CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 291	Date: June 12, 2009
	Change Request 6470

SUBJECT: Reassignment and Ambulatory Surgical Centers (ASCs)

I. SUMMARY OF CHANGES: This change request addresses: (1) the question of whether an ambulatory surgical center may receive reassigned benefits, and (2) situations in which a solo physician/practitioner to whom another physician/practitioner has reassigned his/her benefits dies or has his/her Medicare billing privileges revoked.

NEW / REVISED MATERIAL
EFFECTIVE DATE: JANUARY 1, 2008
IMPLEMENTATION DATE: OCTOBER 5, 2009

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/4.20/Processing CMS-855R Applications

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment – One-Time Notification

Pub. 100-08	Transmittal: 291	Date: June 12, 2009	Change Request: 6470

SUBJECT: Reassignment and Ambulatory Surgical Centers (ASCs)

Effective Date: January 1, 2008
Implementation Date: October 5, 2009

I. GENERAL INFORMATION

A. Background: This change request addresses: (1) the question of whether an ambulatory surgical center (ASC) may receive reassigned benefits, and (2) situations in which a solo physician/practitioner to whom another physician/practitioner has reassigned his/her benefits dies or has his/her Medicare billing privileges revoked.

B. Policy: The purpose of this change request is to address the two aforementioned topics.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

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	
6470.1	The contractor shall note that 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.	X			X						
6470.2	The contractor shall note that it is not necessary for an ASC to separately enroll as a group practice in order to receive benefits. (It can accept reassignment as an ASC.)	X			X						
6470.3	The contractor shall note that should the "owning physician/practitioner" (as that term is defined in Pub. 100-08, chapter 10, section 4.20(C)), pass away or have his/her billing privileges revoked, the practice is automatically dissolved for purposes of Medicare enrollment and all reassignments thereto are automatically terminated.	X			X						
6470.3.1	In the situation described in business requirement 6470.3, the contractor shall revoke the Medicare billing privileges of the owning physician/practitioner and the	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	practice (as that term is defined in Pub. 100-08, chapter 10, section 4.20(C)), in accordance with the revocation procedures outlined in Pub. 100-08, chapter 10 and shall end-date the reassignment using, as applicable, the date of death or the effective date of the revocation.										
6470.4	In the situation described in business requirement 3.1, the contractor shall also notify the employed physician/physician practitioner that: (a) the practice's billing privileges have been revoked, (b) 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 (c) if he/she wishes to provide services at the former practice's location, he/she must submit via Internet-based PECOS (or a paper CMS-855 application) a CMS-855I change of information request to add the owning physician/practitioner's practice location as a new location of the employed physician/practitioner.	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	
6470.5	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 site 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 your 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						

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	

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

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 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.

4.20 – Processing CMS-855R Applications

(Rev.291, Issued: 06-12-09, Effective: 01-01-08, Implementation: 10-05-09)

A. General Information

A 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 CMS-855I as well as the 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 CMS-855B. (See section 5.4 for additional instructions regarding the joint processing of CMS-855Rs, CMS-855Bs, and CMS-855Is.)

Note that benefits are reassigned to a supplier, not to the practice location(s) of the supplier. As such, the carrier shall not require each practitioner in a group to submit a 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 CMS-855I. Here, the only forms that will be required are the CMS-855R, and separate CMS-855Is from the reassignor and the reassignee. (No CMS-855B is implicated.) The reassignee himself/herself must sign section 4B of the CMS-855R, as there is no authorized or delegated official involved.

- The carrier shall follow the instructions in Pub. 100-04, chapter 1, section 30.2 to ensure that a group or person is eligible to receive reassigned benefits.

- If the individual is initiating a reassignment, both he/she and the group's authorized or delegated official must sign section 4 of the CMS-855R. If either of the two signatures is missing, the carrier may return the application per section 3.2 of this manual.

- If the person (or group) is terminating a reassignment, either party may sign section 4 of the CMS-855R; obtaining both signatures is not required. If no signatures are present, the carrier may return the application per section 3.2 of this manual.

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

- The authorized or delegated official who signs section 4 of the CMS-855R must be someone who is currently on file with the carrier as such. If this is a new enrollment,

with a joint submission of the CMS-855B, CMS-855I, and 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 carrier need not verify whether the reassigning individual is a W-2 employee or a 1099 contractor.

- There may be situations where a CMS-855R is submitted and the group practice is already enrolled in Medicare. However, the authorized official is not on file. In this case, the carrier shall return the CMS-855R, with a request that the group submit a CMS-855B change request adding the new authorized official.

- In situations where the supplier is both adding and terminating a reassignment, each transaction must be reported on a separate CMS-855R. The same 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 carrier.

B. 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.

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% 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 10. (It is immaterial whether the practice was established as a sole proprietorship, a PC, a PA, or a solely-owned LLC.) 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 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 wishes to provide services at the former practice's location, he/she must submit via Internet-based PECOS (or a paper CMS-855 application) a 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 4.20(C)(3) only, submission of a (1) complete CMS-855I application as an initial enrollment and (2) a terminating CMS-855R application are not required – even if the employed physician/non-physician practitioner had reassigned all of his/her benefits to the practice.