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Welcome to Medicare Learning Network Podcasts at the Centers for Medicare and Medicaid Services, or "CMS". These podcasts are developed and produced by the Medicare Learning Network® within CMS, and they provide official information for Medicare Fee-For-Service providers.

If you are a physician or other eligible professional who orders "or" refers items or services for Medicare beneficiaries, you will benefit from this podcast! It provides guidance you can use to bill correctly and avoid improper payments, and is based on MLN Matters® Article #SE1221 titled "Phase 2 of Ordering/Referring Requirement."

This podcast is intended for a variety of physicians and non-physician practitioners who order or refer items or services for Medicare beneficiaries resulting from an order or a referral, and submit **claims to their respective Medicare contractors**. These physicians and non-physician practitioners comprise three (3) categories:

- **One,** interns, residents, fellows, and those who are employed by the Department of Veterans Affairs or the Public Health Service who order or refer items or services for Medicare beneficiaries,
- **Two,** Part B providers and suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies or (DMEPOS – ["demeepos"] and
- **Three,** Part A Home Health Agencies, or "HHAs".

Let's begin with three critical points for you to consider:

First, the <u>Impact to You as a Provider</u>

CMS will soon begin denying Part B, DME, and Part A Home Health claims that fail the Ordering/Referring Provider edits. These edits ensure that physicians and others who are eligible to order and refer items or services have established their Medicare enrollment records and practice in a specialty that is eligible to order and refer.

CMS will provide 60 day advanced notice prior to turning on the Ordering/Referring edits. <u>*CMS does not have a date at this time.*</u>

Your second consideration is <u>What You Need to Know.</u>
CMS shall authorize Medicare Administration Contractors to begin editing Medicare claims with Phase 2 Ordering/Referring edits. This means that the Billing Provider will not be paid for the items or services that were furnished based on the order or referral from a provider who does not have a Medicare enrollment record.

Your third consideration is <u>What You Need to Do.</u>
If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based Provider Enrollment, Chain and Ownership System, or PECOS (pronounced PACOS). You may also complete the paper enrollment application form or the (C-M-S 855O).

As background information, the Social Security Act (which we will call "the Act"), requires all physicians and non-physician practitioners be uniquely identified on all claims for ordered or referred services. Effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral. Effective May 23, 2008, the unique identifier became the National Provider Identifier or (N-P-I).

CMS began expanding the claims editing to meet the Act's requirements for ordering and referring providers. Now we will discuss **Phase 1** of the **Ordering/Referring Requirement.**

• Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim is not paid. If the ordering/referring provider is reported on the claim, but does **not** have a current Medicare enrollment record or is **not of a specialty** that's eligible to order and refer, the claim is paid, but the billing provider receives an informational message in the remittance advice indicating that the claim failed the ordering/referring provider edits.

Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. There are eight (8) eligible specialties:

• **One** – Physician, including doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, and doctor of optometry,
• **Two** - Physician Assistant,
• **Three** - Clinical Nurse Specialist,
• **Four** - Nurse Practitioner,
• **Five** - Clinical Psychologist,
• **Six** - Interns, Residents, and Fellows
• **Seven** - Certified Nurse Midwife, and
• **Eight** - Clinical Social Worker.

The informational message indicates the identification of the Ordering/Referring provider is missing, incomplete, or invalid, or the Ordering/Referring Provider is not eligible to order or refer. The informational message on an adjustment claim that does not pass the edits will indicate that the claim/ "or" service lacks information needed for adjudication. The chart on page three
(3) of the MLN Matters® Article describes the informational messages for Part B providers and suppliers who submit claims to Medicare Administration Contractors, and addresses codes for missing/incomplete/ "or" invalid ordering physician provider name or primary identifier.

Please note: **if the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will *not be paid.***

Now we'll discuss Phase 2 of the Ordering/Referring Requirement. As we mentioned earlier, CMS has not announced a date when the edits for Phase 2 will become active. CMS will give the provider community at least 60 days notice prior to turning on these edits. During Phase 2, Medicare will deny Part B, DME and Part A Home Health Agency claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services **need to be enrolled** in Medicare and **must be an eligible specialty**. If the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, **the claim will not be paid.** If the ordering/referring provider is on the claim, but is not enrolled in Medicare, the claim will not be paid. In addition, if the ordering/referring provider is on the claim, but is not of a specialty that is eligible to order and refer, the claim will not be paid. The chart on page four identifies the denial edits for Part B providers and suppliers who submit claims to Medicare Administration Contractors including Durable Medical Equipment.

On April 24, 2012 CMS published the final rule titled "Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements," permitting implementation of Phase 2 edits.

CMS will announce the implementation date for Phase 2 edits in an updated MLN Matters® Article, so look for your advance notice to avoid any interruption in claims payment!

To download the MLN Matters® Article on this topic, go to the CMS website at www.cms.gov\MLNProducts and click on "Outreach and Education" at the top of the page. From that page, scroll down to the Medicare Learning Network section and click on the MLN Matters® Articles link. Follow the links to "2012 MLN Matters® Articles" and search for MM article number "SE1221."

More questions? To learn more about **Phase 2 of Ordering/Referring Requirement** contact your Medicare Administration Contractor or visit our website at www.cms.gov\MLNProducts. Click on "Outreach and Education" at the top of the page.

Scroll down to the Medicare Learning Network® section and click on the MLN Products link. From that page, click on "MLN Provider Compliance" from the menu on the left side of the page.

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