

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](https://www.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 #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM
			7 THROUGH
8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b			e
10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT 18 19 20 21
			CONDITION CODES 22 23 24 25 26 27 28 29 ACDT STATE 30
31 OCCURRENCE CODE	32 OCCURRENCE CODE	33 OCCURRENCE CODE	34 OCCURRENCE CODE
DATE	DATE	DATE	DATE
35 CODE	36 CODE	37 CODE	38
OCCURRENCE SPAN FROM	OCCURRENCE SPAN THROUGH	OCCURRENCE SPAN FROM	OCCURRENCE SPAN THROUGH
39 CODE	40 CODE	41 CODE	
VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT	
a	b	c	d
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE
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23	PAGE OF	CREATION DATE	TOTALS
50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.
A			
B			
C			
54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
58 INSURED'S NAME	59 P.REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME
A			
B			
C			
62 INSURANCE GROUP NO.	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			
66 DX	67	68	69 ADM DX
70	71	72 ECI	73
74	75	76 ATTENDING NPI	76 ATTENDING QUAL
		LAST	FIRST
c.	77 OPERATING NPI	77 OPERATING QUAL	
	LAST	FIRST	
80 REMARKS	81CC a	82	83
78 OTHER NPI	78 OTHER QUAL		
LAST	FIRST		
79 OTHER NPI	79 OTHER QUAL		
LAST	FIRST		
UB-04	d		

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

76 ATTENDING NPI QUAL

LAST FIRST

77 OPERATING NPI QUAL

LAST FIRST

78 OTHER NPI QUAL

LAST FIRST

79 OTHER NPI QUAL

LAST FIRST

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

NUBC[®] National Uniform Billing Committee LIC9213257

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

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA														
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA <input type="checkbox"/> (SSN) BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)						
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)						
CITY			STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY		STATE				
ZIP CODE		TELEPHONE (Include Area Code) ()			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			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) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>				
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)					b. EMPLOYER'S NAME OR SCHOOL NAME				
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>				
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.														
SIGNED _____ DATE _____														
14. DATE OF CURRENT: MM DD YY			15. ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)			16. IF PATIENT HAS PREVIOUS SERVICES, GIVE FIRST DATE			17A. ORDERING OR REFERRING PROVIDER TAXONOMY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____			17b. NPI _____			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by 1. _____ 2. _____ 3. _____ 4. _____)										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														
2														
3														
4														
5														
6														
25. FEDERAL TAX I.D. NUMBER			SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		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.)					32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH # ()						
SIGNED _____ DATE _____					a. NPI _____			b. _____		a. NPI _____		b. _____		

Field 17: Ordering or referring provider name

Field 17A: Ordering or referring provider taxonomy.

Field 17B: Ordering or referring provider NPI