



News Flash - The Office of the Inspector General in the Department of Health and Human Services has issued a policy statement that assures Medicare providers, practitioners, and suppliers affected by retroactive increases in payment rates under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 that they will not be subject to OIG administrative sanctions if they waive retroactive beneficiary cost-sharing amounts attributable to those increased payment rates, subject to the conditions noted in the policy statement. To view the document, go to http://oig.hhs.gov/fraud/docs/alertsandbulletins/2008/MIPPA_Policy_Statement.PDF on the Internet.

MLN Matters Number: MM6129 **Revised**

Related Change Request (CR) #: 6129

Related CR Release Date: August 8, 2008

Effective Date: January 1, 2009

Related CR Transmittal #: R1572CP

Implementation Date: January 5, 2009

New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services

Note: This article was revised on March 2, 2012, to reference MLN Matters® Article SE1201 (<http://www.cms.gov/MLN MattersArticles/downloads/SE1201.pdf>) for important reminders on the requirements for Ordering and Referring Physicians. All other information is unchanged.

Provider Types Affected

This article is intended for providers (ASCs) who submit claims to Medicare Administrative Contractors (A/B MACs) or carriers for services provided to Medicare beneficiaries.

Impact on Providers (ASCs)

This article is based on Change Request (CR) 6129 which states that the Centers for Medicare & Medicaid Services (CMS) has determined that beginning January 1, 2009, **the ordering/referring physician needs to be reported on claims for diagnostic radiology services submitted by ASCs, as it is for other Part B**

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claims for diagnostic services (modifier TC). The name of the ordering/referring physician needs to be present in block 17 and the National Provider Identifier (NPI) of the physician needs to be present in block 17B of the CMS-1500 (or in Data Element Loops 2420E and 2310A of the 837P).

Key Points of CR6129

- Effective for dates of service on or after January 1, 2009 for allowed ASC claims, if modifier = TC, the ordering/referring physician name needs to be included in block 17 and ordering/physician NPI in block 17B of the CMS-1500 for paper claims.
- Effective for dates of service on or after January 1, 2009 for allowed ASC claims, if modifier = TC, the ordering physician name and NPI needs to be present in Loop 2420E NM1 (NM101=DK, NM102=1, NM103=*provider's last name*, NM104=*provider's first name*, NM108=XX, NM109=*provider's NPI*).
- Effective January 1, 2009 for allowed ASC claims, if modifier = TC, the referring physician name and NPI needs to be present in Loop 2310A/2420F NM1 (NM101=DN, NM102=1, NM103=*provider's last name*, NM104=*provider's first name*, NM108=XX, NM109=*provider's NPI*).
- Claims will be returned as **unprocessable (using Claim Adjustment Reason Code 16- Claim/service lacks information which is needed for adjudication)** for the above services without the ordering/referring physician name or NPI on the claim.
- When returning claims as unprocessable, your Medicare Carrier or A/B MAC will use Remittance Advice Remark codes:
 - N264 - Missing/incomplete/invalid ordering provider name;
 - N265 - Missing/incomplete/invalid ordering provider primary identifier;
 - N285 - Missing/incomplete/invalid referring provider name; or
 - N286- Missing/incomplete/invalid referring provider primary identifier.
- If the NPI of the ordering/referring provider cannot be obtained by the billing provider and it cannot be found on the NPI Registry, the billing provider (in X12N 837 transactions) or the service provider (in NCPDP 5.1 transactions) may be used in the ordering/referring field on a temporary basis and such use is subject to postpayment review.

Background

Prior to January 1, 2008, ASCs could not be paid for diagnostic radiology services since these services were not included on the list of ASC-approved procedures. Effective for services on or after January 1, 2008 several radiology codes were

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added to the list of payable ASC procedures. Since ASCs can now bill for these services with the TC modifier, claims from ASCs for these services must be in compliance with Section 1883 (q) of the Social Security Act, which requires that physician ordering/referring information be included on all claims for payable services when there had been a referral by a referring physician.

Additional Information

To see the official instruction (CR6129) issued to your Medicare Carrier or AB/MAC, refer to <http://www.cms.hhs.gov/Transmittals/downloads/R1572CP.pdf> on the CMS website.

Note: This article was revised on September 24, 2008, to change the reference in the "Impact on Providers" section to data loop 2310A, instead of 2310B. All other information is the same.

If you have questions, please contact your Medicare Carrier or A/B MAC at their toll-free number which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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