Priority Health	BILLING POLICY No. 086
ORDERING / REFERRING PROVIDER REQUIREMENTS	
Date of origin: Apr. 15, 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

Ordering providers can order non-physician services for patients.

Referring providers can request items or services which Priority Health may reimburse on behalf of its members.

POLICY SPECIFIC INFORMATION

To qualify as an ordering and referring provider, you must:

- Have an individual National Provider Identifier (NPI)
- Be enrolled with Priority Health in either an “approved” or an “opt-out” status
- Be of an eligible specialty type

Eligible specialty types include:

- Doctor of Medicine or osteopathy
- Doctor of Dental Medicine
- Doctor of Dental Surgery
- Doctor of Podiatric Medicine
- Doctor of Optometry (Optometrists can only order DMEPOS supplies and laboratory or x-ray services payable under Medicare Part B.)
- Physician Assistants
- Clinical Nurse Specialists
- Nurse Practitioners
- Clinical Psychologists
- Interns, Residents and Fellows
- Certified Nurse Midwives
- Clinical Social Workers

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient’s medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Documentation requirements

The ordering provider is responsible for documenting the medical necessity of the lab tests in the patient’s record, regardless of where the test is performed. The ordering provider is responsible if they order excessive or unnecessary lab tests regardless of who actually renders the test.

- Complete and accurate documentation of orders and referrals for services
- Order and referral documentation available upon request

- Charges may be denied for services that lack appropriate order or referral documentation

Coding specifics

The following are examples of services that require ordering or referring provider information (this isn't an all-inclusive list):

- Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)
- Clinical laboratory and pathology services
- Radiology services

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. Learn more about modifier use in our Provider Manual.

Resources

- Ordering & Certifying | CMS
- Ordering Referring Provider Requirements.pdf

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made