

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



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Indirect Payment Procedure (IPP) - Payment to Entities that Provide Coverage Complementary to Medicare Part B

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, suppliers, and other applicable entities submitting claims using the indirect payment procedure to Part B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs (DME MACs) for services to Medicare beneficiaries.

What You Need to Know

The article is based on Change Request (CR) 8638, which updates the manual instructions regarding the indirect payment procedure policy in the "Medicare Claims Processing Manual," Chapter 1, Section 30.2.8.3.

Section 1842(b)(6)(B) of the Social Security Act, as well as the Medicare regulations at 42 Code of Federal Regulations (CFR) Section 424.66, specify that payment may be made to an entity for Part B services furnished by a physician or other supplier under a complementary health benefit plan if the entity meets certain requirements. This process is known as the indirect payment procedure (IPP).

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According to Chapter 1, Section 30.2.8.3 of the "Medicare Claims Processing Manual", because Section 1842(h)(1) of the Social Security Act only permits "physicians and suppliers" to enter into participation agreements and because IPP entities do not meet the definition of a "supplier" as described in 42 CFR. 400.202, IPP entities cannot enter into a participation agreement (Form CMS-460) with Medicare. Therefore, IPP claims are paid at the non-participating physician/supplier rate, which is 95 percent of the physician fee schedule amount.

Payment under the IPP can only be made for covered Part B services. If an IPP entity submits a claim for a beneficiary's service that has already been billed to 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 Medicare (for example, the claim was submitted by an IPP entity before the physician submitted his/her claim), then Medicare cannot make payment to the physician for that same service. Medicare payment can only be made once for a beneficiary's specific service. Therefore, claims for services that have already been billed to Medicare shall be denied (with appeal rights) by Medicare's contractors.

In addition, Medicare payment cannot be made under the IPP for services that are payable for a particular beneficiary under any other Part of Medicare. For example, if a beneficiary's service is payable under Part C and a Medicare Advantage organization is also an IPP entity under 42 CFR 424.66, then a Medicare Part B payment under the IPP cannot be made to that Medicare Advantage organization for that beneficiary's service. In these types of dual or multiple enrollment situations, services that are payable under those other Parts of Medicare (e.g., Parts C or D) cannot also be billed and paid for under Part B. Therefore, IPP entities that submit Part B claims for services that are payable under another Part of Medicare (e.g., Part C or D) shall be denied (with appeal rights) by Medicare's contractors.

Payment for IPP claims by Medicare is conditioned upon the claim and the underlying transaction complying with the Medicare laws, regulations, and program instructions applicable to IPP entities, and on the IPP entity's continued compliance with the regulatory requirements described in 42 CFR 424.66.

Medicare's IPP policy states that Medicare may pay an entity for Part B services furnished by a physician or other supplier if the entity **meets all** of the following requirements:

- (1) Provides coverage of the service under a complementary health benefit plan (that is, the coverage that the plan provides is complementary to Medicare benefits and covers only the amount by which the Part B payment falls short of the approved charge for the service under the plan).
- (2) Has paid the person who provided the service an amount (including the amount payable under the Medicare program) that the person accepts as full payment.

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- (3) Has the written authorization of the beneficiary or of a person authorized to sign claims on the beneficiary's behalf under 42 CFR 424.36 to receive the Part B payment for the services for which the entity pays.
- (4) Relieves the beneficiary of liability for payment for the service and will not seek any reimbursement from the beneficiary, or from the beneficiary's survivors or estate.
- (5) Submits any information the Centers for Medicare & Medicaid Services (CMS) or the MAC may request, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program.
- (6) Identifies and excludes from its requests for payment all services for which Medicare is the secondary payer.

Entities that satisfy all of the requirements above may include employers, unions, insurance companies, and retirement homes. They also may include health care prepayment plans, health maintenance organizations (HMOs), competitive medical plans, and Medicare Advantage organizations.

The IPP permits a physician or supplier to file a single claim with the complementary insurer and receive full payment in a single payment, relieves the beneficiary of the need to file a claim, and protects the beneficiary against any financial liability for the service.

In addition, any entity wishing to bill using the IPP must register through Provider Enrollment and meet such requirements specified in the "Medicare Program Integrity Manual," Chapter 15, Sections 15.7.9 through 15.7.9.7. This part of the manual is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf> on the CMS website.

Additional Information

The official instruction, CR 8638, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2896CP.pdf> on the CMS website.

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

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