CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2896	**Date: March 7, 2014**
	Change Request 8638

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

I. SUMMARY OF CHANGES: The purpose of this CR is to update the manual instructions regarding indirect payment procedure policy (in the Medicare Claims Processing Manual, Pub. 100-04, chapter 1, section 30.2.8.3). Thus, we are modifying the existing instructions in section 30.2.8.3 with a new title and new language.

EFFECTIVE DATE: June 6, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 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	1/30.2.8.3/Indirect Payment Procedure (IPP) - Payment to Entities that Provide Coverage Complementary to Medicare Part B

III. FUNDING:
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

Business Requirements

Pub. 100-04	Transmittal: 2896	Date: March 7, 2014	Change Request: 8638

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I. GENERAL INFORMATION

A. Background: Section 1842(b)(6)(B) of the Social Security Act, as well as the Medicare regulations at 42 C.F.R. § 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." The purpose of this Change Request is to update the manual instructions regarding indirect payment procedure policy.

B. Policy: 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 (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 the beneficiary's behalf under 42 C.F.R. § 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 CMS or the contractor 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.

In addition, any entity wishing to bill using the indirect payment procedure must register through Provider Enrollment and meet such requirements specified in the Program Integrity Manual, Pub. 100-08, chapter 15, sections 15.7.9 through 15.7.9.7.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8638.1	Contractors shall refer to IOM, Medicare Claims Processing Manual, Pub. 100-04, chapter 1, section 30.2.8.3 for information regarding indirect payment procedure policy.		X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8638.2	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		X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	The Medicare regulations at 42 C.F.R. § 424.66

Section B: All other recommendations and supporting information: CRs 8284 and 8266

V. CONTACTS

Pre-Implementation Contact(s): David Walczak, 410-786-4475 or david.walczak@cms.hhs.gov, Frederick Grabau, 410-786-0206 or frederick.grabau@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents
(Rev.2896, 03-07-14)

Transmittals for Chapter 1

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

30.2.8.3 - Indirect Payment Procedure (IPP) - Payment to Entities that Provide Coverage Complementary to Medicare Part B
(Rev. 2896, Issued: 03-07-14, Effective: 06-06-14, Implementation: 06-06-14)

Medicare Part B payment otherwise payable to a beneficiary for the services of a physician or supplier who charges on a fee-for-service basis may be paid to an entity using the indirect payment procedure (IPP). Any entity registered in accordance with the instructions in Pub. 100-08, chapter 15, sections 15.7.9 through 15.7.9.7 and meets the following requirements can bill using the IPP:

- *Provides coverage of the service under a complementary health benefit plan (this is, the coverage that the plan provides is complementary to Medicare and covers only the amount by which the Part B payment falls short of the approved charge for the service under the plan).*

- *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.*

- *Has the written authorization of the beneficiary (or of a person authorized to sign claims on the beneficiary's behalf under 42 C.F.R. § 424.36) to receive the Part B payment for the services for which the entity pays.*

- *Relieves the beneficiary of liability for payment for the service and will not seek any reimbursement from the beneficiary, his or her survivors, or estate.*

- *Submits any information CMS or the contractor may request, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program.*

- *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.

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 C.F.R. § 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% 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 C.F.R. § 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 C.F.R. § 424.66.