements in PECOS that will be absolutely critical to the success of this process. I think you will find that these enhancements will allow you the opportunity—or convince you to—go to the PECOS Web-based system rather than submit a paper application. So here is Zabeen Chong, the Director of the Provider Enrollment Operations Group.

Improvement of the Provider Enrollment, Chain and Ownership System (PECOS)

Zabeen Chong: Thank you, Mark. Good afternoon, everyone. I am excited to present to you some of the improvements we have planned for the 2012 releases of the PECOS system. Our focus is that these enhancements and changes to PECOS will increase the functionality for the provider and also reduce the enrollment application processing time. All of the changes I will be going over will take place throughout 2012, so you will see a good number of them in our January release. We'll have subsequent releases in the April, July, and October timeframes.

We've been doing a lot of outreach efforts with our Provider Focus Group to get feedback on what are the major theme points in the enrollment process. We know there are a number of challenges. There are issues in terms of not being able to easily log in into the system, not being able to reset your user names and passwords. We acknowledge that there were issues in setting up the Authorized Official and that adding support staff is a complicated process.

Duplicate data entry: I know many of you end up having to re-enter the same addresses and phone numbers multiple times when completing a single application. There are also still people who need to mail in paper documents, whether it's the certification statement or the supporting documents for your enrollment application.

We are also working on fixes for being able to search for provider information in the PECOS system. Currently, there is an inability to view the status of providers who have reassigned benefits to your group, or quickly search

through tens or hundreds of enrollments to find a particular enrollment record. Finally, we are also working on any inconsistencies that you may have when you are working with multiple MACs whose processing times differ.

This is a broad spectrum of the issues we are trying to tackle. Our improvement strategy really focuses on three main areas. One, we're obviously trying to increase usability. We want this provider enrollment experience to be somewhat enjoyable for you, and we see the Internet-based PECOS system as the main vehicle for you to use to submit your enrollment applications. We want to move away from paper.

We have been evaluating the user experience from start to finish. We want to simplify your online registration process, reduce data entry time, and then provide tools for large groups and organizations, as Mark alluded to earlier. We are also looking to an all-digital process. We want to remove paper from the enrollment process.

Finally, we are also working on mechanisms to increase transparency. We want to increase the access to information and communication about the status of your enrollment.

I'm going to highlight some of the enhancements coming in 2012. We've heard over and over again that there is a need to allow users to reset their passwords and user names online without CMS intervention. We are actively working on this for our January release, so there won't be any need to call CMS to take care of a simple function, such as resetting your password and user name.

We are also working on streamlining the process for registering an Authorized Official. We understand this process is complex and we are trying to simplify it. We are trying to eliminate much of the paper that's involved and condense the time it takes to get an Authorized Official registered.

Finally, we are also working on the ability for organizations and providers to quickly approve staff or other authorized representatives to work on their behalf. Currently, there isn't a mechanism for a provider to allow someone

else to work on their behalf. We have been tackling this issue for several months. We'll have a solution in place by January, which will be further enhanced in the April timeframe.

In terms of increased transparency of your enrollment, we're working on a couple of features. One, we've heard that groups really like to see all of the providers who have reassigned benefits to that group. We're working on a reassignment report that you can easily access to see all providers who have reassigned benefits to your group. In January, we also will have an improved My Enrollment page. This page will allow large groups or teams to quickly find particular enrollments or increase information about each enrollment upfront. You will have the ability to see the status of multiple changes that have been submitted and the ability to see if a request for revalidation has been sent by the MAC. We are also working on functionality to allow you to filter your enrollments and search on specific criteria. All of these things together will hopefully give you more access to your enrollments and enable you to get to the data more efficiently.

One of the features that will be critical to the revalidation effort is what we're calling the "fast track" view. Currently, if you go into the online system, you need to go through what we call a "topic view," where you need to look at each topic to see what the data is in your application. The fast track view will give you the ability to see all of your application information on a single screen. In terms of revalidation, you will be able to see all of your data on one screen without having to do multiple clicks or go to multiple pages. Then, if you need to make any changes, you can make them. If you don't, it really is a matter of reviewing that information and then submitting your application for revalidation. That feature will be available in the January timeframe.

We are doing a lot of other things to improve overall usability. We will be implementing the ability to collect previously used address information when concluding an application, and the ability to quickly update and resubmit any application returned for correction through the online system.

We are also working on the ability to electronically submit EFT via PECOS as part of any application submission. Today, we know that you need to mail that

in as a separate paper document. We're trying to incorporate that into the online PECOS system.

We are reducing the number of screens and steps for frequent changes as well as revalidation.

One other feature that will be coming later in 2012 is the ability to upload your documents digitally. If there are documents, such as your licensing information, that you need to submit to the MACs, we want to eliminate the mailing process. So, we are incorporating a feature that will allow you to upload electronic versions of your documents—this could be a PDF—during your enrollment application submission. You would have the ability to upload anything that you have electronically into the system, and then the MAC would receive it once you've submitted your application. That's something coming later in 2012.

Another big feature we are planning to deploy is the e-signature functionality. Currently, you are required to sign your certification statement and mail it in, even if you submitted your application online. We will be implementing the ability to e-sign that application and certification statement. We hope this will reduce processing time, not only for you, but also for the MACs, because they would have all of your information once you hit the Submit button.

Mark alluded to larger organizations and that we would be delaying some of those revalidations until we have certain PECOS enhancements in place. One of these features is the bulk upload feature. We want to provide large-group administrators an alternate method for submitting multiple enrollment applications at a single time. Basically, what this means is that we would give certain larger organizations the ability to upload in bulk format, or in a batch format, multiple enrollment applications. These would then be electronically sent to the PECOS system, where we could receive it on our end and then begin processing, versus the larger organizations having to fill out multiple paper applications or having to go into the online system multiple times and submit these applications separately.

Finally, we are also looking at our processing guidelines and the support that we provide to the provider community. We are looking at streamlining our processing guidelines. We want to remove any outdated guidelines, unify our guidance when requesting additional information across MACs, and integrate automated technologies that will increase the amount of sources checked while reducing the amount of time required to check them.

We also have a number of pilot programs in place with various MACs to find better and faster ways to improve the provider enrollment process and to provide support for providers who have questions. We are trying to improve our customer service, whether at the CMS help desk or through the MAC help desk, to make sure providers who have questions get the right person and get their questions answered in a timely fashion. We are also looking at ways to give the MACs the ability to view your in-progress applications so that they can immediately assist you with particular questions during your application process.

These are just some of the enhancements. There are more to come, but we wanted to give you some idea of how we are planning to make PECOS more efficient, why we want you to use the online process versus the paper, and how we are going to make the process more streamlined.

That's the end of my piece. I am going to hand it over to Frank Whelan from the Medicare Program Integrity Group. He will be talking to you about the 855 and some of the changes we've made there.

Changes to the CMS-855A Form

Frank Whelan: Thank you very much, Zabeen. The July 2011 version of the CMS-855A contains various new data elements. The most significant of these are as follows:

First, physician-owned hospitals: A physician-owned hospital means any participating hospital, as that term is defined in 32 CFR 49.24, in which a physician or an immediate family member of the physician has an ownership or investment interest. The new CMS-855A asks whether the provider is a

physician-owned hospital. If the provider is a physician-owned hospital, Attachment 1, Section 1, should be completed for every organization that has any percentage of ownership or investment interest in the provider. And Attachment 1, Section 2, should be completed for every individual who has any percentage of owner or investment interest in the enrollment provider. The bottom line is that the CMS-855A now has an attachment designed to collect additional information on physician-owned hospitals.

With respect to cost report information, in Section 2B1 we now ask for the provider's year-end cost report date. This has been on a previous version of the CMS-855, and we are now re-inserting it on the form.

And third, and perhaps most importantly, on Sections 5 and 6 of the 855A, in Section 5A2 we now ask for more detailed background information on the type of organization identified in Section 5. Specifically, we include checkboxes that identify whether the organization is a medical provider/supplier, a management services company, a medical staffing company, a holding company, an investment firm, a bank or other financial institution, or a consulting firm.

In Sections 5B and 6A we also ask for more detailed information on the relationship between the enrolling provider and the owning and/or managing individual or entity. For instance, we ask for the percentage of the individual's or entity's ownership interest in the provider, and we also ask for the individuals and entities that manage and control the provider. For those types of entities we ask for the types of services that that the individual or entity furnishes.

Another thing we've done is add more detailed instructions regarding the types of ownership interest that have to be reported in Sections 5 or 6. This includes examples on how to calculate indirect ownership interest as well as mortgage and security interest. These instructions, or this level of detail of instruction, were on a previous version of the 855. Based on some feedback we have received, we are including them back on the 855.

Finally, and perhaps most important, we have received a number of questions concerning the data elements from Section 5 and 6 that ask for the percentage

of an individual or entity's management and control over the enrolling provider. On October 25th, this past Tuesday, we sent out a listserv message that furnished clarification on this issue. We notified providers and suppliers, and we'll notify again today, that they need not—repeat, need not—complete the following data elements on either the paper or Internet-based PECOS versions of the CMS-855A application:

- In Section 5, the data element "the exact percentage of operational managerial control this organization has in the provider."

- In Section 6, the following data elements: "the exact percentage of control as an Officer this individual has in the provider, "the exact percentage of control as a Director this individual has in the provider," "the exact percentage of management control this individual has in the provider" (and that data element is under the W-2 Managing Employee heading), "the exact percentage of this contract the Managing Employee controls in the provider," and "the exact percentage of operational or managerial control this individual has in the provider."

- In addition, under the Other Ownership or Control Interest headings in Sections 5 and 6: "The exact percentage of ownership or control interest" does not need to be completed if the organization or individual does not have an ownership, partnership, mortgage, security, or other quantifiable interest in the provider.

The Medicare contractors have already received guidance to this effect.

That's pretty much all I have. I think Tiffany wanted to say some words about advanced diagnostic imaging, so I'll turn it over to you.

Advanced Diagnostic Imaging and Accreditation

Tiffany Stouder: Good afternoon, everybody. As Frank said, my name is Tiffany Stouder and I'm with the Provider Enrollment Operations Group here at CMS. I will be

giving some brief information on advanced diagnostic imaging, also known as ADI.

As you are aware, in January 2012, all providers performing advanced diagnostic imaging services, also known as ADI, as a Part B provider will need to be accredited by one of the CMS-approved accrediting organizations. In an attempt to add no unnecessary work to you as a provider, CMS has limited what is required to be entered on the enrollment application in regard to ADI services in the accreditation information.

After being accredited, you'll need to indicate the accrediting organization's name, the modality you are accredited for, and the effective and end dates of the accreditation on your enrollment application. In conjunction with your application, a weekly file from the accrediting organization will be received here at CMS and this file will be used to verify the information you've provided to us on your enrollment form. It is also used to update the future information on your record PECOS.

Once this information has been verified, it is then sent to the Claims Processing System. I want to make special note that it's extremely important that providers provide the appropriate NPI to the accrediting organizations. If the NPI given in the accrediting organization file does not match up in the PECOS system, we could have issues where the information is not passed down to Claims. If you have any questions pertaining to what NPI is appropriate, please contact your contractor and they can assist you.

That's all I had concerning the ADI. I am going to pass it back over to Frank.

Note: Revalidation Applies to all Providers/Suppliers

Mark Majestic: This is Mark Majestic again. I would like to go back to some of the revalidation topics that have been raised and try to clarify some of them. Several questioners asked, "Does this pertain to me? I am a DME supplier/ I am an IDTF/ I am various types of provider/supplier entities or individuals." I just want to clarify that this revalidation effort applies to all. It applies to everyone regardless of provider or supplier type. That was a recurring

question asked. Another one concerned application fees and Frank will address the submission of application fees.

Revalidation Application Fees

Frank Whelan: With respect to the application fee for 2011, the amount of the fee is $505. With respect to the application fee for 2012, we will be publishing something in the Federal Register in the near future that announces the fee for calendar year 2012.

In terms of who must pay the fee, a provider or supplier that is initially enrolling, or is revalidating, or is adding a new Medicare practice application must pay the application fee. However, the application fee does not apply to physicians or non-physician practitioners enrolling via the CMS-855I and does not apply to physician groups and non-physician practitioner groups enrolling via the CMS-855B. That's all I wanted to mention about the fees.

Zabeen Chong: A couple of things on that. This is Zabeen. In the October release of PECOS, one major enhancements we made was that the application fee can now be submitted during the online process of submitting your application, so there isn't a need now for you to go to the www.pay.gov Web site. All of your application fee submissions can be done through the PECOS system. We've also added another link that if you are the person submitting the application, and someone else is doing the submission of the payment, that person can access another link within PECOS, without having to log in or anything, and submit that fee. (Post call clarification: providers can choose to pay the fee via PECOS or go to a link outside PECOs to pay the fee.)

So there are two avenues, both done through the PECOS system; www.pay.gov just kind of works behind the scenes. If there are questions or issues with your online submission of payment, call the EUS Help Desk and they can direct you to the right person on your fee submission.

I am going to hand it over to Tolla. A number of the questions that came in had to do with which 855 to fill out. She is going to give an overview of the 855s and who should be filling out what.

855 Forms

Tolla Anderson: Hello, this is Tolla Anderson with the Provider Enrollment Operations Group. There are several different types of 855. There is the 855A for organizations that are considered certified and have to go through the State Survey agencies in the Regional Offices. Those types of entities, of course, are hospitals, skilled nursing facilities, home health agencies, hospices, and CMHCs (Community Mental Health Centers)—those types of entities.

There is also the CMS-855B for Part B organizations, for groups and clinics that would like to enroll to bill for Part B services. There is the 855I, which is for individuals, including physicians and non-physician practitioners, who want to enroll to bill as one of those provider types.

We also have the 855R, which is for reassignment. That's when an individual or a non-physician practitioner would like to reassign their benefits over to a Part B organization. Lastly, we have the 855O, which is a new form that's specifically for those types of eligible individuals who want to Order and Refer their services. The 855O is also for those who would not typically enroll in Medicare to bill or receive payments; these are eligible professionals who would be with the DoD or the VA, or those types of entities.

Those eligible professionals or physician/non-physician practitioners who want to opt out of Medicare would submit the opt-out affidavit, which is not a specific form. There is no uniform process for that as far as a form is concerned, but an affidavit should be submitted. With that, I'll hand it back over to Zabeen.

Zabeen Chong: A couple of notes on the 855: The new 855s have a couple of new questions. We've been getting a lot of questions on "Are you accepting new patients?" and on advanced diagnostic imaging. Currently, both of those questions are optional. We have made the ADI questions optional on the online system. We are aware of the bug in the online system for the Accepting New Patients indicator. That is being made optional, but the instruction to the contractors is that they do not need to develop it if you have submitted a paper application and left those fields blank.

I do want to mention and reiterate what Tiffany had to say: Although the ADI questions are currently optional, there is a requirement for claims processing that these questions will need to be completed for your claims to process come January 2012.

NOTE: The Question and Answer Session is not included in this transcript. Questions and answers will be posted to the CMS website.

Diane Maupai: This is Diane Maupai. I'm afraid we are almost out of time for the call. I see that we have 400 people waiting in the queue. I'm sorry we didn't get to everyone. (Post call update: Questions concerning provider enrollment policy should be referred to your MAC. Questions concerning the PECOS system should be referred to the CMS EUS Help Desk at 1-866-484-8049, or send an e-mail to EUSSupport@cgi.com.)

We will be providing listserv messages, educational materials like the MLN Matters articles, listserv messages, and also posting questions and answers to the Web site. We will be adding a revalidation page to the CMS enrollment site. I know that's something that would be very helpful to everyone. So with that, watch for important updates from CMS about when that new information is available and when the transcript and audio from this call is ready.

I'm sure some of you are thinking ,"What can I look at right now after this call?" There have been three MLN Matters articles written about the revalidation, and to locate those articles go to www.cms.gov/mlnmattersarticles . Look in the 2011 articles and search for number 1130. The last article we did, number 1130, talks about the new process for paying the enrollment application fee. Included in that article are links to the first two articles that talked about the overall regulation and some other information about enrollment. The other two resources you have are the regulation published February 2nd of this year, which is CMS 6028, and also Chapter 15 of the Program Integrity Manual, Section 19. So, there are at least a couple of things to get you started.

I'd like to thank our speakers today for a really informative call and I wish you all a good afternoon.

Operator: Thank you for participating in today's call about revalidation of Medicare provider enrollment. You may now disconnect.

END