CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 530	**Date: AUGUST 7, 2009**
	Change Request 6312

SUBJECT: Update Fiscal Intermediary Standard System (FISS) to Deactivate Billing Numbers for Non-Frequent Billers

I. SUMMARY OF CHANGES: Change Requests (CRs) 5296 and 5676 established the criteria and procedures for deactivating billing numbers for providers/suppliers in the Multi-Carrier System (MCS) that had not billed the Medicare program for 1 year. To accomplish this, MCS established procedures for identifying quarterly billing numbers that had not been used for the previous 4 quarters. Those numbers were then deactivated in MCS utilizing Action Reason Code 72. This CR will require FISS to develop a new Reason Code to flag non-billing PTANS. In addition, this CR provides a requirement that FISS provide a quarterly extract report to the Provider Enrollment, Chain and Ownership System (PECOS) for all billing numbers that are deactivated. This extract report will be used to automatically update PECOS with the deactivated PTAN information which will allow PECOS and FISS to remain in sync.

New / Revised Material
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

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: 530	Date: August 7, 2009	Change Request: 6312

SUBJECT: Update Fiscal Intermediary Standard System (FISS) to Deactivate Billing Numbers for Non-Frequent Billers

Effective Date: January 1, 2010

Implementation Date: January 4, 2010

A. Background: Change Requests (CRs) 5296 and 5676 established the criteria and procedures for deactivating billing numbers for providers/suppliers in the Multi-Carrier System (MCS) that had not billed the Medicare program for 1 year. To accomplish this, MCS established procedures for identifying quarterly billing numbers that had not been used for the previous 4 quarters. Those numbers were then deactivated in MCS utilizing Action Reason Code 72. This CR will require FISS to develop a new Reason Code to flag non-billing PTANS. In addition, this CR provides a requirement that FISS provide a quarterly extract report to the Provider Enrollment, Chain and Ownership System (PECOS) for all billing numbers that are deactivated. This extract report will be used to automatically update PECOS with the deactivated PTAN information which will allow PECOS and FISS to remain in sync.

B. Policy: The CMS policy regulation requiring the above action to deactivate non-billing providers and suppliers can be found at 42 CFR 424.540. This CR outlines a systematic approach to identify providers who should be deactivated after 12 consecutive months of non-billing. This initiative is to be a fully automated process between PECOS, FISS, and HIGLAS. Non-billing PTANs will be extracted from FISS, downloaded into PECOS to update the provider enrollment files, cycled through FISS overnight to update the claims system, and then finally passed down stream to HIGLAS.

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	
6312.1	FISS shall generate, on a quarterly basis, an electronic extract out of the base system listing and deactivating all provider PTANs with no claims activity for 12 consecutive months. The extract shall then be systematically loaded into PECOS. A non-billing situation will be identified when a PTAN has not been used to bill for 12 consecutive months.						X				PECOS

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	
6312.2	FISS shall produce this extract based on the claims date of receipt from the pending claims history file.						X				
6312.3	FISS shall create a new status code to be added to the extract file to identify these PTANs as non-billing. This new status code will become part of the deactivated PTANs record and be annotated in all 3 systems (PECOS, FISS, and HIGLAS).						X				
6312.4	PECOS shall use the FISS extract to automatically deactivate the PTANs in the PECOS database with the deactivated PTAN information. **NOTE**: The standard data flow process is as follows and will not change with this CR: PECOS will process the FISS extract record to update the PECOS provider file with the correct date of deactivation. PECOS will move the Medicare deactivation date from the PECOS extract file to the cancel date field in the FISS provider file. Once PECOS and the FISS provider file is updated an extract record to deactivate the provider is then created and sent to HIGLAS thereby ensuring all 3 systems remain in sync.						X				PECOS
6312.5	Prior to deactivating a PTAN, steps shall be taken to ensure that no pending or finalized claims are waiting for payment.						X				
6312.6	FISS shall take steps to ensure that a new provider that has yet to bill the program is not flagged for deactivation unless a claim has not been submitted for 12 consecutive months.						X				
6312.7	Within 1-week after the end of the quarter, PECOS shall generate a report for each Intermediary and A/B MAC showing the number of PTANs that have been deactivated in PECOS.										PECOS
6312.8	Within 2-weeks after the end of the quarter, each Intermediary and A/B MAC shall send a report to the CMS/DPSE contractor liaison and if applicable, the A/B MAC Project Officer, showing the number of active PTANs at the beginning of the quarter, end of the quarter, and PTANs deactivated.	X		X		X					
6312.9	The first report shall include the total number of PTANs currently deactivated in FISS.						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	
6312.10	The format and content of the FISS extract report of deactivated PTANs shall be determined as part of the implementation plan developed between FISS, CMS, and PECOS.						X				PECOS
6312.11	In the event a claim is submitted after the 12 consecutive months of non-billing, FISS shall notify the provider enrollment unit and generate a message via remittance notice using standard reason/remark B7 – *"This provider was not certified/eligible to be paid for this procedure/service on this date of service."*						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:

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

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Michael Collett, OFM/DPSE, (410)786-6121
Post-Implementation Contact(s): Michael Collett, OFM/DPSE, (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.