

# NPI Rules Slow Payments To Pathology Groups, Labs

➤ **Private payers and Medicare carriers kick out high volume of claims for incorrect NPI compliance**

➤➤ **CEO SUMMARY:** *New rules requiring use of National Provider Identification (NPI) numbers took effect on May 23. Since then, Medicare carriers and payers nationwide have rejected claims from pathologists and other providers that do not comply with the new NPI rules. A missing NPI on just one claim will result in the front-end rejection of the entire submission file to Medicare. Cash flow to some pathology groups and other physicians has dropped. It may be another month or more before normal cash flow is restored.*

**C**ASH SHORTAGES FROM UNREIMBURSED MEDICAL CLAIMS were so severe last week that some pathology groups were struggling to meet payroll, according to claims processors. Medicare and private payers have rejected claims at a sharply increased rate since May 23.

To provide pathologists and laboratory directors with an assessment of this unreported, but serious problem to provider cash flow, THE DARK REPORT contacted three national companies that provide billing and collection services to clinical laboratories and pathology group practices. These experts confirmed that a cash flow disruption is under way and is affecting providers throughout the nation.

“Most payers and Medicare carriers were unprepared for the number of problems and the volume of claims that were affected by

the May 23 implementation date for the new NPI rules,” said Pam Evans, Regional Director of Operations for **Pathology Service Associates, LLC**, (PSA) a company in Florence, South Carolina, that provides revenue cycle and business management services for more than 78 pathology groups in 28 states. “Nationally, payers affected by NPI-related problems include those for Medicare, Medicaid, and the Blues plans, among others. We hope that claims processors will correct most of the problems by this time next month. That would enable normal cash flow patterns to be restored.

“On Tuesday, May 27, we recognized the mass chaos from the NPI implementation,” noted Evans. “From what we can tell, as of May 23, payments stopped for NPI-related rejections and will not resume until the problem is resolved. By the end of the first

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week in June, we started seeing some physician practices struggle to meet payroll.

“For many practices, Medicare is 30% to 40% of their business or greater,” added Evans. “If Medicare stops paying, that means less income and it could be 30 to 60 days—possibly longer—before the flow of reimbursement from Medicare claims is restored.”

This problem was not a surprise. “Many payers allowed early testing of claims formats, whereby some NPI-related issues were identified before the May 23 deadline,” she explained. “We are working through those with success. However, other payers were unable to test before the implementation date. The volume of problems confronting these payers is more than they can handle expediently.”

“A distinction should be made regarding the types of NPI issues that are occurring,” Evans continued. “Most providers have their NPI numbers, as there was a big push last year to obtain NPIs for providers, as well as for referring physicians. A few providers who were ill-prepared may still have problems in these areas. The main issues we see relate to the electronic formats by which claims are submitted and how different payers receive and process information.”

“Each payer has a different set of requirements,” she added. “Many payers were hard-pressed to provide detailed information on how claims should be submitted to them. As a consequence, payers must now provide guidance to providers on how to format claims to accommodate their systems and their processing guidelines.”

### ► Rejecting 24% Of Claims

**Emdeon Business Services** of Nashville, Tennessee, a Medicare claims processor, reported that 24% of claims it handled (representing about \$26 million in reimbursement) had been rejected since May 23, the effective date for the new NPI requirement. Normally about 6% of claims (or about \$10.6 million) would be rejected.

In its report, Emdeon suggests that pathology may have a bigger problem with rejected claims than other physician specialties. To determine the extent to which providers’ submissions complied with NPI standards before the deadline of May 23, Emdeon analyzed professional claims it received for one week in April. It found that the use of NPI was drastically lower when secondary providers were involved on a bill from a primary provider, such as is common when laboratories submit bills for work done for referring physicians.

In its analysis, Emdeon also determined that, if all payers strictly adhered to the new NPI rules, 69.3% of all submitted claims nationally would be rejected, causing significant cash flow issues for providers. Emdeon noted that 69.3% of claims nationally would represent almost \$2.5 billion in reimbursement to providers.

### ► Resolving Issues With Claims

“Once a claim is rejected, pathologists and lab directors need to identify and resolve the problem as quickly as possible. They need to work with their payers and Medicare carriers to resubmit any rejected claims,” recommended Evans. “But resolving problems related to NPI rejections can take up to 60 days. Only after the NPI problem has been resolved can the claim be resubmitted. Then the usual processing timeline follows before payment is actually made to providers.”

“The timeline to fix these problems varies from payer to payer for a number of reasons,” said Tanya Canup, PSA Implementation Coordinator. “It depends on what is wrong with each individual claim and what the payer requires to resolve the problem.”

“Some pathologists and other physicians may still need to apply for additional NPIs, complete appropriate paperwork, then submit it to the payer,” observed Canup. “As payers get these forms, it takes them some time to update their systems. **Palmetto GBA** has processed updates in as

## Pathology Groups and Laboratories Frustrated As Private and Government Payers Reject Claims

**N**OT ONLY IS THERE CHAOS in how different payers and Medicare carriers are rejecting claims since the new NPI rules took effect on May 23, but there is lack of uniformity in how payers advise providers about the process to resolve problems with the rejected claims.

“Each carrier gives us different advice about how to resolve the problem,” declared Pam Evans, Regional Director of Operations for Pathology Service Associates, LLC (PSA) of Florence, South Carolina. “There is no standard resolution for this problem. Even though all the carriers serve CMS, each operates independently.

“Pathology poses additional challenges for some payers,” added Evans. “Some hospital-base pathology practices might file relatively simple claims, since they have one NPI number and one legacy number. In most cases, claims from those practices are handled acceptably.

“But if the situation is more complicated, a large proportion of claims can be rejected,” she said. Take the example of a pathology ‘super group’ that has one NPI number and three legacy numbers. If multiple provider types are involved—meaning a physician group and independent lab under one taxpayer identification number, then problems may occur. We see carriers that don’t know how to handle these claims.”

“It seems the operational details of changing from legacy numbers to NPI were not considered fully, particularly for the pathology segment,” stated Tanya Canup, Implementation Coordinator for PSA. “That’s partly because pathology is so complicated. Some pathology groups are based exclusively in hospitals. Some pathology groups own and operate independent laboratories and some pathology groups do both.

“CMS and the carriers did not provide adequate guidance during the NPI application stage to prevent some of the problems we now encounter,” added Canup. “In their defense, they may not have known what problems they would encounter after May 23. That meant many Medicare carriers didn’t know what to do when these claims hit the door.”

“Prior to May 23, we spent a lot of time testing claims, but as long as these claims also included legacy numbers, carriers could identify who should be paid,” interjected Evans. “That changed on May 23, when legacy numbers were no longer included on claims. Payers then saw many gray situations but didn’t know how to process those claims. Plus, some carriers told us simply, ‘if there is any question about where the money should go, it won’t go anywhere.’”

little as two days while some carriers are taking up to 60 days. Only after that process is completed, can the provider resubmit the claims. For physicians, that is a long time to wait for reimbursement.”

“While it is still too early since May 23rd to analyze all data related to the implementation of the NPI rule, some issues and trends have appeared,” said Tim Allaway, Vice President of Payer Services of **RelayHealth**, a medical billing service provide for clinical laboratories and a division of **McKesson**. “There was a definite increase in the percentage of claims received from providers that are rejected at the clearing-

house before being sent to payers. While the increase is not huge, it is significant.

“There was also an increase in the percentage of claims being pended or rejected when they get to the payer,” Allaway added. “This is especially true for the Medicare and Medicaid claims. As with other standards in the industry, implementation of the NPI has varied greatly across the payer community.

“Clinical laboratories have encountered three major issues,” Allaway said. “First, providers may not have registered their NPIs with payers before May 23, thus causing their NPIs not to be included in the payer’s crosswalk system. This causes claim rejec-

tions as payers attempt to map NPIs to legacy provider information.

“Second, providers may not be sending NPIs for all segments where a provider must be identified (billing, rendering, service facility, and referring),” he continued. “Third, providers may be sending NPIs, but not the correct NPI in the correct loop/segment. For example, they may be sending a type 2 (group) NPI in a rendering provider segment. Or, they may be sending a type 1 (individual) NPI in a billing or service facility segment when they are registered as a group.

“At the same time, we can see four major issues that originate with the payers themselves,” he said. “First, some payers did not fully test their NPI-only logic before implementing the system on May 23. Problems have been experienced with front end editors, translators, and second level edits. Interestingly, Medicare seems to have the highest level of rejected claims. Yet Medicare has required NPI on claims since January 2008 and has encouraged providers to test NPI-only claims submissions for several months prior to the May 23 effective date.

### ► Legacy Numbers Used Too

“Second, some payers still require legacy provider identifiers,” added Alloway. “While the law says all covered health plans must use NPI-only to identify providers, some payers remain unable to accept NPI-only claims. A good example is the New York Medicaid system. Third, some Blues, such as those in Oklahoma and Texas, are generating non-compliant files. Fourth, some payers have improper edits in place that continue to require legacy identifiers in some provider loops and segments. **Care-First** in Delaware, is one example. As of June 12, that plan had no estimate as to when it would resolve this situation.

“On top of these four sources of payer-originated problems, we know of one payer that rejected all claims for a period of time after May 23,” Alloway continued. “As a result, providers were required to resubmit all claims. One Medicaid plan incorrectly

## Use of NPI Mandated Under HIPAA Statute

**BLAME THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)** of 1996 for all the turmoil surrounding claims rejected since May 23 for not meeting the new rules for use of National Provider Identifier (NPI) numbers.

HIPAA mandated that all physicians and provider organizations use National Provider Identifier (NPI) numbers on claims. The deadline for large health plans and provider organizations to implement NPI was May 23, 2007, but the federal Department of Health and Human Services (HHS) delayed implementation of NPI for individual physicians and small health plans until May 23 of this year.

On its Web site, HHS says NPI is required for all HIPAA standard transactions, meaning that for all primary and secondary provider fields, only the NPI will be accepted and only the NPI should be sent on all HIPAA electronic transactions (837I, 837P, NCPDP, DDE, 276/277, 270/271 and 835), paper claims (UB-04 and CMS-1500), and SPR remittance advice. Using Medicare legacy identifiers in any primary or secondary provider fields will result in the rejection of the transaction, HHS said. More information is available on CMS' Web site: <http://www.cms.hhs.gov/NationalProviderstand/>.

rejected valid claims by requiring a one-digit payee code. As of June 12, this code resulted in the rejection of almost 7,000 claims valued at more \$15 million in provider payments—and no solution was available as of late last week!”

Eddie Miller, Vice President of Pathology Operations for McKesson, commented: “In monitoring the more than 250 pathology and lab clients we service nationwide, we see a measurable softening of our cash run rates. When we call payers, we discover that a large number of claims are pending in their systems.”

“New NPI rules required labs to adjust quickly,” Miller added. “All of this went into effect on May 23, meaning we are still a few days too early to say that cash flow will be impacted for all pathology groups in the country. But we know that there will be a cash flow effect because we called some of the big carriers to check the status of claims.

“Each time we check with various payers and carriers, we are told that the claims are pending,” he explained. “Normally those claims would have already been paid. In other words, if a carrier typically pays in 14 days and we call on day seven to check the status of a claim and it’s pending in the system—it means that provider is not going to get paid in the normal time.”

### ► Review Front-End Reports

Lâle White, Founder and Executive Chairman of **XIFIN, Inc.**, a company in San Diego that specializes in lab accounts receivable and financial management, agreed that front-end reports are a lab’s first indication of a problem. “Your lab’s front-end reports are like the canary in the coal mine,” she said. “Your first information about rejection of a claim or a submission file is that front-end report. If just one claim within the file is missing an NPI, Medicare will reject the entire submission file on the front end. Medicare advises that it is important to pull out these claims before resubmitting the file in order to eliminate payment delays on clean claims.

“Our clients have worked on the NPI issue for a long time,” continued White. “As a result, the only place where our clinical laboratory clients are experiencing trouble with submitted claims is when they have been unable to get NPIs from their ordering physician-clients.

“On the other hand, I hear stories about laboratories experiencing financial devastation in cases where the payer has not handled the NPI implementation well,” added White. “For example, **Nordian Administrative Services, LLC**, in Lawrence, Kansas, requires a separate EDI registration of the

provider’s facility NPI number to process electronic claims. If this was not done before May 23, Noridian rejected all submissions after May 23. Noridian informed providers that there will be delay of four to five weeks in processing these registrations, which must be done before any electronic claims will be accepted.

“First and foremost, labs should monitor their front-end acknowledgement reports to make sure their claims are being accepted for adjudication,” White explained. “If a laboratory reviews its front-end rejections from Medicare, then it will know if it is going to have a cash flow problem. Most labs and other providers don’t give their front-end rejections the same attention as back-end denials. But that is likely to change if the flow of reimbursement money dries up.

“Next, labs should watch for denials on the back end, which is commonly done by most lab billing departments,” White added. “Labs usually have a procedure to review denials, because they come with explanation of benefits (EOBs) forms from the payer. The problem with the claim can then be fixed, allowing it to be resubmitted.

### ► Be Proactive On Rejections

Despite all the advance warning about the deadline for use of National Provider Identification numbers, it is apparent that Medicare carriers, Medicaid carriers, and private payers did not succeed in preparing providers for an orderly transition. Since the May 23 implementation date for use of NPI, many pathology groups and laboratories have experienced a serious reduction in cash flow due to rejected claims. Billing experts may be optimistic in their predictions that cash flow to providers is likely to return to normal during July. **TDR**

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