

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



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Registration of Entities Using 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® Special Edition (SE) Article is intended for entities that may register for indirect payment of claims submitted to Medicare contractors (A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs (DME MACs)) for services furnished to Medicare beneficiaries.

What You Need to Know



STOP – Impact to You

Medicare Part B payment otherwise payable to an enrollee for the services of a physician or other supplier who charges on a Fee-For-Service (FFS) basis may be paid to an entity under the IPP.

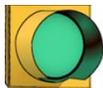
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CAUTION – What You Need to Know

This SE article outlines the IPP registration process for these entities.



GO – What You Need to Do

Make sure that your billing staffs are aware of the IPP registration process.

Background

Medicare Part B payment otherwise payable to a beneficiary for the services of a physician or other supplier who charges on a Fee-For-Service basis may be paid to an entity under the IPP if the conditions described in 42 CFR § 424.66 are met.

Under 42 CFR § 424.66, Medicare may pay an “IPP entity” (such as an employer, union, insurance company, retirement home, health care prepayment plan, health maintenance organization, competitive medical plan, or Medicare Advantage plan) 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 (this 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;
3. Has the written authorization of the beneficiary (or of a person authorized to sign claims on his/her 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, his/her survivors, or estate;
5. Submits any information that CMS or the contractor may request, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program; and
6. Identifies and excludes from its requests for payment all services for which Medicare is the secondary payer.

(You can find 42 CFR § 424.66 at <http://www.gpo.gov/fdsys/granule/CFR-2010-title42-vol3/CFR-2010-title42-vol3-sec424-66/content-detail.html>.)

As an illustration, suppose an entity furnishes complementary coverage for its retired union members and is a retiree drug subsidy plan sponsor. The entity may seek to (1) pay in full its

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retired members' drug benefits and other Part B services, (2) bill the Part B services to Medicare, and (3) receive payment for Medicare claims.

It is important to note that an IPP entity is not a Medicare provider or supplier, is not eligible for a National Provider Identifier, and cannot enroll in the Medicare program.

Nevertheless, it is crucial that Medicare obtain sufficient background information on prospective IPP entities to help ensure the integrity, accuracy, and legitimacy of Medicare payments. Such entities will therefore be required to complete the IPP registration process described below (and in more detail in CR 8284) before they can submit claims via the IPP. CMS will apply the Form CMS-855 process to IPP entities consistent with CMS' authority to request information under 42 CFR § 424.66.

Contractor Jurisdiction

Claims for all Part B items and services - other than for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) - must be submitted to the A/B MAC based on where the service was performed or the item was furnished. Almost all claims for DMEPOS must be submitted to the DME MAC based on where the beneficiary resides; however, claims for Medicare-covered implantable devices (although classified as DME) are submitted to the A/B MAC based on where the implant surgery was performed. These jurisdictional rules for claim submission apply to the submission of registration applications.

Registration Process

To register as an IPP entity, you must:

(1) Complete and submit:

- a. A paper Form CMS-855B application to each A/B MAC to which you intend to submit claims, and/or
- b. A paper Form CMS-855S application to the National Supplier Clearinghouse (NSC) if you intend to submit claims to a DME MAC.

(2) Complete and submit a paper Form CMS-588 (Electronic Funds Transfer (EFT) Agreement) with your Form CMS-855 application.

(3) Submit with each Form CMS-855 application an attestation statement signed by an "authorized official" (as that term is defined in 42 CFR § 424.502) certifying that for each claim you submit, all of the requirements of 42 CFR § 424.66 are met. The certification statement on the Form CMS-855 supplements (but does not supplant) the attestation. **An IPP entity is bound by the terms of the Form CMS-855 certification statement to the same extent it is bound by the attestation's terms.**

(NOTE: Since you may be submitting applications in multiple MAC jurisdictions, it is acceptable to submit a photocopy of a signed attestation rather than an originally signed attestation.)

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(4) Apply for and receive either a Health Plan Identifier (HPID) or an Other Entity Identifier (OEID), furnish it in the appropriate section of the Form CMS-855, and submit actual issuance documentation with each Form CMS-855 application (for example, an issuance notice from the HPID or OEID that includes the number). See CMS' main website at <http://www.cms.hhs.gov> for information on how to obtain a HPID or OEID.

(5) You need not:

- a. Submit licensure or certification information;
- b. Report medical record storage information;
- c. Pay an application fee;
- d. Submit a Form CMS-460 (Medicare Participating Physician or Supplier Agreement); and
- e. Meet the DMEPOS (i) supplier standards, (ii) accreditation requirements, (iii) surety bond requirements, or (iv) liability insurance requirements.

Processing of Registration Applications

Upon receipt of your Form CMS-855 registration application, the Medicare contractor will begin processing it. This includes:

- a. Ensuring that the application is complete;
- b. Verifying the information on the application;
- c. Ensuring that the attestation described above is submitted, signed by an authorized official, and contains the required language;
- d. As needed, asking you for additional or clarifying information to determine whether you are in compliance with the provisions of 42 CFR § 424.66 and all other requirements. It is important that you furnish such information to the Medicare contractor promptly. Failure to do so may result in the rejection of your application; and
- e. Assigning the appropriate specialty code.

If the Medicare contractor and CMS determine that you meet all requirements, the Medicare contractor will (1) establish an effective date of registration, (2) send you an approval letter via regular mail or e-mail, and (3) assign a Provider Transaction Identification Number (PTAN). Please note that after you are registered as an IPP entity, the Medicare contractor (consistent with 42 CFR § 424.66(a)) may request additional information to confirm your continued compliance with all requirements. Moreover, an IPP entity is required to submit to the Medicare contractor all changes to its Form CMS-855 information in accordance with the terms of its signed Form CMS-855 certification statement.

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If the Medicare contractor and CMS determine that you do not meet all requirements, your application will be denied. You will receive a letter outlining (1) the specific reason(s) for the denial and (2) your appeal rights.

Additional Information

Please review CR8284 for more detailed information regarding the registration process. CR8284 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R502PI.pdf> on the CMS website.

If you have any questions, please contact your Medicare contractor 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/MM8266.pdf>) for details on the CMS process for IPP entities to submit paper claims for qualified Part B expenditures, including physician services, supplier services and DMEPOS

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