



May 1, 2013: Important Medicare Date

May impact physicians who order or refer services for Medicare patients, bill for ordered or referred services, or privately contract

Background

Today physicians and health care providers who bill Medicare are required to list the name and National Provider Identifier (NPI) of the ordering/referring physician or health care provider on their claims in order to be paid. Starting May 1, 2013, if the ordering/referring physician or health care provider listed on the claim is not enrolled in Medicare OR does not have a valid opt-out affidavit on file, then the billing physician’s claims will be denied. This requirement was originally scheduled to go into effect in 2010, but the AMA and MGMA successfully convinced the Center for Medicare & Medicaid Service (CMS) to delay this so that more time could be given for physicians to enroll or opt-out.

Impacted Services	Services NOT impacted
<ul style="list-style-type: none"> • Imaging • Clinical laboratory services • DMEPOS • Home health services 	<ul style="list-style-type: none"> • Referrals to physician specialists • Part D or B drugs¹

Opt-Out Physicians

To be clear, physicians who validly opt-out of Medicare are NOT required to enroll in Medicare for purposes of the ordering and referring enrollment requirement. A valid opt-out record with Medicare will meet the requirement. If you privately contract with Medicare patients and enroll in Medicare instead of filing an opt-out affidavit for purposes of meeting the ordering and referring requirements, you may incur legal penalties for privately contracting with your Medicare covered-patients. As a general matter, physicians who privately contract are required to have a valid opt-out affidavit on file with their local Medicare contractor. This is a long-standing policy that has been in effect long before the ordering/referring policy. When an affidavit is filed with Medicare, the contractor manually enters the physician’s information into the Medicare enrollment centralized database known as the Provider Enrollment Chain Ownership System (PECOS). If a physician who has opted out of the program is unclear as to whether or not they are in PECOS and have a valid opt-out affidavit on file, they are strongly urged to check the online Medicare Ordering and Referring File CMS has posted to their [website](#) to see if their name is included.

Where to go for more information

- [AMA website on Medicare enrollment](#)
- [MGMA website on Medicare enrollment](#)
- [CMS website on Referring and Ordering](#)
- [CMS MLN Matters article on referring and ordering](#)

¹ **Note:** Part B DMEPOS drugs could be affected. The AMA and MGMA are seeking clarification on this and will be posting information to our websites as it becomes available.

Frequently Asked Questions on the Medicare Ordering/Referring Enrollment Policy

General Questions

Q. *What is CMS' ordering and referring provider enrollment requirement?*

A. Physicians, non-physician providers, and suppliers who order and refer imaging, clinical laboratory services, durable medical equipment (DME), and Part A home health (HHA) claims must be enrolled in Medicare or have a valid Medicare opt-out record to avoid a denial of claims submitted by the billing provider.

Q. *When does this requirement come into effect?*

A. CMS recently announced that, effective May 1, 2013, it will turn on the edits to deny claims if the ordering or referring provider does not meet the criteria outlined above. This means that the billing provider will not be paid for the services provided or items furnished based on the order or referral. CMS planned on activating the ordering/referring edits in 2010, but the AMA and MGMA were successful in convincing CMS to hold off until physicians and other providers had more time to enroll.

Q. *Does this requirement apply for referrals to physician specialists?*

A. No. The enrollment requirement does not apply to referrals to specialists.

Q. *Will my appeal rights be retained on denied claims?*

A. Yes. Since CMS will be "denying" rather than "rejecting" the claims, appeal rights remain intact.

Q. *What instructions does CMS have for how to list the ordering/referring physician's name on the claim?*

A. Medicare contractors will check the **first letter of the first name** and the **first four letters of the last name of the ordering/referring provider**. If these do not match the name on the NPI record, the claim will not pass the ordering/referring edits, and will be denied. When submitting your claim only include the first and last name as it appears on the ordering and referring file found on [CMS website](#). Middle names (initials) and suffixes (such as MD, RPNA etc.) should not be listed in the ordering/referring fields. Including a middle name/initial and/or suffix will cause the claim to be denied once the edits are turned on. Also, be careful to include the ordering/referring provider's individual NPI on the claim and do not use an organizational NPI.

Q. *How do I know a claim is denied as a result of the ordering/referring edits?*

A. Prior to May 1, CMS is issuing warnings for claims that fail to meet the criteria and would be denied on or after May 1. For Part B providers and suppliers who submit claims the warning codes are:

- N264: Missing/incomplete/invalid ordering physician provider name
- N265: Missing/incomplete/invalid ordering physician primary identifier

For DMEPOS suppliers they are:

- N544: Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless corrected, this will not be paid in the future.

Beginning May 1, MACs will use the following denial edits for Part B providers and suppliers who submit claims to carriers and/or MACs, including DME MACs:

- 254D: Referring/Ordering Provider Not Allowed To Refer
- 255D: Referring/Ordering Provider Mismatch
- 289D: Referring/Ordering Provider NPI Required

For warnings and denial edits impacting home health claims, please see [CMS' MLN Matters article](#).

Enrollment Questions

Q. How do I enroll in Medicare solely for purposes of ordering and referring?

A. You need to fill out the [855-O form](#). Once you've submitted the form, you can check CMS' [website](#) to see if your name appears on the list of physician applications pending contractor review and, once you've been enrolled, your name will appear on the Medicare Ordering and Referring File. The 855-O only allows a provider to order and refer services and does not allow a provider to directly bill Medicare for any services he or she furnishes.

Q. How long does it usually take CMS to process enrollment applications?

A. CMS estimates that it takes 45 days to process applications submitted online and 60 days for those submitted on paper. These estimates are for "clean applications," those that require contractor requests for additional information may take longer.

Q. I submitted my enrollment application on March 30, 2013, but my enrollment wasn't approved and effective until May 15, 2013. The patient I referred was seen by the billing provider on May 5, 2013. Will the claim for that patient be paid if submitted by the billing provider on May 25, 2013?

A. No, the claim will be denied. CMS looks at the date of service when determining whether the ordering and referring enrollment requirement has been met, not the date that the claim is billed.

Q. I enrolled many years ago with Medicare before the Provider Enrollment, Chain, and Ownership System (PECOS) enrollment system was created. Do I need to enroll in PECOS?

A. No, you do not need to enroll in PECOS to satisfy the ordering and referring enrollment requirement. If you have an enrollment record in the older, legacy Medicare enrollment system, that is sufficient. The Medicare legacy system refers to Medicare enrollment record systems maintained by individual Medicare contractors that have not yet transferred these records into PECOS. However, as a practical matter, CMS is in the process of revalidating all enrolled physicians and including their information in PECOS, so you may already have a record in PECOS. Physicians who have updated their enrollment since late 2003 should be in PECOS.

Q. Does the Medicare Ordering and Referring File include physicians who are both enrolled in older Medicare contractor databases AND the newer centralized enrollment database known as PECOS?

A. No. However, Medicare's revalidation effort (aimed at asking physicians and other providers to validate their enrollment information on file with Medicare) has resulted in most physicians being in the newer PECOS system. Nonetheless, Medicare has said their edits should account for anyone who is enrolled no matter which system.

Q. I am completing my residency. Should I enroll for purposes of ordering and referring?

A. State-licensed residents may enroll to order and/or refer and may be listed on claims. Claims for covered items and services from un-licensed interns and residents must still specify the name and NPI of the teaching physician. However, if states provide provisional licenses or otherwise permit residents to order and refer services, CMS will allow interns and residents to enroll to order and refer, consistent with state law.

Privately Contract / Opt-out Questions

Q. How do I know if my local Medicare contractor has me on file as having a valid opt-out affidavit?

A. You can call your [Medicare contractor](#) and check this or go online to view the Medicare Ordering and Referring File and see if you are listed. The online file contains physicians who are enrolled in PECOS as well as those who have a valid opt-out affidavit on file. To view the file go [here](#).

Q. *I do not participate in Medicare and I privately contract with my patients. Should I enroll to satisfy this ordering and referring enrollment requirement?*

A. No. You should file an opt-out affidavit with your local Medicare Administrative Contractor (MAC). Having a valid opt-out record will satisfy the requirement. The AMA has [resources](#) on how to opt-out of Medicare that should be helpful to you. Keep in mind that opt-out records are effective on a quarterly basis and must be filed 30 days in advance of the next quarter before they can become effective. If you privately contract with Medicare patients and enroll with Medicare instead of filing an opt-out affidavit for purposes of meeting the ordering and referring requirements, you may incur legal penalties for privately contracting with your Medicare covered-patients.

Q. *How long is a Medicare opt-out affidavit valid?*

Two years.

Q. *Will my Medicare contractor notify me when my affidavit expires?*

A. No.

Q. *I privately contract with Medicare patients and I have never submitted an affidavit to Medicare. What should I do?*

A. Physicians who privately contract with Medicare patients may not realize that they are required to file an affidavit with their local contractor. Medicare has said these physicians should file their affidavit before the edits are turned on starting May 1, 2013.

Imaging, Drug and Lab Order Services Questions

Q. *Does this requirement apply to orders for prescription drugs?*

A. No. The enrollment requirement does not apply to orders for prescription drugs. However, claims for Part B DMEPOS drugs could be affected. The AMA and MGMA are seeking clarification on this. More information will be forthcoming on our websites as it becomes available.

Q. *Does this requirement apply to the technical and professional component of imaging services?*

A. This requirement only applies to orders for the technical component of imaging services. However, if billing globally, both components will be impacted by the edits and the entire claim will be denied if it doesn't meet the ordering and referring requirements. It is recommended that providers and suppliers bill the professional and technical components separately to prevent a denial for the professional component.

Q. *Does this requirement apply to the technical and professional component of clinical laboratory services?*

A. No. This requirement only applies to the technical component of clinical laboratory services.

ABN / Patient Billing Questions

Q. *Are physicians and other providers permitted to use an Advance Beneficiary Notices (ABN) solely for the purpose of obtaining reimbursement from patients because they expect their claim(s) to deny because the ordering/referring provider is not enrolled (or had a valid opt-out affidavit on file) with Medicare.*

A. If the services being ordered / referred are for services covered by Medicare which are considered medically necessary, then no, an ABN cannot be used.

Q. ***Can a provider bill a Medicare patient directly for services which will be denied because the ordering or referring provider has not enrolled and does not have an opt-out affidavit on file?***

A. No. Medicare has said they have a long standing policy which precludes this.