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Billing NonPhysician Provider Services

Nurse Practitioners and Physician Assistants can be a great asset to a busy practice. But it's important to remember the billing rules associated with these physician extenders.

Most carriers, including Medicare, allow NP's to bill under their own name and PIN numbers. When an NP bills under his/her own PIN numbers, payment is made in the name of the provider, and the provider is only limited based on state scope of practice.

Most carriers, including Medicare, also allow PA's to be credentialed and bill under their own names/PIN numbers. Most carriers do not directly reimburse the PA; they reimburse the practice with which the PA is associated. The PA is limited based on state scope of practice and supervision rules.

There may also be opportunities for the NPP to bill under the name of the physician. When an NPP performs a service billed in the name of a physician, this is called an "incident to" service. In these situations, the "incident to" guidelines must be strictly followed. When an NPP sees patients under their own name/PIN number, the services that they can provide are only limited based on scope of practice and supervision guidelines. However, when the same NPP sees patients "incident to", the "incident to" billing rules supersede scope of practice.

Rules to Remember:

- An NPP working "incident to" cannot see new patients or new problems. The guidelines limit the NPP to carrying out an already established treatment plan developed by a physician.
- In order for services accomplished by an NPP to be billed by a physician, the billing physician must be onsite at the time of service providing direct supervision. "Direct supervision does not mean that the billing physician must be in the room when the services occur, but the billing physician must be onsite in the clinic when the services occur. Even if the clinic is physically attached to a hospital, the billing physician must be in the clinic, not the hospital when the services occur.
- The billing physician is the supervising physician – not necessarily the ordering physician.
- NPP services billed "incident to" cannot be billed based on time. Services based on time can only be reported by the billing provider. If the services are not billed in the NPP's name, then the NPP cannot time code.

As noted, an NPP working "incident to" cannot see or treat new patients. However, a significant number of specialty practices use an NPP in conjunction with new patient encounters. The scenario often includes the NPP taking the initial history and exam, and then the physician joins to confirm the NPP's information/findings, may perform an exam, and then provides the decision making.

Encounters where both a physician and an NPP are involved are called "shared/split" services. Here, the rules differ based on the place of service. In the office, if both the NPP and the physician see the patient, and this is either a new patient or a new problem, then the service must be billed in the name of the NPP; it cannot be billed under the physician's name.

If the patient is established, and the problem is not new, then the service can be billed "incident-to" in the physician's name.

In the hospital, the guidelines are different. If the NPP and the physician see the patient on the same day, then the encounter can be billed in the name of either the NPP or the physician. If only the NPP sees the patient in the hospital on that day (i.e., no physician encounter that day), then the service must be billed in the NPP's name.

The advantage to billing using the "incident to" methodology is that Medicare pays the service at the level of the physician allowable. If the NPP bills, the service is subject to a 15% reduction in the allowable.

There are several disadvantages. First, the NPP is more limited under "incident to". The "incident to" guidelines may limit the practice from getting full value of the NPP's expertise. Second, what happens if the patient the NPP is seeing "incident to" presents for follow-up, but now has a new problem? The NPP can't bill "incident to" for a new problem, so some workflow provision needs to be made for that occurrence. Third, by virtue of the fact that there is a 15% differential in reimbursement, if an NPP bills "incident to", but is not following the "incident to" restrictions, then the NPP is committing a fraudulent billing practice.

Although Medicare reduces the allowable, many other insurers do not. If considering limiting an NPP to providing services on an "incident to" basis, it's a good idea to determine what percentage of your practice the reduction may apply to.

Many practices find that the restrictions are not worth the risk suddenly being non-compliant, and therefore credential their NPP's so that services provided by the NPP are billed in the NPP's name and the limitations/risks of "incident to" are not an issue.

Countdown to ICD-10

We are less than two years away from ICD-10 implementation. CMS is committed to holding firm on the date, so your internal preparations for the transition should be underway. ICD-10 will change every code you currently use. All codes will be alpha-numeric, and they may have up to seven digits. ICD-9-CM includes approximately 16,000 codes; ICD-10-CM includes 68,000 codes. While the generalized ratio is six ICD-10-CM codes to every 1 ICD-9-CM codes, the per-code reality may be much different. For example, the ICD-9-CM code for closed fracture of the shaft of the humerus (812.21) crosswalks to no less than 36 ICD-10-CM codes, all of which are seven-digit codes. The correct code depends on the type of fracture, whether this is the initial or subsequent encounter for care of the fracture, and how the fracture is healing.

In coming issues, we will address preparation steps for ICD-10-CM and provide you with more information.

Worker's Comp Corner: Troubling Study by CWCI Shows 10% of California Comp Physicians Prescribe Vast Majority of Narcotics

A study by the California Worker's Compensation Institute found that 10% of the physicians treating injured workers are prescribing about 80% of the Schedule II Opioids dispensed. These medications include morphine, methadone, oxycodone and fentanyl, and prior CWCI research indicated that the use of these medications has risen sharply in recent years. Even more troubling is that, according to the CWCI, which looked at more than 200,000 prescriptions given to 16,890 California workers between January 2005 and December 2009, use of the drugs has increasingly been for minor spinal complaints, and chronic, non-malignant pain. In fact, almost half of all Schedule II opioid prescriptions in California workers' compensation cases are for such minor back injury claims. This has raised questions about whether Schedule II opioids are being prescribed properly, as well as the cost of these medications, which rose from 3.8% of workers' compensation prescription drug costs in 2005 to 23.6% in 2009. The American College of Occupational and Environmental Medicine said that the use of narcotic drugs is "typically not useful in the sub-acute and chronic phases." It is well known that these medications carry high addiction potential.

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