



*The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers* brochure has been updated and is now available to order print copies or as a downloadable PDF file. To view the PDF file, go to <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsProcess.pdf> or to order hard copies, please visit the MLN Product Ordering Page at [http://cms.meridianksi.com/kc/pfs/pfs\\_lnkfrm\\_fl.asp?lgnfrm=reqprod&function=pfs](http://cms.meridianksi.com/kc/pfs/pfs_lnkfrm_fl.asp?lgnfrm=reqprod&function=pfs) on the CMS website.

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## Assignment of Providers to Medicare Administrative Contractors

**Note:** This article was revised on March 25, 2014, to add a reference to MLN Matters® article MM8442 (<http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8442.pdf>) which amends the "Medicare Claims Processing Manual" to show that provider chains and individual providers are no longer permitted to select the fiscal intermediary or MAC of their choice. All other information remains the same.

### Provider Types Affected

All physicians, providers and suppliers who submit claims to Medicare Administrative Contractors (A/B MACs), fiscal intermediaries (FIs), carriers or Regional Home Health Intermediaries (RHHIs) for services provided to Medicare beneficiaries.

### Impact on Providers

This "One Time Notice" CR describes the Centers for Medicare & Medicaid Services (CMS) approach for assigning providers to MACs and discusses the process of moving providers to MACs.

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## Background

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This article is based on CR 5979 and Section 911 of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)*, Public Law 108–173, amended Title XVIII of the *Social Security Act (the Act)* to add section 1874A, Contracts with Medicare Administrative Contractors (MACs).

### *I. What are “MACs?”*

Under section 911 of the MMA, Congress requires that CMS replace the current fiscal intermediary (FI) and carrier contracts with competitively procured contracts that conform to the Federal Acquisition Regulation (FAR). Under the new Medicare Administrative Contractor (MAC) contracting authority, CMS has 6 years - between 2005 and 2011 - to complete the transition of Medicare Fee-for-Service (FFS) claims processing activities from the FIs and carriers to the MACs.

For information on CMS’ progress in awarding and implementing the MACs, please visit <http://www.cms.gov/Medicare/Medicare-Contracting/MedicareContractingReform/index.html> on the CMS website.

### *II. What is “Provider Nomination?”*

“Provider Nomination” is a phrase that describes the former right of an individual provider or a chain of providers to select assignment to the FI of its choice. In section 911(b) of the MMA, Congress repealed the provider nomination provisions of the Social Security Act. Provider nomination has been replaced with the geographic assignment rule. Generally, a provider will be assigned to the MAC that covers the state where the provider is located. The CMS regulation at 42 CFR 421.404 reflects this policy shift. Other CMS regulations and policy manuals are in the process of being updated.

A moratorium was placed on the “change of intermediary” process for individual providers in October of 2005. *Transmittal 291 (CR # 5720)*, dated September 19, 2007, (see <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R291OTN.pdf> on the CMS website) informed all FIs and A/B MACs that CMS would no longer accept a request to move from one FI/MAC to another FI/MAC from a provider moving in or out of a Medicare chain. There remains one exception for qualified chain providers (QCPs) as discussed in Section V below.

### *III. Where will providers eventually be assigned in the MAC environment?*

#### **A. Home Health & Hospice**

All home health and hospice (HH&H) providers will be assigned to the MAC contracted by CMS to administer HH&H claims for the geographic locale in which the provider is physically located. See the following link for a description of the MAC-environment HH&H regions and the four MACs that will administer HH&H claims for those four regions.

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**B. Durable Medical Equipment**

Each supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) will submit claims to the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) contracted by CMS to administer DMEPOS claims for the geographic locale in which the beneficiary permanently resides. The link above under “A” also provides a description of the MAC-environment DMEPOS regions and the four MACs that will administer DMEPOS claims for those four regions.

**C. Qualified Railroad Retirement Beneficiaries Entitled to Medicare**

Physicians and other suppliers (except for DMEPOS suppliers) will continue to enroll with and bill the contractor designated by the Railroad Retirement Board (under Section 1842(g) of The Act) for Part B services furnished to these beneficiaries. Suppliers of DMEPOS will bill the DME MACs.

**D. Specialty Providers and Demonstrations**

Specialty providers, and providers involved with certain demonstrations, will submit claims to a specific MAC designated by CMS. A list of those specialty services and their designated MACs is reflected in the following table:

**MACs Designated to Process Specialty or Demonstration Claims**

<b>Specialty Service or Demonstration</b>	<b>MAC Jurisdiction</b>
Centralized Billing for Mass Immunizers	4
Indian Health Services	4
Low Vision Demonstration	5,10, 11, 13, and 14
Rural Community Hospital Demonstration	1, 2, 4 and 5
Veterans Affairs Medicare Equivalent Remittance Advice Project	4
Chiropractic Services Demonstration	4 and 5
Home Health Third Party Liability Demonstration Project	14
Medicare Adult Day Care Demonstration	11, 14 and 15
Independent Organ Procurement Organizations	10
Religious Non-medical Health Care Institution (RNHCI)	10
Histocompatibility Lab	10

The following material describes the demonstrations and specialty providers listed above. Generally, a provider will already know whether or not it is participating in one of these categories.

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Centralized Billing for Mass Immunizers - In order to encourage providers to supply flu and pneumococcal (PPV) vaccinations to Medicare beneficiaries, CMS currently authorizes a limited number of providers to centrally bill for flu and PPV immunization claims. Centralized billing is an optional program available to providers who qualify to enroll with Medicare as the provider type “Mass Immunizer,” as well as to other individuals and entities that qualify to enroll as regular Medicare providers. Centralized billers must roster bill, must accept assignment, and must bill electronically.

To qualify for centralized billing, a mass immunizer must be operating in at least three payment localities for which there are three different carriers processing claims. Centralized billers must send all claims for flu and PPV immunizations to a single carrier for payment, regardless of the carrier jurisdiction in which the vaccination was administered and the carrier must make payment based on the payment locality where the service was provided. IOM Pub. 100-04, Chapter 18, Sections 10.3 and 10.3.1 provide more specific information related to this activity.

Indian Health Services - The Indian Health Service (IHS) is the primary health care provider to Medicare beneficiaries who are members of federally recognized tribes living on or near reservations. The Indian health care system, consisting of tribal, urban, and federally operated IHS health programs, delivers a spectrum of clinical and preventive health services to its beneficiaries via a network of hospitals (including CAHs), freestanding clinics, FQHCs, RHCs and other entities.

While §§1814(c) and 1835(d) of the Social Security Act (the Act), as amended, generally prohibit payment to any Federal agency, passage of the Indian Health Care Improvement Act (IHCIA) in 1976 provided for an exception, amending §1880 of the Act, for facilities of the IHS whether operated by such Service or by an Indian tribe or tribal organization (as defined in section 4 of the IHCIA). The exception under § 1880 limited payment to Medicare services provided in hospitals and skilled nursing facilities.

Effective July 1, 2001, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), §432 extended payment on a fee-for-service (FFS) basis to services of physician and non-physician practitioners furnished in IHS hospitals and freestanding clinics. This means that clinics associated with hospitals and freestanding clinics that are owned and/or operated by IHS are authorized to bill only the Jurisdiction 4 MAC. Additionally, Tribal health facilities operated under Indian Self Determination Education and Assistance Act (ISDEAA) authorities are an extension of the IHS and considered facilities of the IHS. By virtue of this, they are authorized to bill the Jurisdiction 4 MAC. ISDEAA authorities provide flexibilities to tribes in the administration of their programs that are not provided to general public providers.

Low Vision Demonstration - The Secretary of the Department of Health and Human Services is directed to carry out an outpatient vision rehabilitation demonstration project as part of the FY 2004 appropriations conference report to accompany Public Law HR 2673. This demonstration project will examine the impact of standardized Medicare

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coverage for vision rehabilitation services provided in the home, office, or clinic, under the general supervision of a physician. The services may be supplied by the following:

- Physicians;
- Occupational therapists;
- Certified low vision therapists;
- Certified orientation and mobility specialists; and
- Certified vision rehabilitation therapists.

This demonstration will last for five (5) years through March 31, 2011, and is limited to services provided specifically in New Hampshire, New York City (all 5 boroughs), North Carolina, Atlanta, Kansas, and Washington State.

Rural Community Hospital Association - The RCH Demonstration Program was mandated by section 410A of the MMA. The Secretary is required to conduct the RCH Demonstration, lasting five (5) years, to test the advisability and feasibility of establishing RCHs to provide Medicare covered inpatient hospital services in rural areas. This Demonstration will allow selected rural hospitals to benefit from cost-based reimbursement for inpatient services.

The Secretary is required to select not more than fifteen (15) hospitals to participate in the demonstration in States with low population densities. Currently, thirteen (13) hospitals participate in the program, serviced by seven different Fiscal Intermediaries (FIs).

Veteran Affairs Medicare Equivalent Remittance Advice Project - Current law permits the Department of VA to collect appropriate Medicare coinsurance and deductible amounts from supplemental insurers for claims for supplies and services ordinarily covered by Medicare but furnished:

- At VA facilities; and
- For veterans eligible to receive both VA health and Medicare benefits and also having Medicare supplemental insurance.

To facilitate this process, the Centers for Medicare & Medicaid Services (CMS) entered into an interagency agreement with the VA whereby the CMS will help the VA work with a CMS contractor to adjudicate these claims to produce a remittance advice equivalent to that ordinarily produced for Medicare claims. The remittance advice, sent to the supplemental insurers, will help the insurers determine payment amounts they owe to the VA. The CMS will not pay these claims. Trailblazer was the contractor selected to perform the work.

Chiropractic Services Demonstration - Section 651 of the MMA requires the Centers for Medicare & Medicaid Services (CMS) to conduct the Expansion of Coverage for Chiropractic Services Demonstration. The purpose of the demonstration is to evaluate the

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feasibility and advisability of expanding coverage of chiropractic services under Medicare. The demonstration is for two years and must be conducted in four geographic areas—two rural and two urban.

Home Health Third Party Liability Demonstration - The CMS and the States of Connecticut, Massachusetts, and New York have developed a demonstration program that will use a sampling approach to determine the Medicare share of the cost of home health services claims for dual eligible beneficiaries that were submitted to and paid by the Medicaid agencies. Sampling will be used in lieu of individually gathering Medicare claims from home health agencies (HHAs) for every dual eligible Medicaid claim each State may have paid in error. This process will eliminate the need for the HHAs to assemble, copy, and submit large numbers of medical records. The project currently covers the home health claims incurred in fiscal years (FY) 2000 through 2007 for Massachusetts and New York and FY 2001 through 2005 for Connecticut.

Medicare Adult Day Care Demonstration - Section 703 of the MMA directs CMS to conduct a demonstration project that will test an alternative approach to the delivery of Medicare home health services. Under this demonstration, Medicare beneficiaries receiving home health may be eligible to receive medical adult day care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home. The statute requires the demonstration to run for a period of three (3) years at no more than five (5) HHA sites in states that license certified medical adult day care facilities.

Implementation of the demonstration began at five (5) sites on August 1, 2006. Participation of Medicare beneficiaries is voluntary; up to 15,000 beneficiaries at any time will be eligible to enroll in the three (3)-year demonstration.

Medicare Home Health Agency Provider Enrollment Demonstration - This demonstration is designed to combat fraudulent home health activity in the Houston and Los Angeles areas. The principal provider enrollment task will be the revalidation of all HHAs in said areas.

Independent Organ Procurement Organizations – An Organ Procurement Organization performs or coordinates the retrieval, preservation, and transportation of organs and maintains a system of locating prospective recipients for available organs.

Religious Non-Medical Health Care Institutions – A RNHCI provides care to beneficiaries in need of skilled nursing facility care or hospital care when the beneficiary's religious beliefs preclude admission to one of these institutional providers. This does not mean that the beneficiary will receive hospital or SNF care in the RNHCI, but that the beneficiary elected to pursue a religious approach to healing. Since the use of diagnoses or medical oversight is prohibited in a RNHCI, they are not candidates for any CMS existing PPS and continue to be paid using the TEFRA methodology.

Histocompatibility Lab - Histocompatibility Laboratories provide services related to tissue typing testing for possible organ recipients and donors to determine compatibility

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for an organ transplant. They operate on a cost reimbursement basis and bill transplant centers for their services.

#### *E. The Geographic-Assignment Rule*

Providers that are not within one of the categories described above (HH&H, DME, RRB, or specialty & demos) will be assigned to the MAC that covers the state where the provider is located. There are two exceptions.

First a qualified chain provider (QCP) may request that its member providers be serviced by a single A/B MAC - specifically, the A/B MAC that covers the state where the QCP's home office is located. The regulation at 42 CFR 421.404(b)(2) defines a qualified chain provider (QCP) as:

- Ten or more hospitals, skilled nursing facilities, and/or critical access hospitals, under common ownership or control, collectively totaling 500 or more certified Medicare beds; or
- Five or more hospitals, skilled nursing facilities, and/or critical access hospitals, under common ownership or control in three or more contiguous states, collectively totaling 300 or more certified Medicare beds.

CMS may assign non-QCP providers, as well as End Stage Renal Disease (ESRD) providers to an A/B MAC outside of the prevailing geographic assignment rule only to support the implementation of the MACs or to serve some other compelling interest of the Medicare program.

The second exception is for providers that meet the “provider-based” criteria of 42 CFR 413.65. Provider-based entities (other than HH+H providers) will be assigned to the MAC that covers the state where the main (“parent”) provider is assigned.

#### *IV. Where will providers be assigned in the interim?*

All existing providers with a Medicare claims history will remain in their current FI assignments until their workload is transferred to an A/B MAC. The “change of intermediary” process ended for individual providers in 2005, and ended for chain providers in 2007. A change of ownership now serves only to update CMS provider data with information about the new owner.

The workload currently serviced by a legacy FI will be absorbed by the incoming MAC within the 12 months following the award of MAC contract. In some situations the workload transition may be delayed by an award protest.

New providers enrolling with Medicare will be assigned to the FI or MAC that covers the state where the provider is physically located, with a few exceptions:

- The “Multi-Provider Complex/Sub-Unit” relationship (ref: 42 CFR 483.5(b)). - An initial enrollment for a sub-unit will be assigned to the FI or MAC that currently

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serves the existing parent hospital – even if the parent hospital is not presently billing in accordance with the “geographic assignment rule.”

- An “initial enrollment” connected with a QCP. - If a QCP acquires a new hospital, skilled nursing facility, or critical access hospital that is located outside home office A/B MAC jurisdiction, then CMS will endeavor to assign the provider to the MAC that covers the state where the QCP’s home office is located. This special assignment is available only for “initial enrollments” – providers that are joining the Medicare program with neither an existing administrative contractor assignment nor a Medicare claims history.

The other exceptions track the MAC-world assignment rules discussed in Sections III-A through III-D above.

#### *V. How long will my interim assignment last?*

An “out-of-jurisdiction provider” (OJP) is a provider that is not currently assigned to the A/B MAC or FI in accordance with Sections III-A through III-D above (including the geographic assignment rule.) For example, an individual, freestanding provider located in Oregon, but currently assigned to the Florida FI, would be an OJP.

New MACs will initially service some OJPs until CMS undertakes the final reassignment of all OJPs to their destination MACs based on the geographic assignment rule.

CMS will start the overall transfer of OJPs to their final destination MACs after two events have taken place. The first event is when all 15 A/B MACs have been awarded and implemented. The second event is when all the systems and contractors that support the claims processing, provider enrollment, and cost report auditing functions at the departure and destination MACs are capable of supporting the move.

## **Additional Information**

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For complete details regarding this CR please see the official instruction (CR5979) issued to your Medicare FI, A/B MAC, or RHHI. That instruction may be viewed by going to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R3330TN.pdf> on the CMS website. To view any of the federal regulations cited in this article or in CR5979, visit <http://www.gpoaccess.gov/cfr/index.html> on the Internet.

If you have questions, please contact your Medicare FI, A/B MAC, or RHHI at their toll-free number which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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