CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 387	**Date: September 1, 2011**
	Change Request 7097

NOTE: Transmittal 355, dated September 17, 2010, is being rescinded and replaced by Transmittal 387, Date September 1, 2011, to remove "doctor of chiropractic medicine" from the list of providers who can order and refer Medicare services. All other information remains the same.

SUBJECT: Eligible Physicians and Practitioners who need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Services for Medicare Beneficiaries

I. SUMMARY OF CHANGES: Most physicians and practitioners only enroll in the Medicare program to furnish covered services to Medicare beneficiaries. However, with the implementation of Section 6405 of the Affordable Care Act, CMS has become aware of certain physicians or practitioners who have unique enrollment issues and will need to enroll in the Medicare program for the sole purpose of ordering or referring items or services for Medicare beneficiaries. These physicians and practitioners do not and will not send claims to a Medicare contractor for the services they furnish.

EFFECTIVE DATE: October 18, 2010
IMPLEMENTATION DATE: October 18, 2010

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	15/16/16.1/Ordering/Referring Providers Who Are Not Enrolled in Medicare

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment – Business Requirements

Pub. 100-08	Transmittal: 387	Date: September 1, 2011	Change Request: 7097

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SUBJECT: Eligible Physicians and Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Services for Medicare Beneficiaries

EFFECTIVE DATE: October 18, 2010
IMPLEMENTATION DATE: October 18, 2010

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) expanded its claim editing of ordering and referring providers to meet the Social Security Act requirements. Physicians and practitioners of the types listed below may order items or services for Medicare beneficiaries or may refer Medicare beneficiaries to other Medicare providers or suppliers.

- Doctor of medicine or osteopathy;
- Doctor of dental medicine;
- Doctor of dental surgery;
- Doctor of podiatric medicine;
- Doctor of optometry;
- Physician assistant;
- Certified clinical nurse specialist;
- Nurse practitioner;
- Clinical psychologist;
- Certified nurse midwife; and
- Clinical social worker.

Over the years, some physicians and practitioners types listed above have traditionally ordered or referred and are identified in Medicare claims as the ordering or referring provider even though they were not enrolled in the Medicare program. Generally, they were identified in claims by surrogate Unique Physician Identification Numbers (UPINs) (e.g., RES000, OTH000). Medicare claims from physicians and practitioners who furnished items or services to Medicare beneficiaries as a result of an order or a referral will not be reimbursed by Medicare for those items or services unless the ordering/referring provider is of the type listed above and has an enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) at the time of the order or referral.

Most physicians and practitioners only enroll in the Medicare program to furnish covered services to Medicare beneficiaries. However, with the implementation of Section 6405 of the Affordable Care Act, CMS has become aware of certain physicians or practitioners who have unique enrollment issues and will need to enroll in the Medicare program for the sole purpose of ordering or referring items or services for Medicare beneficiaries. These physicians and practitioners do not and will not send claims to a Medicare contractor for the services they furnish. Specifically, the process of enrollment to accommodate these physicians and practitioners has been modified. Below are some circumstances of which physicians and practitioners qualify to use the modified application process. If you are:

- Employed by the Department of Veterans Affairs (DVA);
- Employed by the Public Health Service (PHS);
- Employed by the Department of Defense (DOD) Tricare;
- Employed by federally qualified health centers (FQHC), rural health clinics (RHC) or critical access hospitals (CAH);
- Physicians in a fellowship;
- Dentist, including oral surgeons; and
- Any provider can enroll for the sole purpose of ordering or referring, regardless of who their employer is

The physicians and practitioners described above must do the following:

Complete the paper form CMS-855I, "Medicare Enrollment Application for Physicians and Non-Physician Practitioners," by completing the following sections listed below and mail the completed form to the designated Medicare enrollment contractor:

Section 1 – Basic Information (they would be a new enrollee)
Section 2 – Identifying Information (section 2A, 2B, 2D and if appropriate 2H and 2K)
Section 3 – Final Adverse Actions/Convictions
Section 13 – Contact Person
Section 15 - Certification Statement (must be signed and dated—blue ink recommended)

The physicians and practitioners described above must include a cover letter with their paper form CMS-855I, "Medicare Enrollment Application for Physicians and other Practitioners," stating the provider is only enrolling for the sole purpose of ordering and referring items or services for a Medicare beneficiary to other providers and suppliers and cannot be reimbursed for services performed.

The CMS is not requiring the physicians or practitioners to send the CMS 460, Medicare Participating Physician or Supplier Agreement or the CMS 588, Electronic Funds Transfer (EFT) Authorization Agreement, in with the CMS-855I application. License information received from a physician or practitioner who is employed by the DVA or DOD, may be active in a state other than the DOD or DVA location.

Medicare enrollment contractors shall verify the information sent on the application meets the Medicare requirements for the supplier type and, if the application is approved, will enter the information into the PECOS; hence, the physician or practitioner will be on the ordering/referring file in the Medicare claims system. Contractors will send the appropriate notification letter to inform these physician and non-physician practitioners that they are enrolled in the Medicare program for the sole purpose of ordering and referring items or services for Medicare beneficiaries to other providers and suppliers.

Since the modified application does not require physicians and practitioners to complete section 4 and we are requiring the cover letter, Medicare enrollment contractors shall reject the application if section 4 is blank and a cover letter is not attached.

Until PECOS is redesigned, the Medicare contractor will use the information provided from the modified application to populate the PECOS required field.

- All effective dates will be the date of receipt
- Certification Information: Contractor selects NA
- PAR Status: Contractor selects "no" for non-par.

- Practice and Special Payment Address: Contractor enters the correspondence address provided for both and select "other" for the location type and enters "ordering and referring only"
- Reassignment Information: Contractors selects 'None'
- Any additional information that may be needed; the contractor can select the equivalent to "no" N/A, "none."

If, in the future, a physician or practitioner, as described above, with a type listed above, now wishes to be reimbursed by Medicare for services performed, the current information to only order and refer items or services must be deactivated and the new information submitted via the appropriate paper enrollment application(s) or Internet-based PECOS as an update.

Interns and residents cannot enroll in the Medicare program for the sole purpose of ordering items or services for Medicare beneficiaries or referring Medicare beneficiaries to other Medicare providers or suppliers. If an intern or resident orders or refers services to Medicare beneficiaries, the teaching, admitting or attending physician's name and NPI go on the claim as the ordering/referring provider.

B. Policy: On May 5, 2010, CMS published an Interim Final Rule with Comment (IFC) regulation titled, "Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements" in the Federal Register. This IFC will implement several of the requirements of the Patient Protection and Affordable Care Act (Affordable Care Act) (Pub. L. 111-148) designed to support the Administration's efforts to prevent and detect fraud, waste and abuse in the Medicare and Medicaid programs, and to ensure quality care for beneficiaries. Specifically, this regulation implements section 6405 which requires that home health agencies and certain Part B suppliers to include the legal name and National Provider Identifier of a physician or eligible professional on a claim where the physician or eligible professional ordered or referred services for a Medicare beneficiary.

The effective date of previously named regulation is July 6, 2010.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7097.1	Contractors shall accept applications from physician and practitioners who are licensed and of a provider type who is eligible to order or refer.	X			X						
7097.2	Contractors shall verify the information sent on the application and, if the application is approved, will enter the information into the PECOS.	X			X						
7097.3	Contractors shall use the date of filing as the effective date in PECOS and MCS.	X			X						
7097.4	Contractors shall add an MCS action reason code "51" to physician and non-physician practitioners who enroll in Medicare solely to order or refer so they cannot be	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	reimbursed for any services to Medicare beneficiaries.										
7097.5	Contractors shall use the CMS approved letter: Model Approval letter for Providers who Order and Refer Only.	X			X						
7097.6	If, in the future, a physician and practitioner, with a type listed above, and could now be reimbursed by Medicare for services performed, the contractor shall deactivate the current information and the new information must be submitted via the paper application or Internet-based PECOS as an update.	X			X						
7097.7	Contractors shall reject the application if section 4 is blank and a cover letter is not attached.	X			X						
7097.8	Contractors shall populate all PECOS effective dates with the date of receipt of the CMS 855I.	X			X						
7097.9	Contractors shall select NA to populate the PECOS Certification Information	X			X						
7097.10	Contractors shall indicate the physician or practitioner as non-par in PECOS.	X			X						
7097.11	Contractors shall populate the PECOS section 4 practice locations with the correspondence address from PECOS section 2.	X			X						
7097.11.1	Contractors shall populate the PECOS section 4 special payment address with the correspondence address from PECOS section 2.	X			X						
7097.11.2	Contractors shall select 'other' for the practice location type and enter "ordering and referring only."	X			X						
7097.12	Any other PECOS information that may be required, contractors shall select the equivalent to "no," NA, or "none."	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7097.13	A provider education article related to this instruction	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	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 site 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 your 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.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Sandra Olson Sandra.olson@cms.hhs.gov or Alisha Banks Alisha.banks@cms.hhs.gov

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

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *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 Program Integrity Manual
Chapter 15 - Medicare Provider/Supplier Enrollment

Table of Contents
(Rev. 387, 09-01-11)

16.1 – Ordering/Referring Providers Who Are Not Enrolled in Medicare
(Rev.387, Issued: 09-01-11, Effective: 10-18-10, Implementation: 10-18-10)

The Centers for Medicare & Medicaid Services (CMS) expanded its claim editing of ordering and referring providers to meet the Social Security Act requirements. Physicians and non-physician practitioners of the types listed below may order items or services for Medicare beneficiaries or may refer Medicare beneficiaries to other Medicare providers or suppliers.

• Doctor of medicine or osteopathy;
• Doctor of dental medicine;
• Doctor of dental surgery;
• Doctor of podiatric medicine;
• Doctor of optometry;
• Physician assistant;
• Certified clinical nurse specialist;
• Nurse practitioner;
• Clinical psychologist;
• Certified nurse midwife; and
• Clinical social worker.

Over the years, some physicians and non-physician practitioner types listed above have traditionally ordered or referred and are identified in Medicare claims as the ordering or referring provider even though they were not enrolled in the Medicare program. Generally, they were identified in claims by surrogate Unique Physician Identification Numbers (UPINs) (e.g., RES000, OTH000). Medicare claims from providers and suppliers who furnished items or services to Medicare beneficiaries as a result of an order or a referral will not be reimbursed by Medicare for those items or services unless the ordering/referring provider is of the type listed above and has an enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) at the time of the order or referral. CMS has made the following determinations:

Most physicians and practitioners only enroll in the Medicare program to furnish covered services to Medicare beneficiaries. However, with the implementation of Section 6405 of the Affordable Care Act, CMS has become aware of certain physicians or practitioners who have unique enrollment issues and will need to enroll in the Medicare program for the sole purpose of ordering or referring items or services for Medicare beneficiaries. These physicians and practitioners do not and will not send claims to a Medicare contractor for the services they furnish. Specifically, the process of enrollment to accommodate these physicians and practitioners has been modified. Below are some circumstances of which physicians and practitioners qualify to use the modified application process. If you are:

- *Employed by the Department of Veterans Affairs (DVA);*
- *Employed by the Public Health Service (PHS);*
- *Employed by the Department of Defense (DOD) Tricare;*
- *Employed by federally qualified health centers (FQHC), rural health clinics (RHC) or critical access hospitals (CAH);*
- *Physicians in a fellowship;*
- *Dentist, including oral surgeons; and*

- *Any provider can enroll for the sole purpose of ordering or referring, regardless of who their employer is.*

The physicians and practitioners described above must do the following:

Complete the paper form CMS-855I, "Medicare Enrollment Application for Physicians and Non-Physician Practitioners," by completing the following sections listed below and mail the completed form to the designated Medicare enrollment contractor:

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Until PECOS is redesigned, the Medicare contractor will use the information provided from the modified application to populate the PECOS required field.

- *All effective dates will be the date of receipt;*
- *Certification Information: Contractor selects N/A;*
- *PAR Status: Contractor selects "no" for non-par;*

- *Practice and Special Payment Address: Contractor enters the correspondence address provided for both and select 'other' for the location type and enters 'ordering and referring only';*
- *Reassignment Information: Contractors selects 'none'; and*
- *Any additional information that may be needed; the contractor can select the equivalent to 'no', N/A, 'none'.*

If, in the future, a physician or practitioner, as described above, with a type listed above, now wishes to be reimbursed by Medicare for services performed, the current information to only order and refer items or services must be deactivated and the new information submitted via the appropriate paper enrollment application(s) or Internet-based PECOS as an update.

Interns and residents cannot enroll in the Medicare program for the sole purpose of ordering items or services for Medicare beneficiaries or referring Medicare beneficiaries to other Medicare providers or suppliers. If an intern or resident orders or refers services to Medicare beneficiaries, the teaching, admitting or attending physician's name and NPI go on the claim as the ordering/referring provider.

***NOTE:** The action reason code (AR) 51 shall be added by the contractor to the multi-carrier system (MCS) for physician and non-physician practitioners who enroll in Medicare solely to order or refer and so they cannot be reimbursed for any services to Medicare beneficiaries.*