DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-17
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF INFORMATION TECHNOLOGY

Notice of Corrective Action

Date of Notice: FULLDATE

CONTACTNAME
JOBTITLE
CENAME
ADDRESS1
ADDRESS2
CITY, ST ZIP

Re: Corrective Action Number **XXXXX**

Dear TITLE LASTNAME:

On (month, day, year) the Department of Health and Human Services (HHS), Division of National Standards (DNS) within the Centers for Medicare & Medicaid Services' (CMS), opened a corrective action based on one or more violations discovered during the **<Covered Entity Name>** 2017 assessment. DNS will attempt to resolve all violations by informal means, including a corrective action plan as referenced in 45 CFR Part 160.312.

The following violations from the **<Covered Entity Name>** Final Assessment report dated (month, day, year) warrant a corrective action:

Violation #1
Description: 835 transaction does not balance at the transaction level.
Reference: 005010X221A1, Section 1.10.2.1.3 Transaction Balancing

Violation #2
Description: 835 transaction contains an invalid NPI number.
Reference: 005010X221A1, 1000B, N1 Payee Identification, N103 Identification Code Qualifier XX, External Code Source 537, N104 Payee Identification Code

Violation #3
Description: Attestation indicates health plan has not mapped their CARC/RARC/CAGC crosswalk to their internal codes since 2014, and is out of alignment with the current code combinations.
Reference: Operating Rule #: 360, Rule Requirement 4.1.2

As part of the corrective action process, <**Covered Entity Name**> is required to submit a corrective action plan (CAP) that addresses the violations listed above, and includes specific actions planned, dates for those actions, key milestones for monitoring progress, and an expected completion date. We have enclosed a template for your convenience.

You must provide the CAP within 30 days from the date of this letter, (month, day year). We will review the information you submit, and will notify you if it is satisfactory, or if we need additional information.

Please submit your CAP and applicable documentation in Microsoft Word, Excel, or PDF formats, to the HIPAA mailbox at hipaacomplaint@cms.hhs.gov, or write to the Division of National Standards, at:

Centers for Medicare & Medicaid Services
HIPAA Enforcement
Attn: Division of National Standards
P.O. Box 8030
Baltimore, MD 21244-8030

If you have any questions about this letter, please contact (contact name) at contact_name@cms.hhs.gov, or 555-555-5555. When contacting this office, please include the corrective action number located at the top of this letter.

Sincerely,
Madhu Annadata, Director
Division of National Standards
Office of Information Technology

cc:
Contact Name

Enclosures – CAP Template

CAP Template

Assessed Entity Name:	**Submitted by Name:**	**Phone Number:**
Corrective Action Number:	**Submission Date:**	**Email Address:**

Violation Description from Notice	Root Cause of Violation (Optional)	Notes/Comments
1.		
2.		
3.		
4.		
5.		
6.		

Major Milestones Planned Start Date	Planned Completion Date	Responsible Party or Position
Example: code updates *01/01/17*	*01/10/17*	*Developers*
1.		
2.		
3.		
4.		
5.		
6.		

For DNS Official Use Only

Assessor 1 Signature: _____

Assessor 1

Approval Date: _____

Month Day Year

In accordance with the Paperwork Reduction Act (1995), no persons are required to respond to a collection of information, unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is **0938-XXXX (Expires XX/XX/XXXX)**. The time required to complete this information collection is estimated to average **[10 hours]** per response (4 forms x 60 minutes/form), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to:

Centers for Medicare & Medicaid Services
Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact: Cecily Austin at cecily.austin@cms.hhs.gov or Kevin Stewart at kevin.stewart@cms.hhs.gov .