CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 676	**Date: September 16, 2016**
	Change Request 9552

SUBJECT: Clarification of Certain Policies in Pub. 100-08, Chapter 15 Regarding the Processing of Form CMS-855R Applications

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to clarify certain policies in chapter 15 of Pub. 100-08 concerning the processing of Form CMS-855R applications. This CR also adds to chapter 15 a supplementary guide that educates providers and suppliers on the preparation and submission of reassignment applications.

EFFECTIVE DATE: December 19, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 19, 2016

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/Table of Contents
R	15/15.5.20/Processing Form CMS-855R Applications
R	15/15.7/Application Review and Verification Activities
R	15/15.7.6/Special Processing Guidelines for Form CMS-855A, Form CMS-855B, and Form CMS-855I Applications
R	15/15.8.1/Returns
R	15/15.17/Establishing an Effective Date of Medicare Billing Privileges
R	15/15.25.1.1/Corrective Action Plans (CAPs)
R	15/15.25.2.1/Corrective Action Plans (CAPs)

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: 676	Date: September 16, 2016	Change Request: 9552

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I. GENERAL INFORMATION

A. Background: This CR, which includes a supplementary guide concerning the processing of Form CMS-855R applications, clarifies existing reassignment policies and furnishes additional guidance regarding the return of Form CMS-855 applications to providers and suppliers.

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

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
9552.1	The contractor shall be aware that this CR includes a supplementary guide that addresses the preparation, submission, and processing of Form CMS-855R applications.		X							
9552.2	If the contractor returns an application, it shall (1) keep the original application and supporting documents and return a copy, (2) make a copy or scan of the application and documents and return the originals to the provider, or (3) simply send a letter to the provider (in lieu of sending the originals or a copy thereof) explaining that the application is being returned (though not physically returned) and why.	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9552.3	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 5 business days after receipt of the notification from CMS announcing the availability of the 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 community in billing and administering the Medicare program correctly.		X			

IV. SUPPORTING INFORMATION

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

"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).

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.676, Issued: 09-16-16)

15.5.20 – Processing Form CMS-855R Applications

(Rev.676, Issued: 09-16-16, Effective: 12-19-16, Implementation: 12-19-16)

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. Separate Form CMS-855Rs must be completed for each transaction.*

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 *6*B 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 (C*ritical* A*ccess* H*ospital (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, 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 revoked in accordance with the revocation 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 revoking 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 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 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 [insert link] 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.

15.7 – Application Review and Verification Activities

(Rev.676, Issued: 09-16-16, Effective: 12-19-16, Implementation: 12-19-16)

Unless stated otherwise in this chapter or in another CMS directive:

(A) The instructions in sections 15.7 through 15.7.1.6.2 apply to:

- The Form CMS-855A, Form CMS-855B, Form CMS-855I, Form CMS-855R, and Form CMS-855O.

- All Form CMS-855 transaction types identified in this chapter (e.g., changes of information, reassignments).

(B) Except for situations where a "processing alternative" applies (see sections 15.7.1.3.1 through 15.7.1.3.4 of this chapter) *or unless stated otherwise in this chapter or in another CMS directive*, the contractor shall:

- Ensure that the provider has completed all required data elements on the Form CMS-855 (including all effective dates) and that all supporting documentation has been furnished. The contractor shall also ensure that the provider has completed the application in accordance with the instructions (1) in this chapter and in all other CMS directives and (2) on the Form CMS-855. (The instructions on the Form CMS-855 shall be read and applied in addition to, and not in lieu of, the instructions in this chapter and all other applicable CMS directives.)

- Verify and validate all information furnished by the provider on the Form CMS-855.

(C) The instructions in sections 15.7 through 15.7.1.6.2 are in addition to, and not in lieu of, all other instructions in this chapter.

In general, the application review and verification process is as follows:

1. Contractor receives application

2. Contractor reviews application and verifies data thereon

3. If (a) required data/documentation is missing, (b) data cannot be verified, and/or (3) there are data discrepancies, contractor requests missing/clarifying information from the provider.

4. If applicable, contractor (a) verifies any newly furnished data, or (2) seeks additional data/clarification from provider.

5. Final determination

Sections 15.7.1 through 15.7.1.6.2 are structured so as to generally follow Steps 2 through 5 above.

15.7.6 - Special Processing Guidelines for Form CMS-855A, Form CMS-855B, *and* Form CMS-855I Applications

(Rev.676, Issued: 09-16-16, Effective: 12-19-16, Implementation: 12-19-16)

The contractor shall abide by the following:

- If an individual is joining a group that was enrolled prior to the Form CMS-855A or Form CMS-855B (i.e., the group or CAH II never completed a Form CMS-855), the contractor shall obtain a Form CMS-855A from the CAH II or Form CMS-855B from the group. During this timeframe, the contractor shall not withhold any payment from the group solely on the grounds that a Form CMS-855A or Form CMS-855B has not been completed. Once the group or CAH II's application is received, the contractor shall add the new reassignment; if the Form CMS-855R was not submitted, the contractor shall secure it from the provider or supplier.

- If a provider or supplier is changing its TIN, the transaction shall be treated as a brand new enrollment as opposed to a change of information. Consequently, the provider or supplier must complete a full Form CMS-855 application and a new enrollment record must be created in PECOS. (This does not apply to ambulatory surgical centers and portable x-ray suppliers. These entities can submit a TIN change as a change of information unless a change of ownership is involved. If the latter is the case, the applicable instructions in sections 15.7.8.2.1 through 15.7.8.2.1.2 of this chapter should be followed.)

- If the provider or supplier is adding or changing a practice location and the new location is in another State within the contractor's jurisdiction, the contractor shall ensure that the provider or supplier meets all the requirements necessary to practice in that State (e.g., licensure). A complete Form CMS-855 for the new State is not required, though the contractor shall create a new enrollment record in PECOS for the new State.

- All members of a group practice must be entered into PECOS.

15.8.1 – Returns

(Rev.676, Issued: 09-16-16, Effective: 12-19-16, Implementation: 12-19-16)

A. Reasons for Return

Unless stated otherwise in this chapter or in another CMS directive, the contractor (including the National Supplier Clearinghouse) may immediately return the enrollment application to the provider or supplier only in the instances described below. This policy – again, unless stated otherwise in this chapter or in another CMS directive - applies to all applications identified in this chapter (e.g., initial applications, change requests, Form CMS-855O applications, Form CMS-588 submissions, change of ownership (CHOW) applications, revalidations, reactivations):

- The applicant sent its paper Form CMS-855 to the wrong contractor (e.g., the application was sent to Contractor X instead of Contractor Y).

- The contractor received the application more than 60 days prior to the effective date listed on the application. (This does not apply to: (1) providers and suppliers submitting a Form CMS-855A application, (2) ambulatory surgical centers (ASCs), or (3) portable x-ray suppliers (PXRSs).

- The contractor received an initial application from (1) a provider or supplier submitting a Form CMS-855A application, (2) an ASC, or (3) a PXRS, more than 180 days prior to the effective date listed on the application.

- An old owner or new owner in a CHOW submitted its application more than 90 days prior to the anticipated date of the sale. (This only applies to Form CMS-855A applications.)

- The contractor can confirm that the provider or supplier submitted an initial enrollment application prior to the expiration of the time period in which it is entitled to appeal the denial of its previously submitted application.

- The provider or supplier submitted an initial application prior to the expiration of a re-enrollment bar.

- The application is to be returned per the instructions in section 15.7.7.1.4 of this chapter.

- The application is not needed for the transaction in question. Two common examples include:

  - An enrolled physician wants to change his/her reassignment of benefits from one group to another group and submits a Form CMS-855I and a Form CMS-855R. As only the Form CMS-855R is needed, the Form CMS-855I shall be returned.

  - A physician who is already enrolled in Medicare submits a Form CMS-855O application, thinking that he must do so in order to refer services for Medicare beneficiaries. The Form CMS-855O can be returned, as the physician is already enrolled via the Form CMS-855I.

  - The provider or supplier submitted a revalidation application more than six months prior to their revalidation due date.

The contractor need not request additional information in any of these scenarios. For instance, if the application is not necessary for the particular transaction, the contractor can return the application immediately. If an application fee has already been submitted, the contractor shall follow existing instructions regarding the return of the fee.

The difference between a "rejected" application and a "returned" application is that the former is typically based on the provider's failure to respond to the contractor's request for missing or clarifying information. A "returned" application is effectively considered a non-application.

B. Procedures for Returning the Application

If the contractor returns the application:

- It shall notify the provider via letter (sent by mail or e-mail) that the application is being returned, the reason(s) for the return, and how to reapply.

- It shall not enter the application into PECOS. No logging & tracking (L & T) record shall be created.

- Any application resubmission must contain a brand new certification statement page containing a signature and date. The provider cannot simply add its signature to the original certification statement it submitted. (This does not apply to e-signature situations.)

If the contractor returns an application, it shall (1) keep the original application and supporting documents and return a copy, (2) make a copy or scan of the application and documents and return the originals to the provider, or (3) simply send a letter to the provider (in lieu of sending the originals or a copy thereof) explaining that the application is being returned (though not physically returned) and why. If the contractor chooses the third approach and the provider requests a copy of its application, the contractor may fax or mail it to the provider.

C. Other Impacts of a Return

1. Changes of Information and Changes of Ownership (CHOWs)

a. Expiration of Timeframe for Reporting Changes - If the contractor returns a change of information or CHOW submission per this section 15.8.1 and the applicable 90-day or 30-day period for reporting the

change has expired, the contractor shall send an e-mail to its *CMS* Provider Enrollment *& Oversight* Group Business Function Lead (PEOG BFL) notifying him or her of the return. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR § 424.540(a)(2) or revoked under 42 CFR § 424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

b. Timeframe Not Yet Expired - If the contractor returns a change of information or CHOW submission and the applicable 90-day or 30-day period for reporting the change has not yet expired, the contractor shall send the e-mail referred to in (1)(a) above after the expiration of said time period unless the provider has resubmitted the change request/CHOW.

c. Second Return, Rejection, or Denial – If, per (1)(b), the provider resubmits the change of information or CHOW application and the contractor either returns it again, rejects it per section 15.8.2 of this chapter, or denies it, the contractor shall send the e-mail referred to in (1)(a) above regardless of whether the applicable timeframe has expired. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR § 424.540(a)(2) or revoked under 42 CFR § 424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

2. Reactivations – If the contractor returns a reactivation application, the provider's Medicare billing privileges shall remain deactivated.

3. Revalidations – If the contractor returns a revalidation application per this section 15.8.1, the contractor shall – unless an existing CMS instruction or directive dictates otherwise - deactivate the provider's Medicare billing privileges under 42 CFR §424.535(a)(1) if the applicable time period for submitting the revalidation application has expired. If it has not expired, the contractor shall deactivate the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider has resubmitted the application and the contractor (1) returns it again, (2) rejects it per section 15.8.2 of this chapter, or (3) denies it, the contractor shall - unless an existing CMS instruction or directive dictates otherwise – deactivate the provider's billing privileges, assuming the applicable time period has expired.

15.8.2 –Rejections

(Rev.676, Issued: 09-16-16, Effective: 12-19-16, Implementation: 12-19-16)

A. Background

In accordance with 42 CFR § 424.525(a)(1) and (2), the contractor (including the National Supplier Clearinghouse) may reject the provider's application if the provider fails to furnish complete information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the contractor requested the missing information or documentation. For purposes of this policy, this includes situations in which the provider submitted an application that falls into one of the following categories and, upon the contractor's request to submit a new or corrected complete application, the provider failed to do so within 30 days of the request:

(1) The Form CMS-855 or Internet-based Provider Enrollment, Chain and Ownership System (PECOS) certification statement: (a) is unsigned; (b) is undated; (c) contains a copied or stamped signature; (d) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the contractor received the application); or (e) for the paper Form CMS-855, the Form CMS-855O, *or Form CMS-855R submissions where the reassignor and/or reassignee physician/non-physician practitioner must sign the form*, someone other than the *required* physician or non-physician practitioner signed the form.

(2) The submitted paper application is an outdated version of the Form CMS-855.

(3) The applicant failed to submit all of the forms needed to process a reassignment package within 15 calendar days of receipt.

(4) The Form CMS-855 was completed in pencil.

(5) The wrong application was submitted (e.g., a Form CMS-855B was submitted for Part A enrollment).

(6) If a Web-generated application is submitted, it does not appear to have been downloaded from CMS' Web site.

(7) The provider sent in its application or Internet-based PECOS certification statement via fax or e-mail when it was not otherwise permitted to do so.

(8) The provider failed to submit an application fee (if applicable to the situation).

The applications described in (1) through (8) above shall be developed, rather than returned. For instance, if the provider submits an application completed in pencil, the contractor shall request the provider to submit a new application, either in ink or via Internet-based PECOS.

B. Timeframe

The 30-day clock identified in 42 CFR § 424.525(a) starts on the date that the contractor mails, faxes, or e-mails the pre-screening letter or other request for information to the provider. If the contractor makes a follow-up request for information, the 30-day clock does not start anew; rather, it keeps running from the date the pre-screening letter was sent. However, the contractor has the discretion to extend the 30-day time period if it determines that the provider or supplier is actively working with the contractor to resolve any outstanding issues.

C. Incomplete Responses

The provider must furnish all missing and clarifying data requested by the contractor within the applicable timeframe. If the provider furnishes some, but not all, of the requested data, the contractor is not required to

contact the provider again to request the remaining data. It can simply reject the application at the expiration of the aforementioned 30-day period. Consider the following examples:

- The provider submits a Form CMS-855A in which section 3 is blank. On March 1, the contractor requests that section 3 be fully completed. On March 14, the provider submits a completed section 3A. However, section 3B remains blank. The contractor need not make a second request for section 3B to be completed. It can reject the application on March 31, or 30 days after its initial request was made.

- The provider submits an outdated version of the Form CMS-855B. On July 1, the contractor requests that the provider resubmit its application using the current version of the Form CMS-855B. On July 15, the provider submits the correct version, but section 4B is blank. The contractor is not required to make a follow-up request regarding section 4B. It can reject the application on July 31.

D. Creation of Logging & Tracking (L & T) Record

If the contractor cannot create an L & T record in PECOS because of missing data and the application is subsequently rejected, the contractor shall document the provider file accordingly. If the contractor is able to create an L & T record for a rejected application, it shall flip the status to "rejected" in PECOS.

E. Other Impacts of a Rejection

1. Changes of Information and Changes of Ownership (CHOWs)

a. Expiration of Timeframe for Reporting Changes - If the contractor rejects a change of information or CHOW submission per this section 15.8.2 and the applicable 90-day or 30-day period for reporting the change has expired, the contractor shall send an e-mail to its Provider Enrollment Operations Group Business Function Lead (PEOG BFL) notifying him or her of the rejection. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR §424.540(a)(2) or revoked under 42 CFR §424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

b. Timeframe Not Yet Expired - If the contractor rejects a change of information or CHOW submission and the applicable 90-day or 30-day period for reporting the change has not yet expired, the contractor shall send the e-mail referred to in (1)(a) above after the expiration of said time period unless the provider has resubmitted the change request/CHOW.

c. Second Rejection, Return, or Denial – If, per (1)(b), the provider resubmits the change of information or CHOW application and the contractor either rejects it again, returns it per section 15.8.1 of this chapter, or denies it, the contractor shall send the e-mail referred to in (1)(a) above regardless of whether the applicable timeframe has expired. PEOG will determine whether the provider's Medicare billing privileges should be deactivated under 42 CFR §424.540(a)(2) or revoked under 42 CFR §424.535(a)(1) or (a)(9) and will notify the contractor of its decision.

2. Reactivations – If the contractor rejects a reactivation application, the provider's Medicare billing privileges shall remain deactivated.

3. Revalidations – If the contractor rejects a revalidation application per this section 15.8.1, the contractor shall – unless an existing CMS instruction or directive dictates otherwise - deactivate the provider's Medicare billing privileges under 42 CFR §424.535(a)(1) if the applicable time period for submitting the revalidation application has expired. If it has not expired, the contractor shall deactivate the provider's billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider has resubmitted the application and the contractor (1) rejects it again, (2) returns it per section 15.8.1 of this chapter, or (3) denies it, the contractor shall - unless an existing CMS instruction or directive dictates otherwise –deactivate the provider's billing privileges, assuming the applicable time period has expired.

F. Additional Rejection Policies

1. **Resubmission after Rejection** – If the provider's application is rejected, the provider must complete and submit a new Form CMS-855 (either via paper or Internet-based PECOS) and all necessary documentation.

2. **Applicability –** Unless stated otherwise in this chapter or in another CMS directive, this section 15.8.2 applies to all applications identified in this chapter (e.g., initial applications, change requests, Form CMS-855O applications, Form CMS-588 submissions, change of ownership (CHOW) applications, revalidations, reactivations).

3. **Physicians and Non-Physician Practitioners** – Prior CMS guidance instructed contractors to deny, rather than reject, incomplete applications submitted by physicians and certain non-physician practitioners. This policy no longer applies. Such applications shall be rejected if the physician or practitioner fails to provide the requested information within the designated timeframe.

4. **Notice** – If the contractor rejects an application, it shall notify the provider via letter (sent via mail or e-mail) that the application is being rejected, the reason(s) for the rejection, and how to reapply. Absent a CMS instruction or directive to the contrary, the letter shall be sent to the provider or supplier no later than 5 business days after the contractor concludes that the provider or supplier's application should be rejected.

5. **Copy of Application** – If the contractor rejects an application, it shall either (1) keep the original application and all supporting documents, or (2) make a copy or scan of the application and documents and return the originals to the provider. If the contractor chooses the former approach and the provider requests a copy of its application, the contractor may fax or mail it to the provider.

15.17 – Establishing an Effective Date of Medicare Billing Privileges

(Rev.676, Issued: 09-16-16, Effective: 12-19-16, Implementation: 12-19-16)

(This section only applies to the following individuals and organizations: physicians; physician assistants; nurse practitioners; clinical nurse specialists; certified registered nurse anesthetists; anesthesiology assistants; certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals; physician and non-physician practitioner organizations (e.g., group practices) consisting of any of the categories of individuals identified above; *and* ambulance suppliers.*)*

A. Background

In accordance with 42 CFR § 424.520(d), the effective date for the individuals and organizations identified above is the later of:

- The date the supplier filed an enrollment application that was subsequently approved, or
- The date the supplier first began furnishing services at a new practice location.

NOTE: *The date of filing for paper Form CMS-855 applications is the date on which the contractor received the application. For* Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications, *the date of filing* is the date that the contractor received an electronic version of the enrollment application and a signed certification statement submitted via paper or electronically.

B. Retrospective Billing

Consistent with 42 CFR §424.521(a), the individuals and organizations identified above may retrospectively bill for services when:

- The supplier has met all program requirements, including state licensure requirements, and
- The services were provided at the enrolled practice location for up to—

1. 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or

2. 90 days prior to their effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§5121-5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

The contractor shall interpret the phase "circumstances precluded enrollment" to mean that the supplier meets all program requirements (including state licensure) during the 30-day period before an application was submitted and no final adverse action, as identified in § 424.502, precluded enrollment. If a final adverse action precluded enrollment during this 30-day period, the contractor shall only establish an effective billing date the day after the date that the final adverse action was resolved, as long as it is not more than 30 days prior to the date on which the application was submitted.

If the contractor believes that the aforementioned Presidentially-declared disaster exception may apply in a particular case, it shall contact its CMS Provider Enrollment *& Oversight Group* Business Function Lead *(PEOG BFL)* for a determination on this issue.

C. Legal Distinction between Effective Date of Enrollment and Retrospective Billing Date

The effective date of enrollment is "the later of the date of filing or the date (the supplier) first began furnishing services at a new practice location." The retrospective billing date, however, is "up to…30 days prior to (the supplier's) effective date (of enrollment)." To illustrate, suppose that a non-Medicare enrolled

physician begins furnishing services at an office on March 1. She submits a *paper* Form CMS-855I initial enrollment application on May 1*; the contractor receives the application on May 4.* The application is approved on June 1. The physician's effective date of enrollment is May 4, which is the later of (1) the date of filing, and (2) the date she began furnishing services. The retrospective billing date is April 4 (or 30 days prior to the effective date of enrollment), assuming that the requirements of 42 CFR § 424.521(a) are met. *Hence, t*he effective date entered into PECOS and the Multi-Carrier System will be April 4*;* claims submitted for services provided before April 4 will not be paid.

15.25.1.1 – Corrective Action Plans (CAPs)

(Rev.676, Issued: 09-16-16, Effective: 12-19-16, Implementation: 12-19-16)

A. Requirements and Submission of CAPs

The CAP process gives a supplier an opportunity to correct the deficiencies (if possible) that resulted in the denial of its application or the revocation of its *enrollment*. The CAP must:

(1) Contain, at a minimum, verifiable evidence that the supplier is in compliance with Medicare requirements;

(2) Be submitted within 30 days from the date of the denial or revocation notice;

(3) Be submitted in the form of a letter that is signed and dated by the individual supplier, the authorized or delegated official, or a legal representative;

(4) For revocations, be based on § 424.535(a)(1). Consistent with §405.809, CAPs for revocations based on grounds other than § 424.535(a)(1) shall not be accepted. (For revocations based on multiple grounds of which one is § 424.535(a)(1), the CAP may be accepted with respect to (a)(1) but not with respect to the other grounds.) If the supplier submits a CAP that does not comply with this paragraph, the contractor shall notify the supplier via letter or e-mail that it cannot be considered. (If multiple grounds are involved of which one is (a)(1), the contractor shall:

- Only consider the portion of the CAP pertaining to (a)(1), and
- Notify the supplier in its decision letter (or, if the contractor wishes, via letter or e-mail prior to issuing the decision letter) that under §405.809, the CAP was/will be reviewed only with respect to the (a)(1) revocation reason.)

The contractor may create a standard CAP form to be sent with the denial or revocation letter to easily identify it as a CAP when it is returned. The contractor may also accept CAPs via fax or e-mail.

If the submitted CAP does not comply with (1) or (3) above:

- Denials - The contractor need not contact the supplier for the missing information or documentation. It can simply deny the CAP.
- Revocations – The contractor shall not contact the supplier for the missing information or documentation. It shall simply deny the CAP. (Under §405.809(a)(2), the supplier has only one opportunity to correct all deficiencies that served as the basis of its revocation through a CAP.)

The contractor may make a good cause determination so as to accept any CAP that has been submitted beyond the 30-day filing period.

The supplier's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "legal representative" for purposes of signing a CAP.

B. Processing and Approval of CAPs

The contractor shall process a CAP within 60 days of receipt. During this period, the contractor shall not toll the filing requirements associated with a reconsideration request.

If the contractor approves a CAP, it shall rescind the denial or revocation, issue or restore billing privileges (as applicable), and notify the supplier thereof via letter. For new or restored billing privileges – and unless

stated otherwise in another CMS directive or instruction - the effective date is based on the date the supplier came into compliance with all Medicare requirements. Consider the following examples:

1. Denials - A physician's initial enrollment application is denied on March 1. The physician submits a CAP showing that, as of March 20, the physician was in compliance with all Medicare requirements. The effective date of billing privileges should be March 20. The 30-day "backbilling rule" should not be applied in this situation because the rule assumes that the provider was in compliance with Medicare requirements during the 30-day period. This was not the case here. The physician was not in compliance with Medicare requirements until March 20.

2. Revocations – A site visit is conducted of a revalidating ambulance supplier. The supplier is found to be out of compliance with certain enrollment requirements. The supplier's billing privileges were therefore revoked effective April 1. The supplier submitted a CAP showing that – as of April 10 – it was in compliance with all enrollment requirements. The contractor shall apply a new effective date of April 10 to the supplier's Provider Transaction Access Number of April 10. Services furnished during the period when the supplier was out of compliance with Medicare requirements shall not be paid.

For an approved CAP, the contractor shall use the receipt date of the CAP request as the receipt date entered in the Provider Enrollment, Chain and Ownership System.

For DMEPOS suppliers, the effective date is the date it is awarded by the National Supplier Clearinghouse. CMS' approval is required prior to restoring DMEPOS billing privileges.

C. Concurrent Submission of CAP and Reconsideration Request

If a CAP and a reconsideration request (see section 15.25.1.2 below) are submitted concurrently, the contractor shall first process and make a determination on the CAP. The contractor and the reconsideration hearing officer (HO) shall coordinate with one another prior to acting on a CAP or reconsideration request to determine if the other party has received a request.

If the CAP is accepted, the standard approval letter (or, if applicable, a notice of rescission of the revocation) shall be sent to the supplier with a statement that the reconsideration request should be withdrawn.

If the CAP is denied:

- It *cannot* be appealed.
- The contractor shall notify the supplier of the denial via letter.
- *The supplier may continue with the appeals process if it has filed a request for reconsideration or is preparing to submit such a request and has not exceeded the timeframe in which to do so.*
- The reconsideration request, if submitted, shall be processed.

15.25.2.1 – Corrective Action Plans (CAPs)

(Rev.676, Issued: 09-16-16, Effective: 12-19-16, Implementation: 12-19-16)

A. Submission of CAPs

The CAP process gives a provider or supplier (hereinafter collectively referred to as "providers") an opportunity to correct the deficiencies (if possible) that resulted in the denial of its application or the revocation of its *enrollment*. The CAP must:

(1) Contain, at a minimum, verifiable evidence that the provider is in compliance with Medicare requirements;

(2) Be submitted within 30 days from the date of the denial or revocation notice;

(3) Be submitted in the form of a letter that is signed and dated by the individual supplier, the authorized or delegated official, or a legal representative.

(4) For revocations, be based on § 424.535(a)(1). Consistent with § 405.809, CAPs for revocations based on grounds other than § 424.535(a)(1) cannot be accepted. (For revocations based on multiple grounds of which one is § 424.535(a)(1), the CAP may be accepted with respect to (a)(1) but not with respect to the other grounds.) *CMS'* Provider Enrollment *& Oversight* Group (PEOG), which processes all CAPs, will notify the provider if a CAP cannot be accepted.

CAP requests must be sent to the following address:

Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment *& Oversight* Group
7500 Security Boulevard
Mailstop AR 18-50
Baltimore, MD 21244-1850

If the contractor inadvertently receives a CAP request, it shall immediately forward it to *PEOG* at this address or, if possible, to the following *PEOG* mailbox: providerenrollmentappeals@cms.hhs.gov.

Also:

- PEOG may make a good cause determination so as to accept any CAP that has been submitted beyond the 30-day filing period.

- The provider's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "legal representative" for purposes of signing a reconsideration request.

B. Processing and Approval of CAPs

PEOG will process a CAP within 60 days. During this period, *PEOG* will not toll the filing requirements associated with a reconsideration request.

If *PEOG* approves a CAP, it will: (1) notify the contractor to rescind the denial or revocation and *permit* or restore *enrollment* (as applicable), and (2) notify the provider thereof via letter. If applicable, *PEOG* will also notify the contractor of the effective date.

If the CAP is denied:

- *It cannot be appealed.*

- *PEOG will notify the provider or supplier of the denial via letter.*

- *The provider or supplier may continue with the appeals process if it has filed a request for reconsideration or is preparing to submit such a request and has not exceeded the timeframe in which to do so.*

- *The reconsideration request, if submitted, will be processed.*

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. The procedures described in the guide, which include processing alternatives and processing instructions for the CMS-855R, take precedence over all other instructions in the Program Integrity Manual concerning the processing of CMS-855R applications.

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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 develop for the correct version of the 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 CAH II. 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 Part A CAH II.

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. (**Note:** CMS-855R(s) may be submitted via Internet-based PECOS only after the group has been "Approved" in PECOS. The MAC may approve an Internet-based PECOS CMS-855B application without receipt of a CMS-855R.)

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
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 develop via phone or send a development letter to the individual practitioner/contact person to obtain the missing data.

1. **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 if the individual practitioner currently has an active CMS-855I on file and is only submitting a CMS-855R to establish a new reassignment, the effective date of 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 filing 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.

2. **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.

3. **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 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).

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.
- 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 individual/entity/contact person to obtain the missing data.

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.
- Entity's Medicare Identification Number (or PTAN) (if issued) is listed in the Medicare Identification Number field. The MAC may use its shared systems, PECOS, or its provider files as a resource to determine the PTAN before

contacting the entity to develop for this information. If the entity is submitting an initial enrollment concurrently with the CMS-855R to establish a new reassignment, a PTAN need not be listed, as one has not been assigned; the entity may enter the word "pending" in this field or leave the field blank.
- Entity's NPI is listed in the NPI field.

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 permitted 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).
- 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.
- 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.

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

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 via downloaded paper certification statements (downloaded from www.cms.gov). If the provider or supplier downloads the paper certification statement from the CMS website, it shall write the web tracking ID on the top of the certification statement.

Providers and suppliers should not submit signatures both electronically and by paper.

The MAC shall not begin processing new reassignment applications until all signatures are received from the individual practitioner and the authorized/delegated official. 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 Signed fields.

- 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, middle initial, and last name with any suffixes. 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.)