CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 557	**Date: September 14, 2009**
	Change Request 6574

NOTE: Transmittal 536, dated August 21, 2009 is rescinded and replaced by Transmittal 557, dated September 14, 2009. This instruction erroneously referenced Electronic Funds Transfer (EFT) in BR 6574.1 and was deleted along with BR 6574.3. Also, the effective and implementation dates were changed. All other information remains the same.

SUBJECT: Part B Individual Practitioner Supplier Enrollment Revalidation

I. SUMMARY OF CHANGES: The Centers for Medicare and Medicaid Services will begin a limited provider revalidation effort in fiscal year (FY) 2009. This revalidation effort will focus on the top 50 Part B individual practitioner supplier billers within each State for each contractor's identification number.

New / Revised Material
Effective Date: October 23, 2009
Implementation Date: October 23, 2009

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/A	

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: 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:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 557	Date: September 14, 2009	Change Request: 6574

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SUBJECT: Part B Individual Practitioner Supplier Enrollment Revalidation

Effective Date: October 23, 2009

Implementation Date: October 23, 2009

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services will begin a limited provider revalidation effort in fiscal year (FY) 2009. This revalidation effort will focus on the top 50 Part B individual practitioner supplier billers within each State for each contractor's identification number.

B. Policy: Consistent with the Federal Regulations found at 42 CFR 424.515 and Chapter 10, section 9 of the Program Integrity Manual (PIM), suppliers are required to revalidate their enrollment information every 5 years.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6574.1	All carriers and A/B MACs shall begin revalidating the top 50 billing (dollar value of submitted claims) Part B individual practitioner suppliers, including members of groups who also bill separately under their own PTAN, within each State for each of their contractor identification numbers that do not have an established record in the Provider Enrollment, Chain and Ownership System (PECOS).	X			X						
6574.2	The carriers and A/B MACs shall follow the revalidation instructions found in Chapter 10, section 9 of the Program Integrity Manual (PIM).	X			X						
6574.3	This requirement has been removed.										
6574.4	The Division of Provider and Supplier Enrollment (DPSE) expects that each carrier and A/B MAC shall mail initial revalidation packages to the selected Part B individual practitioner suppliers within 30 days of issuance of this change request.	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6574.4.1	Carriers and A/B MACs with more than one contractor identification number or State should solicit one State every 30 days.	X			X						
6574.5	Each carrier and A/B MAC shall send a list via email of the selected Part B individual practitioner suppliers and a 30, 60 and 90 day status report to their DPSE liaison or DPSE BFL.	X			X						
6574.5.1	This list/report shall contain the following data: practitioner name, NPI, date revalidation letter sent, date of response and final disposition with date completed.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:
Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: For all other recommendations and supporting information, use this space:
N/A

V. CONTACTS

Pre-Implementation Contact(s): Michael Collett (410) 786-6121

Post-Implementation Contact(s): Michael Collett (410) 786-6121

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Intermediaries (RHHIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *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.