

NPI Article

By now you've probably received something in the mail from the Centers for Medicare & Medicaid Services (CMS), or a private insurer telling you to apply for the NPI. What is this, and why do you need to do it?

The NPI stands for "National Provider Identifier" and, if things go according to plan, after May 23, 2007, it will be the one and only number that identifies you as a health care provider, replacing all other numbers. Right now you have your Medicare number, your Medicaid number, your Blue Cross/Blue Shield number, your Tricare number, and those are just the government payers! Then there's Aetna, Cigna, United, Magellan, and all of the rest.

Why is the NPI necessary? Well, in short, because it's the law. Remember HIPAA? The website for the NPI gives the clearest definition:

"The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers...The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information."

Ok, so now it's ten years after HIPAA was enacted, and we're just getting started!

Well, all right, it's the law, but other than the fact that it's the law, why is the NPI *REALLY* necessary? People ask me that all the time, and to understand the answer, you need to understand a bit about how electronic claims work.

As a biller for mental health services who sends claims electronically on a daily basis, I can attest to the fact that the numerous provider numbers, a different one for each payer, makes transmitting claims electronically much more difficult. Right now, each payer wants their unique provider number of varying lengths in a different spot on the claim form. *And if you don't do it THEIR way, you don't get paid!!* When a claim is transmitted electronically via a clearinghouse, the clearinghouse must take the data from the biller/provider/hospital and "map" it into a HIPAA-compliant (ANSI) electronic format. Unique provider numbers of varying alpha or numeric characters, of different lengths, and in different places, makes programming the mapping more intricate and challenging, thus delaying the transmission – and thereby delaying payment.

So, then I am usually asked, *"Why do electronic transmissions have to go through a clearinghouse – why can't you just use the Internet to submit claims to each insurance company's website?"* Well, there are lots of reasons. For one, not all payers have websites that allow submissions. For another, there are literally hundreds if not thousands of payers out there. If you're curious as to how many, here's a link to a clearinghouse payer list: http://www.medavanthealth.com/payerlist/default_db.asp. While most mental health providers only bill to a small fraction of these payers, remember that there are hospitals, labs, clinics, and so forth that must submit to many more payers than we do. This leads to the third and perhaps the most compelling reason why Internet submissions are not industry-standard. It is true that for small practices with only one provider doing his/her own billing,

online submissions may be time-savers. This is especially true for clinicians with a healthy portion of self-pay patients reducing the number of claims! However, this is an inefficient way of billing electronically when there are large numbers of claims. Imagine billing for a hospital, clinic, or larger practice - there are simply too many claims to allow each claim to be submitted online, one at a time. At least one, maybe more, employee would be needed to do nothing but input claims. Then someone has to go back to each website to look up claim status, intervene in case of problems, and so forth.

Ultimately, the clearinghouse serves as a central mechanism that allows whoever is doing the billing to communicate with all payers through one portal. Billing services, larger practices, clinics and institutional providers use in-house software programs that “batch” claims and send one claim file to clearinghouse. The clearinghouse converts the data to comply with HIPAA, as described above, and then sorts the claims to be transmitted to the multitude of payers. Each payer is identified by means of a single 5-character ID called a “payer ID.” The clearinghouse also serves other useful functions. For example, payers then send back reports to the clearinghouse that claims are accepted. This is proof of “timely filing” – no more excuse “*we didn’t receive your claim!*” Payers report when a claim is denied because someone no longer has insurance – typically within 3 days. Imagine how much easier it is to collect from patients when you can get this information in 3 days instead of the 4 to 6 weeks’ response time for paper claims.

Back to the National Provider Identifier. At this point I am always asked, “*well, I don’t submit electronically, so I don’t need to get one, right?*”

Sorry, wrong. Unfortunately, HIPAA has mandated that ALL claims, even paper claims, be submitted with the NPI as of May 23, 2007. In fact, CMS has changed the 1500 claim form. All claims –paper or electronic- submitted after May 23, 2007 must be on the new form and with the NPI. Unfortunately, the new claim form has not yet been approved by the OMB, so you cannot order them yet or begin using them. If you would like to see the draft copy, email me at susan@psychadminpartners.com and I will send you a sample.

There’s one more area of resistance I frequently encounter. “*What if I don’t participate with any insurance companies but submit only so that my patients can get reimbursed?*” Well, if you are submitting via a claim form, you will need an NPI and the new form come May 23, 2007. Your participating-provider status and whether or not you are accepting assignment is irrelevant. If you are handing your client a superbill, you might be able to get away without an NPI for awhile after next May, but at some point down the line you can expect that your clients will encounter difficulties getting paid unless you can provide the insurance company with your NPI.

Applying is really not that difficult. If you’ve ever filled out a Medicare provider enrollment form, this is nothing. Trust me, I’ve now done about 15 of these. All you need is your license number and provider ID’s with other insurance companies. The application asks for other provider ID’s so that they can build a database of what they are calling “legacy” provider ID’s. This will make it easier to identify providers during the transition period from unique ID’s to the NPI. The easiest way to apply is online at: <https://nppes.cms.hhs.gov/NPPES/Welcome.do>. For questions via e-mail, customerservice@npienumerator.com. If you do not have the ability to apply online, call the National Plan and Provider Enumeration System (NPPES) at 1-800-465-3203 to order an application form. Their address is: NPI Enumerator, PO Box 6059, Fargo, ND 58108-6059

Of course, you DO have till May 23, 2007 to apply. But, think about this: Every single provider, regardless of specialty or type of practice, needs an NPI. The NPPES does check by social security number to validate providers' information. This is a monumental task. Already, the time to get an NPI has jumped in the last two months from 5 to 15 days for online submissions. Medicare now requires that if you make any changes to your provider enrollment, you must furnish the NPI.

I strongly encourage everyone to plan ahead. If you wait till next spring like the majority of others, the NPPES will be so overwhelmed that it might take literally months after May 23, 2007 to get your NPI. If that happens, your cash flow will dwindle to ZERO unless you have a 100% self-pay practice where everyone pays at the time of service. Without an NPI, you will be forced to hold all your claims for months while you wait for the NPPES to issue your NPI. And remember, "timely filing" will still apply!

As a matter of fact, I'm something of a pessimist. Realize that every major insurance company out there must revamp its computer systems to accept the new claim form – even claims submitted on paper. I strongly suspect that come next summer, there will be a huge claims backlog while systems problems get sorted out. In fact, I am encouraging everyone I work with to put aside money now to cover the cash-flow crunch that I believe must inevitably happen during the transition period.

In the long run, say ten years into the future, by 2016, my opinion is that the NPI will have achieved its stated goal and as a result clinicians will see faster payment. But over the next year, the challenges for the industry are enormous and managing cash flow will be critical. No one will do it for us – we each have to ensure the financial wellbeing of our own practice.