



Preparing for a Transition from an FI/Carrier to a Medicare Administrative Contractor (MAC) or from one Durable Medical Equipment (DME) MAC to another DME MAC – JA1017

Note: This Job Aid was initially issued as JA0837 in 2008. It is being re-issued as JA1017 in order to update the content to reflect current experiences with transitions to a MAC.

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| Key Words | SE1017, Transition, MAC, DME MAC |
| Contractors Affected | <ul style="list-style-type: none"> • Carriers • Fiscal Intermediaries (FIs) • Part A/B Medicare Administrative Contractors (A/B MACs) • Regional Home Health Intermediaries (RHHIs) • Durable Medical Equipment MACS (DME MACs) |
| Provider Types Affected | <p>Provider types affected are all fee-for-service physicians, providers, and suppliers who submit claims to FIs Carriers, RHHIs, or DME MACs for services provided to Medicare beneficiaries. Providers already billing MACs have already transitioned and need not review this article. However, suppliers billing DME MACs may find the article of value as the Centers for Medicare & Medicaid Services (CMS) recompletes the DME MAC contracts, which could cause a transition from an incumbent DME MAC to a new DME MAC.</p> |



- This information is intended to assist all providers that will be affected by MAC implementations (or DME MAC transitions due to recompleting the DME MAC contracts).
- CMS is providing this information to make providers aware of what to expect as their FI or carrier transitions its work to a MAC (or the provider's DME MAC to another DME MAC). This information should minimize disruption in a provider's Medicare business.
- Providers should note that other Medicare contractors servicing their region will be unaffected by this change, such as the Qualified Independent Contractor (QIC for reconsiderations), Recovery Audit Contractor, the Program Safeguard Contractor, and the Zone Program Integrity Contractor.

NOTE to DME suppliers: This information focuses on transitions from carriers or FIs to MACs, but suppliers should note the information may also pertain to their business if there is a transition from their DME MAC to another DME MAC, as those contracts are recompeted

MAC Implementation Milestones/Definitions

- There are specific milestones in the cutover from carrier or FI work to MAC. Providers are advised to be aware of, and to take specific action relative to the milestones defined below:
 - **Award** – This is the point at which a MAC is announced as having won the contract for specific FI or carrier work.
 - **Cutover** – This is the date on which the carrier or FI work ceases and MAC work begins. Cutover is often done in phases by State-level jurisdictions. Because of the amount of activity involved in a cutover, there may be interrupted services for a day or two.
 - **Outgoing Contractor** - A Medicare carrier or FI whose Title XVIII contract is non-renewed as a result of Medicare Contracting Reform and whose work will transition to a MAC.
 - **Incoming MAC** - The entity that has won a contract under Medicare Contracting Reform and which will assume the workload that was performed by a carrier or FI.

Provider Needs to Know...

PRE-AWARD

- If a provider is in a jurisdiction where a new MAC has not yet been awarded, the provider can remain current with updates on Medicare Contracting Reform by visiting <http://www.cms.gov/medicarecontractingreform/> on the CMS website.

POST-AWARD

- Once the award to the MAC is made, providers should immediately begin to prepare for the cutover. Providers should be aware of the following recommendations to help in this effort:
 - **Pay attention to the mail** received from the outgoing Medicare contractor and the new MAC. Providers will be receiving letters and listserv messages about the cutover from both. These letters should include discussions on what, if any, impact the cutover will have on the provider's payment schedule, issuance of checks, impact on paper and electronic claims processing, electronic funds transfers, appeals, customer service, etc. Providers should focus on necessary actions that must be taken and the critical due dates assigned, to avoid any disruptions in claims payment.
 - **Sign up for the new MAC's listserv**, or if they aren't signed up for their current FI or carrier's listserv, they should do so immediately. While in many cases the list of providers that were in the jurisdiction of the outgoing Medicare contractor will be shared with the incoming MAC, that may not always be the case. Subscribing to the MAC listserv distribution will ensure that news and resource tools are received as

they become available concerning the implementation.

- **Access and bookmark the MAC's website**, particularly any part of the site devoted to information about the MAC transition/implementation) and visit it regularly. The MAC may have a new website that will have general information, news and updates, information on the MAC's requirements of providers, copies of newsletters, and information on meetings and conference calls that are being conducted by the MAC.
- **Review the Frequently Asked Questions (FAQs) on the MAC's website.**
- **Participate in the MAC's advisory groups and "Ask the Contractor" teleconferences.** (Note that these advisory groups are usually limited in size.) Every MAC will be conducting conference calls to give providers the opportunity to ask questions and have open discussion. Take advantage of the opportunity to communicate with the new MAC!
- **Review the MAC's Local Coverage Determinations (LCDs)** as they may be different from the outgoing contractor's LCDs. The MAC must provide education on LCDs. Providers should monitor MAC communications and website for information regarding potential changes to the LCDs.

TWO TO THREE MONTHS PRIOR TO CUT-OVER

- Providers should complete and return their Electronic Funds Transfer (EFT) agreements.
 - CMS requires that each provider currently enrolled for EFT complete a new CMS-588 for the new MAC and if not on EFT, this may be a good opportunity to consider enrollment in EFT. (If the new MAC is the same entity as the current FI/carrier, then a new EFT agreement is not needed.)
 - This form is a legal agreement between the provider and the MAC that allows funds to be deposited into the provider's bank account. It is critical for the MAC to receive these forms before any payments are issued.
 - Providers should complete the CMS-588 and submit it to the MAC to ensure that there is no delay or disruption in payment.
 - Providers are encouraged to do this no later than 60 days prior to cutover. If the provider fails to submit the CMS-588 form as required, the new MAC will place him in a "Do Not Forward" (DNF) status as required by Chapter 1, Section 80.5 of the Medicare Claims Processing Manual.
 - Providers should contact their MAC with any questions concerning the agreement.
 - The CMS-588 form can be found at <http://www.cms.gov/cmsforms/downloads/CMS588.pdf> on the CMS website.
 - Providers are encouraged to submit the agreements no later than 60 days prior to the planned cutovers. To do so, they will need to note the mailing address for the form, which is available on the MAC's website. Their current contractor may also provide instructions on its website on accurately completing the form.
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- The new MAC may also request a provider to execute a new **Electronic Data Interchange (EDI) Trading Partner Agreement** as well. If so, the agreement should be completed in a timely manner. Some helpful information on such agreements is available at <http://www.cms.gov/EducationMaterials/downloads/TradingPartner-8.pdf> on the CMS website.
- Some (not all) MAC contractors may assign a new EDI submitter/receiver and logon IDs as the cutover date approaches.
 - Providers should review their mailings from the MAC and/or their website for information about assignment of new IDs and whether he has to do anything to get those IDs.
 - The MAC EDI staff will send these submitter IDs and passwords in hardcopy or electronically. **Providers do not need to do anything to get the new IDs.** However, if they do receive a new ID and password, CMS strongly suggests that they contact the incoming MAC to test these IDs. Since there may be a different EDI platform, it is critical to consider testing to minimize any disruption to business at cutover.
- **Providers should contact their claims processing vendor, billing department, and clearinghouse** to ensure that they are aware of all changes affecting their ability to process claims with the new MAC. They should ask their vendor, "Are you using the new contractor number or ID of the new MAC, submitter number and logon ID?"; "Have you tested with the MAC?"
- Because the contractor number is changing, EDI submissions need to reflect the new MAC number at cutover.
- Providers should be aware of the last date they can receive and download electronic remittance advices (ERAs) from their outgoing contractor.
- Providers should be aware that some MACs may offer participation in an "early boarding" process for electronic claims submission and/or Electronic Remittance Advice (ERA).
 - This will enable submitters the ability to convert to the new MAC prior to cutover.
 - If a provider is currently receiving ERAs, he will continue to do so after cutover. As mentioned previously, some MACs may assign a new submitter/receiver ID and password – providers should watch for and document them for use after cutover to the MAC.

CUT-OVER WEEKEND

- Providers should be aware that in certain situations, CMS will have the outgoing Medicare contractor release claims payments a few days early in preparation for implementation weekend (weekend prior to cutover). Providers will be notified prior to the cutover date if they will receive such payments. While the net payments are the same, providers will experience increased total payments followed by no payments for a two week period.
 - Providers may also experience system "**dark days**" around cutover weekends.
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Providers will be notified by the MAC or outgoing contractor if a dark day(s) is planned for the MAC implementation. During a dark day, the Part A provider will have limited EDI processing and no access to Fiscal Intermediary Standard System to conduct claim entry or claim correction, verify beneficiary eligibility and claim status. Those providers who currently bill carriers may also experience some limited access to certain functions, such as beneficiary eligibility and claims status on dark days.

- Providers should be aware that some Interactive Voice Response (IVR) functionality may also be unavailable during a dark day.

POST CUT-OVER

- The first 1-2 weeks may be extremely busy at the MAC. The outgoing Medicare contractor will have the "in-process" work delivered to the new MAC shortly after cutover. It takes a week in most cases to get that workload into the system and distributed to staff.
- The new MAC will likely have new mailing addresses and telephone numbers or will transition the outgoing contractor toll-free number for use.
- Providers may experience longer than normal wait times for Customer Service Representatives (CSRs) and lengthier calls the first few weeks after implementation. The telephone lines are always very busy immediately following cutover. The MAC's staff will carefully research and respond to new callers to be certain that there are no cutover issues that have not been discovered.
- **Providers should learn how to use the MAC's IVR.** The MAC IVR software and options may be different from the outgoing FI or carrier. A new IVR can take time to learn. Most calls are currently handled by IVR. If users are unfamiliar and resort to calling the CSR line, the result is a spike in volume of calls to CSRs that are difficult to accommodate.
- Providers should check the MAC's outreach and education event schedule on the MAC's and outgoing contractor's websites. It is recommended that provider's staff attend some of the education courses that may be offered by the MAC.
- There may be changes in faxing policies (e.g., for medical records).
- There will be changes to PO Boxes and addresses for the submission of requests for Redeterminations (appeals), inquiries, and written reopening requests.
- The MAC may edit claims differently from the outgoing contractor, so it is important to review Remittance Advices (RAs) carefully to identify when this occurs.
- Providers may experience changes in RA coding. While the combination of codes used on the RA is often directed by CMS, there may be payment situations where the codes used on the RA are at the discretion of the contractor. In addition, some contractors may have their own informational codes that they use on paper RA for some payment situations.

CMS POST CUT-OVER MONITORING

- Post-cutover is the CMS-designated period of time beginning with the MAC's operational date.
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- During the post-cutover period, CMS will monitor the MAC's operations and performance closely to ensure the timely and correct processing of the workload that was transferred.
- The post-cutover period is generally three months, but it may vary in length depending on the progress of the implementation.

ADDITIONAL ASSISTANCE

- There are three attachments at the end of this article to assist in keeping informed of the progress of the cutover as well as documenting important information:
 - Attachment A is a summary of what needs to be done and information needed;
 - Attachment B may be used to track communications offered by the MAC, such as training classes and conferences, and staff participation; and
 - Attachment C may be used to assist in tracking major MAC milestones.

Background

- Medicare Contracting Reform (or Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) mandates that the Secretary for Health & Human Services replace the current contracting authority to administer the Medicare Part A and Part B Fee-For-Service (FFS) programs, contained under Sections 1816 and 1842 of the Social Security Act, with the new MAC authority. Medicare Contracting Reform requires that CMS conduct full and open competitions, in compliance with general federal contracting rules, for the work currently handled by FIs and carriers in administering the Medicare FFS program.
- When completed, there will be 15 new MACs processing Part A and Part B claims.
- Each MAC services a distinct set of contiguous states, also known as a "jurisdiction".
- Each MAC will handle different volumes of work based upon the geographic breakout of the 15 MACs. Because of this, the MACs will vary in geographic size and the amount of work they handle. Having 15 MACs, should result in greater consistency in the interpretation of Medicare policies, which is a key goal of Medicare Contracting Reform.

Operational Impact N/A

Reference Materials The related MLN Matters® article can be found at <http://www.cms.gov/MLN MattersArticles/downloads/se1017.pdf> on the CMS website.

The following MLN Matters® articles provide additional information about the MAC implementation process:

- MM5979: "Assignment of Providers to Medicare Administrative Contractors" located at <http://www.cms.gov/MLN MattersArticles/downloads/mm5979.pdf>; and
 - MM6207: "Initial Enrollment Assignment for Federally Qualified Health Centers (FQHCs), End Stage Renal Disease (ESRD) Facilities, and Rural Health Clinics (RHCs)," located at <http://www.cms.gov/MLN MattersArticles/downloads/MM6207.pdf> on the CMS website.
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