Workgroup for Electronic Data Interchange (WEDI)

National Provider Identifier Policy Advisory Group (NPI PAG)

Recommendations to the WEDI Board of Directors

August 10, 2004

Section 1: National Provider System/National Provider and Payer Enumeration System (NPPES) Issues

1. Meeting the Enumeration Deadline[1]

Issue: If the NPPES enumerator fails to meet the May 2005 regulatory deadline for beginning to issue provider identifiers, the industry may not be able to complete implementation before the regulatory deadline of May 2007 (May 2008 for small health plans). The WEDI NPI PAG believes that no successful implementation can occur in less than 18 months from the time NPIs are available for use.

Recommendation 1.1: The NPI PAG recommends that WEDI strongly advocate that there be no delay and urge the Centers for Medicare and Medicaid Services (CMS) to make every effort to ensure the timely roll out of NPIs.

Recommendation 1.2: If there is a delay of less than 6 months in issuing the NPIs, the NPI PAG recommends that WEDI's position should be that the industry believes it could complete implementation prior to the regulatory deadline and no action to extend the deadline would be needed.

Recommendation 1.3: If there is a delay in issuing the NPIs of equal to or greater than 6 months, the NPI PAG believes that successful industry implementation of the NPI could not be completed by the regulatory deadline. The WEDI NPI PAG recommends that this eventuality be revisited at a NPI PAG session in conjunction with the WEDI SNIP conference in November 2004.

2. Auto-Enumeration and Bulk Enumeration[2]

Issue: The PAG debated the pros and cons of bulk enumeration vs. individual application for NPIs.

Recommendation 2.1: The NPI PAG recommends that WEDI concur with the previous CMS decision that auto-enumeration or bulk enumeration is advisable in order to save significant time and to minimize workload on the providers who will need NPIs.

Recommendation 2.2: The NPI PAG recommends that WEDI encourage the use of the Medicare UPIN (Unique Physician Identification Number) database for bulk enumeration. The PAG also recommends that WEDI recommend that providers be

empowered to authorize any single third party to aggregate and submit electronic databases to NPPES for bulk enumeration.

For example, dentists might elect to have either their state or national association – but not both – modify existing records or build new records to submit en masse to the NPPES. Any authorized third party could provide this service to providers as long as 1) it is properly authorized by the provider obtaining the NPI, and 2) it meets appropriate criteria to be established by CMS/NPPES for minimum size of database, data content, data validation, data attestation, etc.

3. Piloting and Testing NPPES and NPI[3]

Issue: The industry believes there is a need for testing and a pilot of the NPI prior to full-scale implementation.

Recommendation 3.1: The NPI PAG recommends that WEDI urge CMS to establish a series of customary information technology testing processes for the NPPES and NPI prior to full scale launch. This should include a "full cycle" test with the industry to validate the NPI application, enumeration, and dissemination process. Real data should be utilized in the final testing processes so that successful tests can be moved directly into production..

Recommendation 3.2: The NPI PAG recommends that WEDI should encourage its members to participate in proofing, testing and piloting.

4. NPPES Level 2 Users[4]

Issue: Industry users, e.g., health plans, clearinghouses, large provider organizations, etc., need access to NPPES data and NPIs in order to successfully map or migrate current identifiers to the new NPIs.

Recommendation 4.1: The NPI PAG recommends that WEDI should recommend to CMS that upon completion of appropriate user agreements, NPPES Level 2 users should be able to receive all the data elements in the NPPES. (The user agreements are needed to resolve privacy concerns of data use, including situations under which the SSN is shared or withheld.)

Recommendation 4.2: The NPI PAG recommends that WEDI recommend to CMS that the NPPES data should be made available to all covered entities electronically. It should be available though various media including on-line, Internet and multiple query options.

Recommendation 4.3: The NPI PAG recommends that WEDI recommend to CMS that the NPPES should include the X12 274 transaction ("Healthcare Provider Information") as an available option to disseminate the NPPES data.

Recommendation 4.4: The NPI PAG recommends that WEDI recommend that CMS should add a Provider Type field to the NPPES and match licensure against provider type rather than matching against provider taxonomy.

Recommendation 4.5: The WEDI NPI PAG finds that use of provider type and provider taxonomy is unclear in the Final Rule. The NPI PAG recommends that the NPI PAG hold further PAG deliberation, then engage in discussion with CMS that would lead to an appropriate clarification of the rule.

Recommendation 4.6: The NPI PAG recommends that WEDI recommend to CMS that the NPPES should situationally require providers to submit their other federal identifiers on both paper and web applications, i.e. for provider types who are assigned DEA, OSCAR, CLIA, etc. numbers.

5. Timeline for Implementation[5]

Issue: In order to begin planning and execution of the necessary IT system changes, contract changes or business process changes, the industry needs certainty about the data elements in and available from the NPPES. The Final Rule has a caveat which allows unspecified revisions to the data elements listed in the Final Rule. [§162.408(b) and (f)]. Lack of certainty about which elements will be available Level 2 users prevents development of their mapping or crosswalking tools.

Recommendation 5.1: The NPI PAG recommends that WEDI recommend that CMS give the industry the final list of NPPES data elements, including any definition for any elements not previously defined by the HIPAA regulation, no later than September 30, 2004.

Recommendation 5.2: The NPI PAG recommends that WEDI recommend CMS notify the industry of all changes to the NPPES system by publishing the information on the CMS HIPAA Website.

Recommendation 5.3: The NPI PAG recommends that WEDI recommend CMS notify the industry of all changes to the NPPES system by establishing a dedicated CMS Office of HIPAA Standards (OHS) listserv.

Section 2: National Provider Identifier Implementation Issues

6. Implementation, Overall Timing, Sequencing and Tracking[6]

Issue: One of the lessons learned from implementing the HIPAA transactions is that efficient and successful implementation demands that all parties collaborate and coordinate around a common set of implementation sequence expectations.

Recommendation 6.1: The NPI PAG recommends that WEDI request responses from CMS by October 1, 2004, to the following questions that arose at the NPI PAG meeting June 22, 2004:

- What are the additional NPPES system changes and when will they be ready?
- What other bulk enumeration might occur besides UPIN?
- When will CMS (Medicare) be ready to accept NPI on data files routinely expected from the industry (such as Medicare encounters)?
- What are the criteria CMS is using to convert UPIN to NPI?
- When will CMS stop issuing UPINs?

Recommendation 6.2: The NPI PAG recommends that WEDI adopt the following seven step sequence as a high level proposed "rule book" for implementation of the NPI:

1) Obtain answers and definitions from CMS by 10/1/04;
   - From recommendation 6.1, above

2) Communication & Education;
   - Includes Data Dissemination guidelines, Business Rules, Guides, by audience (payer, provider, clearinghouse, etc.)
   - Start this in 2004
   - Education is an ongoing process, not a one time event.
   - Communication/Education is CMS' job - with partnership from the industry

3) Specifications for deployment of systems changes. Start Enumeration;
   - Set expectations for **not** sending the NPI until Step 3

4) Pre-implementation phase A;
   - This is an agreement between parties to 'begin'.
   - Provider sends NPI in addition to legacy number
   - Clearinghouse passes NPI and the legacy number (when a clearinghouse is involved)
   - Payers accept NPI with the legacy number as the secondary ID.
   - Payers and Clearinghouses use this phase to build their crosswalk tables.

5) Pre-implementation phase B. All parties are using and passing NPI (provider, vendor, clearinghouse, and payer);
   - Based on agreements between partners
   - Some may test once and feel ready for all submitters; others may want to test with each submitter

- Concept of "round trip." All parties in the transmission chain should ensure that the NPI flows successfully from the initiation of the original transaction (e.g., 837) through the receipt and processing of the response transaction (e.g., 835)

6) Migration phase;
- Continue to send the NPI plus the legacy identifier
- Begin to edit against the NPI (e.g. you sent this number, it's invalid, or you sent this number but we had matched to a different number) – provide feedback to trading partners on data integrity
- No rejections based on the NPI sent

7) Shut down of legacy identifier.
- Payers use NPI as primary identifier
- Create plans for claim runoff (run-out)
- Adjustments timeline
- Allow rejections based on NPI sent. Pursue 'bad' data with the entity who sent it to you. It ultimately works back to the provider and the entry in NPPES.

Recommendation 6.3: Further discussion is needed regarding timing of implementation and the NPI PAG recommends that WEDI charge WEDI SNIP with responsibility for developing further sequencing details, as it did for the transactions final rule.

7. Cross-Indexing the NPI[7]

Issue: Various entities including, but not limited to, health plans, clearinghouses, large provider organizations and institutions need to build maps, crosswalks and other tools to accurately and successfully migrate providers from their old identifiers to the providers' new NPI or NPIs. Data from the NPPES is essential to this effort.

Recommendation 7.1: The NPI PAG recommends that WEDI should recommend that CMS share the logic/criteria it will be using for a crosswalk with bulk enumeration. The crosswalk logic/criteria used by CMS for bulk enumeration will assist other entities in building their own crosswalks.

Recommendation 7.2: As a recommendation to the health care industry, the NPI PAG recommends that WEDI recommend that trading partner migration begin ASAP so that health plans can begin building their cross indices. Providers should begin using the NPI as well as their legacy provider identifiers in the appropriate electronic data fields so that health plans can begin collecting this data as soon as possible. Health plans may use this data to assist in the building of their cross indexes or to validate their cross index files. This correlates to steps 4 and 5 of recommendation 6.2.

Section 3: Requirements and Rule Interpretation Issues

8. Use of NPI on Paper Forms and Other Non-Standard or Non-HIPAA Transactions[8]

Issue: Use of different identifiers on different submission media, e.g., electronic vs. paper, requires dual business processes that negate some of the key advantages of standardization. The consensus of the NPI PAG is to encourage universal use of the NPI. Although CMS makes it clear that its authority to mandate use of the NPI does not extend beyond covered transactions by covered entities, there is no federal prohibition against the use of NPI in non-HIPAA situations and no prohibition against other methods of encouraging or requiring use of the NPI on paper and other non-standard transactions.

Recommendation 8.1: The NPI PAG recommends that WEDI recommend that the NPI should be used on paper forms.

Recommendation 8.2: The NPI PAG recommends that WEDI recommend that organizations publishing paper forms change their paper forms or their usage instructions to accommodate the NPI.

9. Identifiers in Addition to the NPI[9]

Issue: The NPI PAG believes that after the transition to the NPI is completed and with some revisions contract provisions and concomitant process changes, health plans will be able to determine the applicable claim pricing from the association of the NPI with other data in the transaction or available to the health plan IT system. The PAG believes a payer-assigned provider ID on a claim is not desirable. However, the PAG also believes that at this early stage of NPI development, there are sufficient unknowns so as to make it impossible to state with certainty that additional identifiers will not be needed in the short or medium term.

Recommendation 9.1: The NPI PAG recommends that the NPI PAG should study the additional identifier issue further. The NPI PAG may wish to collaborate with CMS, the six Designated Standards Maintenance Organizations (DSMOs), WEDI SNIP, and such other entities as may be appropriate.

10. NPI Subpart Enumeration[10]

Issue: The NPI Final Rule creates "subparts" of institutions that in certain situations need or may use their own Type 2 NPIs, but the Final Rule neither requires nor prohibits uniform practices for usage of any subpart NPIs across multiple payers. For example, a general hospital may have an overall NPI, but also have a "subpart" NPI for its Emergency Department (ED). If the hospital bills a federal program using the ED NPI

but bills a non-federal health plan using the hospital's overall NPI, then there could be identification problems in crossover/coordination of benefit situations. Similarly, if the hospital (or its clearinghouse or billing service) sometimes bills a health plan using the overall NPI for a given service and sometimes bills using the subpart NPI for that same service, then that inconsistent practice could jeopardize the ability to correctly associate the transaction with the appropriate provider profile. Finally, inconsistent use of subpart NPIs might adversely affect accuracy of data being reported to state health data agencies.

Recommendation 10.1: The NPI PAG recommends that WEDI recommend to CMS and the industry that providers should determine their subparts as required by applicable Federal regulation and also determine any further subparts that the Final Rule permits. Each provider should then uniformly bill all payers using its chosen level of granularity. For example, if a provider organization bills Medicare end stage renal dialysis (ESRD) services using a subpart NPI, then that provider organization should bill its ESRD services to all non-Medicare payers using the subpart NPI. Conversely, the organization would not submit Medicare ESRD bills using a subpart NPI but non-Medicare ESRD bills using the parent organization NPI.

(end)

Appendix

Parking Lot Issues for Further NPI PAG Deliberation

Category 1: NPPES Issues

- Issue 12 Maintenance of NPI Data and Reconciliation of Changes
- NPPES should be linked to PECOS and OSCAR?
- What processing time frames will there be for the upcoming enumerator contract?
- Recommended requirements for active CMS participation in industry coordination and implementation activities.
- Want NPI to be expanded to currently non-eligible providers (taxis, alternative practitioners) One universal numbering schema.
- Will determination of the bulk enumeration be made prior to the contract with the enumerator, and how will the providers be notified?
- What are the verification/validation parameters in the NPS system to ensure that providers are not getting inappropriate multiple npis.
- What will data elements be that will allow/support enumeration for an additional NPI?
- How will individual providers with multiple state licenses be handled by NPS.
- NPI not have leading zero.
- Who will be required to sign off on the NPI application?
- What is the timing from application to issuance? Web, paper, bulk.
- Can a payer or a provider actually apply for an NPI for a given practitioner (third party applications)
- Is there a different application for an organization than an individual?
- Crosswalks between taxonomy and Medicare specialty codes available?

Category 2: Implementation Issues

Implementation Issues from the WEDI SNIP NPI Issues Paper

SNIP Issue 3 How can Health Organizations (WEDI, NCPDP, ADA, AHA, AMA, BCBSA, etc) assist the implementation? Can these organizations assist with advance preparation of applications? With outreach programs?

SNIP Issue 4 How to ensure the readiness of vendors on which the industry is dependent.

SNIP Issue 6 Testing and implementation approaches to avoid deadline crisis

SNIP Issue 9 Transition: Business process begins prior to but completes after NPI deadline

SNIP Issue 16 Use of NPI on NCPDP transactions

New Implementation Issues arising at the 6/22/2004 WEDI NPI PAG Meeting

A How can health plans, payers and PBMs assist implementation? (merge into issue 3)

B When will CMS publish and commit to the answers to these questions? (added to issue 5)

C When will they publish a detailed project timeline against which industry can gauge adherence to the May 2005 deadline? (merge with issue 5)

D Is there going to be a mechanism to track implementation by vendors? (added to issue 4)

E What government sponsored other ID numbers will be discontinued and at what point? (e. g. CLIA)

F Is there a complaint mechanism that is part of implementation?

G UPIN is one source for bulk load. When will CMS decide on what other databases will be used for bulk enumeration? (moved to NPS breakout)

H How will the NPI affect the EDI envelopes?

I When will CMS publish its test plan to test NPI with providers and payers? (added to issue 6)

Category 3: Rule and Interpretation Issues

(Pending)

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[1] NPI PAG summary document reference = 1A.

[2] NPI PAG summary reference = 1B.

[3] NPI PAG summary reference = 1D

[4] NPI PAG summary reference = 1E and 2B

[5] NPI PAG summary reference = 1F

[6] NPI PAG summary reference = 2A

[7] NPI PAG summary reference = 2B

[8] NPI PAG summary reference = 3A

[9] NPI PAG summary reference = 3B

[10] NPI PAG summary reference = 3C