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Medicare Revalidations: Improvements and Cautions

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All providers and suppliers need to revalidate their Medicare enrollment information under new screening requirements imposed by Section 6401(a) of the Affordable Care Act (ACA), as set forth in 42 CFR §424.515. This new revalidation requirement is in addition to the ongoing obligation for providers and suppliers to keep their enrollment information current by filing a "change of information" to reflect any changes in enrollment data, such as a change of ownership, final adverse action, change in practice location, etc.

In the revalidation process, each provider and supplier must revalidate their entire Medicare enrollment record so the Centers for Medicare and Medicaid Services (CMS) can assure that it has current information, including all active practice locations and current reassignments. If the required revalidation is not filed on time or is incomplete, Medicare enrollment may be deactivated and payments will cease. Deactivated providers and suppliers will have to file entirely new applications to reinstate their enrollment records and reestablish their right to bill Medicare.

CMS Addresses Revalidation Process Problems

Providers/suppliers have encountered various problems in complying with the revalidation requirements. For example, some providers/suppliers were told that they could not revalidate their enrollments until they received a revalidation notification letter from the Medicare Administrative Contractor (MAC). If they did not receive the letter due, for instance, to a faulty or outdated address, they could be disenrolled for failure to revalidate on time, resulting in a gap in payment until a new enrollment could be filed and processed. CMS's new process aims to address some of the logistical issues that providers/suppliers have encountered.

CMS has updated its website with information about the revalidation process and these improvements. The web page can be accessed here. CMS also published a MedLearn Network article that can be accessed here. In addition, CMS scheduled an Open Door Forum MLN call for Tuesday, March 1, from 2 to 3:15 p.m. ET. Interested parties can register here. For later on-demand access, CMS will post the audio recording and written transcript approximately 2 weeks after the call on the MLN Connects National Provider Calls and Events webpage, which can be accessed here.

Specifics about CMS Guidance and Improvements to the Revalidation Process

Choosing PECOS or Paper

CMS encourages providers/suppliers to submit revalidations using the Internet-based PECOS website, which can be accessed here. After completing their data input, providers/suppliers must sign the electronic revalidation application on PECOS. Supporting documentation can be uploaded via PECOS or can be mailed in hard copy format to the MAC along with a signed certification statement. The application fee ($554 for 2016) can also be paid online through PECOS.

Alternatively, providers/suppliers can print and complete the revalidation application in paper format using the applicable CMS-855 form. The signed application, supporting documentation, and appropriate fee can be submitted to the MAC via regular mail. The MAC will then enter the information into the PECOS system.

Although the PECOS system was challenging to use and overwhelmed by volume when it was first introduced several years ago, CMS advises that filing the revalidation through the PECOS system should now be the faster, more efficient option. Using PECOS avoids an extra step in the process of requiring the MAC to enter the data for the provider/supplier. The provider/supplier can perform its own quality control on data input, avoiding the risk that the MAC could make a data entry error.

The Revalidation Time Frame and Due Dates

Revalidations have been scheduled to take place in waves, with specific due dates that fall on the last day of the month assigned to each provider/supplier by which they need to submit their revalidations. The provider/supplier will continue to be subject to its assigned due date during future periodic revalidation cycles. DME suppliers need to revalidate about every 3 years, while all other providers/suppliers must meet the revalidation requirement approximately every 5 years.

CMS encourages filing applications up to 6 months before the assigned due date. However, any application that is submitted more than 6 months before the assigned due date will be deemed to be an "unsolicited" revalidation application and will be rejected and returned.

Beginning February 25, 2016, CMS will publish an online database of all currently enrolled providers/suppliers. The database can be accessed at https://data.cms.gov/revalidation.[1] CMS plans to update this file periodically and provide a revalidation due date lookup tool with a data file that is downloadable in various formats.

This file will only list the revalidation due dates for the providers/suppliers that are due for upcoming revalidation within the next 6 months. All others will display "TBD" in the due date field and, for the time being, DME supplier information will not have due dates listed.

If an individual provider has reassigned payments to another organization, a crosswalk listing of reassignments will also be available at https://data.cms.gov/revalidation.[2]

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[1] The CMS webpages were not fully operational when this alert was prepared.

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MACs will continue to send notices to providers/suppliers 2 to 3 months before the revalidation due date, reminding them that their filing due date is approaching and listing any organizations to which they currently reassign. These notices will be sent either via email or regular mail to a minimum of 2 addresses, based on information reported on past applications for correspondence purposes. To assure that they receive the MAC's notice on time, providers/suppliers should review their PECOS files online and update any information that is not current. If a provider/supplier does not receive the notice from the MAC and is within 2 months of the due date listed on the CMS online revalidation file, the provider/supplier should proceed to submit the revalidation application.

File on Time to Avoid Deactivation, Payment Holds, and Payment Gaps

To avoid a "hold" on Medicare payments and the possible deactivation of Medicare enrollment and billing privileges, a provider/supplier must submit a complete revalidation application and supporting documentation by the due date. The provider/supplier must also respond within 30 days to all requests by the MAC for additional information.

If the revalidation application is late, or the necessary additional information is submitted after the due date, the enrollment record may be deactivated. If this happens, payments will cease. While deactivated providers/suppliers will keep their original Provider Transaction Access Numbers (PTANs), they risk a gap in their enrollment and a loss of revenue. A deactivated provider/supplier will have to file an entirely new and complete application to reestablish its Medicare enrollment record and reinstate billing privileges. Retroactive billing will not be allowed for the period of deactivation. Reactivation will begin on the date the MAC receives the new – and complete – application.

Large Group Coordination

CMS defines "large groups" as those that have more than 200 members enrolled. These groups are to receive notices from their MAC listings indicating which of the providers in their groups are due for revalidation. On the revalidation application, providers/suppliers must report all groups to which they are reassigning. Since only one application for each provider/supplier can be submitted, CMS encourages groups to stay abreast of due dates for their practitioners so all materials are submitted in a timely fashion. MACs will have specialized staff to coordinate and facilitate the process for large groups.

Do Not Forget About Medicaid

Section 6401 of the ACA also requires Medicaid programs to revalidate enrollment information for all enrolled providers, regardless of provider type. Under this new enrollment screening criteria, revalidations must take place at least every 5 years for Medicaid as well. Individual states have implemented their own revalidation initiatives and providers/suppliers must comply with those program requirements if they want to continue in good standing with their state Medicaid programs.

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