PUBLICATION

Ordering/Referring Phase 2 Begins May 1st - Claims Will Be Denied [Ober|Kaler]

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In an April 24, 2009 transmittal, CMS announced a two-phase claims editing expansion designed to allow verification that the physician or non-physician practitioner (NPP) listed as the ordering/referring provider on a Medicare claim has an approved enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS). PECOS is the national electronic database for recording and retaining data on all Medicare-enrolled providers and suppliers. This initiative is one of CMS' efforts to combat fraud and abuse.

Although CMS had already implemented Phase 1 and was moving towards implementing Phase 2 when health care reform legislation was enacted, Section 6405 of the Patient Protection and Affordable Care Act (PPACA) codified this initiative. On May 5, 2010, CMS published an Interim Final Rule to implement Section 6405 of PPACA. In the Interim Final Rule, CMS noted this claim edit requirement would apply to orders and referrals for home health, laboratory, imaging, DMEPOS, and specialist services. The Interim Final Rule provided one key exception -- allowing orders or referrals from providers who have *validly opted out* of the Medicare program. For additional background information, refer to the *Payment Matters* article, "Will Your Claims Survive the Automated Ordering and Referring NPI Edits?"

For physicians and NPPs who do not need individual billing privileges, CMS developed the CMS 855O application form. This particular enrollment form is for use by physicians or NPPs who will only provide orders and referrals for Medicare beneficiaries. It is t not for those physicians who plan to also furnish and bill for covered services, either directly or through a reassignment. Through submission of a CMS 855O form, the non-billing or non-reassigning physician or NPP can obtain an enrollment record in PECOS that will allow claims for services ordered by the physician or NPP to process.

The modifications made to the Medicare claims system in this two-phase initiative include edits to determine whether the:

(1) Service billed is one that requires an ordering/referring provider; and, if so, whether the ordering/referring provider is on the claim;
(2) Ordering/referring provider is in the PECOS database or in the enrollment contractor's master provider file; and
(3) Ordering/referring provider is or is not of one of the specialties eligible to order or refer the item billed.

During Phase 1, any claim that failed these edits was still processed but the system notified the billing provider via a message on the remittance advice that such claims may not be paid in the future if the ordering/referring provider is not enrolled in Medicare or if the ordering/referring provider is not of the specialty eligible to provide the specific order or referral. However, during Phase 2, ***which takes effect May 1, 2013***, claims failing these edits will be denied. The announcement of the Phase 2 effective date was made in a recent MLN Matters publication entitled, "Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims." The standard appeals process will be available for claims that are denied based on these edits.

In addition to flagging claims that do not pass the expanded claims edits, CMS has made available on its Medicare provider/supplier enrollment website an "Ordering and Referring File" which contains the NPIs and names of physicians and NPPs who have current enrollment records in PECOS. Additionally, there are lists of those with enrollment applications that are in process. CMS periodically updates these files and the files are searchable, but searching is time-consuming due to the size of the files. Furthermore, the CMS files do not contain the list of those who have validly opted out of Medicare. Rather, each Medicare Administrative Contractor (MAC) maintains its own opt-out list.

Comments

To avoid claims denials, compliance is critical. If steps to obtain an enrollment record in PECOS or to validly opt out have not yet been taken, there is little time for physicians and NPPs to do so before claims will be denied. Home health agencies, laboratories, imaging centers, DMEPOS suppliers, and specialists should ensure that billing procedures are identifying claims that are flagged because of non-compliance by those who order or refer, so that steps can be taken to avoid future denied claims.