Ordering, referring, prescribing, and attending (ORPA)

Edits and Requirements

The State of Oregon requires that any billing or rendering provider seeking to be reimbursed for services under a Medicaid benefit enroll with the Oregon Health Authority and obtain a Medicaid identification number. The following FAQ provides answers to new provider and claim completion requirements.

This requirement has expanded and now captures ordering, referring, prescribing, and attending (ORPA) providers. CMS, in conjunction with the Patient Protection and Affordable Care Act, requires all ORPA providers to be enrolled with Oregon Medicaid program (42 CFR 455.410 Enrollment and Screening of Providers).

PacificSource began enforcing this requirement in alignment with the Oregon Health Authority August 1, 2017. All claims submitted with dates of service on or after August 1, 2017 will be validated for ordering, referring, prescribing, and attending providers against enrollment in the Oregon Medicaid program.

What does this mean for providers?

- All providers who are referring a patient for service must have an active Oregon Medicaid identification number.
- All providers who are ordering services must have an active Oregon Medicaid identification number.
- All providers who are prescribing medications must have an active Oregon Medicaid identification number.
- All providers who are attending to patients must have an active Oregon Medicaid identification number.
- This applies to all-out-of state providers who are referring, ordering, prescribing, and attending. All out-of-state providers must have active enrollment with the State of Oregon Medicaid.

Note: The provider's NPI/taxonomy combination identifies the provider's Medicaid identification number and provider type within the Oregon Medicaid system.

What does this mean for pharmacies and prescription medications?

- Pharmacy claims require the pharmacy and the prescribing physician to have active Oregon Medicaid identification numbers.

What if a provider is enrolled with another state's Medicaid program?

- Enrollment in another state's Medicaid program does not exempt a provider from enrolling with the Oregon Medicaid program.

If Oregon Medicaid is the secondary payer, must the ORPA requirement still be met?

- Yes. The provider enrollment applies even if Medicaid is the secondary payer.

I am a member of a group; do I list my group NPI or my individual NPI?

- Only individual NPIs are accepted as an ORPA provider on a claim.

What will happen to my claim if the ORPA provider isn't enrolled with Oregon Medicaid?

- If the ordering, rendering, prescribing, or attending provider on the claim is not enrolled in Oregon Medicaid, the claim will be denied as the provider is not Medicaid-reimbursable.

If my claim is denied because the ORPA provider was not enrolled with Oregon Medicaid, can the ORPA provider enroll retroactively?

- Yes. Oregon Medicaid permits retroactive enrollments up to 12 months prior to the date of enrollment. This is done on the condition that the provider is appropriately licensed and the enrollment complies with program integrity provisions. Once the provider is enrolled, the claim can be resubmitted by the billing provider for payment as long as the resubmission happens within timely filing requirements.

Where can I find more information about these requirements?

- GPO.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-sec455-410.pdf

How do I enroll in the Oregon Medicaid program?

- Please reach out to PacificSource Provider Operations at MedicaidProvNet@pacificsource.com or 800-624-6052.

An ordering and/or referring provider is required for the following services.

Service

- Independent Labs
- Hearing Aid Dealers
- Pharmacy
- Physical, Occupational, and Speech Therapies
- Durable Medical Equipment/Vision Hardware/Orthotics/Prosthetics/Medical Supplies
- Imaging Services

Claim Types (required for services listed above)

- Institutional - CMS UB-04: Referring Attending required on **all** UB-04's
- Professional - CMS 1500: Ordering and/or referring required.

Specifications for billing an electronic professional and institutional claim

Electronic Data Interchange (EDI) – 837 claims

Professional Looping Segments

Loop ID - 2420E Ordering Provider Name

- **NM1** Ordering Provider Name
- **N3** Ordering Provider Address
- **N4** Ordering Provider City, State, ZIP Code
- **REF** Ordering Provider Secondary Identification
- **PER** Ordering Provider Contact Information

Loop ID - 2310A Referring Provider Name

- **NM1** Referring Provider Name
- **REF** Referring Provider Secondary Identification

Institutional 837 Looping Segments

Loop ID - 2310A Attending Provider Name

- **NM1** Attending Provider Name
- **PRV** Attending Provider Specialty Information
- **REF** Attending Provider Secondary Identification

Loop ID - 2310F Referring Provider Name

- **NM1** Referring Provider Name
- **REF** Referring Provider Secondary Identification

Specifications for billing an institutional paper claim (CMS UB-04)

1

2

3a PAT. CNTL #

b. MED. REC. #

4 TYPE OF BILL

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM THROUGH

7

8 PATIENT NAME a

b

9 PATIENT ADDRESS a

b c d e

10 BIRTHDATE | 11 SEX | ADMISSION 12 DATE 13 HR 14 TYPE 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

a b c d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
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20									20
21									21
22									22
23		***PAGE _____ OF _____***	***CREATION DATE***		***TOTALS***				23

50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI

A B C

57 OTHER PRV ID

58 INSURED'S NAME | 59 P. REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO.

A B C

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

A B C

66 DX

68

69 ADM DX

72 ECI

73

74

c.

76 ATTENDING NPI QUAL

LAST FIRST

77 OPERATING NPI QUAL

LAST FIRST

80 REMARKS

81CC a

d

78 OTHER NPI QUAL

LAST FIRST

79 OTHER NPI QUAL

LAST FIRST

UB-04 CM

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC™ National Uniform Billing Committee

LIC9213257

Field 76: Attending provider NPI

Field 76: Attending provider taxonomy

Field 76: Attending provider first name

Field 76: Attending provider last name

Field 78 or 79: Referring provider NPI

Field 78 or 79: Referring provider taxonomy

Field 78 or 79: Referring provider last/first name

Specifications for billing a professional paper claim (CMS-1500)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA — PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY — SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED — Self, Spouse, Child, Other

7. INSURED'S ADDRESS (No., Street)

CITY — STATE

8. PATIENT STATUS — Single, Married, Other; Employed, Full-Time Student, Part-Time Student

CITY — STATE

ZIP CODE — TELEPHONE (Include Area Code) ( )

ZIP CODE — TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. AUTO ACCIDENT? YES NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

Field 17: Ordering or referring provider name

...information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED — DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

Field 17A: Ordering or referring provider taxonomy.

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD ... GIVE FIRST DATE

FROM — TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES

Field 17B: Ordering or referring provider NPI

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by ...

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. ... CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED — DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org — *PLEASE PRINT OR TYPE* — APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)