

CMS Guidance Document	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Executive Guidance Number 0048	Date: August 31, 2007
Planned Web Site Address http://www.cms.hhs.gov/manuals/	Release planned: September 17, 2007

PROGRAM AREA: Claims Processing

SUBJECT: Cessation of FI-to-FI Moves for Providers that are Members of Chains

APPLIES TO: No Provider Impact

I. SUMMARY OF DOCUMENT: Joint Signature Memorandum JSM-05542, dated October 18, 2005, instructed all fiscal intermediaries (FIs) that, effective October 1, 2005, CMS would no longer accept a provider's request to move from one FI to another FI. The moratorium is still in effect. However, a downstream provider that was acquired by a chain subsequent to October 1, 2005 could be allowed to move from one FI to another FI if that chain was approved for centralized billing and CMS approved the move.

At this time, two developments are driving CMS's decision to cease FI-to-FI moves at this time for providers that are members of chains: (1) CMS needs to stabilize chain configurations, provider assignments, and claim histories in anticipation of the transition of workload from legacy FIs to the MACs; and (2) CMS seeks to limit the number of transitions each provider is subjected to during workload transition.

II. CHANGES IN POLICY INSTRUCTIONS: (If not applicable, indicate N/A)

STATUS: R=REVISED, N=NEW, D=DELETED.

Status	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. CLEARANCES:

Clearance & Point of Contact (POC)	Name/Telephone/Component
Senior Official Clearance	Liz Richter/(410) 786-4164/CMM
Agency POC	Brian Johnson/(410) 786-7601/CMM/MCMG/DPA

IV. TYPE (Check appropriate boxes for type of guidance)

	Audit Guide
X	Change Request
	HPMS
	Joint Signature Memorandum/Technical Director Letter
	Manual Transmittal/Non-Change Request
	State Medicaid Director Letters

	Other
--	--------------

V. STATUTORY OR REGULATORY AUTHORITY: [include the citation of what statute or regulation is being interpreted. If not applicable, indicate N/A]

Attachment – One-Time Notification

Pub. 100-20	Transmittal:	Date:	Change Request: 5720
--------------------	---------------------	--------------	-----------------------------

SUBJECT: Cessation of FI-to-FI Moves for Providers That Are Members of Chains

Effective Date: 30 days after issuance

Implementation Date: 30 days after issuance

I. GENERAL INFORMATION

A. Background: Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173, amended Title XVIII of the Act to add section 1874A, Contracts with Medicare Administrative Contractors (MACs). Section 1874A of the Act replaces the prior Medicare intermediary and carrier contracting authorities formerly found in sections 1816 and 1842 of the Act, respectively. In section 911(b) of Public Law 108–173, Congress reiterated the requirement that CMS begin to move beyond the legacy nomination-based intermediary agreements.

JSM 05542, dated October 18, 2005, instructed all fiscal intermediaries (FIs) that, effective October 1, 2005, CMS would no longer accept a provider’s request to move from one FI to another FI. The moratorium is still in effect. However, a downstream provider that was acquired by a chain after October 1, 2005 could be allowed to move from one FI to another FI if that chain was approved for centralized billing and CMS approved the change.

At this time, two developments are driving CMS’ decision to cease FI-to-FI moves for providers that are members of chains:

- CMS needs to stabilize chain configurations, provider assignments, and claim histories in anticipation of the transition of workload from legacy FIs to the MACs; and
- CMS seeks to limit the number of transitions each provider is subjected to during workload transition.

B. Policy: Section 42 CFR 421.404 presents the basic rule that a provider will enroll with and receive services from the FI or MAC that administers claims for the state in which the provider is located. An exception to this rule exists for chains that meet the criteria to be a “qualified chain provider.”

II. BUSINESS REQUIREMENTS TABLE

Use “Shall” to denote a mandatory requirement

Number	Requirement	Responsibility (place an “X” in each applicable column)							
		A	D	F	C	D	R	Shared-System Maintainers	OTHER
		/	M	I	A	M	H		

									F I S S	M C S	V M S	C W F	
5720.1	When a chain requests centralized billing, the FI/MAC shall refer the chain to the CMS regional office with responsibility for the state where the chain's home office is located in order to obtain approval.	X	X					X					
5720.2	No provider that is a member of a Medicare chain shall be allowed to move from one FI/MAC to another FI/MAC unless: (1) the provider is newly acquired by the chain and has not yet filed its CMS Form 855; (2) the acquiring chain has met the criteria to be a 421.404(b) qualified chain provider; (3) the qualified chain provider has requested centralized billing with the understanding that all of its providers will be assigned to the home office MAC; and (4) the move is to the MAC that serves the home office or to an FI in the home office MAC jurisdiction.	X	X					X					
5720.2.1	A new Medicare provider (without existing Medicare claims history) that is acquired by a chain shall be assigned to an FI consistent with the policy described in requirement 5720.2.	X	X					X					
5720.3	When a provider is approved by CMS to move from one FI/MAC to another FI/MAC, the Medicare contractor to which the provider is moving shall require the provider to submit a complete CMS Form 855A for all locations under that tax identification number. (The application shall be treated as an "initial enrollment.")	X	X					X					
5720.3.1	The outgoing FI/MAC shall require, from the outgoing provider, a CMS Form 855A indicating a voluntary withdrawal.	X	X					X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)							
		A /	D M	F I	C A	D M	R H	Shared-System Maintainers	OTHER

