NHIC, Corp.
A CMS Contractor

J14 A/B MAC
NHIC, Corp. - J14 MAC Part A/RHHI Special Message
April 16, 2013

NHIC, Corp. calls your attention to these very important reminders regarding claims submitted on or after May 1st, 2013.

CMS Will Turn On Ordering/Referring Provider Edits on May 1, 2013
From MLN Matters® Number SE1305

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 was determined to be the National Provider Identifier (NPI). The Centers for Medicare & Medicaid Services (CMS) has implemented edits on ordering and referring providers when they are required to be identified in Part B, DME, and Part A HHA claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

Do Not Include Middle Names and Suffixes of Ordering/Referring Providers on Claims
From the CMS e-News for Thursday, April 4, 2013:

Effective May 1, 2013, CMS will turn on the edits to deny Part B, Durable Medical Equipment (DME), and Part A Home Health Agency (HHA) claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid NPI and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare.
All enrollment applications, including those submitted over the Internet, require verification of the information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application.

Effect of Ordering and Referring Denial Edits on the Technical and Professional Component of Imaging Services

Consistent with the Affordable Care Act and 42 CFR § 424.507, suppliers submitting claims for imaging services must identify the ordering or referring physician or practitioner. Imaging suppliers covered by this requirement include the following: independent diagnostic testing facilities (IDTFs), mammography centers, portable x-ray facilities and radiation therapy centers. The rule applies to the technical component of imaging services, and the professional component will be excluded from the edits, which

are scheduled to begin May 1, 2013. However, if billing globally, both components will be impacted by the edits and the entire claim will deny if it doesn't meet the ordering and referring requirements. ***It is recommended that providers and suppliers bill the global claims separately to prevent a denial for the professional component***.

Question and Answers Regarding the Edits

From MLN Matters® Number SE1305

1. What are the ordering and referring edits?
The edits will determine if the Ordering/Referring Provider (when required to be identified in Part B, DME, and Part A HHA claims) (1) has a current Medicare enrollment record and contains a valid National Provider Identifier (NPI) (the name and NPI must match), and (2) is of a provider type that is eligible to order or refer for Medicare beneficiaries.

2. Why did Medicare implement these edits?
These edits help protect Medicare beneficiaries and the integrity of the Medicare program.

3. How and when will these edits be implemented?
These edits were implemented in two phases:

Phase 1 -Informational messaging: Began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication.

For Part A/RHHI providers who order and refer, the claims system initially processed the claim and added the following remark message:

N272	Missing/incomplete/invalid other payer attending provider identifier

For adjusted claims the CARC code 16 and/or the RARC code N272 was used.

Phase 2: Effective May 1, 2013, CMS will turn on the Phase 2 edits. In Phase 2, if the ordering/referring provider does not pass the edits, the claim will be denied. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral
Below are the denial edits for Part A/RHHI providers who submit claims:

37236 This reason code will assign when:	* The statement "From" date on the claim is on or after the date the phase 2 edits are turned on * The type of bill is '32' or '33' * Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the

	eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from EPCOS or the specialty code is not a valid eligible code
37237 This reason code will assign when:	* The statement "From" date on the claim is on or after the date the phase 2 edits are turned on * The type of bill is '32' or '33' * The type of bill frequency code is '7' or 'F-P' * Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code