CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2860	**Date: January 22, 2014**
	Change Request 8266

NOTE: This CR is no longer Sensitive and Controversial.

Transmittal 2699, dated May 10, 2013, is being rescinded and replaced by Transmittal 2860, dated January 22, 2014, in order to clarify that the algorithm for the Health Plan Identifier (HPID) in BR 8266.1.5.1 begins with a "7" rather than a "5" and to correct the attachment page as a "Business Requirement" and not a "One Time Notification." All other information remains the same.

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

I. SUMMARY OF CHANGES: This CR establishes a process for IPP entities to submit paper claims for qualified Part B expenditures, including physician services, supplier services, anddurable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

EFFECTIVE DATE: For claims processed on or after January 1, 2014
IMPLEMENTATION DATE: October 7, 2013 - For Analysis, Design, and Coding; January 6, 2014 - For Testing and Implementation

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
N/A	

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

Attachment – Business Requirement

Pub. 100-04	Transmittal: 2860	Date: January 22, 2014	Change Request: 8266

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I. GENERAL INFORMATION

A. Background: The process by which the Centers for Medicare & Medicaid Services (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 (1) meets all of the requirements of the regulation at 42 CFR § 424.66, (2) is registered as an "IPP entity" in accordance with the instructions in Pub. 100-08, chapter 15, section 15.7.9 through 15.7.9.7, and (3) and submits claims in accordance with the specifications of this Transmittal, then Medicare may pay that IPP entity for Part B items and services furnished to a Medicare beneficiary by a physician or other supplier.

Since January 1, 2012, the Electrical Workers Insurance Fund (EWIF) – which is a health benefit plan that furnishes Medicare complementary coverage for its retired union members and that is also a Retiree Drug Subsidy (RDS) Plan Sponsor – has been the only entity billing under the IPP. CMS is enhancing the IPP process to ensure that any additional entities that qualify according to the requirements in 42 C.F.R. § 424.66 and all other applicable requirements, including registration, may submit IPP claims to Medicare.

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, this Transmittal will focus mostly on the differences that the IPP requires and on eliminating potential ambiguities that the IPP might generate.

Though this Transmittal will implement 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.

B. Policy: This CR establishes a process for IPP entities to submit paper claims for qualified Part B expenditures beginning 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 Medicare Administrative Contractors (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 or by legacy contractors. 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 are hereby incorporated by reference, and 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.

Because IPP entities do not meet the definition of a "health care provider" (as described in 45 CFR § 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 § 162.

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.

I. General Policies:

1. The IPP is available only to an entity that: a) meets all of the requirements of the regulation at 42 CFR § 424.66; b) is registered as an IPP entity in accordance with the instructions in Pub. 100-08, chapter 15, sections 15.7.9 through 15.7.9.7); and c) that submits IPP claims in accordance with the terms of this Transmittal.

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 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 this and any other IPP-specific Transmittals 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 would not meet the definition of a "supplier" as described in 42 CFR § 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.

II. 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.

3. No payment shall be made for any item or service furnished by a physician or other supplier that was not, on the date of service, 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 on the date of service.

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. § 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.

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.

III. 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 this Transmittal. Medicare claims administration contractors shall follow established Medicare fee-for-service rules when processing IPP claims except as may be necessary to implement the policies stated in this Transmittal. 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 A/B MACs or by Part B legacy contractors. 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 A/B MAC or legacy contractor 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. Medicare claims administration contractors shall reject and return-as-unprocessable all IPP claims submitted on any other form or in any

other format.

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 A/B MAC or Part B legacy contractor 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 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 § 424.44.

4. Standard claims processing rules generally apply to IPP billing. Contractors shall note the different requirements applicable to IPP billing and process IPP claims accordingly. The specifications of the business requirements are controlling, but the following are noted for emphasis.

a. Medicare claims administration contractors 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. Contractors 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.

IV. Beneficiary Appeal Rights

A beneficiary, on whose behalf an IPP entity has submitted a claim adjudicated to finality by the claims administration contractor, shall have party status under 42 CFR § 405.906 and may appeal the initial determination of such IPP claim. Medicare claims administration contractors will inform beneficiaries regarding IPP initial determinations via Medicare Summary Notice (MSN) message 29.34.

V. 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. Medicare claims administration contractors 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.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC				Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8266.1	Contractors shall accept and process claims submitted by IPP entities under the IPP in accordance with all applicable Medicare fee-for-service rules and procedures, except as noted in other business requirements in this CR.		X	X								
8266.1.1	Contractors shall only accept claims submitted by organizations that have been registered as IPP entities in accordance with Medicare policy. IPP registration requirements and instructions will be provided under a separate Transmittal.		X	X								
8266.1.1.1	Even if an IPP entity completes the registration process prior to January 1, 2014, contractors shall not accept any claims from registered IPP entities prior to January 1, 2014.		X	X								
8266.1.1.2	Contractors shall accept and process claims submitted by IPP entities within the timely filing period, even if the IPP registration date is <u>after</u> the date of service on the claim. Per business requirement 22, the rendering provider reported in Item 24J must be enrolled in Medicare on the date of service submitted on the claim.		X	X						X		
8266.1.2	Contractors shall accept claims submitted by IPP entities only when submitted on the paper claim form CMS-1500 until such time as an electronic process is established.		X	X								
8266.1.3	Contractor shall not subject IPP claims to the ASCA edits.		X	X						X		
8266.1.4	Contractors shall not accept electronic claims submitted by IPP entities at this time.		X	X								
8266.1.5	Contractors shall recognize an IPP claim when the 10-digit HPID or OEID, preceded by a qualifier of "XV", is submitted in Item 33b of the CMS-1500 <u>and</u> the HPID or OEID belongs to an entity with specialty "C2" (Complimentary Insurers Registration Process).		X	X					X			

Number	Requirement	Responsibility										
		A/B MAC		DME MAC				Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8266.1.5.1	Contractors shall note that the HPID and OEID will be 10-digit numbers, beginning with "7" or "6", respectively.		X	X					X	X		NSC
8266.1.5.2	Contractors shall map the HPID/OEID, reported in Item 33b of the CMS-1500, to Loop 2010AA, REF02 (REF01=XV) in the current OCR format.		X	X					X	X		
8266.1.5.3	Contractors shall bypass any editing which would reject the qualifier XV in this loop/segment.		X	X						X		
8266.1.6	Unless otherwise indicated in this Transmittal, contractors shall continue to process EWIF claims as previously instructed until such time as CMS issues separate instructions to include EWIF in the IPP process established by this CR.		X	X							X	
8266.1.7	Contractors shall apply standard claims filing jurisdiction rules to IPP claims (i.e., based on the zip code where the service was performed or the address of the beneficiary's residence), without regard to the location of the IPP entity itself.		X	X								
8266.2	Contractors shall populate the billing provider NPI field within the claims system with the 10-digit HPID or OEID submitted in Item 33b of the CMS-1500, without the preceding qualifier.		X	X					X			
8266.2.1	Contractors shall take necessary action to allow the HPID/OEID to process through the system in the billing provider NPI field.		X	X					X	X		HIGLAS
8266.2.2	Contractors shall associate the HPID/OEID to a contractor-established PTAN, as necessary, to adjudicate IPP claims.		X									
8266.3	Contractors shall use the NSC number assigned to each IPP entity as an indirect biller for IPP claims that are submitted to the DME MACs.			X						X		
8266.4	Contractors shall append and recognize demonstration code "70" on all IPP claims that are submitted to the DME MACs and A/B MACs, including EWIF claims. Demonstration		X	X					X	X	X	HIGLAS

Number	Requirement	Responsibility										
		A/B MAC		DME MAC				Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	code “70” must be appended in the first demonstration code position.											
8266.5	CWF shall revise the name of the “NPI Placeholder Field” to “COBYPASS” and adjust edits as necessary to reflect the new name.										X	
8266.5.1	For claims processed on or after January 1, 2014, contractors shall begin to send the “Y” indicator to CWF in the “COBYPASS” field to indicate that the IPP claims should not cross over.		X	X					X	X		
8266.5.2	For claims processed on or after January 1, 2014, contractors shall send the “I” indicator to CWF to identify claims from the EWIF, but not for any other IPP billers.		X									
8266.5.3	For claims processed on or after January 1, 2014, CWF shall modify its existing consistency and utilization error codes to reflect the changes to continue to identify EWIF claims through the receipt of the ‘I’ indicator as well as to identify claims from any other IPP biller through the receipt of Demonstration Code ‘70’ for Part B claims, and to identify “COBYPASS” as the new field name.										X	
8266.5.4	CWF shall continue to bypass the BCPI Model 4 edits and IURs when the “I” indicator is submitted in the COBYPASS field and shall also bypass when Demonstration Code 70 is present on the claim.										X	
8266.6	Contractors shall accept a claim and not return it as unprocessable because of the lack of an NPI in Item 33a of the CMS-1500 claim form when a 10-digit HPID or OEID is submitted in Item 33b.		X	X								
8266.6.1	Contractors shall use standard messaging for remittance advices (such as the messages below) to reject or return claims as unprocessable when submitted with a 10-digit identifier in Item 33b but without qualifier “XV”. CARC 16 - Claim/service lacks information or		X	X								

Number	Requirement	Responsibility										
		A/B MAC		DME MAC				Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.). **NOTE**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information. and/or RARC N259 - Missing/incomplete/invalid billing provider/supplier secondary identifier.											
8266.6.1.1	For the purpose of returning or rejecting an IPP claim submitted without the appropriate qualifier in Item 33b, contractors shall assume the identifier submitted in Item 33b is an HPID or OEID.		X	X								
8266.7	Contractors shall consider IPP entities to have the same status as the rendering supplier on the claim date of service with respect to that supplier's status under the Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) with respect to an item subject to DMEPOS CBP.			X						X		
8266.8	Contractors shall use standard messaging for remittance advices including denial and return/reject as unprocessable messages, (e.g., for the denials of duplicate claims, denials for coverage determinations, ineligible provider/supplier, etc.).		X	X								
8266.9	Contractors shall treat IPP claims the same as any other claim with regard to duplicate claim editing and deny subsequent claims (no matter if they are submitted by an IPP entity or a physician or		X	X						X		

Number	Requirement	Responsibility										
		A/B MAC		DME MAC				Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	supplier) when a paid claim is found in history (no matter if it is for the IPP entity or the physician or supplier) for the same beneficiary, same HCPCS, and same date of service.											
8266.9.1	CWF shall create a new edit to reject an incoming claim received from the IPP entity, physician or supplier and there is a claim in history from an IPP entity, physician or supplier for the same Beneficiary with the same HCPCS code and same DOS. The new edit shall not be overridable.										X	
8266.10	Contractors shall use Group Code CO for all denied IPP claims.		X	X					X	X		
8266.11	Contractors shall apply coinsurance and deductibles to claims submitted under the IPP for those items and services that are normally subject to coinsurance and deductibles.		X	X						X		
8266.12	Contractors shall, for a payable claim, pay IPP entities at the non-participating rate for services that are normally subject to the reduced, non-participating rate.		X						X			
8266.12.1	Contractors shall, for a payable claim, pay IPP entities on an assignment-related basis.		X	X					X	X		
8266.12.2	Contractors shall not make any incentive payments to IPP entities billing under the IPP under any circumstances (e.g., HPSA, HSIP, and PCIP).		X									
8266.13	Contractors shall make all payments to IPP entities via electronic funds transfer (EFT) according to the normal guidelines.		X	X						X		
8266.14	Contractors shall afford IPP entities normal appeal rights.		X	X								
8266.15	Contractors shall send Medicare Summary Notices (MSN) for all IPP claims.		X	X						X		
8266.15.1	Contractors shall continue to use MSN message 29.34 for all services submitted by IPP entities.		X	X						X		

Number	Requirement	Responsibility										
		A/B MAC		DME MAC				Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8266.16	Contractors shall report all payments made to IPP entities on a 1099 and shall not report any such payments on the 1099s of the rendering providers shown on IPP claims.		X	X						X		HIGLAS
8266.17	Contractors shall use the standard paper remittance for all IPP claims and will include the HPID/OEID of the IPP entity on the remittance advice in the space where the NPI would normally appear.		X									
8266.18	Contractors shall use the standard paper remittance for all IPP claims and exclude the NSC number on remittance advices sent to IPP entities.			X						X		
8266.19	Contractors shall continue to afford a beneficiary, who is the subject of an IPP claim, the same rights of appeal that the beneficiary would have had if the claim had been submitted by a provider, supplier or non-participating hospital under 42 CFR 424.33, or by the beneficiary under 42 CFR 424.34.		X	X								
8266.20	Contractors shall not make payment under the IPP for Part B services furnished by institutional providers.		X	X								
8266.21	Contractors shall continue to deny claim lines submitted by an IPP for services where Medicare is the secondary payer.		X	X							X	
8266.22	Contractors shall deny claims and use standard messaging when IPP claims are submitted with a rendering NPI in Item 24J belonging to a provider who was not a Medicare-enrolled physician or supplier on the claim date of service.		X	X								
8266.23	Contractors shall deny claims and use standard messaging when IPP claims are submitted with a rendering NPI in Item 24J belonging to a provider who was enrolled in Medicare on the claim date of service, but did not have the applicable specialty required or permitted for		X	X								

Number	Requirement	Responsibility										
		A/B MAC		DME MAC				Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	furnishing the item or service.											
8266.24	Contractors shall, within 30 days of issuance of this CR, be prepared to advise IPP entities regarding applicable Medicare fee-for-service policies and procedures and shall, upon receiving an IPP registration application form from the IPP entity, or notice from the NSC of an IPP entity's registration, advise the IPP entity regarding such policies and procedures.		X	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC				Other
		Part A	Part B					
8266.25	MLN Article: A provider education article related to this instruction will be available at http://www.cms.hhs.gov/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: N/A
Use "Should" to denote 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): Fred Grabau, frederick.grabau@cms.hhs.gov (For policy-related questions) , David Walczak, david.walczak@cms.hhs.gov (For policy-related questions) , Brian Reitz, brian.reitz@cms.hhs.gov (For questions related to physician claims processing) , Felicia Rowe, felicia.rowe@cms.hhs.gov (For questions related to supplier claims processing) , Frank Whelan, frank.whelan@cms.hhs.gov (For questions related to registration of IPP entities) , Tolla Anderson, tolla.anderson@cms.hhs.gov (For questions related to registration of IPP entities).

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

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 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.