CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 445	**Date: December 14, 2012**
	Change Request 7864

Transmittal 437, dated November 2, 2012, is being rescinded and replaced by Transmittal 445, dated December 14, 2012, to change the effective and implementation dates. All other information remains the same.

SUBJECT: Revision to Section 15.5.20 of Chapter 15 of the Program Integrity Manual (PIM)

I. SUMMARY OF CHANGES: The purpose of this CR is to ensure that Pub. 100-08, Chapter 15, section 15.5.20 of this manual is consistent with the policies outlined in 42 CFR 424.80(b)(1) and Pub. 100-04, Chapter 1, sections 30.2.1(D) and (E) and 30.2.6 and 30.2.7.

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 1, 2014

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	15/15.5.20/Processing Form CMS-855R Applications

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor's activities are to be carried out within their operating budgets.

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 obliged 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 Instructions

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-08	Transmittal: 445	Date: December 14, 2012	Change Request: 7864

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SUBJECT: Revision to Section 15.5.20 of Chapter 15 of the Program Integrity Manual (PIM)

Effective Date: January 1, 2014

Implementation Date: January 1, 2014

I. GENERAL INFORMATION

A. Background: Consistent with 42 CFR §424.80(b)(1) and (b)(2) and CMS 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 supplier's employer if the 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 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 that the requirements for a reassignment exception are met and that the reassignee meets all enrollment requirements. For example, on the Part A side, this might occur with (1) a physician or other supplier reassigning benefits to a hospital, skilled nursing facility, or critical access hospital or (2) a nurse practitioner reassigning to a critical access hospital. The entity receiving the reassigned benefits must enroll with the contractor via a Form CMS-855B, and the physician or other supplier reassigning benefits must complete and submit a Form CMS-855I and Form CMS-855R. This change request updates section 15.5.20 of chapter 15 of the PIM to reflect these policies.

B. Policy: The purpose of this CR is to ensure that Pub. 100-08, Chapter 15, section 15.5.20 of this manual is consistent with the policies outlined in 42 CFR 424.80(b)(1) and Pub. 100-04, Chapter 1, sections 30.2.1(D) and (E) and 30.2.6 and 30.2.7.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7864.1	**NOTE:** The contractor shall observe the revision to section 15.5.20 of chapter 15 of the PIM stating that Part A and Part B entities other than physician/practitioner group practices can receive reassigned benefits, assuming all other requirements for reassignment are met and that the reassignee meets all enrollment requirements.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7864.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the Contractors next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

X-Ref Requirement Number	Recommendations or other supporting information:
	None

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact:
Frank Whelan, frank.whelan@cms.hhs.gov, (410) 786-1302.

Post-Implementation Contact(s):
Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers:*

No additional funding will be provided by CMS; contractor's activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

15.5.20 – Processing Form CMS-855R Applications

(Rev. 445, Issued: 01-14-12, Effective: 01-01-14, Implementation: 01-01-14)

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, or (2) terminate an existing reassignment.

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. (See section 15.7.6 for additional instructions regarding the joint processing of *Form* CMS-855Rs, *Form* CMS-855Bs, and *Form* CMS-855Is.)

NOTE: Benefits are reassigned to a supplier, not to the practice location(s) of the 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.

In addition:

- 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 is *involved*.) The reassignee himself/herself must sign section 4B 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 supplier is eligible to receive reassigned benefits. **NOTE:** 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 supplier's employer if the 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 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 supplier reassigning benefits to a hospital, skilled nursing facility, or critical access hospital or (2) a nurse practitioner reassigning to a critical access hospital. The entity receiving the reassigned benefits must enroll with the contractor via a Form CMS-855B, and the physician or other supplier reassigning benefits must complete and submit a Form CMS-855I and Form CMS-855R.*

- If the individual is initiating a reassignment, both he/she and the group's authorized or delegated official must sign section 4 of the *Form* CMS-855R. If either of the two signatures is missing, the contractor *shall develop for it.*

- If the person (or group) is terminating a reassignment, either party may sign section 4 of the *Form* CMS-855R; obtaining both signatures is not required. If no signatures are present, *the contractor shall develop for a signature.*

- A *Form* CMS-855R is required to terminate a reassignment. The termination cannot be done via the *Form* CMS-855I.

- The authorized or delegated official who signs section 4 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* CMS-855B, *Form* CMS-855I, and *Form* CMS-855R, the person must be listed on the CMS-855B as an authorized or delegated official.

- The effective date of a reassignment is the date on which the individual began or will begin rendering services with the reassignee.

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

- There may be situations where a *Form* CMS-855R is submitted and the *reassignee* is already enrolled in Medicare *via the Form CMS-855B*. However, the authorized official is not on file. In this case, the contractor *shall develop for a Form CMS-855B change request that adds the new* authorized official.

- In situations where the 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.

- In situations where an individual is reassigning benefits to a person/entity, both the reassignor and the reassignee must be enrolled with the same contractor.

B. *Ambulatory Surgical Centers (ASCs)* and Reassignment

Physicians and non-physician practitioners who meet the reassignment exceptions in 42 CFR §424.80, and *Publication* 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 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.

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

There are situations where a physician/non-physician practitioner (the "owning physician/practitioner") owns 100 *percent* 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, 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 billing privileges for both shall be revoked in accordance with the revocation procedures outlined in this chapter. (It is immaterial whether the *practice is* a sole proprietorship, *a professional corporation*, or *a solely-owned limited liability company.) The* contractor shall end-date the reassignment using, as applicable, the date of death or the effective date of the revocation.

Besides revoking the billing privileges of the owning physician/practitioner and the practice, the contractor shall notify the employed physician/practitioner that:

(1) The practice's billing privileges have been revoked;

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

(3) If the employed physician/practitioner *wants* to provide services at the former practice's location, he/she must submit *a Form CMS-855I change 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 *an* (1) *initial* Form CMS-*855I,* and (2) a terminating *Form CMS-855R are* not required – even if the employed physician/non-physician practitioner had reassigned all of his/her benefits to the practice.