

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



NEW product from the Medicare Learning Network® (MLN)

- "[Vaccine Payments Under Medicare Part D](#)" Fact Sheet, ICN 908764, downloadable and hard copy

MLN Matters® Number: MM8266

Related Change Request (CR) #: CR 8266

Related CR Release Date: January 22, 2014

Effective Date: For claims processed on or after January 1, 2014

Related CR Transmittal #: R2860CP

Implementation Date: January 6, 2014

Part B Claims Submission under the Indirect Payment Procedure (IPP)

Note: This article was revised on June 4, 2014, to add a reference to MLN Matters® article MM8638 (<http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8638.pdf>) for information about the updated manual instruction regarding Medicare's indirect payment policy. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for entities submitting paper claims under the Indirect Payment Procedure (IPP) to Medicare Administrative Contractors (MACs), including Durable Medical Equipment Medicare Administrative Contractors (DME MACs), for services to Medicare beneficiaries.

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Provider Action Needed



STOP – Impact to You

This article is based on Change Request (CR) 8266, which establishes a process for IPP entities to submit paper claims for qualified Part B expenditures, including physician services, supplier services, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).



CAUTION – What You Need to Know

This article describes the process established for IPP entities to submit paper claims for qualified Part B expenditures for claims processed on or after January 1, 2014.

- IPP claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), including drugs administered via DME, will continue to be processed by the DME MACs.
- IPP claims for other Part B services, including drugs administered incident to a physician service, will continue to be processed by the Part B MACs.

IPP entities are generally required to adhere to standard Medicare policies and procedures that would apply to a physician or other supplier billing for a Part B item or service. Therefore, such IPP entities are expected to know and comply with the relevant Medicare Fee-For-Service policies and procedures, which may be found in the “CMS Internet Only Manual” at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html> and such applicable updates commonly published by CMS as transmittals, which may be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html> on the Centers for Medicare & Medicaid Services (CMS) website.



GO – What You Need to Do

IPP entities and their billing staffs should be aware that CR8266 directs Medicare contractors to implement the framework needed within the Medicare claims processing system to handle IPP claims. You may not begin submitting claims until you are registered and approved to submit IPP claims. Watch for a separate CR which will outline the registration process for IPP entities.

Background

The process by which the CMS accepts and processes claims submitted by entities that provide coverage complementary to Medicare Part B is called the Indirect Payment Procedure (IPP). If an entity:

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- (1) Meets all of the requirements of the regulation at 42 Code of Federal Regulations (CFR) Section 424.66;
- (2) Is registered as an “IPP entity” in accordance with the instructions in “Medicare Program Integrity Manual,” Pub. 100-08, Chapter 15, Section 15.7.9 through 15.7.9.7; and
- (3) Submits claims in accordance with the specifications of CR8266,

then Medicare may pay that IPP entity for Part B items and services furnished to a Medicare beneficiary by a physician or other supplier.

Although the IPP differs in many respects from the direct payment process, the most important features of Medicare Part B coverage policy, Fee-For-Service payment policy, Fee-For-Service billing procedures, and related matters adhere to the same Medicare Part B standards to which direct billers are subject. Accordingly, CR8266 focuses mostly on the differences that the IPP requires and on eliminating potential ambiguities that the IPP might generate.

Though CR8266 implements the framework needed within the claims processing system to handle IPP claims, IPP entities may not begin submitting claims until they are registered and approved to submit IPP claims. Implementation of the registration process for IPP entities will be handled in a separate CR.

Medicare Policy for IPP Entities

Because IPP entities do not meet the definition of a “health care provider” (as described in 45 CFR Section 160.103), such entities are not eligible for a National Provider Identifier (NPI). Therefore, in order to facilitate the submission of IPP entities claims, IPP entities must apply for and receive either a Health Plan Identifier (HPID) or an Other Entity Identifier (OEID) as specified by 45 CFR Section 162.

For more information on the HPID and the OEID, go to <http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html> on the CMS website.

Policies and procedures applicable to claim submission by, and payment to, IPP entities will be different in several aspects from those normally applied to physicians and other suppliers that bill directly for Part B items and services. These IPP-specific policies and procedures follow.

General Policies

1. The IPP is available only to an entity that: (1) meets all of the requirements of the regulation at 42 CFR Section 424.66; (2) is registered as an IPP entity in accordance with the instructions in the "Medicare Program Integrity Manual," Chapter 15, Sections 15.7.9 through 15.7.9.7; and (3) submits IPP claims in accordance with the terms of CR8266.
2. An IPP entity that submits claims under the IPP is subject to standard Medicare policies and procedures, including but not limited to Medicare Part B coverage

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policies, payment policies, billing procedures, and related policies and procedures except as specified in this Transmittal and all other applicable CMS directives.

3. In the event of an actual or perceived conflict between standard Medicare Part B processes and IPP, the specifications of CR8266 and any other IPP-specific CRs that may be issued in the future will govern the IPP.
4. IPP entities cannot enter into a participation agreement (Form CMS-460) with Medicare. (Section 1842(h)(1) of the Social Security Act permits only “physicians and suppliers” to enter into participation agreements; an IPP entity does not meet the definition of a “supplier” as described in 42 CFR section 400.202.) Therefore, IPP claims are paid at the non-participating physician/supplier rate, which is 95% of the physician fee schedule amount.
5. An IPP entity may choose to file IPP claims for only some items and services, or for some enrollees, or a combination thereof.

Coverage and Payment Policies

1. All payments to IPP entities shall be made in accordance with general Medicare Fee-For-Service coverage and payment policies.
2. No payment shall be made to IPP entities for any item or service that is not covered by Medicare Part B on the Date of Service (DOS).
3. No payment shall be made for any item or service furnished by a physician or other supplier that was not, on the DOS, enrolled in Medicare in the applicable specialty required or permitted for furnishing the item or service.
4. No payment shall be made to an IPP entity for any item or service furnished to an individual who was not entitled to, and enrolled in, Medicare Part B as a beneficiary for the DOS.
5. No payment shall be made to an IPP entity for any item or service if payment is prohibited because a statutory exclusion applies or if payment is otherwise barred under any applicable statutory or regulatory standard.
6. No payment shall be made for any item or service furnished by a “provider”, as that term is defined in 42 C.F.R. Section 400.202.
7. No incentive payment shall be made to an IPP entity. Such payments include, but are not necessarily limited to, the following incentive payments: Health Professional Shortage Area (HPSA), Primary Care Incentive Payment (PCIP), HPSA Surgical Incentive Payment (HSIP), e-Prescribing, Physician Quality Reporting Systems (PQRS), and Electronic Health Records (EHR).
8. IPP entities must accept assignment on all IPP claims.

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9. Medicare Secondary Payer rules apply. Medicare will not make payment on an IPP claim when CMS records show that Medicare is not the primary payer for a particular claim.
10. Medicare payment can only be made once for a beneficiary's particular service. If an IPP entity submits a claim for a beneficiary's service that has already been billed to and paid by Medicare (for example, the claim was submitted by a physician before the IPP entity submitted its claim), then Medicare cannot make payment to the IPP entity for that same service. Conversely, if a physician or supplier submits a claim for a beneficiary's service that has already been billed to and paid by Medicare (for example, the claim was submitted by an IPP entity before the physician submitted his claim), then Medicare cannot make payment to the physician for that same service.

IPP Billing and Claims Processing Policies

1. Standard claims submission and processing rules will generally apply to IPP billing. The IPP entity must submit claims that conform to Medicare requirements for physicians and other suppliers except as noted in CR8266. Clarifications and exceptions to standard Medicare claims submission and processing rules are noted below.
2. Standard claims filing jurisdiction rules apply to IPP billing. As such, the location of the IPP entity is irrelevant to establishing claims filing jurisdiction.
 - a. Claims for most Part B services, including drugs administered incident to a physician service, will generally be processed by MACs. Claims filing jurisdiction for such claims is based on the location where the service was performed, i.e., where the physician or other supplier performed the service.
 - b. Claims for most DMEPOS items and supplies, including drugs administered via DME, will generally be processed by the DME MACs. Claims filing jurisdiction for most DMEPOS claims is based on the location where the beneficiary permanently resides. Claims for some items of DME, such as implantable devices, must be submitted to the same MAC to which the surgical service claim was submitted. (Although IPP entities are generally permitted to submit some claims under the IPP but not others, if the IPP entity elects to submit a claim for an implantable device under the IPP, the IPP entity must also submit the related surgical claim. Otherwise, the claim for the implanted device will be denied.) CMS publishes an annual DMEPOS jurisdiction list that indicates the claims filing jurisdiction for items of DMEPOS.
3. Standard claims completion and submission rules generally apply to IPP billing. Exceptions are as follows:
 - a. The IPP entity must submit all IPP claims on the paper claim form CMS-1500 until such time as an electronic claims submission process is established for IPP claims. MACs will reject and return-as-unprocessable all IPP claims submitted on any other form or in any other format.

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- b. The IPP entity must, on all IPP claims, include its name and address in Item 33 of the CMS-1500.
 - c. The IPP entity must include its HPID or OEID in Item 33b of the CMS-1500, preceded by qualifier “XV”. For example, if an IPP entity has an OEID of 2222222222, then the value entered in Item 33b should be “XV2222222222”.
 - d. The IPP entity must annotate its Tax Identification Number (TIN) in Item 25 of the CMS-1500.
 - e. The IPP entity must include the NPI of the rendering physician or supplier in Item 24J of the CMS-1500.
 - f. The IPP entity must include the name and NPI of the ordering or referring physician in Item 17 of the CMS-1500.
 - g. The IPP entity must not submit an IPP claim, except a DMEPOS claim, until it is registered as an IPP entity with the appropriate MAC that has claims filing jurisdiction for the IPP claim. The IPP entity must not submit an IPP DMEPOS claim until it is registered as an IPP entity with the National Supplier Clearinghouse (NSC), at which time the IPP entity may file a DMEPOS claim to the DME MAC having jurisdiction for adjudicating such a claim. Once registered, the IPP entity may file any IPP claim that predates the effective date of its registration as an IPP entity provided the claims meet the timely filing rule specified in 42 CFR Section 424.44.
4. Standard claims processing rules generally apply to IPP billing. The specifications of the business requirements in CR8266 are controlling, but the following are noted for emphasis.
 - a. MACs shall reject and return-as-unprocessable an IPP claim that is submitted with missing, incomplete, or invalid information, including but not limited to the information specified in paragraph 3, above.
 - b. MACs shall append demonstration code “70” to all IPP claims upon receipt. IPP claims shall be identified by the presence of an HPID or OEID belonging to a registered IPP entity in Item 33b of the CMS-1500 claim form.

Medicare Secondary Payer & Coordination of Benefits

1. Medicare Secondary Payer (MSP) rules apply. Medicare will not make primary payment on an IPP claim when CMS records show that Medicare is not the primary payer for a particular claim. MACs will inform beneficiaries regarding the applicability of MSP to IPP initial determinations via Medicare Summary Notice (MSN) message 29.35.
2. IPP claims are excluded from the National Coordination of Benefits Agreement (COBA) crossover process.

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Additional Information

The official instruction, CR8266 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2860CP.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

You may want to review MM8266 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1406.pdf>) which describes the types of organizations that may be an IPP entity and the IPP registration process for these entities

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