

## **Do You Have Your National Provider Identifier?**

By Kurt Schaeffler, CPA, CPC-A

If you want to get paid for claims sent on or after May 23, 2007, you will need to have your National Provider Identifier (NPI). Have you applied for your NPI? If not, you should get started with this process **NOW!** CMS has stressed that from the time you obtain your NPI to the time it takes to do the remaining work to use it, could take up to **120 days**. Therefore, if you obtain your NPI on January 2, 2007, the earliest you could possibly use it would be May 1, 2007. That would leave **only** 22 days to spare!

### **Background and Purpose**

The NPI is a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It required that most HIPAA covered entities including health plans, health care clearinghouses and health care providers that conduct electronic transactions obtain this identifier to simplify the electronic claims and other transaction processes in accordance with national standards (i.e. standard transaction sets). These transaction sets include claims, eligibility inquiries and responses, claim status inquiries and responses, referrals, and remittance advices.

The NPI will replace current provider identifiers, such as the Medicare Identification Number, often referred to as the Online Survey, Certification and Reporting (OSCAR) number, which is used by providers to bill the Medicare program. Implementation of the NPI will eliminate the need for providers to use different identifiers when conducting transactions with multiple health plans. Health plans include Medicare, Medicaid and private insurers.

### **Do I need an NPI?**

If you are an individual provider of services or an organization such as a hospital or nursing facility, and transmit health information electronically, you will need an NPI. Even if you perform these transactions using a billing agency, you will still need to obtain an NPI.

### **How do I apply for an NPI?**

Applying for an NPI is free and providers can apply in one of three ways. The most efficient application process for health care providers is to log onto the National Plan and Provider Enumeration System (NPPES) at <https://nppes.cms.hhs.gov> and apply on-line. Paper applications and having an organization submit your application on your behalf are the other ways to apply. Remember that you only need to apply one time for an NPI as the same NPI

will be used for every health plan for which you engage in electronic transactions.

### **CMS NPI Application Tips**

The provider will need their federal employer identification number when applying for an NPI. In addition, include your current legacy identifier when applying for your NPI, not just for Medicare but for all payors. CMS defines your legacy identifier as your current:

- Online Survey Certification and Reporting (OSCAR) system number
- National Supplier Clearinghouse (NSC) number
- Provider Identification Number (PIN)
- Unique Physician Identification Number (UPIN)

If reporting a Medicaid number, include the associated State name. This information is critical for payors in the development of crosswalks to aid in the transition of the NPI.

### **I got my NPI and now what do I do?**

It is strongly suggested that once you get your NPI and begin billing with it prior to May 23, 2007, that you continue to submit your legacy identifier as a secondary identifier in addition to the new NPI. Therefore, if there is an issue with your NPI, you have less of a risk of claim rejection.

### **Taxonomy versus NPI**

Taxonomies are different than the NPI. Taxonomies are additional codes that are used to distinguish the provider type. When a single organization has more than one provider type (e.g. hospital and home health agency under one federal identification number) and chooses not to have two separate NPIs, they must report the taxonomy code related to the service they are billing for (e.g. home health agency or hospital) when submitting a claim. The taxonomy code will assist Medicare in crosswalking from the NPI of the provider to each of its subparts.

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## **Deficit Reduction Act Requires False Claims Education January 1, 2007!**

By Dawn L. Rowe, CPA, MBA, CPC

Does your organization receive more than \$5 million in annual Medicaid revenues? If not, you can breathe a sigh of relief and stop reading. If so, effective January 1, 2007 you are required to:

- Inform employees (including management) about certain fraud and abuse laws and whistleblower protections;
- Adopt written policies for employees and contractors that provide details about the False Claims Act and State laws;
- Outline your policies and procedures (in writing) for detecting fraud and abuse, and;
- Update your employee handbook to include all this.

### **Practical Considerations**

*Written policies and procedures:* If you haven't done so already, you will most likely need to consider contacting your attorney to assist with drafting the detailed information about the federal and state False Claims Acts. You'll want to include, at a minimum:

- A description of what the False Claims Act does;
- Examples of what constitutes a false claim;
- What remedies are available under the Act and how an employee may use the remedies;
- How individuals are protected under the whistleblower laws;
- Your recommendations on what employees should do if they think a false claim may have been made (who to report it to, etc.);
- Outline of the policies and procedures you have in place for detecting fraud and abuse.

*Update your employee handbook* to contain the above. If you don't have one, there does not appear to be a provision requiring one.

*Informing employees & contractors:* Consider integrating these required disclosures in with your HIPAA training and perform at your new employee orientation. Distribute written policies and procedures to all existing employees along with an updated copy of your employee handbook. Send contractors your policies upon entering into agreements with them. You should develop a system to document your compliance with these requirements.

### **Additional Clarifications Provided by CMS**

These requirements are based on interpretations of Section 6032 of the Deficit Reduction Act of 2005, which was

signed into law by President Bush last February. In December CMS sent a letter to State Medicaid Directors advising them of the above requirements, and the necessity to modify the State Plan. In addition, the letter included clarification regarding the \$5,000,000 annual threshold. Specifically, "if an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions...apply if the aggregate payments to that entity meet the \$5,000,000 annual threshold. This applies whether the entity submits claims for payment using one or more provider...or tax identification numbers." The \$5,000,000 threshold effective January 1, 2007 will be based on the amounts received by the entity in federal fiscal year 2006 (ending 9/30/06). Going forward, it will be based on payments received by an entity during the preceding Federal fiscal year.

Further clarification was also provided on contractual employees that these provisions apply to. Contractors or agents that work on behalf of the entity, or who furnish or "authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of the health care provided by the entity" must receive copies of your written policies and procedures concerning the False Claims Act.

For a copy of the CMS letter go to [www.cms.gov/Medicaid](http://www.cms.gov/Medicaid) and click on the link for State Medicaid Director letters.

CMS is also hosting a conference call on January 11 at 1pm to answer provider's questions. Call 1-888-677-1819, password: Provider. The conference leader is Aaron Wesolowski.

## **Tax Relief and Health Care Act Prevents Mandated Part B Therapy Fee Schedule Payment Reductions**

By Dawn L. Rowe, CPA, MBA, CPC  
Kurt Schaeffler, CPA, CPC-A

The Tax Relief and Health Care Act of 2006 that was signed into legislation on December 8, 2006, reversed the statutorily mandated 5% negative update to the Part B therapy fee schedule payment rates that would have occurred January 1, 2007. With this legislation, the dollar conversion factor used to convert fee schedule units to dollars remained at the 2006 level as \$37.8975. However, this doesn't mean that the fee schedule amounts are the same as last year due to refinements made to the resource-based practice expense relative value units (RVUs) and the methodology used for determining practice expense (such as overhead) RVUs.

## **2007 Fee Schedule Pricing**

Full details are listed in the December 1, 2006 Federal Register, and in the subsequent Tax Relief Act. We have posted prices for the most common Medicare Part B therapy procedures for the three Maryland regions on our website at [www.schiavi-wallace.com](http://www.schiavi-wallace.com) by clicking on the “Newsletter” link “2007 Therapy Fees”. If you don’t see a particular code, you can also use the physician fee schedule look-up feature on the CMS website at <http://www.cms.hhs.gov/apps/pfslookup/default.asp>. You’ll need to know your locality, and be sure to use the transitional pricing for “non-facility”.

Remember to check your charges by procedure code to make sure they are at or above the fee schedule payment amounts. Medicare will pay you the lesser of 80% of your charge or the fee schedule amount. Therefore, it’s a good idea to review your charges by procedure code with every fee schedule update.

## **Therapy Cap Exceptions Process Extended through December 31, 2007 Manual Exceptions Discontinued**

By Dawn L. Rowe, CPA, MBA, CPC  
Kurt Schaeffler, CPA, CPC-A

The Tax and Health Care Act of 2006 legislation signed last month not only prevented the 5 percent cut to Medicare fee schedule payments for 2007, but also extended the exception process for Medicare therapy caps by one year until December 31, 2007. However, a major change between 2006 and 2007 is that beginning January 1, 2007, there is no longer a manual exceptions process. For 2007, all services that require exceptions to caps shall be processed using the automatic process. All requests for an exception should have a KX modifier added to claims line. As a reminder, this modifier indicates that the clinician attests that services are medically necessary and justification is documented in the medical record. See the table referenced at <http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf> (Pub. 100-04 Medicare Claims Processing Manual, Transmittal 1145) for those conditions and complexities that might qualify for the automatic exception process.

### **Cap Increases to \$1,780**

While most services may qualify for the exceptions process, the annual limit on Part B therapy services that do not, increases to \$1,780 for physical and speech therapy *combined* and a separate \$1,780 annual limit for occupational therapy. The limits were \$1,740 in 2006 for cases where the exceptions process did not apply. CMS reminds providers that beneficiaries are responsible for the

20% coinsurance and any deductible, if not yet met. Therefore, if the deductible has been met, Medicare will pay up to 80% of the \$1,780, or \$1,424 and the beneficiary will be responsible for the 20% coinsurance or \$356. However, if the beneficiary has not met their deductible the beneficiary will also be responsible for that. In 2007 the deductible is \$131, so the beneficiary would pay the \$131 plus 20% of the remainder as follows:

Total Allowed Annual Limit	\$1,780.00
Deductible	<u>(131.00)</u>
Balance after deductible	\$1,649.00
Coinsurance (20%)	<u>(329.80)</u>
Medicare Pays	<u>\$1,319.20</u>

In this example the beneficiary would be responsible for the deductible plus coinsurance or \$131 plus \$329.80 for a total of \$460.80.

Medicare will apply the financial limitation in order, according to the dates when the claims are received. Therefore, it’s important to get your Part B claims in timely, to avoid instances where the beneficiary receives therapy from another provider, perhaps after they leave your facility, and the second provider get their claims in first. The Common Working File will track the limits.

As in the past, the limits do not apply to therapy provided in hospital outpatient departments, unless provided to a resident of a Medicare-certified bed in a skilled nursing facility. This distinction is important because it allows nursing facilities that are not 100% certified the option of offering residents in non-certified beds the opportunity to receive therapy from a hospital outpatient department. Transportation for such therapy would not be covered, and therefore, the option would be limited to residents who could arrange for their own transportation.

### **Need More Information?**

For more information on the therapy caps, or the exceptions process, go to the CMS website at [www.cms.hhs.gov/therapyservices](http://www.cms.hhs.gov/therapyservices) and click on the link for therapy caps.

**Note to users:** All information provided is of a general nature and is not intended to address the circumstances of any particular individual or entity. Although we endeavor to provide accurate and timely information, there can be no guarantee that such information is accurate as of the date it is received or that it will continue to be accurate in the future. No one should act upon such information without appropriate professional advice after a thorough examination of the facts of the particular situation.

## **New Coinsurance and Deductible Amounts Effective January 1, 2007**

The 2007 Medicare coinsurance amount for days 21-100 of a Medicare Part A stay have increased from \$119 per day to \$124 per day effective January 1. In addition, the Medicare Part B deductible is now \$131.

Remember, you will also need to update the State coinsurance worksheet you use to paper bill the State for dual eligibles when you expect to receive some reimbursement from the State. This occurs in cases where the Medicaid payment would have been higher than the Medicare payment for dual eligibles. Specifically, you'll need to change the \$119 to \$124 next to the "days paper billed on the UB-92 at" cell.

### **Staff Accountant/Consultant**

Schiavi, Wallace & Rowe, PC, is seeking a staff accountant. Responsibilities include projects such as auditing, financial projections, reimbursement and internal control reviews, cost report preparation, and accounting compilations.

Qualifications: 2+ years experience in public accounting or provider setting. CPA candidate. Excellent Excel skills a must.

Competitive salary and benefit package including PTO and 401K, limited travel.

Please visit [www.schiavi-wallace.com](http://www.schiavi-wallace.com) for firm information; email resume to [info@schiavi-wallace.com](mailto:info@schiavi-wallace.com).