CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 490	**Date: November 6, 2013**
	Change Request 8387

Transmittal 483, dated August 16, 2013, is being rescinded and replaced by Transmittal 490, dated November 6, 2013 to: (1) explain the purpose of this change request (CR), (2) remove federally qualified health centers (FQHCs) and rural health clinics (RHCs) as entities eligible to accept reassignments, and (3) clarify that Part A reassignments only apply to critical access hospitals billing under Method II (CAH II). Also, since all legacy contractors have now transitioned to MACs, the FIs and Carriers have been unchecked from the business requirements. All other information remains the same.

SUBJECT: Reassignment to Part A Critical Access Hospitals billing under Method II (CAH II)

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to allow Part A reassignments for critical access hospitals billing under Method II (CAH II) via the Form CMS-855R and Form CMS-855A enrollments applications. This CR will also ensure the validation of NPIs in FISS.

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	Table of Contents
R	15/15.7.6/ Special Processing Guidelines for Form CMS-855A, Form CMS-855 B, Form CMS-855I and Form CMS-855R
R	15/5.5.20/Processing Form CMS-855R Applications

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

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 490	Date: November 6, 2013	Change Request: 8387

Transmittal 483, dated August 16, 2013, is being rescinded and replaced by Transmittal 490, dated November 6, 2013 to: (1) explain the purpose of this change request (CR), (2) remove federally qualified health centers (FQHCs) and rural health clinics (RHCs) as entities eligible to accept reassignments, and (3) clarify that Part A reassignments only apply to critical access hospitals billing under Method II (CAH II). Also, since all legacy contractors have now transitioned to MACs, the FIs and Carriers have been unchecked from the business requirements. All other information remains the same.

SUBJECT: Reassignment to Part A Critical Access Hospitals Billing under Method II (CAH II)

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

I. GENERAL INFORMATION

A. Background: The Centers for Medicare and Medicaid Services (CMS) released guidance regarding reassignments to entities that complete the Form CMS-855A enrollment application in CR 7864 (Transmittal 437), issued on November 2, 2012. (Transmittal 445 rescinded and replaced Transmittal 437 on December 2, 2012. It changed the effective and implementation dates of CR 7864 to January 1, 2014.) CR 7864 revised CMS Pub. 100-08, chapter 15, section 15.5.20 to state that consistent with 42 CFR §424.80(b)(1) and (b)(2) and CMS Pub. 100-04, Chapter 1, sections 30.2.1(D) and (E) and 30.2.6 and 30.2.7 - Medicare may pay: (1) a physician or other supplier's employer if the supplier is required, as a condition of employment, to turn over to the employer the fees for his or her services; or (2) an entity (i.e., a person, group, or facility) that is enrolled in the Medicare program for services furnished by a physician or other supplier under a contractual arrangement with that entity. Per this instruction, a Medicare-enrolled entity that normally enrolls via the Form CMS-855A may become eligible to receive reassigned benefits by completing a Form CMS-855B enrollment application. To illustrate, assume a skilled nursing facility (SNF) enrolled in Medicare via the Form CMS-855A. It wishes to receive reassigned benefits from one of its newly-enrolling physicians. Per CR 7864, the physician would submit a Form CMS-855I to enroll and a Form CMS-855R for reassign benefits to the SNF; the SNF would submit a Form CMS-855B to receive the reassigned benefits.

After additional analysis, CMS has determined that critical access hospitals (CAHs) billing under Method II need not and should not complete a separate Form CMS-855B to receive reassigned benefits. The physician or non-physician practitioner can reassign benefits directly to the CAH'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 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).

The purpose of the subject CR is to (1) revise Pub. 100-08, chapter 15, sections 15.5.20 and 15.7.6 to reflect this policy, and (2) outline various changes to the Provider Enrollment, Chain and Ownership System (PECOS) that are needed to ensure that CAHs that bill Method II can receive reassigned benefits through their Form CMS-855A enrollment without having to complete a separate Form CMS-855B form. All other Part A entities shall continue to establish part B group enrollments. This CR is only changing the reassignment process for CAHs.

B. Policy: The subject CR (1) revises Pub. 100-08, chapter 15, sections 15.5.20 and 15.7.6 to reflect this policy, and (2) outlines various changes to the Provider Enrollment, Chain and Ownership System (PECOS) that are needed to ensure that CAHs that bill Method II can receive reassigned benefits through their Form CMS-855A enrollment without having to complete a separate Form CMS-855B form.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8387.1	**NOTE**: The contractor shall observe the revision to Pub. 100-08, chapter 15, sections 15.5.20 stating that CAHs that bill Method II (CAH IIs) need not and should not complete a separate Form CMS-855B form to receive reassigned benefits; the physician or non-physician practitioner can reassign benefits directly to the CAH II's Part A enrollment.	X	X										
8387.2	PECOS shall allow contractors to capture an individual (CMS-855I) reassignment of benefits to a Part A (CMS-855A) CAH II.	X	X										PECOS
8387.3	PECOS shall allow contractors to initiate reassignment from the CMS-855A (CAH IIs only) enrollment of the entity accepting reassignment.	X	X										PECOS
8387.3.1	Current functionality in PECOS allows an individual to reassign benefits or accept reassignment of benefits within the CMS-855I enrollment; this functionality shall remain in PECOS.												PECOS
8387.4	PECOS shall not allow the Medicare ID for individuals to be captured for Part A reassignments (i.e. CMS-855A-to-CMS-855I).												PECOS

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8387.5	PECOS shall allow the individual to reassign to a Part A CAH II enrollment.												PECOS
8387.6	PECOS shall allow contractors to add a new reassignment or update an existing reassignment without editing the individual or organization's full enrollment, the user will be able to otherwise update the existing enrollment with updates that need to be submitted, even if the MAC has not fully processed the reassignment updates .	X	X										PECOS
8387.7	PECOS shall update standard batch processes which include an end-dating procedure for enrollments, to include end-dating of reassignment data when an entity (i.e. CAH II) whose enrollment is being end-dated has a reassignment for Part A.												PECOS
8387.8	PECOS shall not send any Part A reassignment information down to FISS. The information shall only be housed in PECOS for informational purposes.												PECOS
8387.9	PECOS shall ensure for data conversion purposes that all reassignments have two entities (individual reassigning and entity accepting benefits) that are active in PECOS for Part A reassignments.												PECOS
8387.10	PECOS shall allow contractors to "reactivate" a historic reassignment when both entities are active in PECOS.	X	X										PECOS
8387.10.1	Historic reassignments shall be reactivated singularly or in bulk for an individual Part A organization specific to CAH II; the data shall be restored to its previous state in all scenarios.												PECOS
8387.11	The PECOS-HITECH data service shall transmit reassignment data from Part A (i.e. CAH II only) and Part B reassignments to enable HITECH to make appropriate EHR Incentive Payments.												PECOS
8387.11.1	The TIN, LBN, Contractor ID, and Medicare ID (CCN for Part A (i.e. CAH II only)) shall be transmitted to HITECH for active enrollments.												PECOS

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8387.12	The HITECH-PECOS data service shall be able to return all CAH II reassignments from PECOS and display as required the Legal Name, NPI, TIN and CCN for payee selection on the Personal Information page.												PECOS
8387.12.1	Any additional validations needed based on the CAH II designation shall occur outside of the service.												PECOS
8387.13	Contractors shall be required to provide a new effective date of reassignment and indicate additional required information that needs to be provided or updated in PECOS.		X										
8387.14	The PECOS shall provide to FISS an initial file of the following physician/non-physician practitioner specialties eligible as an attending or rendering physician who is enrolled in PECOS in an approved status: 1. doctor of medicine or osteopathy; 2. dental surgery (19); 3. podiatric medicine (48); 4. optometry (41); 5. chiropractic medicine (35); 6. physician assistant (97); 7. certified clinical nurse specialist (89); 8. nurse practitioner (50); 9. clinical psychologist (68); 10. certified nurse midwife (42); 11. licensed clinical social worker (80); 12. certified registered nurse anesthetist (43); and 13. registered dietitian/nutritional professional												PECOS

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	(71).												
8387.14.1	The PECOS shall provide the file in the same format as the current ordering/referring file.								X				PECOS
8387.14.2	The PECOS shall provide a nightly file of attending or rendering physicians or non-physician practitioners who are newly added to PECOS or who were on the initial or previous nightly files and a change of information has been submitted.								X				PECOS
8387.15	For Part A reassignment to CAH II's, contractors shall validate the physician's name and NPI, reported in the claim level Attending and/or the Claim and Line level rendering physician NPI fields on an 85x bill type that also contains revenue code(s) 096x, 097x, and/or 98x, against the file sent from PECOS.								X				
8387.15.1	Contractors shall only check the first four letters of the last name and exclude special characters, hyphenated last names, apostrophe's, etc.								X				
8387.15.2	Contractors shall reject the claim if the Attending or Rendering reported physician name and NPI's are not found on the PECOS file.								X				
8387.15.3	Contractors shall apply group code CO - Contractor Obligation and use MSN 9.4 for rejected claims.	X											
8387.15.4	Contractors shall apply CARC code 16 and/or RARC code N253 or N290. 1. N253 – Missing/incomplete/invalid attending provider primary identifier. 2. N290 - Missing/incomplete/invalid rendering provider primary identifier.	X											
8387.15.5	Contractors shall allow the physician NPI validation edit to be overridden by contractors, as directed by CMS.								X				
8387.16	Medicare systems shall not allow the CAH II								X				

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	provider's NPI to be reported in the Attending or Rendering physician NPI fields.												

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8387.17	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 community in billing and administering the Medicare program correctly.	X							

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): Alisha Banks, 410-786-0671 or alisha.banks@cms.hhs.gov

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

VI. FUNDING

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

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS 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
Table of Contents
(Rev. 490, Issued: 11-06-13)

15.5.20 – Processing Form CMS-855R Applications

(Rev. 490, Issued: 11-06-13, Effective: 01-01-14, Implementation: 01-06-14)

A. General Information

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

If the individual who wants to reassign his or her benefits is not enrolled in Medicare, the person must complete a Form CMS-855I as well as a Form CMS-855R. (The CMS-855I and CMS-855R can be submitted concurrently.) Moreover, if the entity to which the person's benefits will be reassigned is not enrolled in Medicare, the organization must complete a Form CMS-855B *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.)

*B*enefits 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 locatio*n.*

*A*n 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 4B of the Form CMS-855R, as there is no authorized or delegated official involved.

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

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

*C*onsistent 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 (CAH II)* or (2) a nurse practitioner reassigning to a *CAH II.*

If the entity receiving the reassigned benefits is <u>not</u> 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 <u>is</u> 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 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 CMS-855I and CMS-855R shall be submitted to the Part B MAC and the CMS-855A submitted 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 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 CMS-855I and/or 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 has been received from the RO but not yet updated in PECOS, prior to returning the applications.

C. A*mbulatory* S*urgical* C*enters (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 billing privileges 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 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 15.5.20(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.

E. Miscellaneous Reassignment Policies

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

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

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

4. The authorized or delegated official who signs section 4 of the Form CMS-855R must be currently on file with the contractor as such. If this is a new enrollment - with a joint submission of the Form(*s)* CMS-855*A or CMS 855*B, 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.

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

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

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

8. 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.

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

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

(Rev. 490, Issued: 11-06-13, Effective: 01-01-14, Implementation: 01-06-14)

A. Reassignment Packages

In situations where an entity wants to simultaneously enroll a group practice, the individual practitioners therein, and to reassign benefits accordingly, the contractor shall adhere to the instructions contained in the

scenarios below. During the pre-screening process, the contractor shall examine the incoming forms to see if a reassignment may be involved.

1. Only the Form CMS-855Rs are submitted - If a brand new group with new practitioners is attempting to enroll but submits only the Form CMS-855Rs for its group members (i.e., neither the initial Form CMS-855B nor the initial Form CMS-855Is were submitted), the contractor shall develop for the other forms if they are not submitted within 15 calendar days after receipt of the Form CMS-855Rs.

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

3. Only the Form CMS-855B is submitted - If a brand new group wants to enroll but submits only the Form CMS-855B without including the Form CMS-855Is and Form CMS-855Rs for its group members (i.e., the Form CMS-855B arrives alone, without the other forms), the contractor shall develop for the other forms if they are not submitted within 15 calendar days after receipt of the Form CMS-855B.

4. Only the Form CMS-855I is submitted – Suppose an individual: (1) submits only the Form CMS-855I without including the Form CMS-855B and Form CMS-855R, and (2) indicates on the Form CMS-855I that he/she will be reassigning all or part of his/her benefits to the group practice. The contractor shall develop for the other forms if they are not submitted within 15 calendar days after receipt of the Form CMS-855*I*.

   Suppose an individual: (1) submits only the Form CMS-855I, and (2) indicates on the Form CMS-855I that he/she will be reassigning all or part of his/her benefits to an existing Part A CAH II. The contractor shall develop for the CMS-855R if it is not submitted within 15 calendar days after receipt of the Form CMS-855I. Upon receipt of the CMS-855R, the contractor shall process the application and reassign the individual to the Part A entity.

B. Additional Instructions

The contractor shall *abide by* the following:

1. 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.

2. If a *provider or* supplier is changing its tax identification number (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 the Provider Enrollment, Chain and Ownership System (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.)

3. 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.

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