Ohio | Department of Medicaid

Mike DeWine, Governor
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TO: Contracted Medicaid Managed Care Plans
Contracted MyCare Ohio Plans

FROM: Roxanne Richardson, Deputy Director of Managed Care
Office of Managed Care

DATE: May 3, 2018 – Updated February 8, 2019 & October 6, 2020

SUBJECT: Provider Enrollment, Rendering NPI and Ordering, Referring and Prescribing (ORP)

Rendering Practitioner NPI

The national standard for the EDI 837 professional transaction requires that an NPI be submitted in the billing provider field on all claims. For program integrity purposes, ODM also requires the rendering provider NPI on a claim when the practitioner who performed the service is different from the billing provider for most services.

- On a claim with multiple details, if all services were rendered by the same individual practitioner, the NPI of the rendering provider can be reported at either the header or on each claim detail; however, if services on a claim were provided by different practitioners, the rendering provider should be reported at the claim detail.
- ODM requires community behavioral health centers (CBHCs) and professional medical groups to enroll with ODM and enroll and affiliate employees who render services, including CBHC dependently licensed practitioners and paraprofessionals.
- ODM requires FQHCs, RHCs, and clinics to enroll with ODM and enroll and affiliate employees or contractors who render services, including dependently licensed practitioners as described in MAL 622 and 622-A.
- Fee-for-service (FFS) claims that require the NPI of the professionals referenced above will deny when the rendering NPI is not on the claim. MCPs are expected to do the same.
- Plans are not required to ensure the individual rendering practitioner is affiliated to their agency at this time. Plans should not deny a claim when the practitioner is not affiliated to the agency/billing provider.
- For network providers, plans must verify both the billing and rendering NPI is in-network and enrolled with ODM as a participating provider. Plans should verify the NPI by using MITS or the PMF. Out-of-network providers must be identified on the claim but are not required to be enrolled with ODM at this time and may not be listed on the PMF.
- Home health and waiver service providers (including transportation providers) will continue to submit claims as they do today and are not required to have an individual rendering NPI on the claim at this time. The rendering NPI requirement is being implemented in 2021.
- For the EDI 837 institutional transaction, the attending NPI should be held to the same requirements stated above for the rendering NPI.

ODM Front Door Network Provider Enrollment

Under 42 CFR 438.602(b) – "Screening, enrollment and revalidation of providers" the State must screen, enroll and periodically revalidate all MCP network providers. The provision does not require providers to render services to FFS beneficiaries.

- **New Network Providers** - Plans must require ODM enrollment prior to contracting with any new provider.
    - MCPs may execute a temporary, 120-day provider agreement for a new provider pending the outcome of the ODM provider enrollment process but must terminate the agreement if ODM determines the provider may not be enrolled with ODM.
    - When implementing the 120-day temporary agreement, no advanced provider termination notification is required. However, plans are encouraged to include such language in their temporary 120-day contracts. Claims for dates of service prior to termination of the 120-day contract are the responsibility of the plan.
- **Current Network Providers** - The PMF shows all providers enrolled with ODM. Plans should use the PMF to determine if their network providers are currently enrolled and active providers with ODM. Plans must conduct an exhaustive PMF search including looking for provider tax ID, NPI, name/owners, etc.
- Plans must use their contracting processes to ensure providers enroll with ODM if they have not enrolled previously. After three documented outreach attempts over at least a thirty-day period, plans may deny claims for providers who fail to enroll with ODM.
- Plans may deny claims for providers who are known to the PMF/MITS but fail to revalidate with ODM Provider Enrollment.
    - If the ODM application is in process, the MCP may continue to pay network provider claims during the provider enrollment period. This can be determined by looking up the provider in MITS.
    - A Medicaid provider application may be backdated up to 365 days upon request.
    - Providers may resubmit claims or the "deficiency" denial can be updated and paid. This is plan specific.
- Currently, providers under single case agreements (i.e. out of network, non-par providers) are not subject to the federal requirements in 42 CFR 438.602(b).
    - In limited circumstances, plans may execute a single case agreement for instances where providers render services for a beneficiary on a one-time, individual, or limited basis.
    - CMS has communicated that ODM should enroll providers under single case agreements as a best practice. ODM will continue to work with plans to enroll these providers as a best practice although it is not required at this time.
- In-network, out-of-state pharmacy locations are not required to enroll with ODM. ODM will monitor encounter data, including claims from excluded providers, for billing trends and may develop a threshold after which providers must enter into a contract.

Ordering, Referring and Prescribing (ORP)

42 CFR 455 Subpart E states "*The State Medicaid agency must require all claims for payment for items and services that were ordered or referred to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services."*

- Claims for payment of items and services ordered, referred or prescribed should include the NPI of the physician or other professional who ordered, referred or prescribed such items or services.
- The ORP professional does not need to be in-network or enrolled with ODM at this time.
- Plans must have system edits in place to accommodate this requirement. The ORP NPI must be accepted on the claim and then sent to ODM on the encounter. The ORP NPI data will be collected by ODM.
- ODM requires an ordering for all services billed on a professional claim that are performed by the providers listed in the attached MHTL. The exceptions are:
    - Federally Qualified Health Center (provider type 12) – an ordering provider is needed only for physical therapy, occupational therapy and speech therapy.

- Medicaid School Program (provider type 28) – an ordering (or referring) provider is needed only for physical therapy, occupational therapy, speech language pathology and audiology services. (This does not pertain to managed care plans.)
- Clinic (provider type 50) – an ordering provider is needed only for therapy, DME and laboratory services.
- Institutional claims will continue as they are today. These claims include an attending NPI and are not required to have an ORP on the claim.

- ODM FFS requires an ORP provider for all waiver service claims. In FFS, this is the individual's attending physician who signs off on the individual's plan of care. While ODM is not requiring the MCOPs to implement ORP for waiver service claims at this time, MCOPs may require the ORP for these claims, specifically for waiver nursing services and home health aide services as a best practice.

Questions pertaining to this letter should be sent to ManagedCarePolicy@medicaid.ohio.gov.