CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 503	**Date: January 24, 2014**
	Change Request 8545

SUBJECT: Inter-Jurisdictional Reassignments

I. SUMMARY OF CHANGES: The purpose of this CR is to address situations where a physician or non-physician practitioner reassigns his or her Medicare benefits to an entity located in another contractor jurisdiction.

EFFECTIVE DATE: February 25, 2014
IMPLEMENTATION DATE: February 25, 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
N	15/15/20.1/Inter-Jurisdictional Reassignments

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 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 Instruction

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 503	Date: January 24, 2014	Change Request: 8545

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I. GENERAL INFORMATION

A. Background: The purpose of this CR is to address situations where a physician or non-physician practitioner reassigns his or her Medicare benefits to an entity located in another contractor jurisdiction.

B. Policy: This CR outlines the applicable enrollment and licensure requirements when a physician or non-physician practitioner seeks to reassign his or her Medicare benefits to an organization located in a different contractor jurisdiction.

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	
8545.1	The contractor shall observe the policies outlined in Publication 100-08, chapter 15, section 15.20.1.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8545.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider		X			

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	community in billing and administering the Medicare program correctly.					

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): Frank Whelan, 410-786-1302 or frank.whelan@cms.hhs.gov

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

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 do 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.

Medicare Program Integrity Manual
Chapter 15 - Medicare Enrollment

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(Rev.503, Issued, 01-24-14)

15.20.1 – Inter-Jurisdictional Reassignments

(Rev.503, Issued: 01-24-14, Effective: 02-25-14, Implementation: 02-25-14)

If a physician/NPP (reassignor) is reassigning his or her benefits to an entity (reassignee) located in another contractor jurisdiction – a practice that is permissible - the following principles apply:

1. The reassignor must be properly licensed or otherwise authorized to perform services in the state in which he or she has his or her practice location. The practice location can be an office or even the individual's home (for example, a physician interprets test results in his home for an independent diagnostic testing facility).

2. The reassignor need not – pursuant to the reassignment - enroll in the reassignee's contractor jurisdiction nor be licensed/authorized to practice in the reassignee's state. If the reassignor will be performing services within the reassignee's state, the reassignor must enroll with the Medicare contractor for – and be licensed/authorized to practice in – that state.

3. The reassignee must enroll in the contractor jurisdictions in which (1) it has its own practice location(s), and (2) the reassignor has his or her practice location(s). In Case (2), the reassignee:

- *Shall identify the reassignor's practice location as <u>its</u> practice location on its Form CMS-855B.*

- *In Section 4A of its Form CMS-855B shall select the practice location type as "Other health care facility" and specify "Telemedicine location."*

- *Need not be licensed/authorized to perform services in the reassignor's state.*

To illustrate, suppose Dr. Smith is located in Contractor Jurisdiction X and is reassigning his benefits to Jones Medical Group in Contractor Jurisdiction Y. Jones must enroll with X <u>and</u> with Y. Jones need not be licensed/authorized to perform services in Dr. Smith's state. However, in Section 4 of the Form CMS-855B it submits to X, Jones must list Dr. Smith's location as its practice location.