CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 898	**Date: September 6, 2019**
	Change Request 11371

SUBJECT: Updates to Provider Enrollment Processing Instructions in Chapter 15 of Publication (Pub.) 100-08, Program Integrity Manual, and to the CMS-855R Processing Guide

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) updates general information for provider enrollment, including various processing alternatives for each Form CMS-855 application, Form CMS-20134, and Form CMS-588. This instruction also includes updates for Processing Independent Diagnostic Testing Facilities (IDTFs) in chapter 15 of Pub. 100-08 and an update to the CMS-855R Processing Guide.

EFFECTIVE DATE: October 7, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 7, 2019
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	15/15.5/15.5.3/Final Adverse Actions
R	15/15.5/15.5.4/Practice and Administrative Location Information
R	15/15.5/15.5.19.1/Independent Diagnostic Testing Facility (IDTF) Standards
R	15/15.5/15.5.19.3/Interpreting Physicians
R	15/15.5/15.5.19.5/Supervising Physicians
R	15/15.5/15.5.20/Processing Form CMS-855R Applications
R	15/15.7/15.7.1.3.1/Processing Alternatives – Form CMS-855B and Form CMS-855I
R	15/15.7/15.7.1.3.2/Processing Alternatives – Form CMS-855A
R	15/15.7/15.7.1.3.3/Processing Alternatives – Form CMS-855O
R	15/15.7/15.7.1.3.4/Processing Alternatives – Form CMS-855R
R	15/15.7/15.7.1.3.5 - Processing Alternatives – Form CMS-20134
R	15/15.11/Electronic Fund Transfers (EFT)
R	15/15.24/15.24.9/Revocation Letter Guidance
R	15/15.28/Deceased Practitioners
R	15/15.29/15.29.4.4/Change of Information Received Prior to or After the Revalidation Letter is Mailed
R	15/15.29/15.29.11/Revalidation Extension Requests

III. FUNDING:
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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-08	Transmittal: 898	Date: September 6, 2019	Change Request: 11371

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I. GENERAL INFORMATION

A. Background: This CR will update general information for provider enrollment, including various processing alternatives for each Form CMS-855 application, Form CMS-20134, and Form CMS-588. This instruction also includes updates for processing IDTFs in chapter 15 of Pub. 100-08 and an update to the CMS-855R Processing Guide.

B. Policy: This CR does not involve any legislative or regulatory policy.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11371.1	Contractors shall accept a Lockbox as a Special Payment Address.	X	X	X						NSC
11371.1.1	Contractors shall request additional information if it has any reason to suspect that the special payment address may violate the Payment to Agent rules.	X	X	X						NSC
11371.2	Contractors shall add equipment placed on permanent placed mobile units to an IDTF's enrollment, provided the equipment and services provided meet the applicable IDTF standards.		X							
11371.2.1	Contractors shall not require IDTFs that utilize a permanent placed mobile		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	unit to complete a second enrollment, IDTFs that utilize a permanent placed mobile unit are not considered sharing space.									
11371.3	Contractors should use the sale date an IDTF established as the date it met the current CMS standards, instead of establishing a new date if the IDTF undergoes an ownership change that results in a new enrollment in the Provider Enrollment and Chain/Ownership System (a new federal Tax Identification Number change is a result of this change).		X							
11371.4	Contractors shall request a change of information from an IDTF if the MAC receives notification from an interpreting physician that he/she is no longer interpreting tests for the IDTF in order to end-date the interpreting physician from the enrollment.		X							
11371.5	Contractors shall request a change of information from an IDTF if the MAC receives notification from a supervising physician that he/she is no longer supervising tests for the IDTF in order to end-date the supervising physician from the enrollment.		X							
11371.5.1	Contractors shall proceed with non-compliance revocation procedures if the IDTF does not provide a change of information to add a new supervising physician		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	if the IDTF end-dates its only supervising physician on file.									
11371.6	Contractors shall enter an effective date of a termination of a reassignment as the day after the day listed in the application.		X							
11371.7	Contractors shall develop for missing information in Sections 5A and 6A, including any missing roles of owning and managing organizations or individuals.	X	X	X						
11371.8	Contractors shall issue all revocation letters via certified letter, per regulations found in 42 Code of Federal Regulations 405.800(b)(1).	X	X	X						NSC
11371.9	Contractors shall issue two revocation letters to any solely-owned organizations, one to the organization and one for the individual.		X							
11371.10	If a Change of Information application is received after the contractor has mailed the revalidation notice, the contractor shall: (1) Develop for a complete application containing the missing data elements, and (2) Treat it as a revalidation.	X	X	X						NSC
11371.11	Contractors shall request documentation that supports “proof of life” (for example, Retirement, Survivors, and Disability Insurance document issued by the Social Security Administration (SSA)).	X	X	X						NSC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11371.11.1	In the event a provider/supplier is unable to obtain such documentation, the MAC shall submit a request to their Provider Enrollment Operations Group Business Function Lead containing the provider/supplier's name, date of birth and Social Security Number (SSN) so that CMS can confirm proof of life with SSA.	X	X	X						NSC
11371.12	If the Form CMS-588 is received and is missing the checkbox for the SSN or Employer Identification Number (EIN), but the contractor can ascertain the correct option via the supporting documents submitted or elsewhere on the application, the contractor should proceed without development back to the provider or supplier.	X	X	X						NSC
11371.13	Contractors shall follow the revised CMS-855R Processing Guide.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Andrew Stouder, 410-786-0222 or Andrew.Stouder@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 1

Medicare Program Integrity Manual
Chapter 15 - Medicare Enrollment

Table of Contents
(Rev.898, Issued: 09-06-19)

Transmittals for Chapter 15

15.29.4.4 – Change of Information Received Prior to *or After the* Revalidation Letter *is* Mailed

15.5.3 – Final Adverse Actions

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

Unless stated otherwise, the instructions in this section 15.5.3 apply to the final adverse action sections of the Form CMS-855 and Form CMS-20134:

A. Disclosure of Final Adverse Action

If a final adverse action is disclosed on the Form CMS-855 or Form CMS-20134, the provider must furnish documentation concerning the type of final adverse action being reported, the date of the final adverse action occurred, and what court or governing/administrative body imposed the action. The documentation must be furnished regardless of whether the final adverse action occurred in a state different from that in which the provider seeks enrollment or is enrolled.

In addition:

1. Reinstatements - If the person or entity in question was excluded or debarred but has since been reinstated, the contractor shall confirm the reinstatement through the OIG or, in the case of debarment, through the federal agency that took the action. The contractor shall also ensure that the provider submits written proof of the reinstatement (e.g., reinstatement letter).

2. Scope of Disclosure – All final adverse actions that occurred under the LBN and TIN of the disclosing entity (e.g., applicant; section 5 owner) must be reported.

   Example (a) - Smith Pharmacy, Inc. had 22 separately enrolled locations in 2009. Each location was under Smith's LBN and TIN. In 2010, two locations were excluded by the OIG and then subsequently revoked by CMS, Smith submits a Form CMS-855S application for a new location on Jones Street. Suppose, however, that each of Smith's locations had its own LBN and TIN. The Jones Street application need not disclose the two revocations from 2010.

   Example (b) - An HHA, hospice, and hospital are enrolling under Corporation X's LBN and TIN. X is listed as the provider in section 2 of each applicant's Form CMS- 855A. All three successfully enroll. Six months later, Company X's billing privileges for the HHA are revoked due to an OIG exclusion. Both the hospice and the hospital must report that X was excluded on a Form CMS-855A change request because X is under the provider's LBN and TIN. Assume now that X seeks to enroll an ASC under X's LBN and TIN. The exclusion would have to be reported in section 3 of the ASC's initial Form CMS-855B.

   Example (c) – Company Y is listed as the provider/supplier for two HHAs and two suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). These four providers/suppliers are under Y's LBN and TIN. Each provider/supplier is located in a different State. All are enrolled. Y's billing privileges for one of the DMEPOS suppliers are revoked due to a felony conviction. Y now seeks to enroll an ASC in a fifth State. Y must disclose its felony conviction even though the felony conviction occurred in a state different from that in which the ASC is located.

3. Timeframe – With the exception of felony and misdemeanor convictions all other final adverse actions must be reported in the final adverse legal action of the Form CMS-855 or Form CMS-20134, all final adverse actions must be reported regardless of when the final adverse legal action occurred.

4. Evidence to Indicate Final Adverse Action – There may be instances where the provider or supplier states on Form-855 or Form CMS-20134 that the person or entity has never had a final adverse action imposed against him/her/it, but the contractor finds evidence to indicate otherwise. In such cases, the contractor shall follow the decision tree in section 15.5.3.1.

Note that MDPP suppliers enrolling through the CMS-20134 are not required to submit any final adverse action as it relates to MDPP coaches submitted on Section 7 of that form.

B. Reportable Final Adverse Actions

Providers and suppliers shall disclose all reportable Final Adverse Actions on their enrollment applications. To satisfy the reporting requirement the provider or supplier shall complete the Final Adverse Legal Action section(s) (Form CMS-855 or Form CMS-20134) in its entirety and attach all applicable documentation concerning the adverse action, to the application. It shall be noted that all final adverse actions must be reported, regardless of whether any records have been expunged or pending appeal.

Reportable Final Adverse Actions that must be disclosed on the Form CMS-855 or Form CMS-20134 include:

1. Felony conviction(s) within 10 years

   - Providers are required to report a felony (Federal or State) when--
     - A conviction has occurred; and
     - The felony judgment (disposition) date is within 10 years, from the submission date of a Form CMS-855 or Form CMS-20134 application.
   - A conviction has occurred when a judgment has been entered against an individual/entity by a judge/jury or the court has accepted a plea of guilty or nolo contendere.
   - A felony conviction shall be reported even if the conviction has been sealed, expunged or there is an appeal or post-trial motion pending.

2. Misdemeanor Conviction Within 10 years
   - Report a misdemeanor conviction (Federal or State) when—
     - A conviction has occurred; and
     - The misdemeanor judgment (disposition) date is within 10 years, from the submission date of an Form CMS-855 or Form CMS-20134 application, and
     - The misdemeanor is related to:
       - The delivery of an item/service under Medicare or a State health care item/service
       - The abuse or neglect of a patient in connection with the delivery of a health care item or service
       - Theft, Fraud, Embezzlement, breach of fiduciary duty or other financial misconduct in connection with the delivery of health care item/service
       - The interference with or obstruction of any investigation into any criminal offense
       - The unlawful manufacture, distribution, prescription or dispensing of a controlled substance

- A conviction has occurred when a judgment has been entered against an individual/entity by a judge/jury or the court has accepted a plea of guilty or nolo contendere.

- A misdemeanor conviction shall be reported even if the conviction has been sealed, expunged or there is an appeal or post-trial motion pending.

3. Current or Past Suspension(s)/Revocations(s) of a medical license

   - A medical license board suspends or revokes a medical license for any period of time.

4. Current or Past Suspensions(s)/Revocation(s) of an accreditation

   - An accrediting body suspends or revokes an accreditation for any period of time.

5. Current or Past Suspension(s) or Exclusion(s) imposed by the U.S. Department of Health and Human Service's Office of Inspector General (OIG)

   - Items/services furnished, ordered or prescribed by a specified individual/entity are not reimbursed under Medicare, Medicaid and/or all other Federal health care programs until the individual or entity is reinstated by the HHS OIG.

6. Current or Past Debarment(s) from participation in any Federal Executive Branch procurement or non-procurement program

   - An individual or entity is suspended throughout the Executive Branch or the Federal government, as it applies to procurement and non-procurement programs. An individual or entity will not be solicited from, contracts will not be awarded to or existing contracts will not be renewed or otherwise extended to those individuals or entities with a debarment. (e.g. GSA debarment)

7. Medicaid exclusion(s), revocation(s) or termination(s) of any billing number

   - A state terminates an active provider agreement or prohibits a provider from enrolling in the Medicaid program.

8. Any other Current or Past Federal Sanction(s)
   - A penalty imposed by a Federal governing body (e.g. Civil Monetary Penalties (CMP), Corporate Integrity Agreement (CIA)).

C. Prior Approval

If a current exclusion or debarment is disclosed on the Form CMS-855 or CMS-20134, the contractor shall deny the application in accordance with the instructions found in chapter 15.5.3.1.

D. Review of PECOS

If the contractor denies an application or revokes a provider based on a final adverse action, the contactor shall search PECOS to *determine whether the person/entity with the final adverse action has any other associations, as it applies (e.g., is listed in PECOS as an owner of three Medicare-enrolled providers).*

If such an association is found and there are grounds for revoking the billing privileges of the other provider(s), the contractor shall initiate revocation action against the associate provider(s).

E. Chain Home Offices, Billing Agencies, and HHA Nursing Registries

If the contractor discovers that an entity listed in section 7, 8, or 12 of the Form CMS-855*A* has had a final adverse action imposed against it, the contractor shall contact its PE*OG* BFL for guidance. For any final adverse actions against individuals listed in section 7 of the Form CMS-20134, contractors shall refer to 15.5.9 where this process is outlined in detail.

F. System for Award Management (SAM)

When an entity or individual is listed as debarred in the SAM (formerly, the General Services Administration Excluded Parties List System), the SAM record may identify associated entities and persons that are also debarred. To illustrate, suppose John Smith is identified as debarred. The SAM record may also list individuals and entities associated with John Smith that are debarred as well, such as "John Smith Company," "Smith Consulting," "Jane Smith," and "Joe Smith."

If the contractor learns via the Form CMS-855 or CMS-20134 verification process, a *Unified* Program Integrity Contractor (*U*PIC) referral, or other similar means that a particular person or entity is debarred, the contractor shall search the person/entity in the SAM to see if the SAM record discloses any associated parties that are debarred. If associated parties are listed, the contractor – after verifying, via the instructions in this chapter, that the associated party is indeed debarred – shall check PECOS to determine whether the party is listed in any capacity. If the party is listed, the contractor shall take all applicable steps outlined in this chapter with respect to revocation proceedings against the party and against any persons/entities with whom the party is associated. For instance, using our example above, if the contractor confirms that Jane Smith is debarred and PECOS shows Jane Smith as an owner of Entity X, the contractor shall, as applicable, initiate revocation proceedings against X.

15.5.4 – Practice and Administrative Location Information

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

Unless specifically indicated otherwise, the instructions in this section 15.5.4 apply to the Form CMS-855A, the Form CMS-855B, the Form CMS-855I, and the CMS-20134.

The instructions in section 15.5.4.1 apply only to the Form CMS-855A; the instructions in section 15.5.4.2 apply only to the Form CMS-855B; and the instructions in section 15.5.4.3 only apply to the Form CMS-855I; and the instructions in section 15.5.4.4 only apply to the Form CMS-20134.

A. Practice and Administrative Location Verification

The contractor shall verify that the practice and administrative locations listed on the application actually exist. If a particular location cannot at first be verified, the contractor shall request clarifying information; for instance, the contractor can request that the applicant furnish letterhead showing the appropriate address.

The contractor shall also verify that the reported telephone number is operational and connects to the practice location/business listed on the application. However, the contractor need not contact every location for applicants that are enrolling multiple locations; the contractor can verify each location's telephone number with the contact person listed on the application and note the verification accordingly in the contractor's verification documentation per section 15.7.3 of this chapter (The telephone number must be one where patients and/or customers can reach the applicant to ask questions or register complaints). The contractor may also match the applicant's telephone number with known, in-service telephone numbers - via, for instance, the Yellow Pages or the Internet - to correlate telephone numbers with addresses. If the applicant uses his/her/its cell phone for their business, the contractor shall verify that this is a telephone connected directly to the business. If the contractor cannot verify the telephone number, it shall request clarifying information from the applicant; the inability to confirm a telephone number may indicate that an onsite visit is necessary. In some instances, a 1-800 number or out-of-state number may be acceptable if the applicant's business location is in another State but his/her/its practice locations are within the contractor's jurisdiction. For MDPP suppliers enrolling through the Form CMS-20134, the entity must maintain a

primary business telephone number listed under the name of the organization in public view. Public view could signify, for example, that the phone number is listed on a website, on flyers and materials. Additional information on this requirement and the need for a site visit is detailed in 15.6.1.1.3.

Additionally, once the verification of practice or administrative locations is complete, the contractor need not verify the address via the Internet (for example, 411.com, USPS.com, etc.). *Address functionality used in* PECOS verifies the validity of an address with the United States Postal Service (USPS). Additional verification is only needed if *address functionality in PECOS* cannot validate an actual address.

Also:

- If an individual practitioner or group practice: (1) is adding a practice location and (2) is normally required to complete a questionnaire in section 2 of the Form CMS-855I, Form CMS-855B, or CMS-20134 specific to its supplier type (e.g., psychologists, physical therapists, MDPP supplier), the person or entity must submit an updated questionnaire to incorporate services rendered at the new location.

- For providers/suppliers paid via the Fiscal Intermediary Shared System (FISS), the practice location name entered into the Provider Enrollment, Chain and Ownership System (PECOS) shall be the "doing business as" name (if it is different from the legal business name). For suppliers paid via the Multi-Carrier System (MCS), the practice location name entered into PECOS shall be the legal business name.

B. Do Not Forward (DNF)

Unless instructed otherwise in another CMS directive, the contractor shall follow the DNF initiative instructions in Pub. 100-04, chapter 1, section 80.5. Returned paper checks, remittance notices, or EFT payments shall be flagged if returned from the post office or banking institution, respectively, as this may indicate that the provider's "special payment" address (section 4 of the Form CMS-855 or CMS-20134) or EFT information has changed. The provider should submit a Form CMS-855, Form CMS-20134, or Form CMS-588 request to change this address; if the provider does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System, it must complete an entire Form CMS-855, or Form CMS-20134 as well as Form CMS-588. The Durable Medical Equipment Medicare Administrative Contractors are responsible for obtaining, updating and processing Form CMS-588 changes.

In situations where a provider is closing his/her/its business and has a termination date (e.g., he/she is retiring), the contractor will likely need to make payments for prior services rendered. Since the practice location has been terminated, the contractor may encounter a DNF message. If so, the contractor should request the provider to complete the "special payment" address section of the Form CMS-855 or Form CMS-20134 and to sign the certification statement. The contractor, however, shall not collect any other information unless there is a need to do so.

C. Remittance Notices/Special Payments

For new enrollees, all payments must be made via EFT. The contractor shall thus ensure that the provider has completed and signed the Form CMS-588 and shall verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.

If an enrolled provider that currently receives paper checks submits a Form CMS-855 or Form CMS-20134 change request – no matter what the change involves – the provider must also submit:

- A Form CMS-588 that switches its payment mechanism to EFT. (The change request cannot be processed until the Form CMS-588 is submitted.) All future payments (excluding special payments) must be made via EFT.

- An updated section 4 that identifies the provider's desired "special payments" address.

The contractor shall also verify that the bank account is in compliance with Pub. 100-04, chapter 1, section 30.2.

Once a provider changes its method of payment from paper checks to EFT, it must continue using EFT. A provider cannot switch from EFT to paper checks.

The "special payment" address may only be one of the following:

- One of the provider's practice locations

- A P.O. Box

- *A Lockbox. The contractor shall request additional information if it has any reason to suspect that the arrangement, at least with respect to any special payments that might be made, may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.*

- The provider's billing agent. The contractor shall request additional information if it has any reason to suspect that the arrangement – at least with respect to any special payments that might be made – may violate the Payment to Agent rules in Pub. 100-04, chapter 1, section 30.2.

- The chain home office address. Per Pub.100-04, chapter 1, section 30.2, a *Part A* chain organization may have payments to its providers sent to the chain home office. The legal business name of the chain home office must be listed on the Form CMS-588. The TIN on the Form CMS-588 should be that of the provider.

- Correspondence address

15.5.19.1 – Independent Diagnostic Testing Facility (IDTF) Standards

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A. IDTF Standards

Consistent with 42 CFR §410.33(g), each IDTF must certify on its Form CMS-855B enrollment application that it meets the following standards and all other requirements:

1. Operates its business in compliance with all applicable Federal and State licensure and regulatory requirements for the health and safety of patients.

    - The purpose of this standard is to ensure that suppliers are licensed in the business and specialties being provided to Medicare beneficiaries. Licenses are required by State and/or Federal agencies to make certain that guidelines and regulations are being followed and to ensure that businesses are furnishing quality services to Medicare beneficiaries.

    - The responsibility for determining what licenses are required to operate a supplier's business is the sole responsibility of the supplier. The contractor is not responsible for notifying any supplier of what licenses are required or that any changes have occurred in the licensure requirements. No exemptions to applicable State licensing requirements are permitted, except when granted by the State.

    - The contractor shall not grant billing privileges to any business not appropriately licensed as required by the appropriate State or Federal agency. If a supplier is found providing services for which it is not properly licensed, billing privileges may be revoked and appropriate recoupment actions taken.

2. Provides complete and accurate information on its enrollment application. Changes in ownership, changes of location, changes in general supervision, and final adverse actions must be reported to the

contractor within 30 calendar days of the change. All other changes to the enrollment application must be reported within 90 days.

NOTE: This 30-day requirement takes precedence over the certification in section 15 of the Form CMS-855B whereby the supplier agrees to notify Medicare of any changes to its enrollment data within 90 days of the effective date of the change. By signing the certification statement, the IDTF agrees to abide by all Medicare rules for its supplier type, including the 30-day rule in 42 CFR §410.33(g)(2).

3. Maintain a physical facility on an appropriate site. (For purposes of this standard, a post office box, commercial mailbox, hotel, or motel is not an appropriate site. The physical facility, including mobile units, must contain space for equipment appropriate to the services designated on the enrollment application, facilities for hand washing, adequate patient privacy accommodations, and the storage of both business records and current medical records within the office setting of the IDTF, or IDTF home office, not within the actual mobile unit.)

   - IDTF suppliers that provide services remotely and do not see beneficiaries at their practice location are exempt from providing hand washing and adequate patient privacy accommodations.

   - The requirements in 42 CFR §410.33(g)(3) take precedence over the guidelines in sections 15.5.4 and 15.5.4.2 of this chapter pertaining to the supplier's practice location requirements.

   - The physical location must have an address, including the suite identifier, which is recognized by the United States Postal Service (USPS).

4. Has all applicable diagnostic testing equipment available at the physical site excluding portable diagnostic testing equipment. The IDTF must—

   (i) Maintain a catalog of portable diagnostic equipment, including diagnostic testing equipment serial numbers, at the physical site;

   (ii) Make portable diagnostic testing equipment available for inspection within 2 business days of a CMS inspection request; and

   (iii) Maintain a current inventory of the diagnostic testing equipment, including serial and registration numbers, and provide this information to the designated fee-for- service contractor upon request, and notify the contractor of any changes in equipment within 90 days.

5. Maintain a primary business phone under the name of the designated business. The IDTF must have its--

   (i) Primary business phone located at the designated site of the business or within the home office of the mobile IDTF units.

   (ii) Telephone or toll free telephone numbers available in a local directory and through directory assistance.

   The requirements in 42 CFR §410.33(g)(5) take precedence over the guidelines in sections 15.5.4 and 15.5.4.2 of this chapter regarding the supplier's telephone requirements.

   IDTFs may not use "call forwarding" or an answering service as their primary method of receiving calls from beneficiaries during posted operating hours.

6. Have a comprehensive liability insurance policy of at least $300,000 per location that covers both the place of business and all customers and employees of the IDTF. The policy must be carried by a non-

relative-owned company. Failure to maintain required insurance at all times will result in revocation of the IDTF's billing privileges retroactive to the date the insurance lapsed. IDTF suppliers are responsible for providing the contact information for the issuing insurance agent and the underwriter. In addition, the IDTF must--

(i) Ensure that the insurance policy must remain in force at all times and provide coverage of at least $300,000 per incident; and

(ii) Notify the CMS designated contractor in writing of any policy changes or cancellations.

7. Agree not to directly solicit patients; this includes - but is not limited to - a prohibition on telephone, computer, or in-person contacts. The IDTF must accept only those patients referred for diagnostic testing by an attending physician who: (a) is furnishing a consultation or treating a beneficiary for a specific medical problem, and (2) uses the results in the management of the beneficiary's specific medical problem. Non-physician practitioners may order tests as set forth in §410.32(a)(3).

    - By the signature of the authorized official in section 15 of the Form CMS-855B, the IDTF agrees to comply with 42 CFR §410.33(g)(7).
    - The supplier is prohibited from directly contacting any individual beneficiary for the purpose of soliciting business for the IDTF. This includes contacting the individual beneficiary by telephone or via door-to-door sales.
    - There is no prohibition on television, radio or Internet advertisements, mass mailings, or similar efforts to attract potential clients to an IDTF.
    - If the contractor determines that an IDTF is violating this standard, the contractor should notify its Provider Enrollment Operations Group (PEOG) liaison immediately.

8. Answer, document, and maintain documentation of a beneficiary's written clinical complaint at the physical site of the IDTF. (For mobile IDTFs, this documentation would be stored at their home office.) This includes, but is not limited to, the following:

    (i) The name, address, telephone number, and health insurance claim number of the beneficiary.

    (ii) The date the complaint was received; the name of the person receiving the complaint; and a summary of actions taken to resolve the complaint.

    (iii) If an investigation was not conducted, the name of the person making the decision and the reason for the decision.

9. Openly post these standards for review by patients and the public.

10. Disclose to the government any person having ownership, financial, or control interest or any other legal interest in the supplier at the time of enrollment or within 30 days of a change.

11. Have its testing equipment calibrated and maintained per equipment instructions and in compliance with applicable manufacturers' suggested maintenance and calibration standards.

12. Have technical staff on duty with the appropriate credentials to perform tests. The IDTF must be able to produce the applicable Federal or State licenses or certifications of the individuals performing these services.

13. Have proper medical record storage and be able to retrieve medical records upon request from CMS or its fee-for-service contractor within 2 business days.

14. Permit CMS, including its agents, or its designated fee-for-service contractors, to conduct unannounced, on-site inspections to confirm the IDTF's compliance with these standards. The IDTF must---

    (i) Be accessible during regular business hours to CMS and beneficiaries; and

    (ii) Maintain a visible sign posting its normal business hours.

15. Enrolls in Medicare for any diagnostic testing services that it furnishes to a Medicare beneficiary, regardless of whether the service is furnished in a mobile or fixed-base location.

16 Bills for all mobile diagnostic services that are furnished to a Medicare beneficiary, unless the mobile diagnostic service is part of a service provided under arrangement as described in section 1861(w)(1) of the Act. (Section 1861(w)(1) states that the term "arrangements" is limited to arrangements under which receipt of payments by the hospital, critical access hospital, skilled nursing facility, home health agency or hospice program (whether in its own right or as an agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.)

    If the IDTF claims that it is furnishing services under arrangement as described in section 1861(w)(1), the IDTF must provide documentation of such with its initial or revalidation Form CMS-855 application.

The IDTF must meet all of the standards in 42 CFR §410.33 – as well as all other Federal and State statutory and regulatory requirements – in order to be enrolled in, and to maintain its enrollment in, the Medicare program. Failure to meet any of the standards in 42 CFR §410.33 or any other applicable requirements will result in the denial of the supplier's Form CMS-855 application or, if the supplier is already enrolled in Medicare, the revocation of its Medicare billing privileges.

B. Sharing of Space and Equipment

Effective January 1, 2008, with the exception of hospital-based and mobile IDTFs, a fixed-base IDTF does not: (i) share a practice location with another Medicare-enrolled individual or organization; (ii) lease or sublease its operations or its practice location to another Medicare-enrolled individual or organization; or (iii) share diagnostic testing equipment used in the initial diagnostic test with another Medicare-enrolled individual or organization. (See 42 CFR §410.33(g)(15).)

If the contractor determines that an IDTF is leasing or subleasing its operations to another organization or individual, the contractor shall revoke the supplier's Medicare billing privileges.

C. One Enrollment per Practice Location

An IDTF must separately enroll each of its practice locations (with the exception of locations that are used solely as warehouses or repair facilities). This means that an enrolling IDTF can only have one practice location on its Form CMS-855B enrollment application; thus, if an IDTF is adding a practice location to its existing enrollment, it must submit a new, complete Form CMS-855B application for that location and have that location undergo a separate site visit. Also, each of the IDTF's mobile units must enroll separately. Consequently, if a fixed IDTF site also contains a mobile unit, the mobile unit must enroll separately from the fixed location.

Each separately enrolled practice location of the IDTF must meet all applicable IDTF requirements. The location's failure to comply with any of these requirements will result in the revocation of its Medicare billing privileges.

If an IDTF adds equipment for diagnostic testing that is mobile in nature, but is fixed permanently to the IDTF's physical location (i.e.: a CT scanner that is mounted in a bus or trailer, but is parked at the IDTF's

site for use by the IDTF), a second enrollment is not necessary. This equipment can be listed in the Form CMS-855B along with the services performed on the equipment. In these cases, the MAC shall indicate the use of a fixed mobile unit is in use at the IDTF's site in the site visit request so the site inspector will know to view the fixed mobile equipment as part of the IDTF.

D. Effective Date of Billing Privileges

The filing date of an IDTF Medicare enrollment application is the date that the contractor receives a signed application that it is able to process to approval. (See 42 CFR §410.33(i).) The effective date of billing privileges for a newly enrolled IDTF is the later of the following:

(1) The filing date of the Medicare enrollment application that was subsequently approved by a Medicare fee-for-service contractor; or

(2) The date the IDTF first started furnishing services at its new practice location.

A newly-enrolled IDTF, therefore, may not receive reimbursement for services furnished before the effective date of billing privileges.

The contractor shall note that if it rejects an IDTF application and a new application is later submitted, the date of filing is the date the contractor receives the new enrollment application.

If an IDTF undergoes an ownership change that results in a new enrollment in PECOS (a new federal Tax Identification Number is a result of this change), MACs should use the transfer of ownership/business date as indicated by the IDTF, instead of establishing a new effective date.

E. Leasing and Staffing

For purposes of the provisions in 42 CFR §410.33, a "mobile IDTF" does not include entities that lease or contract with a Medicare enrolled provider or supplier to provide: (1) diagnostic testing equipment; (2) non-physician personnel described in 42 CFR §410.33(c); or (3) diagnostic testing equipment and non-physician personnel described in 42 CFR §410.33(c). This is because the provider/supplier is responsible for providing the appropriate level of physician supervision for the diagnostic testing.

An IDTF is not required to report equipment that the IDTF is leasing for a period less than 90 days, unless the IDTF is leasing equipment for services that they have not already reported on a CMS-855B IDTF Attachment. For all new services being provided, IDTFs would need to complete a change of information to include the equipment and CPT/HCPCS codes that will be billed. Any accreditation for the services provided would need to be obtained by the IDTF.

15.5.19.3 – Interpreting Physicians

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A. **Listing Interpreting Physicians --** The applicant shall list all physicians for whose diagnostic test interpretations it will bill. This includes physicians who will provide interpretations subject to the anti-markup payment limitation as detailed in CMS Publication 100-04, chapter 1, § 30.2.9 - whether the service is provided to the IDTF on a contract basis or is reassigned.

The contractor shall ensure and document that:

- All listed physicians are enrolled in Medicare

- All interpreting physicians who are reassigning their benefits to the IDTF have the right to do so

- The interpreting physicians listed are qualified to interpret the types of tests (codes) listed. (The contractor may need to contact another contractor to obtain this information.) If the applicant does not list any interpreting physicians, the contractor need not request additional information because the applicant may not be billing for the interpretations; that is, the physicians may be billing for the interpretation themselves.

A Form CMS-855R need not accompany a Form CMS-855B application submitted by an independent diagnostic testing facility (IDTF) that employs or contracts with an interpreting physician.

B. Changes of Interpreting Physicians

If an interpreting physician is being added or changed, the updated information must be reported via a Form CMS-855B change request. The new interpreting physician must have met all of the necessary requirements at the time any tests were performed to perform services as an interpreting physician.

If the contractor receives notification from an interpreting physician that he/she is no longer interpreting tests at the IDTF, the contractor shall request from the supplier a Form CMS-855B change of information to end date the interpreting physician from the enrollment.

15.5.19.5 – Supervising Physicians

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A. General Principles

Under 42 CFR §410.33(b)(1), an independent diagnostic testing facility (IDTF) must have one or more supervising physicians who are responsible for:

- The direct and ongoing oversight of the quality of the testing performed;
- The proper operation and calibration of equipment used to perform tests; and
- The qualifications of non-physician IDTF personnel who use the equipment.

Not every supervising physician has to be responsible for all of these functions. For instance, one supervising physician can be responsible for the operation and calibration of equipment, while another supervising physician can be responsible for test supervision and the qualifications of non-physician personnel. The basic requirement, however, is that all supervising physician functions must be properly met at each location, regardless of the number of physicians involved. This is particularly applicable to mobile IDTF units that are allowed to use different supervising physicians at different locations. They may have a different physician supervise the test at each location. The physicians used need only meet the proficiency standards for the tests they are supervising.

Under 42 CFR §410.33(b)(1), each supervising physician must be limited to providing general supervision at no more than three IDTF sites. This applies to both fixed sites and mobile units where three concurrent operations are capable of performing tests.

B. Information about Supervising Physicians

The contractor shall ensure and document that each supervising physician is: (1) licensed to practice in the State(s) where the diagnostic tests he or she supervises will be performed, (2) Medicare-enrolled, and (3) not currently excluded or debarred. The physician(s) need not necessarily be Medicare-enrolled in the State where the IDTF is enrolled; moreover, the physician need not be furnishing medical services outside of his/her role as a supervising physician (i.e., he/she need not have his/her own medical practice separate from the IDTF). If the physician is enrolled in another State or with another contractor, however, the contractor shall ensure that he or she is appropriately licensed in that State.

In addition:

- Each physician of the group who actually performs an IDTF supervisory function must be listed.

- If a supervising physician has been recently added or changed, the updated information must be reported via a Form CMS-855B change request. The new physician must have met all of the supervising physician requirements at the time any tests were performed.

- If the contractor knows that a listed supervising physician has been listed with several other IDTFs, the contractor shall check with the physician to determine whether he or she is still acting as supervising physician for these other IDTFs.

- If the supervising physician is enrolling in Medicare and does not intend to perform medical services outside of his/her role as a supervising physician:

    - The contractor shall still send the physician an approval letter (assuming successful enrollment) and issue a Provider Transaction Access Number

    - The physician shall list the IDTF's address as a practice location

    - The space-sharing prohibition in 42 CFR §410.33(g) does not apply in this particular scenario.

C. General, Direct, and Personal Supervision

Under 42 CFR §410.33(b)(2), if a procedure requires the direct or personal supervision of a physician as set forth in 42 CFR §410.32(b)(3), the contractor shall ensure that the IDTF's supervising physician furnishes this level of supervision.

The contractor's enrollment staff shall be familiar with the definitions of personal, direct and general supervision set forth at 42 CFR §410.32(b)(3), and shall ensure that the applicant has checked the highest required level of supervision for the tests being performed.

Each box that begins with "Assumes responsibility," must be checked. However, as indicated previously, the boxes can be checked through the use of more than one physician.

D. Attestation Statement for Supervising Physicians

A separate attestation statement must be completed and signed by each supervising physician listed. If Question E2 is not completed, the contractor may assume – unless it has reason to suspect otherwise - that the supervising physician in question supervises for all codes listed in section 2 of the IDTF attachment. If Question E2 is completed, the contractor shall ensure that all codes listed in section 2 are covered through the use of multiple supervising physicians.

With respect to physician verification, the contractor shall *contact each supervisory physician by telephone to verify that the physician: (1) actually exists (e.g., is not using a phony or inactive physician number); (2) indeed signed the attestation; and (3) is aware of his or her responsibilities.*

If the physician is enrolled with a different contractor, the contractor shall contact the latter contractor and obtain the listed telephone number of the physician.

E. Changes of Supervising Physicians

If a supervising physician is being added or changed, the updated information must be reported via a Form CMS-855B change request. The new supervising physician must have met all of the necessary requirements at the time any tests were performed to perform services as a supervising physician.

If the contractor receives notification from a supervising physician that he/she is no longer supervising tests at the IDTF, the contractor shall request from the supplier a Form CMS-855B change of information. If the IDTF did not have another supervising physician listed on the current application, the IDTF must submit a change of information adding a new supervising physician. If the IDTF does not provide this information, the MAC shall proceed with non-compliance revocation procedures as noted in Section 15.27.2 of this chapter.

15.5.20 – Processing Form CMS-855R Applications

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A. General Information

A Form CMS-855R application must be completed for any individual who will: (1) reassign his/her benefits to an eligible entity, (2) terminate an existing reassignment, or (3) update the primary practice location listed on the Form CMS-855R.

If the individual who wants to reassign his or her benefits is not enrolled in Medicare, the person must complete a Form CMS-855I as well as a Form CMS-855R. (The CMS-855I and CMS-855R can be submitted concurrently.) Moreover, if the entity to which the person's benefits will be reassigned is not enrolled in Medicare, the organization must complete a Form CMS-855B or, if applicable, a Form CMS-855A. (See section 15.7.6 for additional instructions regarding the joint processing of Form CMS-855As, Form CMS-855Rs, Form CMS-855Bs, and Form CMS-855Is.)

Benefits are reassigned to a provider or supplier, not to the practice location(s) of the provider or supplier. As such, the contractor shall not require each practitioner in a group to submit a Form CMS-855R each time the group adds a practice location.

An individual can receive reassigned benefits. The most common example of this is a physician or practitioner who reassigns his/her benefits to a physician who is either (1) a sole proprietor, or (2) the sole owner of an entity listed in section 4A of the Form CMS-855I. Here, the only forms that are necessary are the Form CMS-855R and separate Form CMS-855Is from the reassignor and the reassignee. (No Form CMS-855B or Form CMS-855A is involved.) The reassignee himself/herself must sign section 6B of the Form CMS-855R, as there is no authorized or delegated official involved.

The contractor shall follow the instructions in Pub. 100-04, chapter 1, sections 30.2 – 30.2.16 to ensure that a physician or other provider or supplier is eligible to receive reassigned benefits.

B. Reassignment to Entities that Complete the Form CMS-855A

Consistent with 42 CFR §424.80(b)(1) and (b)(2) and Pub. 100-04, chapter 1, sections 30.2.1(D) and (E) and 30.2.6 and 30.2.7, Medicare may pay: (1) a physician or other provider or supplier's employer if the provider or supplier is required, as a condition of employment, to turn over to the employer the fees for his or her services; or (2) an entity (i.e., a person, group, or facility) that is enrolled in the Medicare program for services furnished by a physician or other provider or supplier under a contractual arrangement with that entity. This means that Part A and Part B entities other than physician/practitioner group practices can receive reassigned benefits, assuming the requirements for a reassignment exception are met. For example, on the Part A side, this might occur with (1) a physician or other provider or supplier reassigning benefits to a hospital, skilled nursing facility, or critical access hospital billing under Method II (Critical Access Hospital (CAH) II) or (2) a nurse practitioner reassigning to a CAH II.

If the entity receiving the reassigned benefits is not a CAH II, it must enroll with the contractor via a Form CMS-855B, and the physician/practitioner reassigning benefits must complete and submit a Form CMS-855I and Form CMS-855R.

If the entity receiving the reassigned benefits is a CAH II, the entity need not and should not complete a separate Form CMS-855B form to receive reassigned benefits. The physician/practitioner can reassign benefits directly to

the CAH II's Part A enrollment. The distinction between CAHs billing Method I vs. Method II only applies to outpatient services; it does not apply to inpatient services.

Under Method I:

- The CAH bills for facility services
- The physicians/practitioners bill separately for their professional services

Under Method II

- The CAH bills for facility services

- If a physician/practitioner has reassigned his/her benefits to the CAH, the CAH bills for that particular physician's/practitioner's professional service

- If a CAH has elected Method II, the physician/practitioner is not required to reassign his or her benefits to the CAH. For those physicians/practitioners who do not reassign their benefits to the CAH, the CAH only bills for facility services and the physicians/practitioners separately bill for their professional services (similar to Method I).

Although eligible physicians or non-physician practitioners are not required to reassign their benefits to a CAH that bills Method II, doing so allows them to participate in the Electronic Health Records (EHR) Incentive Program for Eligible Professionals (EPs).

In this scenario, the Forms CMS-855I and CMS-855R shall be submitted to the Part B MAC and the Form CMS-855A to the Part A MAC. The Part B MAC shall be responsible for reassigning the individual to the Part A entity.

The reassignment to the Part A entity shall only occur if the Form CMS-855A for the CAH II has been finalized. This can be determined by viewing PECOS to identify if an approved enrollment exists for the CAH II. If one does not, the Part B MAC shall return the Form CMS-855I and/or Form CMS-855R to the provider. If an enrollment record exist but is in an Approved Pending RO Review status, the Part B MAC shall contact the Part A MAC to determine if the tie-in notice has been received from the RO but not yet updated in PECOS, prior to returning the applications.

C. Ambulatory Surgical Centers (ASCs) and Reassignment

Physicians and non-physician practitioners who meet the reassignment exceptions in 42 CFR §424.80, and Pub. 100-04, chapter 1, sections 30.2.6 and 30.2.7, may reassign their benefits to an ASC.

If a physician or non-physician practitioner wishes to reassign its benefits to an existing (that is, a currently-enrolled) ASC, both the individual and the entity must sign the CMS-855R. However, it is not necessary for the ASC to separately enroll as a group practice in order to receive benefits. It can accept reassignment as an ASC.

D. Reassignment and Revoked/Deceased Physicians and Non-Physician Practitioners

There are situations where a physician/non-physician practitioner (the "owning physician/practitioner") owns 100% of his/her own practice, employs another physician (the "employed physician/practitioner") to work with him/her, and accepts reassigned benefits from the employed physician/practitioner. Should the sole proprietor or sole owner die or have his/her billing privileges revoked, *and the provider or supplier fails to submit an updated CMS-855 within 90 days*, the practice is automatically dissolved for purposes of Medicare enrollment and all reassignments to the practice are automatically terminated as well. Neither the owning physician/practitioner nor the practice is enrolled in Medicare any longer and the enrollments for both shall be *deactivated* in accordance with the *deactivation* procedures outlined in this chapter. (It is immaterial whether the practice was established as a sole proprietorship, a professional corporation, a professional association, or a solely-owned limited liability company.) In addition, the contractor shall end-date the reassignment using, as applicable, the date of death or the effective date of the revocation.

Besides *deactivating* the enrollments of the owning physician/practitioner and the practice, the contractor shall notify the employed physician/practitioner that:

(1) The practice's enrollments have been *deactivated*;

(2) Any services furnished by him/her on behalf of the practice after the date of the owning physician/practitioner's death *or date of revocation or deactivation* will not be paid; and

(3) If the employed physician/practitioner wishes to provide services at the former practice's location, he/she must submit via Internet-based PECOS (or a paper Form CMS-855 application) a Form CMS-855I change of information request to add the owning physician/practitioner's practice location as a new location of the employed physician/practitioner. For purposes of this section 15.5.20(C)(3) only, submission of a (1) complete Form CMS-855I application as an initial enrollment and (2) a terminating Form CMS-855R application are not required – even if the employed physician/non-physician practitioner had reassigned all of his/her benefits to the practice.

E. Miscellaneous Reassignment Policies

1. A Form CMS-855R is required to terminate a reassignment. The termination cannot be done via the Form CMS-855I (except for Internet-based PECOS applications when the termination is for the last PTAN on an enrollment).

2. The authorized or delegated official who signs section 6 of the Form CMS-855R must be currently on file with the contractor as such. If this is a new enrollment - with a joint submission of the Form(s) CMS-855A or CMS 855B, Form CMS-855I, and Form CMS-855R - the person must be listed on the CMS-855A or CMS-855B as an authorized or delegated official.

3. If the Form CMS-855R is accompanied by an initial Form CMS-855I or submitted as a "stand-alone" form (that is, a Form CMS-855R is submitted as a new reassignment, such as when an enrolled physician who is operating as a sole proprietor joins a group practice and reassigns his benefits to the group), the effective date of the enrollment and the reassignment shall be consistent with the 30-day rule (i.e., the later of the date of filing or the date the reassignor first began furnishing services at the new location) specified in section 15.17 of this chapter.

4. The contractor need not verify whether the reassigning individual is a W-2 employee or a 1099 contractor.

5. In situations where the provider or supplier is both adding and terminating a reassignment, each transaction must be reported on a separate Form CMS-855R. The same Form CMS-855R cannot be used for both transactions.

6. The Form CMS-855R application shall not be used to:

- Report employment arrangements of physician assistants (PAs); employment arrangements for PAs must be reported on the Form CMS-855I.
- Revalidate reassignments; the individual practitioner should only use the Form CMS-855I and list his or her active reassignment information in section 4B thereof.
- Go to https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending to view the CMS-855R Processing Guide, which constitutes a general Form CMS-855R processing guide for providers/suppliers and contractors. The procedures described in the Guide, which include processing alternatives and processing instructions for the Form CMS-855R, take precedence over all other instructions in this chapter concerning the processing of Form CMS-855R applications.

F. Reassignment Termination Effective Date

When approving a Form CMS-855R to terminate a reassignment, the contractor shall enter an effective date of termination in PECOS as the day after the day listed on the application. For example: a physician submits a CMS-855R to terminate a reassignment to a group and lists June 30, 2019 as the date of termination. The effective date of the termination listed in PECOS and any correspondence to the provider should be July 1, 2019.

15.7.1.3.1 – Processing Alternatives – Form CMS-855B and Form CMS-855I

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A. General Processing Alternatives

The following general alternatives are applicable to all sections of the Form CMS-855B and the CMS-855I, unless otherwise specified:

1. Information Disclosed Elsewhere - If a data element on the supplier's Form CMS-855 application is missing but the information is disclosed: (1) elsewhere on the application or (2) in the supporting documentation submitted with the application, the contractor need not obtain the missing data via an updated Form CMS-855 page and a newly-signed certification statement; no further development – not even by telephone – is required. The following information, however, must be furnished in the appropriate section(s) of the Form CMS-855, even if the data is identified elsewhere on the form or in the supporting documentation:

   a. Any final adverse action data requested in sections 3, 4A (Form CMS-855I only), 5B (Form CMS-855B only), and 6B of the Form CMS-855

   b. *All ownership and managing control information in section 5A and 6A of the Form CMS-855B*

   c. The applicants legal business names (LBN) or legal names
   Note: If an application is submitted with a valid NPI and PTAN combination, but the LBN field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in section 4 of the Form CMS-855I and the contractor is able to confirm the correct LBN based on the NPI and PTAN combination provided, the contractor is not required to develop. (This also applies to Employer's Name for PA's in section 2E of the Form CMS-855I)

   d. Tax identification numbers (TIN)
   e. NPI-legacy number combinations in Section 4 of the Form CMS-855
   Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI before developing to the provider.

   f. Supplier/practitioner type (section 2A of the Form CMS-855B and section 2D of the Form CMS-855I)

2. Licenses

In situations where the supplier is required to submit a copy of a particular professional or business license, certification, registration, or degree but fails to do so, the contractor need not obtain such documentation from the provider if the contractor can verify the information independently. This may be done by: (1) reviewing and printing confirming pages from the applicable state, professional, or school Web site, (2) requesting and receiving from the appropriate state, professional, or educational body written confirmation of the supplier's status therewith, or (3) utilizing another third-party verification source. Similarly, if the provider submits a copy of the applicable license, certification, registration or degree but fails to complete the applicable section of the form, the section need not be completed if the data in question can be verified on the license/certification itself or via any of the three mechanisms described above. The contractor shall not develop for a correction to the form if the license information can be verified as described above.

- The above-referenced written confirmation of the supplier's status can be in the form of a letter, fax, or email, but it must be in writing. Documentation of a verbal conversation between the contractor and the body in question does not qualify as appropriate confirmation.

- This exception only applies to those documents that traditionally fall within the category of licenses, registrations, certifications, or degrees. It does not apply to items such as adverse action documentation, paramedic intercept services documents, etc. Furthermore, the exception is moot in cases where: (1) a particular license/certification is not required by the state, or (2) the license/certification has not been obtained because a state survey has not yet been performed (i.e., for certified suppliers).

3. City, State, and ZIP Code **-** If an address (e.g., correspondence address, practice location) lacks a city, state *or zip + four*, the contractor can verify the missing data in any manner it chooses. In addition, the contractor can obtain the "zip + four" from either the U.S. Postal Service or the address validation in PECOS.

4. Inapplicable Questions - The supplier need not check "no" for questions that obviously do not apply to its supplier type. For instance, a nurse practitioner need not check "no" to question 1(a) in Section 2C of the Form CMS-855I.

5. Clinical Laboratory Improvement Act (CLIA) and Drug Enforcement Agency (DEA) - CLIA and DEA certificates need not be submitted if the applicable CLIA and DEA information was furnished on the Form CMS-855. Likewise, if the aforementioned certificates are furnished but the applicable Form CMS-855 sections are blank, no further development is needed.

6. Practice Locations - Each practice location is to be verified. However, there is no need to separately contact each location on the application. Such verification can be done via the contact person listed on the application; the contact person's verification shall be documented in the provider file pursuant to section 15.7.3 of this chapter.

B. Sectional Processing Alternatives

The processing alternatives in this subsection B are in addition to, and not in lieu of, those in subsection A.

1. Section 1 (Form CMS-855B and Form CMS-855I)

With the exception of: (1) the voluntary termination checkbox, (2) the effective date of termination, and (3) physician assistant and reassignment data in section 1A of the Form CMS-855I, any blank data/checkboxes in section 1 can be verified through any means chosen by the contractor (e.g., email, telephone, fax).

2. Section 2

a. Form CMS-855B

- All information in section 2B1 (with the exception of the TIN and LBN) can be captured by telephone, fax, email, or Web site.

- If the contractor is aware that a particular state does not require licensure/certification and the "Not Applicable" boxes are not checked in section 2A2, no further development is needed.

b. Form CMS-855I

- If blank, "Type of Other Name" and "Gender" can be captured orally.

- If the contractor is aware that a particular state does not require licensure/certification and the "Not Applicable" boxes are not checked in section 2A, no further development is needed.

- In section 2D1, if the supplier uses a checkmark, an "X," or other symbol to identify his/her primary and secondary specialties (as opposed to a "P" or "S"), no additional development is needed.

- When processing a non-physician practitioner's (NPP) application, the contractor need not automatically request a copy of the NPP's degree or diploma (if it is not submitted) if his or her education can be verified through other authorized means; requesting a copy of the degree or diploma should only be done if educational information cannot otherwise be verified.

- Medical or Professional School and Year of Graduation – If the Form CMS-855 lacks the Medical or Professional School and/or the year of graduation, but the information is disclosed in the supporting documentation submitted with the application or already exists in PECOS, no further development is needed.

3. <u>Section 4</u>

a. Form CMS-855B

- In section 4A, the type of practice location checkboxes need not be completed if the type of location is apparent to the contractor. The contractor can confirm the information via telephone, email, or fax.

- In section 4B, if neither box is checked and no address is provided, the contractor can contact the supplier by telephone, email, or fax to confirm the supplier's intentions. If the "special payments" address is indeed the same as the practice location, no further development is needed. If, however, the supplier wants payments to be sent to a different address, the address in 4B must be completed via the Form CMS-855.

- In section 4E, if the "Check here" box is not checked and no address is provided, the contractor can contact the supplier by telephone, email or fax to confirm the supplier's intentions. If the base of operations address is the same as the practice location, no further development is needed. If the supplier indicates that the base of operations is at a different location, the address in 4E must be completed via the Form CMS-855.

- In section 4F, if the vehicle certificates are furnished but the applicable Form CMS-855 sections are blank, the contractor can verify via telephone, email or fax that said vehicles are the only ones the supplier has.

b. Form CMS-855I

- If an application is submitted with a valid NPI and PTAN combination, but the LBN field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in section 4 of the Form CMS-855I and the contractor is able to confirm the correct LBN based on the NPI and PTAN combination provided, the contractor is not required to develop.

- In section 4C, the type of practice location checkboxes need not be completed if the type of location is apparent to the contractor; the contractor can confirm the information via telephone, email or fax.
- In section 4E, if neither box is checked and no address is provided, the contractor can contact the supplier by telephone, email or fax to confirm the supplier's intentions. If the "special payments" address is the same as the practice location, no further development is needed. If, however, the supplier wants payments to be sent to a different address, the address in 4E must be completed via the Form CMS-855.

4. Section 8 (Form CMS-855B and Form CMS-855I) - If the telephone number is blank, the number can be verified with the supplier by telephone, email or fax. If the section is blank, including the check box, no additional development is necessary.

5. Section 13 (Form CMS-855B and Form CMS-855I)

- If this section is completely blank, the contractor need not develop for this information and can simply contact an authorized or delegated official (or, for Form CMS-855I applications, the physician/practitioner).

- If neither box is checked but the contact person information is incomplete (e.g., no telephone number listed), the contractor can either: (1) develop for this information by telephone, email or fax, or (2) contact an authorized or delegated official (or, for Form CMS-855I applications, the physician/practitioner).

- Currently there is no option on the CMS-855 form to delete a contact person. Therefore, contractors shall accept end dates of a contact person via phone, email, fax or mail from the individual provider, the Authorized or Delegation official, or a current contact person on file. Contractors shall document in the comment section in PECOS who requested the termination, how it was requested (email, phone or fax) and when it was requested. The addition of contact persons must still be reported via the appropriate CMS-855 form.

6. Section 15 (Form CMS-855I) Section 15 and 16 (Form CMS-855B)

The telephone number can be left blank. No further development is needed.

7. Attachment 1 (Form CMS-855B)

- *In section D, the "Land," "Air," and "Marine" boxes need not be checked (or developed) if the type of vehicle involved is clear.*
- *Contractors are not required to develop for the written statement from the supplier, signed by the President, Chief Executive Officer or Chief Operating Officer of the airport from where the aircraft is hangared that gives the name and address of the facility.*

8. Attachment 2 (Form CMS-855B)

In section E, the telephone number of the supervising physician can be left blank. No further development is needed.

C. Supporting Documents

If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again during the enrollment process. The MAC shall utilize the existing documentation for verification. Documentation submitted with a previously submitted enrollment application, or documentation currently uploaded in PECOS, qualifies as a processing alternative, unless stated otherwise in this chapter or any CMS directive. In addition, per section 15.7.3 of this chapter, the contractor shall document in the provider file that the missing information was found elsewhere in the enrollment package, with previously submitted applications or documentation currently uploaded in PECOS. This excludes information that must be verified at the current point in time (i.e. a license without a primary source verification method). Additionally, contractors shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

15.7.1.3.2 – Processing Alternatives – Form CMS-855A

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A. General Processing Alternatives

The following general alternatives are applicable to all sections of the Form CMS-855A, unless otherwise specified:

1. Information Disclosed Elsewhere – If a data element on the provider's Form CMS-855A application is missing but the information is disclosed (1) elsewhere on the application or (2) in the supporting documentation submitted with the application, the contractor need not obtain the missing data via an updated Form CMS-855A page and a newly-signed certification statement; no further development – not even by telephone – is required. The following information, however, must be furnished in the appropriate section(s) of the Form CMS-855A, even if the data is identified elsewhere on the form or in the supporting documentation:

a. Any final adverse action data requested in sections 3, 5B and 6B of the Form CMS-855A

b. *All ownership and managing control information in section 5A and 6A of the Form CMS-855A*

c. All legal business names (LBNs)(e.g., provider, chain home office)
Note: If an application is submitted with a valid NPI and OSCAR combination, but the LBN field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in section 4 of the Form CMS-855A and the contractor is able to confirm the correct LBN based on the NPI and OSCAR combination provided, the contractor is not required to develop.

d. All tax identification numbers (TINs)(e.g., provider, owning organization)

e. NPI-legacy number combinations in section 4 of the Form CMS-855A
Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI before developing to the provider.

f. Provider type

g. The following data in sections 2F, 2G and 2H:

- "Doing business as" name
- Effective dates of sale/transfer/consolidation
- Checkbox in section 2F indicating whether seller will accept assets/liabilities
- Names of units with separate legacy numbers/NPIs;
- All NPIs and legacy numbers
  Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the OSCAR or NPI before developing to the provider.

2. Licenses - In situations where the provider is required to submit a copy of a particular professional or business license, certification, or registration but fails to do so, the contractor need not obtain such documentation from the provider if the contractor can verify the information independently. This may be done by: (1) reviewing and printing confirmation pages from the applicable state web site, (2) requesting and receiving from the appropriate state body written confirmation of the provider's status therewith, and (3) using any other third-party verification source. Similarly, if the provider submits a copy of the applicable license, certification, or registration but fails to complete the appropriate section of the form, the section need not be completed if the data in question can be verified on the license/certification itself or via any of the three mechanisms above.

- The above-referenced written confirmation from a state body of the provider's status can be in the form of a letter, fax, or email, but it must be in writing. Documentation of a verbal conversation between the contractor and the body in question does not qualify as appropriate confirmation.

- This exception only applies to those documents that traditionally fall within the category of licenses, registrations, or certifications. It does not apply to items such as adverse action documentation, bills of sale, etc. Furthermore, the exception is moot in cases where: (1) a particular license/certification is not required by the state, or (2) the license/certification has not been obtained because a state survey has not yet been performed.

3. City, State, and ZIP Code - If an address (e.g., correspondence address, practice location) lacks a city, state *or zip + four*, the contractor can verify the missing data in any manner it chooses. In addition, the contractor can obtain the "zip + four" from either the U.S. Postal Service or the *address v*alidation in PECOS.

B. Sectional Processing Alternatives

The processing alternatives in this subsection B are in addition to, and not in lieu of, those in subsection A.

1. Section 1

With the exception of (1) the voluntary termination checkbox and (2) the effective date of termination, any blank data/checkboxes in section 1 can be verified through any means chosen by the contractor (e.g., email, telephone, fax).

2. Section 2

- Other than the TIN and the LBN, all information in section 2B1 can be captured by telephone, email, fax, or a Web site.
- If the contractor is aware that a particular state does not require licensure/certification and the "Not Applicable" boxes in section 2B2 are not checked, no further development is needed.
- With respect to sections 2F, 2G, and 2H, if the old/new owner's current contractor is not listed, the contractor can research this data on its own or obtain it from the provider by any means.

3. Section 4

- In section 4A, if the "type of practice location" checkbox is blank, the contractor can confirm the information via email or fax.
- In section 4B, if neither box is checked and no address is provided, the contractor can contact the provider by telephone, email, or fax to confirm the provider's intentions. If the provider replies that the "special payments" address is the same as the practice location, no further development is needed. If, however, the provider wants payments to be sent to a different address, the address in 4B must be completed via the Form CMS-855A.
- In section 4D, if the "Check here" box is not checked and no address is provided, the contractor can contact the provider by telephone, email or fax to confirm the provider's intentions. If the provider replies that the base of operations address is the same as the practice location, no further development is needed. If the provider indicates that the base of operations is at a different location, the address in 4D must be completed via the Form CMS-855A.
- In section 4E, if the vehicle certificates are furnished but the applicable CMS-855A sections are blank, the contractor can verify via telephone, email or fax that said vehicles are the only ones the provider has.

4. Section 7

- If all of section 7 is blank (including the check box just above section 7A), no additional development is necessary.

- If the provider indicates that it is part of a chain but the checkboxes in section 7A are blank, the contractor can verify the type of transaction involved via email or fax.

- In section 7B, if the person is also listed with complete information in section 6A (e.g., the individual's Social Security Number (SSN) is listed in section 6A1), only the individual's first and last name need be listed in section 7B.

- In section 7C, if the entity is also listed with complete information in section 5A, the company's legal business name is the only data that must be listed in section 7C. (If blank, the cost report date, the home office's contractor, and the chain number can be developed by phone, email, or fax.)

- If blank, data in section 7D can be collected by telephone, email or fax.

- If blank, data in section 7E can be collected by email or fax.

5. Section 8

- If the telephone number is blank, the number can be verified with the provider by telephone, email or fax.

- If all of section 8 is blank (including the check box), no additional development is necessary.

6. Section 12

- If it is obvious that the entity is not enrolling as a home health agency (HHA), the checkbox above section 12A can be left blank.

- If the entity is an HHA:

  - If section 12A1 or 12A3B is blank, the data can be verified by telephone, email, or fax.

  - If the telephone number in section 12B is blank, the number can be verified with the provider by telephone, email or fax.

7. Section 13

- If this section is completely blank, the contractor need not develop for this information and can simply contact an authorized or delegated official.
- If neither box is checked but the contact person information is incomplete (e.g., no telephone number listed), the contractor may either (1) develop for this information by telephone, email or fax, or (2) contact an authorized or delegated official.

- Currently there is no option on the CMS-855 form to delete a contact person. Therefore, contractors shall accept end dates of a contact person via phone, email, fax or mail from the individual provider, the Authorized or Delegation official, or a current contact person on file. Contractors shall document in the comment section in PECOS who requested the termination, how it was requested (email, phone or fax) and when it was requested. The addition of contact persons must still be reported via the appropriate CMS-855 form.

8. Sections 15 and 16

The telephone number can be left blank. No further development is needed.

C. Supporting Documents

If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again during the enrollment process. The MAC shall utilize the existing documentation for verification. Documentation submitted with a previously submitted enrollment application, or documentation currently uploaded in PECOS, qualifies as a processing alternative, unless stated otherwise in this chapter or any CMS directive. In addition, per section 15.7.3 of this chapter, the contractor shall document in the provider file that the missing information was found elsewhere in the enrollment package, with previously submitted applications or documentation currently uploaded in PECOS. This excludes information that must be verified at the current point in time (i.e. a license without a primary source verification method). Additionally, contractors shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

15.7.1.3.3 – Processing Alternatives – Form CMS-855O

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A. General Processing Alternatives

The following general alternatives are applicable to all sections of the Form CMS-855O, unless otherwise specified:

1. Information Disclosed Elsewhere - If a data element on the supplier's Form CMS-855O application is missing but the information is disclosed (1) elsewhere on the application or (2) in the supporting documentation submitted with the application, the contractor need not obtain the missing data via an updated Form CMS-855O page and a newly-signed certification statement; no further development – not even by telephone – is required. The following information, however, must be furnished in the appropriate section(s) of the Form CMS-855O, even if the data is identified elsewhere on the form or in the supporting documentation:

   a. Any final adverse action data requested in section 3
   b. Legal names
   c. Tax identification number (TIN)
   d. NPI-legacy number combinations in section 2 (if applicable)
      Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI before developing to the provider.
   e. Data in section 1B

2. Licenses

In situations where the supplier is required to submit a copy of a particular professional or business license, certification, registration, or degree but fails to do so, the contractor need not obtain such documentation from the provider if the contractor can verify the information independently. This may be done by: (1) reviewing and printing confirming pages from the applicable state, professional, or school web site, (2) requesting and receiving from the appropriate state, professional, or educational body written confirmation of the supplier's status therewith, or (3) utilizing another third-party verification source. Likewise, if the provider submits a copy of the applicable license, certification, registration or degree but fails to complete the applicable section of the form, the section need not be completed if the data in question can be verified on the license/certification itself or via any of the three mechanisms above.

- The above-referenced written confirmation of the supplier's status can be in the form of a letter, fax, or email, but it must be in writing. Documentation of a verbal conversation between the contractor and the body in question does not qualify as appropriate confirmation.

- This exception only applies to those documents that traditionally fall within the category of licenses, registrations, certifications, or degrees such as adverse action documentation. Furthermore, the exception is moot in cases where a particular license/certification is not required by the state.

3. City, State, and ZIP Code **-** If a particular address lacks a city, state *or zip + four*, the contractor can verify the missing data in any manner it chooses. In addition, the contractor can obtain the "zip + four" from either the U.S. Postal Service or the address validation in PECOS.

4. Drug Enforcement Agency (DEA) - DEA certificates need not be submitted if the applicable DEA information was furnished on the CMS-855. Similarly, if the aforementioned certificates are furnished but the applicable CMS-855 sections are blank, no further development is needed.

B. Sectional Processing Alternatives

The processing alternatives in this subsection B are in addition to, and not in lieu of, those in subsection A.

1. Section 1

With the exception of the voluntary termination checkbox, any blank data/checkboxes in section 1 can be verified through any means chosen by the contractor (e.g., email, telephone, fax).

2. Section 2

- If blank, "Type of Other Name" and "Gender" can be captured orally.

- If the contractor is aware that a particular state does not require licensure/certification and the "Not Applicable" boxes are not checked in section 2C, no further development is needed.

- When processing a non-physician practitioner's (NPP) application, the contractor need not automatically request a copy of the NPP's degree or diploma (if it is not submitted) if his or her education can be verified through other authorized means; requesting a copy of the degree or diploma should only be done if educational information cannot otherwise be verified.

- Medical or Professional School and Year of Graduation – If the Form CMS-855 lacks the Medical or Professional School and/or the year of graduation, but the information if disclosed in the supporting documentation submitted with the application or already exists in PECOS, no further development is needed.

3. Section 4

If the supplier uses a checkmark, an "X," or other symbol to identify his/her primary and secondary specialties (as opposed to a "P" or "S"), no additional development is needed.

4. Section 6

If this section is completely blank, the contractor need not develop for this information and can simply contact the physician or practitioner.

C. Supporting Documents

If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again during the enrollment process. The MAC shall utilize the existing documentation for verification. Documentation submitted with a previously submitted enrollment application, or documentation currently uploaded in PECOS, qualifies as a processing alternative, unless stated otherwise in this chapter or any CMS directive. In addition, per section 15.7.3 of this chapter, the contractor shall document in the

provider file that the missing information was found elsewhere in the enrollment package, with previously submitted applications or documentation currently uploaded in PECOS. This excludes information that must be verified at the current point in time (i.e. a license without a primary source verification method). Additionally, contractors shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

15.7.1.3.4 – Processing Alternatives – Form CMS-855R

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

All data elements in sections 1, 2, 3, and 4 must be completed via the CMS-855R.

Regarding section 2:

- If an application is submitted with a valid NPI and PTAN combination, but the LBN field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in section 2 of the Form CMS-855R, and the contractor is able to confirm the correct LBN based on the NPI and PTAN combination provided, the contractor is not required to develop.
- *MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI of the group/organization/individual that is receiving the reassigned benefits before developing to the provider for existing individual practitioners only. If information is missing from the 855R that cannot be verified in PECOS, the Shared Systems or provider files, then a development would have to be issued (i.e.: group information is missing from the 855R and not included in the 855I Section 4, this cannot be verified elsewhere).*

Regarding section 3:

- *MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI of the individual practitioner who is reassigning benefits before developing to the provider for existing individual practitioners only.*

Regarding section 5:

- If this section is completely blank, the contractor need not develop for this information and can simply contact the party that submitted the form (e.g., the enrolling physician).

- If a contact person is listed, any other missing data (e.g., address, e-mail) can be captured via telephone.

15.7.1.3.5 - Processing Alternatives – Form CMS-20134

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A. General Processing

The following general alternatives are applicable to all sections of the Form CMS-20134, unless otherwise specified:

1. Information Disclosed Elsewhere - If a data element on the supplier's Form CMS-20134 application is missing but the information is disclosed: (1) elsewhere on the application or (2) in the supporting documentation submitted with the application, the contractor need not obtain the missing data via an updated Form CMS-20134 page and a newly-signed certification statement; no further development – not even by telephone – is required. The following information, however, must be furnished in the appropriate section(s) of the Form CMS-20134, even if the data is identified elsewhere on the form or in the supporting documentation:

   a. Any final adverse action data requested in sections 3, 5B, and 6B

   b. *All ownership and managing control information in section 5A and 6A of the Form CMS-20134.*

c. The applicants legal business names (LBN) or legal names

Note: If an application is submitted with a valid NPI and PTAN combination, but the LBN field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in section 4 of the Form CMS-20134 and the contractor is able to confirm the correct LBN based on the NPI and PTAN combination provided, the contractor is not required to develop.

d. Tax identification numbers (TIN)

e. NPI-legacy number combinations in Section 4 of the Form CMS-20134
Note: MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI before developing to the provider.

f. Supplier/practitioner type in section 2A of the Form CMS-20134

1. Recognition Status
In situations where an MDPP supplier is required to submit a copy of its CDC recognition but fails to do so, the contractor need not obtain such documentation from the supplier if the contractor can verify the information independently. This may be done by: (1) reviewing and printing confirming pages from the Centers for Disease Control and Prevention Web site, (2) requesting and receiving from the CDC written confirmation of the supplier's status therewith, or (3) utilizing another third-party verification source. Similarly, if the supplier submits a copy of the applicable recognition, but fails to complete the applicable section of the form, the section need not be completed if the data in question can be verified on the recognition itself or via any of the three mechanisms described above. The contractor shall not develop for a correction to the form if the recognition information can be verified as described above.

- The above-referenced written confirmation of the supplier's status can be in the form of a letter, fax, or email, but it must be in writing. Documentation of a verbal conversation between the contractor and the body in question does not qualify as appropriate confirmation.

2. City, State, and ZIP Code **-** If an address (e.g., correspondence address, practice location) lacks a city, state *or zip + four*, the contractor can verify the missing data in any manner it chooses. In addition, the contractor can obtain the "zip + four" from either the U.S. Postal Service or the address validation in PECOS.

3. Inapplicable Questions - The supplier need not check "no" for questions that obviously do not apply to its supplier type.

4. Administrative Locations - Each administrative location is to be verified. However, there is no need to separately contact each location on the application. Such verification can be done via the contact person listed on the application; the contact person's verification shall be documented in the provider file pursuant to section 15.7.3 of this chapter.

B. Sectional Processing Alternatives

The processing alternatives in this subsection B are in addition to, and not in lieu of, those in subsection A.

1. Section 1

With the exception of: (1) the voluntary termination checkbox and (2) the effective date of termination, any blank data/checkboxes in section 1 can be verified through any means chosen by the contractor (e.g., email, telephone, fax).

2. Section 2

- All information in section 2B1 (with the exception of the TIN and LBN) can be captured by telephone, fax, email, or Web site.

3. Section 4

- In section 4A, the type of location checkboxes need not be completed if the type of location is apparent to the contractor. The contractor can confirm the information via telephone, email, or fax.

- In section 4B, if neither box is checked and no address is provided, the contractor can contact the supplier by telephone, email, or fax to confirm the supplier's intentions. If the "special payments" address is indeed the same as the administrative location, no further development is needed. If, however, the supplier wants payments to be sent to a different address, the address in 4B must be completed via the Form CMS-20134.

- In section 4E, if the "Check here" box is not checked and no address is provided, the contractor can contact the supplier by telephone, email or fax to confirm the supplier's intentions. If the base of operations address is the same as the practice location, no further development is needed. If the supplier indicates that the base of operations is at a different location, the address in 4E must be completed via the Form CMS-20134.

4. Section 7

- If the date of change for an individual coach is completely blank, the contractor must develop for this information.

5. Section 8

- If the telephone number is blank, the number can be verified with the supplier by telephone, email or fax. If the section is blank, including the check box, no additional development is necessary.

6. Section 13

- If this section is completely blank, the contractor need not develop for this information and can simply contact an authorized or delegated official.

- If neither box is checked but the contact person information is incomplete (e.g., no telephone number listed), the contractor can either: (1) develop for this information by telephone, email or fax, or (2) contact an authorized or delegated official.

- Currently there is no option on the CMS-20134 form to delete a contact person. Therefore, contractors shall accept end dates of a contact person via phone, email, fax or mail from the individual provider, the Authorized or Delegation official, or a current contact person on file. Contractors shall document in the comment section in PECOS who requested the termination, how it was requested (email, phone or fax) and when it was requested. The addition of contact persons must still be reported via the Form CMS-20134.

7. Section 15 (Form CMS-855I) Section 15 and 16 (Form CMS-855B)

The telephone number can be left blank. No further development is needed.

C. Supporting Documents

If the supporting documentation currently exists in the provider's file, the provider or supplier is not required to submit that documentation again during the enrollment process. The MAC shall utilize the existing documentation for verification. Documentation submitted with a previously submitted enrollment application, or

documentation currently uploaded in PECOS, qualifies as a processing alternative, unless stated otherwise in this chapter or any CMS directive. In addition, per section 15.7.3 of this chapter, the contractor shall document in the provider file that the missing information was found elsewhere in the enrollment package, with previously submitted applications or documentation currently uploaded in PECOS. This excludes information that must be verified at the current point in time (i.e. a license without a primary source verification method). Additionally, contractors shall not utilize information submitted along with opt-out applications for enrollment application processing or vice-versa.

15.11 – Electronic Fund Transfers (EFT)

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A. General Information

If a provider does not have an established enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) and wants to change any of its EFT information (e.g., bank routing number), it must submit a complete Form CMS-855 or Form CMS-20134 before the contractor can effectuate the change.

With the exception of the situation described in section (B) below, it is immaterial whether the provider or the bank was responsible for triggering the changed data. Under 42 CFR §424.510(d)(2)(iv) and §424.510(e):

- All providers (including Federal, State and local governments) enrolling in Medicare must use EFT in order to receive payments. Moreover, any provider not currently on EFT that (1) submits any change to its existing enrollment data or (2) submits a revalidation application must also submit a Form CMS-588 and thereafter receive payments via EFT.

- If a provider is already receiving payments via EFT and is located in a jurisdiction that is undergoing a change of Medicare contractors, the provider must continue to receive payments via EFT. However, the change in contractors does not require the provider to submit a new Form CMS-588 unless CMS states otherwise.

- For web-based application submissions, the Form CMS-588 shall be submitted via PECOS upload functionality.

B. Verification

Providers and suppliers may submit a Form CMS-588 via paper or through PECOS. In either case, the contractor shall ensure that:

- The information submitted on the Form CMS-588 is complete and accurate.

- The provider/supplier submitted (1) a voided check or (2) a letter from the bank verifying the account information.

- The routing number and account number matches what was provided on the Form CMS-588.

- The signature is valid. (**NOTE:** For electronic Form CMS-588 submissions, the provider can either e-sign the form or via PECOS upload functionality).

- *If the Form CMS-588 is received and is missing the checkbox for the Social Security Number (SSN) or Employer Identification Number (EIN), but the contractor can ascertain the correct option via the supporting documents submitted or elsewhere on the application, the contractor may proceed without development back to the provider or supplier.*

Once the Form CMS-588 has been processed, the 588 form will be printed and delivered to the contractor's financial area along with the voided check and letter from the bank verifying account information, for proper processing of the EFT information. If this information cannot be verified and the provider fails to timely respond to a developmental request, the contractor shall reject the Form CMS-588 and, if applicable, the accompanying Form CMS-855 or Form CMS-20134.

C. Miscellaneous Policies

1. Banking Institutions - All payments must be made to a banking institution. EFT payments to non-banking institutions (e.g., brokerage houses, mutual fund families) are not permitted.

If the provider's bank of choice does not or will not participate in the provider's proposed EFT arrangement, the provider must select another financial institution.

2. Verification - The contractor shall ensure that all EFT arrangements comply with CMS Publication 100-04, chapter 1, section 30.2.5.

3. Sent to the Wrong Unit - If a provider submits an EFT change request to the contractor but not to the latter's enrollment unit, the recipient unit shall forward it to the enrollment staff, which shall then process the change. The enrollment unit is responsible for processing EFT changes. As such, while it may send the original EFT form back to the recipient unit, the enrollment unit shall keep a copy of the EFT form and append it to the provider's Form CMS-855 or Form CMS-20134 in the file.

4. Bankruptcies and Garnishments – If the contractor receives a copy of a court order to send payments to a party other than the provider, it shall contact the applicable RO's Office of General Counsel.

5. Closure of Bank Account – If a provider has closed its bank/EFT account but will remain enrolled in Medicare, the contractor shall place the provider on payment withhold until an EFT agreement (and Form CMS-855 or Form CMS-20134, if applicable) is submitted and approved by the contractor. If such an agreement is not submitted within 90 days after the contractor learned that the account was closed, the contractor shall commence deactivation procedures in accordance with the instructions in this chapter. The basis for deactivation would be §424.540(a)(2) due to the provider's failure to comply with the EFT requirements outlined in §424.510(e)(1) and (e)(2).

6. Reassignments – If a physician or non-physician practitioner is reassigning all of his/her benefits to another supplier and the latter is not currently on EFT, neither the practitioner nor the reassignee needs to submit a Form CMS-588. This is because (1) the practitioner is not receiving payment directly, and (2) accepting a reassignment does not qualify as a change of information request. If, however, the group later submits a change of information request and is not on EFT, it must submit a Form CMS-588.

7. Final Payments – If a non-certified supplier (e.g., physician, ambulance company) voluntarily withdraws from Medicare and needs to obtain its final payments, the contractor shall send such payments to the provider's EFT account of record. If the account is defunct, the contractor can send payments to the provider's "special payments" address or, if none is on file, to any of the provider's practice locations on record. If neither the EFT account nor the aforementioned addresses are available, the provider shall submit a Form CMS-855, or Form CMS-20134, Form CMS-588 request identifying where it wants payments to be sent.

8. Chain Organizations - Per CMS Publication 100-04, chapter 1, section 30.2, a *Part A* chain organization may have payments to its providers be sent to the chain home office. However, any mass EFT changes (involving large numbers of chain providers) must be submitted and processed in the same fashion as any other change in EFT data. For instance, if a chain has 100 providers and each wants to change its EFT account to that of the chain home office, 100 separate Form CMS-588s must

be submitted. If any of the chain providers have never completed a Form CMS-855*A*, they must do so at that time.

15.24.9 – Revocation Letter Guidance

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

The contractor:

- Shall submit one or more of the Primary Revocation Reasons as found in section 15.27.2 or the MDPP specific Revocation Reason outlined in 15.27.3.c into the appropriate section of the Revocation Letter. Only the CFR citation and a short heading shall be cited for the primary revocation reason*;*

- *Shall include sufficient details to support the reason for the provider or supplier's revocation;*

- *Shall issue all revocation letters via certified letter, per regulations found in 42 CFR 405.800(b)(1), and;*

- *Shall issue two revocation letters to any solely owned organizations, one for the individual and the other for the organization.*

15.28 – Deceased Practitioners

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A. Reports of Death from the Social Security Administration (SSA)

Contractors, including the NSC MAC, will receive from CMS a monthly file that lists individuals who have been reported as deceased to the SSA. To help ensure that Medicare maintains current enrollment and payment information and to prevent others from utilizing the enrollment data of deceased individuals, the contractor shall undertake the activities described below.

B. Verification Activities for Individuals Other than Physicians, Non-Physician Practitioners and/or Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

If the person is an owner, *sole owner of a professional corporation or professional association, managing employee,* director, officer, authorized official, etc., the contractor shall verify and document that the person is deceased using the process described in section (C)(1) below.

Once the contractor verifies the report of death, it shall notify the provider or supplier organization with which the individual is associated that it needs to submit a Form CMS-855 change request that deletes the individual from the provider or supplier's enrollment record. If the provider fails to submit this information within 90 calendar days of the contractor's request, the contractor shall deactivate the provider's Medicare billing privileges in accordance with 42 CFR §424.540(a)(2). (DMEPOS Suppliers Only - If a DMEPOS supplier fails to submit this information within 30 calendar days of the contractor's request, the contractor shall deactivate the supplier's billing privileges in accordance with 42 CFR §424.57(c)(2).)

The contractor need not, however, solicit a Form CMS-855 change request if the organization is enrolled with another contractor. Here, the contractor shall notify (via fax or e-mail) the contractor with which the organization is enrolled of the situation, at which time the latter contractor shall take actions consistent with this section 15.28.

C. Reports of Death from Third-Parties

1. Verification

If a contractor, including DME MACs or the NSC MAC, receives a report of death from a third-party (state provider association, state medical society, academic medical institution, etc.), the contractor shall verify that the physician, non-physician practitioner or DMEPOS supplier is deceased by:

- Obtaining oral or written confirmation of the death from an authorized or delegated official of the group practice to which the physician, non-physician practitioner or DMEPOS supplier had reassigned his or her benefits;

- Obtaining an obituary notice from the newspaper;

- Obtaining oral or written confirmation from the state licensing board (e.g., telephone, e-mail, computer screen printout);

- Obtaining oral or written confirmation from the State Bureau of Vital Statistics; or

- Obtaining a death certificate, Form SSA-704, or Form SSA-721 (Statement of Funeral Director).

2. Post-Confirmation Actions

Once the contractor verifies the death, it shall:

1. Undertake all actions normally associated with the deactivation of a supplier's billing privileges.

2. Search PECOS to determine whether the individual is listed therein as an owner, *sole owner of a professional corporation or professional association,* managing employee, director, officer, partner, authorized official, or delegated official of another supplier.

3. If the person is not in PECOS, no further action with respect to that individual is needed.

4. If the supplier is indeed identified in PECOS as an owner, officer, etc., the contractor shall notify the organization with which the person is associated that it needs to submit a Form CMS-855 change request that deletes the individual from the entity's enrollment record. If a provider fails to submit this information within 90 calendar days of the contractor's request, the contractor shall deactivate the provider's billing privileges in accordance with §424.540(a)(2). (DMEPOS Suppliers Only - If a DMEPOS supplier fails to submit this information within 30 calendar days of the contractor's request, the contractor shall deactivate the supplier's billing privileges in accordance with §424.57(c)(2).)

The contractor need not, however, ask for a Form CMS-855 change request if the organization is enrolled with another contractor. In this situation, the contractor shall notify (via fax or e-mail) the contractor with which the organization is enrolled of the situation, at which time the latter contractor shall take actions consistent with this section 15.28.

The contractor shall place verification documentation in the provider or supplier file in accordance with section 15.7.3 of this chapter.

D. Education & Outreach

Contractors, including DME MACs and the NSC MAC, shall conduct outreach to state provider associations, state medical societies, academic medical institution, and group practices, etc., regarding the need to promptly inform contractors of the death of physicians and non-physician practitioners participating in the Medicare program.

E. Trustees/Legal Representatives

1. NPI - The trustee/legal representative of a deceased physician, non-physician practitioner or DMEPOS supplier's estate may deactivate the NPI of the deceased provider by providing written documentation to the NPI enumerator.

2. Special Payment Address - In situations where a physician, non-physician practitioner or DMEPOS supplier has died, the contractor can make payments to the individual's estate per the instructions in Pub. 100-04, chapter 1. When the contractor receives a request from the trustee or other legally-recognized representative of the physician, non-physician practitioner or DMEPOS supplier's estate to change the physician, non-physician practitioner or DMEPOS supplier's special payment address, the contractor shall, at a minimum, ensure that the following information is furnished:

- Form CMS-855 change of information request that updates the "Special Payment" address in the application. The Form CMS-855 can be signed by the trustee/legal representative.

- Any evidence – within reason - verifying that the physician, non-physician practitioner or DMEPOS supplier is in fact deceased.

- Legal documentation verifying that the trustee/legal representative has the legal authority to act on behalf of the provider, non-physician practitioner or DMEPOS supplier's estate.

The policies in this section 15.28(E)(1) and (2) apply only to physicians, non-physician practitioners*, sole owners of a professional corporation or professional association,* and DMEPOS suppliers who operated their business as sole proprietors. It does not apply to situations in which the physician or non-physician practitioner reassigned his or her benefits to another entity.

F. Proof of Life Documentation

On rare occasions erroneous death information may be received through the DMF process that results in systematic enrollment deactivations in PECOS or records populated on the Deceased Associates reports in PECOS for MAC deactivation actions. In order for the providers/suppliers to reactivate their enrollments and have the date of death removed from their PECOS records, MACs shall request documentation that supports "proof of life" (for example, Retirement, Survivors, and Disability Insurance document issued by SSA). In the event a provider/supplier is unable to obtain such documentation, the MAC shall submit a request to their PEOG Business Function Lead (BFL) containing the provider/supplier's name, date of birth and SSN so that CMS can confirm proof of life with SSA.

15.29.4.4 – Change of Information Received Prior to *or After the* Revalidation Letter *is* Mailed

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

If a change of information (COI) application is received from the provider/supplier prior to the contractor having mailed the revalidation letter, the contractor shall process the COI as normal and proceed with mailing the revalidation notice.

If the provider/supplier submits an application marked as a revalidation but only includes enough information to be considered a COI, the contractor shall*:* (1) develop for a complete application containing the missing data elements, and (2) treat it as a revalidation.

If a change of information (COI) application is received after the contractor has mailed the revalidation notice, the contractor shall: (1) develop for a complete application containing the missing data elements, and (2) treat it as a revalidation.

15.29.11 – Revalidation Extension Requests

(Rev. 898, Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

MACs shall only accept extension requests from a provider or supplier that was not given the full *seven* months advance notice prior to their revalidation due date as a result of the due date list being untimely posted to the CMS website. MACs shall no longer accept extension requests from the providers or suppliers for any other reason.

If there is a delay in posting the above referenced list, which impacts a provider or supplier receiving the full six month advance notice, the MAC shall accept the provider or supplier's extension request and grant the provider or supplier an extension up to the full six month period from the date of the list being posted with no impacts to their effective date. MACs shall accept these type of extension requests from the provider or supplier and the requests may be made by the provider or supplier in writing (fax/email permissible) or via phone requested by the individual provider, Authorized/Delegated Official or contact person.

Processing the CMS-855R Medicare Enrollment Application - Reassignment of Benefits

Disclaimer: The information contained in this guide is to assist providers/suppliers in completing the CMS-855R application and MACs in processing the CMS-855R application.

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General Information

A. Purpose of the CMS-855R

The CMS-855R application is used by individual physicians and non-physician practitioners (hereafter collectively referred to as "individual practitioners") who want to reassign their right to receive Medicare payments to another eligible individual or entity (i.e., sole proprietorship/clinic/group practice/other health care organization); Medicare eligible professionals may also reassign their benefits to a critical access hospital (CAH) that bills Method II in order to participate in the Electronic Health Records (EHR) Incentive Program for Eligible Professionals (EPs). In addition, the CMS-855R is used to terminate a currently established reassignment of benefits.

Reassigning Medicare benefits allows an eligible individual or entity to submit claims on behalf of and receive payment for Medicare Part B services that the performing practitioner provides for the eligible billing individual or entity. Both the individual practitioner and the eligible individual or entity must be currently enrolled (or concurrently enrolling via submission of the (1) CMS-855I/CMS-855B for the eligible individual or entity and (2) the CMS-855I for the individual practitioner) in the Medicare program before the reassignment can take effect.

The Internet-based Provider Enrollment, Chain and Ownership System (PECOS) can be used to add or terminate a reassignment of benefits. To obtain additional information on Internet-based PECOS, refer to http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html.

In lieu of PECOS, the most current version of the CMS-855R application shall be completed. To obtain the current version of the form, refer to https://www.cms.gov/Medicare/cms-forms/cms-forms/cms-forms-list.html. If an outdated version of the application is submitted, the MAC shall *return the application form*.

B. Reassignment Packages

A separate CMS-855R must be submitted for each individual practitioner or eligible individual or entity for which a reassignment is being established or terminated. The individual practitioner may receive multiple Provider Transaction Access Numbers (PTANs) under a single Employer Identification Number (EIN), but may not reassign benefits to more than one EIN on a single CMS-855R application.

In situations where an entity wants to simultaneously enroll a group practice, the individual practitioners therein, and to reassign benefits accordingly, the MAC shall adhere to the instructions contained in the scenarios below. As early in the process as possible, the MAC shall examine the incoming forms to see if a reassignment may be involved; also, the MAC is encouraged (though not required) to have the same analyst handle all applications in the package.

1. **Only the CMS-855Rs are submitted** - If a brand new group with new practitioners is attempting to enroll but submits only the CMS-855Rs for its group members (i.e., neither

the initial CMS-855B nor the initial CMS-855Is were submitted), the MAC shall develop for the other forms.

2. **Only the CMS-855R is submitted and a CMS-855A/CMS-855B and CMS-855I is already on file** – Suppose an individual practitioner: (1) submits only the CMS-855R without including the CMS-855A/CMS-855B and CMS-855I, and (2) indicates on the CMS-855R that he/she will be reassigning all or part of his/her benefits to the sole proprietor/eligible organization or group. The MAC shall not develop for the other forms if they are already on file. The Part B MAC shall simply process the CMS-855R and reassign the individual practitioner's benefits to the sole proprietor /eligible organization or group.

3. **Only the CMS-855B is submitted** - If a brand new group wants to enroll but submits only the CMS-855B without including the CMS-855Is and CMS-855Rs for its group members (i.e., the CMS-855B arrives alone, without the other forms), the MAC shall develop for the other forms.

4. **Only the CMS-855I is submitted** – Suppose an individual practitioner: (1) submits only the CMS-855I without including the CMS-855B and CMS-855R, and (2) indicates on the CMS-855I that he/she will be reassigning all or part of his/her benefits to the group practice. The MAC shall develop for the other forms.

Suppose an individual practitioner: (1) submits only the CMS-855I, and (2) indicates on the CMS-855I that he/she will be reassigning all or part of his/her benefits to an existing Part A CAH II. The MAC shall develop for the CMS-855R. Upon receipt of the CMS-855R, the MAC shall process the application and reassign the individual practitioner's benefits to the Part A entity.

C. When Not to Use the CMS-855R

The CMS-855R shall not be used to report employment arrangements of physician assistants. Employment arrangements for physician assistants must be reported on the CMS-855I application. In addition, a CMS-855R application is not required to be submitted with a CMS-855B for an independent diagnostic testing facility (IDTF) that employs or contracts with interpreting physicians.

The CMS-855R shall not be used to revalidate reassignments. The individual practitioner should only use the CMS-855I and list his/her active reassignment information in section 4B thereof.

The CMS-855R application is required to terminate a reassignment. The termination cannot be done via the CMS-855I form (except for Internet-based PECOS applications when the termination is for the last PTAN on an enrollment).

Processing the CMS-855R Application

Note: If a data element on the individual practitioner's CMS-855R application is missing but the information is disclosed (1) elsewhere on the application or (2) in the supporting documentation

submitted with the application, the MAC need not obtain the missing data via an updated CMS-855R form page and a newly-signed certification statement; no further development – not even by telephone – is required. However, the following information must be furnished in the appropriate section(s) of the CMS-855R, even if the data is identified elsewhere on the form or in the supporting documentation:

a. Legal business names (LBN) or legal names
    - If an application is submitted with a valid National Provider Identifier (NPI) and Provider Transaction Number (PTAN) combination but the Legal Business Name (LBN) field is blank, an incomplete or inaccurate LBN is submitted, or the applicant includes a DBA name in section 4 of the Form CMS-855I or section 2 of the Form CMS-855R, and the contractor is able to confirm the correct LBN based on the NPI and PTAN combination provided, the contractor is not required to develop.
b. Tax identification numbers (TINs), EINs or Social Security Numbers (SSNs)
c. NPI-legacy number combinations in sections 2 and/or 3 of the CMS-855R

Section 1: Basic Information

The MAC shall ensure that the applicant completes this section of the CMS-855R with the submittal reason and effective date. (Note that a separate CMS-855R is required for each new reassignment or termination). The "Complete All Sections" column provides the sections of the CMS-855R that must be completed for each reason for submission.

Reason for Submitting This Application

This section identifies the reason for the application submission. If a submittal reason is not identified, the MAC shall contact the applicant/contact person via phone, or send a development letter to the individual practitioner/contact person to obtain the missing data.

- **You are enrolling or are currently enrolled in Medicare and will be reassigning your benefits**

    - The individual practitioner checks this box if he/she is establishing a new reassignment to an eligible individual or entity. The MAC shall ensure that an effective date is listed that identifies the effective date of the reassignment, and that all sections are completed as required.
    - If the individual practitioner is initially enrolling in Medicare and does not have a current CMS-855I application on file, he/she must submit a CMS-855I in addition to the CMS-855R. The MAC shall develop by mail, fax, or e-mail for the CMS-855I application if it is not currently on file.
    - If the CMS-855R is accompanied by an initial CMS-855I or submitted as a "stand-alone" form (that is, a CMS-855R is submitted as a new reassignment, such as when an enrolled physician who is operating as a sole proprietor joins a group practice and reassigns his benefits to the group), the effective date of the enrollment and the reassignment shall be consistent with the 30-day rule requirements specified in the Program Integrity Manual, chapter 15, section 15.17 (i.e., the later of the date of receipt by the MAC or the date the practitioner first began furnishing services at the new location). (**Note**: The effective date of the reassignment shall not be prior to the effective dates of the enrollments of the individual practitioner and the eligible individual or entity to which benefits are

reassigned.

- **You are an *individual* terminating a reassignment with a Sole Proprietor[1] or Clinic/Group/Organization**

  - The individual practitioner checks this box if he/she has a current reassignment of benefits arrangement with an eligible individual or entity that he/she wishes to terminate.
  - The MAC shall ensure that a termination date for the reassignment is listed in the Effective Date field and that sections 1, 2, 3, 5, and 6A of the CMS-855R application are completed as required. If the termination date is not included, the MAC shall send a development letter by mail, fax, or e-mail to the individual practitioner/contact person to obtain the missing data.

- **You are a *sole proprietor/clinic/group/organization* terminating a reassignment with an individual**

  - The eligible individual or entity checks this box if he/she/it has a current reassignment of benefits arrangement with an individual practitioner that he/she/it wishes to terminate.
  - The MAC shall ensure that a termination date for the reassignment is listed in the Effective Date field and that sections 1, 2, 3, 5, and 6B of the CMS-855R application are completed as required. If the termination date is not included, the MAC shall send a development letter by mail, fax or e-mail to the contact person to obtain the missing data.
  - Groups that are terminating physician assistant employments should use the CMS-855B. Sole proprietors and incorporated individuals who are terminating physician assistant employments should use the CMS-855I.

Section 2: Organization/Group/*Individual* Receiving the Reassigned Benefits

The MAC shall ensure that information is populated in each field to identify the eligible individual or entity to whom benefits are being reassigned, or with whom the reassignment is being terminated. The eligible individual or entity must be currently enrolled or enrolling concurrently in the Medicare program; otherwise, the reassignment cannot be processed.

A separate CMS-855R must be submitted for each sole proprietor/clinic/group/organization for which a reassignment is being established or terminated. The individual practitioner may receive multiple PTANs under a single EIN, but may not reassign benefits to more than one EIN on a single CMS-855R application.

If a **Sole Proprietor** is receiving the reassigned benefits, the MAC shall ensure that the:

[1] A business is a sole proprietorship if it meets all of the following criteria:
- It files a Schedule C (1040) with the IRS (this form reports the business's profits/losses);
- One person owns all of the business's assets; and
- It is not incorporated.

- Legal name of the eligible individual is listed in the Organization/Group Legal Business Name field.
- Eligible individual's EIN (if he or she has one) is reflected in the TIN field.
- Eligible individual's PTAN (if he or she has one) is listed in the Medicare Identification Number field. If the eligible individual is submitting an initial enrollment with the CMS-855R to establish a new reassignment, a PTAN need not be listed, as one has not been assigned; the individual can enter the word "pending" in this field or leave the field blank.
- National Provider Identifier (NPI) of the eligible individual accepting the reassignment is listed in the NPI field.
- The individual practitioner and the eligible individual or entity are currently enrolled or enrolling concurrently in the Medicare program; otherwise, the reassignment cannot be processed. The MAC must check PECOS or its internal tracking systems for the CMS-855I and/or CMS-855B application(s).
- Data elements in sections 1, 2, and 3 of the CMS-855R are completed and the data furnished therein is consistent with that submitted on the CMS-855I (e.g., the practitioner's SSN matches that on his/her CMS-855I), and the data elements in section 6A/6B are completed and the appropriate signatures are present. If any of the information is missing or there is inconsistent data, the MAC shall develop for the information (e.g., sending a development letter by mail, fax or e-mail), unless exceptions have been provided through other CMS guidance.

In addition:

- The MAC shall verify the NPI against the National Plan and Provider Enumeration System (NPPES) or PECOS.
- When processing the CMS-855R application, the MAC need not perform any verification or validation activities involving the individual practitioner or the eligible individual or entity (e.g., reviewing licensure, checking the Medicare Exclusion Database (MED)). These validations are conducted during the CMS-855I and CMS-855B initial enrollment and revalidation processes, and via the monthly License Continuous Monitoring (LCM) checks and the systematic monthly MED checks in PECOS.
- *MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI of the group/organization/individual that is receiving the reassigned benefits before developing to the provider for existing individual practitioners only. If information is missing from the 855R that cannot be verified in PECOS, the Shared Systems or provider files, then a development would have to be issued (i.e.: group information is missing from the 855R and not included in the 855I Section 4, this cannot be verified elsewhere).*

If a C**linic/Group/Organization/Sole Owner/CAH** is receiving the reassigned benefits, the MAC shall ensure that the:

- Legal business name is reported in the Organization/Group Legal Business Name field. This name must exactly match the name on the entity's Internal Revenue Service (IRS) tax documents (CP-575), unless exceptions have been permitted through CMS guidance.

- Entity's TIN (as reported to the IRS) is listed in the TIN field.
- *MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI of the group/organization/individual that is receiving the reassigned benefits before developing to the provider for existing individual practitioners only. If information is missing from the 855R that cannot be verified in PECOS, the Shared Systems or provider files, then a development would have to be issued (i.e.: group information is missing from the 855R and not included in the 855I Section 4, this cannot be verified elsewhere).*

In addition:

- The MAC shall verify the legal business name against the IRS documentation, NPPES, or PECOS.
- If the entity is a CAH, the entity need not and should not complete a separate CMS-855B form to receive reassigned benefits. (**Note:** A reassignment to a CAH is only required if the Medicare eligible professional wants to participate in the EHR Incentive Program for EPs.)
- The MAC shall verify the NPI against NPPES or PECOS.
- When processing the CMS-855R application, the MAC need not perform any verification or validation activities involving the individual practitioner or the eligible individual or entity (e.g., reviewing licensure, checking the MED). These validations are conducted during the CMS-855I and CMS-855B initial enrollment and revalidation processes, and via the monthly LCM checks and the systematic monthly MED checks in PECOS.
- The MAC shall ensure that the data elements in sections 1, 2, and 3 of the CMS-855R are completed and the data furnished therein is consistent with that submitted on the CMS-855I (e.g., the practitioner's SSN matches that on his/her CMS-855I), and the data elements in section 6A/B are completed and the appropriate signatures are present. If any of the information is missing or there is inconsistent data, the MAC shall develop for the information (e.g., sending a development letter by mail, fax, or e-mail), unless exceptions have been provided through other CMS guidance.
- If any required data elements in section 2 are not included, the MAC shall send a development letter by mail, fax or e-mail to the eligible individual or entity/ contact person to obtain the missing data.

Section 3: Individual Practitioner Who Is Reassigning Benefits

The information supplied in this section is for the individual practitioner who will be reassigning his/her benefits or who will be terminating a reassignment. The MAC shall ensure that the:

- Individual practitioner's legal name (as reported to the Social Security Administration (SSA)) is listed in the First Name, Middle Initial, and Last Name fields. Any suffixes that may be reported to the IRS should also be included.
- SSN (as reported to the SSA) of the individual practitioner is reflected in the Social Security Number field.
- Medicare Identification Number (or PTAN) (if issued) of the individual practitioner is listed in the Medicare Identification Number field. If the individual practitioner is submitting an initial enrollment application concurrently with the

CMS-855R to establish a new reassignment, a PTAN need not be listed, as one has not been assigned; the individual practitioner can enter the word "pending" in this field or leave the field blank. If the reassignment is being terminated, the PTAN should be listed on the CMS-855R. The MAC may use the shared systems, PECOS, or its provider files as a resource for determining the PTAN before developing for this data.

- NPI of the individual practitioner reassigning his/her benefits is reflected in the National Provider Identifier field; it should match the information provided to NPPES.
  - *MACs may use the shared systems, PECOS or their provider files as a resource to determine the PTAN or NPI of the individual practitioner who is reassigning benefits before developing to the provider for existing individual practitioners only.*
- If the individual practitioner is enrolled currently as an ordering and certifying provider, the CMS-855O enrollment must be deactivated and the MAC shall develop for the CMS-855I if one is not submitted.
- When processing the CMS-855R application, the MAC need not perform any verification or validation activities involving the individual practitioner or the eligible individual or entity (e.g., reviewing licensure, checking the MED). These validations are conducted during the CMS-855I and CMS-855B initial enrollments and revalidation processes, and via the monthly LCM checks and the systematic monthly MED checks in PECOS.
- If any required data elements in section 3 are not included, the MAC shall send a development letter to the provider/contact person by mail, fax or e-mail to obtain the missing data, unless exceptions have been provided through other CMS guidance.

Section 4: Primary Practice Location

The individual practitioner may identify the primary physical practice location of the eligible individual or entity where the individual practitioner will render services most of the time; however, this section is optional and not required to be completed by the practitioner. If data is not populated in this section, the MAC shall take no further action. If data is populated in this section, the MAC shall choose the practice location entered on the CMS-855R from the selection of active practice locations provided in the drop-down selection in the reassignment grid in PECOS.

The practice location address must be the physical address where the practitioner sees patients. If the address listed is not a physical address linked to the group (i.e., section 4A of the CMS-855B), the MAC shall proceed with processing. Development is not required.

Section 5: Contact Person *Information*

This section captures information regarding the person who should be contacted regarding this application. Multiple contact persons may be listed, and the individual practitioner/contact person may copy this page and include it in the enrollment package sent to the MAC. The MAC shall ensure that the contact person provided the required data elements, such as his/her first name, middle initial, and last name with any suffixes, as well as the address, city/town, state, zip code and telephone. The contact person's fax number, e-mail address, and his/her relationship or

affiliation with the eligible individual or entity is optional and not required to be submitted.

Communications regarding the processing of the CMS-855R shall be sent to the contact person listed. If multiple contact persons are listed, the MAC shall contact the first contact person listed

on the application. If he/she is not available, the MAC shall contact the other person(s) listed, unless the individual practitioner indicates otherwise via any means.

If no contact person is listed in this section, the MAC shall contact the individual practitioner listed in section 3 or the authorized or delegated official or another contact person on file. The MAC need not develop for the information in this section. If a contact person is listed, any other required data for the contact person (e.g., address) can be captured via telephone. This instruction applies only to section 5.

Section 6: Certification Statements and Signatures

The signatures in this section authorize the reassignment of benefits to an eligible individual or entity or the termination of a reassignment of benefits. Signature dates cannot be more than 120 days prior to the receipt date.

Providers and suppliers are able to submit their reassignment certifications either by signing section 6A and 6B of the paper CMS-855R application or, if completing the reassignment via Internet-based PECOS, by submitting signatures electronically or *uploading the signature using the PECOS upload functionality*.

The MAC shall begin processing new reassignment applications *when the application is received. The MAC shall develop for any missing signatures using their current process.* This is for both paper and Internet-based PECOS CMS-855R applications. The MAC is not required to compare signatures of individual practitioners and authorized/delegated officials to that of a signature already on file. In addition, the MAC shall not request the individual's driver's license or current passport to verify signature.

Applications submitted to terminate a reassignment or to update the primary practice location only require one signature from either the individual practitioner or the authorized/delegated official. Currently, when an update to the primary practice location is submitted via Internet-based PECOS, it is categorized as "Add a New Reassignment" and requires both signatures to be completed. This will be addressed in a future PECOS release.

Section 6A – Individual Practitioner

The MAC shall ensure that the:

- Individual practitioner provided his/her first name, middle initial, and last name with any suffixes.
- Individual practitioner signed and dated the form in the Signature and Date Signedfields.

- If any required data elements in section 6A are missing, the MAC shall send a development letter by mail, fax, or e-mail to the individual practitioner/contact person to obtain the missing data. (**Note:** Middle initials and suffixes are not required fields

and do not require development if missing.)

- When establishing a reassignment of benefits, the certification statement must be signed and dated by the individual practitioner **and** the authorized or delegated official. If the authorized or delegated official is not on file, the MAC shall send a development letter by mail, fax, or e-mail to the provider/contact person to (1) have an authorized or delegated official on file sign the application or (2) add the authorized or delegated official to the organization's enrollment via the CMS-855B application.
- When terminating a current reassignment, the certification statement must be signed and dated by **either** the individual practitioner or the authorized or delegated official. Both signatures are not required.

Section 6B – Delegated or Authorized Official of Group Practice/Clinic

The MAC shall ensure that the:

- Eligible individual accepting the assigned benefits or the authorized or delegated official of the clinic/group/organization must sign in this section. The signee must provide his/her first name, and last name. *The signee may include a middle initial and suffix, if they so choose.* The individual/authorized/delegated official must sign and date in the Signature and Date Signed fields. It is preferred that the signatures be provided in blue ink to identify a true original signature; however, it is not required.
- The certification statement is signed and dated by the individual practitioner **and** the authorized or delegated official when establishing a reassignment of benefits. If the authorized or delegated official is not on file, the MAC shall send a development letter by mail, fax, or e-mail to the provider/contact person to either have an authorized or delegated official on file sign the application or to add the authorized or delegated official to the organization's enrollment via the CMS-855B application.

When terminating a current reassignment, the certification statement must be signed and dated by **either** the individual practitioner or the authorized/delegated official. Both signatures are not required.

If any required data elements in section 6B are missing, the MAC shall send a development letter by mail, fax, or e-mail to the individual practitioner/contact person to obtain the missing data. (**Note:** Middle initials and suffixes are not required fields and do not require development if missing.)