CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 762	**Date: December 29, 2017**
	Change Request 10386

SUBJECT: Update to Chapter 15 of Pub. 100-08

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to clarify the requirements for issuing revalidation approval letters and releasing information to callers over-the-phone. This CR also removes the following text from 15.29.4.3. "and establish an effective date based on the receipt date of the application."

EFFECTIVE DATE: January 29, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 29, 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
R	15/15.23/15.23.2/Release of Information
R	15/15.24/Model Letter Guidance
R	15/15.29/15.29.4/15.29.4.3/Revalidation Received After a Deactivation Occurs

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: 762	Date: December 29, 2017	Change Request: 10386

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I. GENERAL INFORMATION

A. Background: This CR will clarify the requirements for issuing revalidation approval letters and releasing information to callers over-the-phone. This CR adds a requirement for the Medicare Administrative Contractors (MACs) to insert language into revalidation approval letters to notify providers/suppliers of a 'gap in billing,' if applicable. In addition, this CR provides clarification to the MACs on the information they are able to release to callers over-the-phone.

B. Policy: There are no regulatory, legislative, or statutory requirements related to this CR.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
10386.1	The MACS shall insert the following statement into reactivation approval letters, if applicable; • While your PTAN(s) and effective date(s) remain the same, you will have a gap in billing privileges from [deactivation date] through [reactivation date] for failing [to timely submit your revalidation application or to respond to a development request related to a revalidation application].You will not be reimbursed for services provided to Medicare beneficiaries during this time period since you were not in		X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	compliance with Medicare requirements.									
10386.2	The following information shall be made available over-the-phone to a caller who is able to provide a provider/suppliers name, PTAN, TIN/SSN and NPI number. The caller does not need to be listed on the provider/supplier's enrollment record as a contact person: • *Revalidation status (i.e., whether or not a provider/supplier has been revalidated), revalidation due date, revalidation approval date, the specific information related to a revalidation development request, and the date a provider/supplier was deactivated due to non-response to a revalidation or non-response to a development request.*	X	X	X						NSC
10386.3	MACs shall be aware that the following statement has been removed from Pub. 100-08, Chapter 15/15.29.4.3 – Revalidation Received After a Deactivation Occurs in order to avoid confusion.		X							

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, 4107862656 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

15.23.2 – Release of Information

(Rev. 762, Issued: 12-29-17, Effective: 01-29-18, Implementation: 01-29-18)

On October 13, 2006, CMS published System of Records Notice for the Provider Enrollment, Chain and Ownership System (PECOS) in the Federal Register. Consistent with this notice, once the provider has submitted an enrollment application (as well as after it has been enrolled), the contractor shall not release – either orally or in writing - provider-specific data to any outside person or entity, unless specified otherwise in this chapter. (Provider-specific data includes, but are not limited to, owners/managers, adverse legal history, practice locations, group affiliations, effective dates, etc.) Examples of outside persons or entities include, but are not restricted to, national or state medical associations or societies, clearinghouses, billing agents, provider associations, or any person within the provider's organization other than the provider's authorized official(s) (section 15 of the CMS-855), delegated official(s) (section 16), or contact persons (section 13). The only exceptions to this policy are:

- A routine use found in the aforementioned System of Records applies.

- The provider (or, in the case of an organizational provider, an authorized or delegated official): (1) furnishes a signed written letter on the provider's letterhead stating that the release of the provider data is authorized, and (2) the contractor has no reason to question the authenticity of the person's signature. The letter can be mailed, faxed, or emailed to the contractor.

- The release of the data is specifically authorized in some other CMS instruction or directive.

(These provisions also apply in cases where the provider requests a copy of any Form CMS-855 paperwork the contractor has on file.)

It is recommended that the contractor notify the provider of the broad parameters of the aforementioned policy as early in the enrollment process as possible.

- *The following information shall be made available over-the-phone to a caller who is able to provide a provider/suppliers name, PTAN, TIN/SSN and NPI number. The caller does not need to be listed on the provider/supplier's enrollment record as a contact person:*

Revalidation status (i.e., whether or not a provider/supplier has been revalidated), revalidation due date, revalidation approval date, the specific information related to a revalidation development request, and the date a provider/supplier was deactivated due to non-response to a revalidation or non-response to a development request.

In addition:

- When sending emails, the contractor shall not transmit sensitive data, such as social security numbers or employer identification numbers.

- The contractor may not send PECOS screen printouts to the provider.

- With the exception of CMS-855S applications, if any contact person listed on a provider or supplier's enrollment record, requests a copy of a provider or supplier's Medicare approval letter or revalidation notice, the contractor shall send to the contact person via email, fax or mail. This excludes Certification Letters (Tie In notices), as the contractor is not responsible for generating these approvals.

15.24 – Model Letter Guidance

(Rev. 762, Issued: 12-29-17, Effective: 01-29-18, Implementation: 01-29-18)

A. Format Requirements

All letters sent by contractors to providers and suppliers shall consist of the following format:

- The CMS logo (2012 version) displayed per previous CMS instructions.

- The contractor's logo shall be displayed however the contractor deems appropriate. There are no restrictions on font, size, or location. The only restriction is that the contractor's logo must not conflict with the CMS logo.

- All text, with the exception of items in the header or footer, shall be written in Times New Roman 12 point font.

- All dates in letters, except otherwise specified, shall be in the following format: month dd, yyyy (e.g., January 26, 2012).

Any exceptions to the above must be approved by the contractor's CMS Provider Enrollment & Oversight Group Business Function Lead (PEOG BFL).

Letters shall contain fill-in sections as well as static, or "boilerplate" sections. The fill-in sections are delineated by words in brackets in italic font in the model letters.

- The contractor shall populate the fill-in sections with the appropriate information such as primary regulatory citation and specific denial and revocation reasons, names, addresses, etc.

- The fill-in sections shall be indented ½ inch from the normal text of the letter.

- All specific or explanatory (not primary CFR citations) reasons shall appear in **bold type.**

- There may be more than one primary reason listed.

- The static sections shall be left as-is unless there is specific guidance for removing a section (e.g., removing a CAP section for certain denial and revocation reasons; removing State survey language for certain provider/supplier types that do not require a survey). If there is no guidance for removing a static section, the contractor must obtain approval from its PEOG BFL to modify or remove such a section.

The following do not require PEOG BFL approval:

- Placing a reference number or numbers between the provider/supplier address and the salutation.

- Appropriate documents attached to specific letters as needed.

- Placing language in any letter regarding self-service functions such as the Provider Contact Center Interactive Voice Response (IVR) system and Electronic Data Interchange (EDI) enrollment process.

The contractor shall use the following model letter formats. Unless as stated otherwise in this chapter, any exceptions to these formats must be approved by the contractor's PEOG BFL.

The above format, with the exception of static and fill-in sections, shall also be used for "as needed" letters (such as letters for individual provider or supplier circumstances).

B. Sending Letters

1. The contractor shall issue approval letters within 5 business days of approving the enrollment application in PECOS.

2. The approval letter shall be sent to the contact person listed on the application via scanned email, fax or mail. If there is no contact person on file, the approval letter shall be sent to the provider or supplier at the email or mailing address provided in the correspondence address section.

3. For all applications other than the Form CMS-855S, the contractor shall send development/approval letters, etc., to the contact person if one is listed; otherwise, the contractor may send the letter to the provider or supplier at the email or mailing address provided in the correspondence address or special payments address sections. The National Supplier Clearinghouse shall continue to send letters to the supplier's correspondence address until their automated process can be updated to include the contact person as a recipient of the letters.

C. Reactivation Letters

If a provider or supplier is to experience a gap in billing due to failure to respond to a revalidation request or failure to respond to a development request during revalidation, the contractor shall include the following in the reactivation approval letter:

- *While your PTAN(s) and effective date(s) remain the same, you will have a gap in billing privileges from [deactivation date] through [reactivation date] for failing [to timely submit your revalidation application or to respond to a development request related to a revalidation application]. You will not be reimbursed for services provided to Medicare beneficiaries during this time period since you were not in compliance with Medicare requirements.*

15.29.4.3 – Revalidation Received After a Deactivation Occurs

(Rev. 762, Issued: 12-29-17, Effective: 01-29-18, Implementation: 01-29-18)

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. 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