CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 642	Date: February 26, 2010
	Change Request 6417

Transmittal 572, dated October 2, 2009, is being rescinded and replaced by Transmittal 642, dated February 26, 2010. The implementation date is being changed from October 5, 2009 to January 3, 2011. The implementation date changes for Phase 2 apply to Business Requirement 6417.9 only. All other material remains the same.

SUBJECT: Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)

I. SUMMARY OF CHANGES: Section 1833(q) of the Social Security Act requires that all physicians and non-physician practitioners that meet the definitions at section 1861(r) and 1842(b)(18)(C) be uniquely identified for all claims for services that are ordered or referred. 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 ordering/referring provider on the claim if that service or item was the result of an order or referral. CMS is expanding the claim editing to meet the Social Security Act requirements for ordering and referring providers.

NEW / REVISED MATERIAL
EFFECTIVE DATE: OCTOBER 5, 2009
IMPLEMENTATION DATE: JANUARY 3, 2011

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:

SECTION A: For Fiscal Intermediaries and 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.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 642	Date: February 26, 2010	Change Request: 6417

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SUBJECT: Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)

EFFECTIVE DATE: OCTOBER 5, 2009
IMPLEMENTATION DATE: JANUARY 3, 2011

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) is expanding the claim editing to meet the Social Security Act requirements for ordering and referring providers. In this document the word 'claim' mean both electronic and paper claims. The following are the only providers who can order/refer beneficiary services:

- doctor of medicine or osteopathy;
- dental medicine;
- dental surgery;
- podiatric medicine;
- optometry;
- chiropractic medicine;
- physician assistant;
- certified clinical nurse specialist;
- nurse practitioner;
- clinical psychologist;
- certified nurse midwife;
- clinical social worker.

The claim editing is being expanded to verify the ordering/referring provider on a claim is eligible to order/refer and is enrolled in Medicare. The editing expansion will be done in two phases.

Phase 1 - The multi-carrier system (MCS) will receive a national file from the Provider Enrollment, Chain and Ownership System (PECOS) of only the physicians and non-physician practitioners who are in PECOS, including inactive and deceased providers, who are of the specialty eligible to order or refer under the Medicare program. Nightly thereafter, MCS will receive a national PECOS file of newly added physicians and non-physician practitioners and of physicians and non-physician practitioners whose data have been updated. When a claim is received, MCS will determine if the ordering/referring provider is required for the billed service. 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, MCS will verify that the ordering/referring provider is on the national PECOS file. If the ordering/referring provider is not on the national PECOS file, MCS will search the contractor's master provider file next for the ordering/referring provider. If the ordering/referring provider is not on the national PECOS file and is not on the contractor's

master provider file, or if the ordering/referring provider is on the contractor's master provider file but is not of the specialty eligible to order or refer, the claim, during Phase 1, will continue to process but a message will be included on the remittance advice notifying the billing provider that the 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 order or refer.

Phase 2 – As stated above, MCS will still receive a national file from PECOS and will determine if the ordering/referring provider is required for the billed service. 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, MCS will verify that the ordering/referring provider is on the national PECOS file. If the ordering/referring provider is not on the national PECOS file, MCS will search the contractor's master provider file for the ordering/referring provider. If the ordering/referring provider is not on the national PECOS file and is not on the contractor's master provider file, or if the ordering/referring provider is on the contractor's master provider file but is not of the specialty eligible to order or refer, the claim, during Phase 2, will not be paid.

In both phases, MCS will use this process to determine if the ordering/referring provider on the claim matches the providers in the national PECOS file or in the contractor's master provider file: MCS will verify the National Provider Identifier (NPI) of the ordering/referring provider reported on the claim against the national PECOS file first, if a match is not found the MCS will verify the NPI of the ordering/referring provider on the claim against the MCS master provider file. If a match is found, the MCS will then compare the first letter of the first name and the first 4 letters of the last name of the matched record. If the names match, the ordering/referring provider on the claim is considered verified.

All providers should be verifying their enrollment on the CMS on-line enrollment systems known as Internet-based PECOS.

When this change request is implemented, the requirement (Transmittal 270, Change Request 6093, dated October 15, 2008, Reporting NPIs for Secondary Providers) to use the billing provider's NPI as the NPI of the ordering/referring provider, and the name of the ordering/referring physician or non-physician practitioner, if the NPI of the ordering/referring provider cannot be determined by the billing provider is no longer valid.

B. Policy: Section 1833(q) of the Social Security Act requires that all physicians and non-physician practitioners that meet the definitions at section 1861(r) and 1842(b)(18)(C) be uniquely identified for all claims for services that are ordered or referred. 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 ordering/referring provider on the claim if that service or item was the result of an order or referral. Effective May 23, 2008, the unique identifier must be an NPI. In addition, only Medicare-enrolled physicians and non-physician practitioners as defined above are eligible to order/refer services for Medicare beneficiaries.

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	
6417.1	The PECOS shall provide an initial file of all physician's										PECOS

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	
	and non physician practitioners nationally who are enrolled and are eligible to order /refer. This will include inactive and deceased providers.										
6417.1.1	The PECOS shall provide a format of the file to MCS. The file will consist of the following data element: 1. first, middle and last name; 2. NPI; 3. effective date (if available); 4. Termination date (if available); and 5. CMS specialty code and description.										PECOS
6417.1.2	The PECOS file naming convention and file location shall be determined as part of the implementation plan developed between EDS, CMS, and PECOS.							X			PECOS EDS CMS/ DPFS
6417.1.3	The CMS-1500 claim form states to not use periods or commas with in the name. A hyphen can be used for hyphenated names. Therefore, contractors shall ignore special characters received from PECOS except for hyphens.	X			X			X			
6417.2.	Contractors shall not use the effective date, termination dates, CMS specialty code and description. These fields are currently information fields only which may be used in the future.	X			X			X			
6417.3	The PECOS shall provide a nightly file of only physicians or non physician practitioners who are newly added to PECOS or who were on the initial or earlier nightly files and who have a change of information.										PECOS
6417.4	Contractors shall determine if ordering/referring provider is required on a claim which has a date of receipt on or after the implementation date.	X			X			X			
6417.5	The contractors shall deny a claim for a service on a claim which requires an ordering/referring provider and the information is not provided.	X			X			X			
6417.6	If a service on a claim requires ordering/referring provider information and is provided the contractor shall use the NPI legal name submitted to verify provider is on the PECOS file.	X			X			X			
6417.6.1	Contractors shall use the MCS master provider file for verification if the NPI and/or legal name cannot be found on the PECOS file.	X			X			X			
6417.6.2	Contractors shall compare the first letter of the first name and the first four letters of the last name of the matched record. If the names match, the provider on the claim is	X			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	
	considered verified.										
6417.7	If multiple provider identification numbers (PINs) are associated to the NPI in MCS, contractors shall use the first active PIN with an eligible specialty to order and refer.	X			X			X			
6417.8	Phase 1 – contractors shall initially process the claim and add remark messages (RARC codes) N264 (missing/incomplete/invalid ordering physician provider name) and N265 (missing/incomplete/invalid ordering physician primary identifier) to the remittance advice if the ordering/referring provider is not found on the PECOS file or the contractor's provider file or if the ordering/referring provider is on the contractor's master provider file but is not of the specialty eligible to order or refer. For adjusted claims use CARC code 45 along with RARC codes N264 and N265.	X			X			X			
6417.9	Phase 2 (implementation 1/3/2011) - contractors shall reject the service if the ordering/referring provider is not found on the PECOS file or the contractor's provider file or if the ordering/referring provider is on the contractor's master provider file but is not of the specialty eligible to order or refer. For adjusted claims, use CARC code 16 along with RARC codes N264 and N265.	X			X			X			
6417.10	Contractors shall reflect the ordering/referring name from the file used for the legal name validation on the MSN.	X			X			X			
6417.10.1	Contractor shall continue to not include a placeholder NPI on the MSN.	X			X			X			
6417.11	In a new report, MCS shall indicate the number of claims which requires an ordering/referring be submitted and the number of claims that are rejected by new online edits/audits.							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	
6417.12	A provider education article related to this instruction will be available at	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	
	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:

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

V. CONTACTS

Pre-Implementation Contact(s): Sandra Olson 410-786-1325 sandra.olson@cms.hhs.gov Patricia Peyton 410-786-1812 patricia.peyton@cms.hhs.gov

Post-Implementation Contact(s): Sandra Olson 410-786-1325 sandra.olson@cms.hhs.gov Patricia Peyton 410-786-1812 patricia.peyton@cms.hhs.gov

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.