

FOMA ARTICLE – JULY 2007

USING NPP's NUMBER

Don't skip this section as you may THINK you're doing it correctly or you may not have a mid-level YET – but you'll need to know this if you add one. An NPP is a non-physician practitioner (Physician Assistant and Nurse Practitioner). Medicare has very [strict rules](#) regarding this (translation: The OIG will assess fines and penalties against YOU, if you do not bill it properly), so it's vital that you realize when you can and cannot bill under the physician's number in your practice. In this past week, I've been in 2 Osteopathic practices (physicians that I've known for many years) that had NPPs in their practice. BOTH of them had been billing everything to all carriers under the physicians' numbers as if the physicians saw the patients. One of them had gotten advice from an attorney who told them they could do it this way. WRONG!!!! That attorney is a moron if that is what he told them and he should be prohibited from even talking to doctors.

Medicare has very clear instructions as to when you can and cannot bill under the physician's numbers. Yes – I've discussed this many times over the years in my newsletter, but let's go over it one more time.

- “Incident to” means billing under the physician's number exactly as if the physician saw the patient and provided the service.
- Billing under the NPP's number means that you have gotten the NPP a number within your group and the checks come to the group for what the NPP did.
- Neither of these require a modifier on the claim to denote who did the service, as these are NOT Locum Tenen billings.

So – when do you bill under each? That depends on the payer's policies and what you have agreed to. For instance, many carriers will ALWAYS allow you to bill incident-to (under the physician's number) while some require you have the NPP credentialed with them. If you're going to play in their sand box (or litter box may be more appropriate), then you need to know the rules and their policy.

Medicare is very clear on this in the Medicare Carrier Manual, Internet Only Manual and the CMS website. There is no gray area and no reason for not knowing the rules. The “**3 NP** rule is an easy way to remember their policy”

1. If it is a **New Patient** being seen by the NPP then you have to bill under the NPP's number.
2. If it is a **New Problem** being seen by the NPP, then you have to bill under the NPP's number.
3. If there is **No Physician** in the suite/building (physician under whose name it would have been billed), then you have to bill under the NPP's number.

If you bill Medicare otherwise (other than a Rural Health Clinic – which has different rules), then you are in violation of Medicare and you can be fined, penalized, strung up by your heels, etc... Remember, ignorance of the law is no excuse.

RURAL HEALTH CLINICS CAN INCREASE INCOME

For years, I've been speaking to the Texas Assn of Rural Health Clinics on how to code, bill and increase income. It's amazing to me that so many RHCs believe they cannot bill for diagnostics, procedures, etc... - and they are right only IF (big IF) they have not carved out a diagnostic or procedure center in their RHC. What this means is that they find a portion of the clinic that they do diagnostics in (perhaps it's a treatment room) and they take that amount out of their cost report. They also pull out of the cost report the salary for the time any employee spends in that room doing procedures or diagnostics. They obtain a new NPI (if they don't already have one) for the provider and then they can get their encounter rate by being an RHC and they can bill Medicare Part B for the diagnostics/procedures they do in that area on a CMS 1500 using CPT codes. I have yet to do this with a client RHC that we didn't see an increase in profits in the first year of less than \$100,000. It's really quite simple and then the physician is getting the information they need at the time of service instead of waiting until the patient can get them elsewhere. They also find that the referrals to other specialists (I say "other specialists" because Family Practice IS a specialty) reduce, so that the patient is getting the best care. Many are not aware that more than 30% of referrals to cardiologists by primary care physicians turn out to be non cardiology issues, so by doing the right diagnostics at the time of service really helps the patients. By the way – this applies to non RHCs as well!

BEING CLIA WAIVED SAVES ME MONEY..... NOT!

As a consultant and seminar leader, I'm in a heck of a lot of primary care offices that have chosen to be CLIA Waived with Medicare because they think that being moderately complex is either too much trouble or loses them money. OK – being moderate on your lab may be a little trouble at first until you set up some protocols, but the losing money myth is not true. In fact, over the past few years, every time we've consulted with a practice seeing 20 – 25 non capitated patients a day and advised them on how to set up a moderate lab, the practice would increase their monthly NET PROFITS by more than \$18,000 a month. One office conservatively increased their monthly net profits (after equipment, supplies, employee, certification, etc) saw more than \$40,000 per month in profits. Think about this. Labs such as Quest, LabCorp, etc... are willing to put their employee into your office and provide you with some supplies and some equipment to give them all of the lab tests. Why? The answer is simple. THEY are making thousands of dollars per month on you. Why shouldn't you make it? If you have questions on this – call and we'll give you a brief free consult on the phone about it.

DON IS TRAVELLING FULL TIME

Yep – my wife and I spent last January in Florida and loved it (in a beach house in St Augustine) and that convinced us that we should spend more time traveling. So, we bought an RV and we've been traveling on the road since February. In fact, we're going to spend next February in Florida visiting Osteopathic doctors and speaking at the FOMA convention as well as the Physicians Assistants convention. I'm telling you this, in case you want us to stop by for a cup of coffee while we're spending a month in your state. Visit our site, see our daily blog to see where we are and give us a call at 800 256-7045 and we'll see what our schedule allows.

(We answer questions for FOMA members at no charge, so if you have one – send us an email to donsel@donself.com and we'll try to help)

Q. If a physician joins our practice and sees a patient he saw before joining our practice, is that patient considered established since the patient is not new to the physician?

A. You are correct that the patient is considered to be established if the new physician (or any physician in your group) has seen the patient face-to-face (or face-to-something else if your doc is a proctologist) within the previous 3 years.

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