CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 861

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: FEBRUARY 17, 2006

Change Request 4286

NOTE: Transmittal 861, dated February 17, 2006, is being re-issued to correct the transmittal page and the Internet Only Manual. Section 20.5.2, Communications, should be shown as a deletion on the transmittal page and deleted from the Internet Only Manual because it is replaced with Section 20.5.1. All other information remains the same.

SUBJECT: Sunset of the Policies for Provider Nominations for an Intermediary and the Provider Requests for a Change of Intermediary - Revisions to Publication 100-04, Chapter 1, Section 20.

I. SUMMARY OF CHANGES: Manual revisions shall be made to chapter 1, section 20 to reflect the change in statute that a new freestanding Medicare provider that enters the program shall no longer select its fiscal intermediary (FI), the provider must be assigned to the designated local FI. In addition, providers shall no longer be able to request a change in their FI, they must remain with the FI to which they have been assigned.

NEW/REVISED MATERIAL
EFFECTIVE DATE: October 1, 2005
IMPLEMENTATION DATE: March 17, 2006

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	Chapter 1/Section 20/Table of Contents
R	1/20 Provider Assignment to an FI
R	1/20/20.2 Provider Change of Ownership (CHOW)

R	1/20/20.3 Multi-State Provider Chains Billing FIs
R	1/20/20.4 CMS No Longer Accepts Provider Requests to Change their FI
R	1/20/20.5 Solicitation of a Provider to Secure a Change of FI
R	1/20/20.5.1 Communications
D	1/20/20.5.2 Communications

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 861	Date: February 17, 2006	Change Request 4286

NOTE: Transmittal 861, dated February 17, 2006, is being re-issued to correct the transmittal page and the Internet Only Manual. Section 20.5.2, Communications, should be shown as a deletion on the transmittal page and deleted from the Internet Only Manual because it is replaced with Section 20.5.1. All other information remains the same.

SUBJECT: Sunset of the Policies for Provider Nominations for an Intermediary and the Provider Requests for a Change of Intermediary - Revisions to Publication 100-04, Chapter 1, Section 20.

I. GENERAL INFORMATION

A. Background:

Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This allows the Secretary to take appropriate steps to transition from agreements under section 1816 and contracts under section 1842 of the Social Security Act to contracts with Medicare Administrative Contractors under section 1874A.

The provider nomination provision and the change of intermediary policy have sunset. New freestanding providers are no longer permitted to express a preference for a particular FI. New providers must be assigned to the designated local FI. For providers located in Puerto Rico and the U.S. Virgin Islands, they must be assigned to Cooperativa de Seguros de Vida de Puerto Rico. In addition, existing providers shall no longer be able to request a change of FI, they must continue with the FI to which they have been assigned.

B. Policy: The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), section 911 (d)(2)(B) allows the Centers for Medicare & Medicaid Services to take appropriate steps to transition providers to the Medicare Administrative Contractors (MACs).

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)					
		FI	RHHI	Carrier	DMERC	Shared System Maintainers	Other

						FISS	MCS	VMS	CWF	
4286.1	The Regional Offices shall assign new freestanding Medicare providers to the designated local FI.									Regional Offices
4286.2	Cooperativa de Seguros de Vida de Puerto Rico. shall receive all new freestanding Medicare providers located in Puerto Rico and the U.S. Virgin Islands.	X								
4286.3	All FIs shall inform freestanding Medicare providers of the enrollment changes.	X								
4286.4	FIs that receive applications from new Medicare providers that do not belong in their jurisdiction shall forward these new applications to the appropriate FI.	X								
4286.5	New providers that belong to CMS-recognized chains have the option to be assigned to the designated local FI or the FI that serves the home office.	X								
4286.6	All FIs shall inform existing freestanding Medicare providers that they shall no longer be able to request a change of FI.	X								

III. PROVIDER EDUCATION:

Requirement Number	**Requirements**	**Responsibility ("X" indicates the columns that apply)**								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4286.7	Refer to JSM -05542 and JSM -06054. A provider education article (Medlearn Matters Number SE0582) related to this instruction is available at www.cms.hhs.gov/medlearn/matters									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: No business requirement is necessary to explain how to handle workload back to the 10/1/2005 effective date.

X-Ref Requirement #	Instructions

B. Design Considerations: None

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: None

F. Testing Considerations: None

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1**,** 2005 **Implementation Date:** March 17, 2006 **Pre-Implementation Contact(s):** Sandra Clarke, sandra.clarke2 @cms.hhs.gov; (410) 786-6975 **Post-Implementation Contact(s):** Sandra Clarke; sandra.clarke2@cms.hhs.gov ; (410) 786-6975	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

Medicare Claims Processing Manual

Chapter 1-Provider Assignment to an FI

Table of Contents

(Rev. 861, 02-17-06)

20 - Provider *Assignment to an* FI

(Rev. 861, Issued: 02-17-06; Effective: 10-01-05; Implementation: 03-17-06)

Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This allows the Secretary to take appropriate steps to transition from agreements under section 1816 and contracts under section 1842 of the Social Security Act to contracts with Medicare Administrative Contractors under section 1874A.

The Centers for Medicare & Medicaid Services no longer allows freestanding or independent providers that enter the Medicare program to express a preference for a particular FI. The Regional Offices (ROs) must assign the new provider to the designated local FI. Please note that for Puerto Rico and the U.S. Virgin Islands, the providers must be assigned to Cooperativa de Seguros de Vida de Puerto Rico. FIs that receive applications for new Medicare providers that do not belong in their jurisdiction shall forward these new applications to the appropriate FI.

The assignment of providers to the local FI also includes the following types of providers:

- Comprehensive outpatient rehabilitation facilities (CORFs);
- Community mental health centers (CMHCs);
- Outpatient physical therapy (OPT) facilities;
- Rehabilitation agencies (these fall under the umbrella of OPT facilities); and
- End-stage renal disease (ESRD) facilities.

This group of providers will not be able to become chain organizations or receive single FI status. However, exceptions have been made for ESRD facilities. CMS has allowed some ESRD facilities to have single FI status.

Freestanding or independent *R*ural *H*ealth *C*linics (RHCs) must be assigned to their designated FI.

Provider-based RHCs are serviced by the same FI as the parent provider. That is, if the RHC is provider-based to a hospital, then the hospital's FI processes both the hospital's and the RHC's claims.

All *F*ederally *Q*ualified *H*ealth *C*are *C*enters (FQHCs) are assigned to United Government Services (UGS). See §20.1 for HHAs and *H*ospice FI designations.

20.2 - Provider Change of Ownership (CHOW)

(Rev. 861, Issued: 02-17-06; Effective: 10-01-05; Implementation: 03-17-06)

Providers (as defined in 1861(u) of the Act, and institutional suppliers such as RHCs) that undergo a change in their ownership structure are required to notify CMS concerning the identity of the old and new owners. They are also required to inform CMS on how they will organize the new entity and when the change will take place. A terminating cost

report will be required from the seller owner in all CHOWs for certification purposes. There are five types of changes that can occur:

1. A CHOW in accordance with 42 CFR 489.18;

2. Changes in the ownership structure to an existing provider that do not constitute a CHOW;

3. A new owner who purchases a participating provider but elects not to accept the automatic assignment of the existing provider agreement, thus avoiding the old owner's Medicare liabilities;

4. An existing provider who acquires another existing provider (acquisition/merger); and

5. Two or more existing providers who are totally reorganizing and becoming a new provider (consolidation).

Providers that undergo a change of ownership *will usually continue* with the same FI that served the previous owner. However, if the prospective owner does not wish to accept the automatic assignment of the existing provider agreement, *this means that the existing provider agreement is terminated effective with the CHOW date. The regional office must be notified in writing of the CHOW per instructions contained in section 3210.5 of the State Operations Manual. The prospective owner provides a notice 45 -days in advance of the CHOW to the CMS/RO to allow for the orderly transfer of any beneficiaries that are patients of the provider. All reasonable steps must be taken to ensure that beneficiaries under the care of the provider are aware of the prospective termination of the agreement. There may be a period when the facility is not participating and beneficiaries must have sufficient time and opportunity to make other arrangement for care prior to the CHOW date*.

After the CHOW has taken place, the RO acknowledges the refusal to accept assignment in a letter to the new owner, with copies to the State Agency (SA) and the FI. The RO completes a form CMS-2007 with the date the agreement is no longer in effect, noting that the termination is due to the new owner's refusal to accept assignment of the provider agreement.

If the new owner refuses to accept assignment and also wishes to participate in the Medicare program, the RO will first process the refusal as indicated above and then treat the new owner as it would any new applicant to the program. The RO will obtain and process the application documents, have the SA perform an initial survey and if all the requirements for participation are met, assign an effective date of participation. The earliest possible effective date for the applicant is the date that the RO determines that all Federal requirements are met. Once this is completed, a new provider agreement with a new provider number will be issued to the new owner. The provider will be assigned to the local FI.

See chapter 10, of the Medicare Program Integrity Manual, for complete requirements for completion of Form CMS-855 in change of ownership situations.

20.3 - Multi-State Provider Chains Billing FIs

(Rev. 861, Issued: 02-17-06; Effective: 10-01-05; Implementation: 03-17-06)

NOTE: The CMS does deny certain freestanding providers *to become chain organizations, please refer to section. §20 for a list of these providers.*

New providers that belong to CMS-recognized chains have the option of being assigned to the local designated FI or to the FI that serves the chain home office.

A centralized chain of providers may, because of the nature of its operations, require services through a single FI in order to improve administration. If a single FI would not be possible with the usual election procedures (e.g., the desired FI is not authorized to serve in some areas where the chain facilities are located), the chain may nevertheless request special authorization for the FI to serve all its component facilities. Such requests are submitted to the RO that has jurisdiction of the State in which the home office of the chain is located. The following factors will be considered, among others, in determining whether such authorization may be granted:

Size	The chain must comprise a minimum of ten participating facilities or 500 certified beds. However, where the chain has facilities in three contiguous States, it may be eligible if it comprises five facilities or 300 certified beds.
Central Controls	The chain must demonstrate that effective central controls are exercised assuring substantial uniformity in the operating procedures, utilization controls, personnel administration, and fiscal operations of the individual provider.
Savings or Efficiencies	The provider must demonstrate that the change is consistent with effective and efficient administration of the Medicare program. If the provider alleges that cost savings or other efficiencies will be realized; these must be quantified in terms of savings to the Government.
FI Capacity	Based on the chain's size and location of the individual facilities, the elected FI must be found to have the resources and capacity to effectively serve the chain. **NOTE:** If the HHA or Hospice chain chooses a single RHHI, the single RHHI services the entire chain and it also does the audit. The single designated RHHI handles the chain's home office audit, desk review and all of the chain's cost reports. The single designated RHHI determines the scope of individual provider audits and negotiates the final settlements for each cost report. The designated RHHI processes and pays claims as well as conducts medical field reviews. See 42 CFR 421.117(e).

The CMS must review the request and determine whether the arrangement is in the best interest of the program. If the request is approved, the RO initiates all actions necessary to tie the multi-State chain to the FI/FIs.

20.4 – CMS No Longer Accepts Provider Requests to Change their FI.

(Rev. 861, Issued: 02-17-06; Effective: 10-01-05; Implementation: 03-17-06)

Medicare providers will no longer be able to request a change of FI, they must remain with the FI to which they have been assigned.

20.5 - Solicitation of a Provider to Secure a Change of FI

(Rev. 861, Issued: 02-17-06; Effective: 10-01-05; Implementation: 03-17-06)

If FIs solicit nominations from providers currently served by other FIs, the program suffers unnecessary disruption and cost. Consequently, FIs must refrain from such solicitation, and providers are asked to alert their RO whenever they become the object of such activity. Likewise, if an FI becomes aware that its providers are being solicited, it should discuss the circumstances with its RO.

Solicitation is defined as "**an FI taking the initiative in furnishing to any Medicare provider presently served by another FI, information, promises, projections, or other material intended to cause the provider to seek CMS' approval for a change of FI**."

The RO serving the provider involved will investigate allegations of solicitation. Where CMS determines that an FI did solicit a provider's nomination contrary to these instructions, the FI will be barred from servicing that provider. Additionally, periods of geographic suspension of availability for provider service may be imposed upon an offending FI on a State, regional, or nationwide basis depending on the frequency and nature of the complaints.

20.5.1 - Communications

(Rev. 861, Issued: 02-17-06; Effective: 10-01-05; Implementation: 03-17-06)

If an FI receives a request for Medicare material or information from a provider serviced by another FI, it may comply with the request only after first notifying its servicing RO in writing that the request has been received. If the provider requests a visit by the FI, CMS considers a single visit sufficient to make a presentation; however, the RO may authorize multiple visits if the FI furnishes sufficient justification. For each contact or visit it has with a provider it does not service, the purpose of which is to discuss the Medicare program, the FI is expected to maintain a file of written reports.