

## CMS Comments on WEDI NPI PAG Recommendations

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

#### **1. Meeting the Enumeration Deadline**

**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). WEDI believes that no successful implementation can occur in less than 18 months from the time NPIs are available for use.

**Recommendation 1.1:** WEDI strongly advocates that there be no delay. WEDI urges the Centers for Medicare and Medicaid Services (CMS) to make every effort to ensure the timely roll out of NPIs.

*CMS Comment: CMS expects the NPI enumeration system (known as the National Provider and Plan Enumeration System, or NPPES) to be able to accept applications for NPIs from health care providers (both individuals and organizations) by May 23, 2005. CMS will continually re-assess the situation and will notify WEDI and the industry if a delay is expected.*

**Recommendation 1.2:** If there is a delay of less than 6 months in issuing the NPIs, WEDI believes the industry could complete implementation prior to the regulatory deadline and no action to extend the deadline would be needed.

*CMS Comment: If CMS expects a delay of 6 months or more beyond the May 23, 2005 effective date for the NPPES to accept applications for NPIs, we will adjust the compliance dates accordingly by way of the regulatory process.*

**Recommendation 1.3:** If there is a delay in issuing the NPIs of equal to or greater than 6 months, WEDI believes that successful industry implementation of the NPI could not be completed by the regulatory deadline. Should a delay of 6 months or more occur, then WEDI recommends that the Department of Health and Human Services (HHS) take appropriate action to ensure that the industry has a full 24 months between the time NPIs are generally available for use and the time by which implementation must be completed.

*CMS Comment: We agree. See our Comment on Recommendation 1.1, above.*

#### **2. Auto-Enumeration and Bulk Enumeration**

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

**Recommendation 2.1:** WEDI concurs 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.

*CMS Comment: CMS agrees that bulk enumeration, known as Electronic File Interchange (EFI), will save time and will minimize the workload for many health care providers because they would not have to apply for their NPIs (an organization would do so on their behalf). CMS will work with WEDI to develop the format and requirements for EFI. We expect that the NPPES will not be able to accommodate the EFI process until late 2005.*

**Recommendation 2.2:** WEDI encourages the use of the Medicare UPIN (Unique Physician Identification Number) database for bulk enumeration. WEDI notes its members' concerns about the quality of the UPIN database and assumes that CMS will only utilize the UPIN database if its content is found to be – or is remediated to become – sufficiently accurate for NPI assignment. It is suggested that WEDI be given the opportunity to review any revisions (cleanup) of the UPIN database and comment as appropriate. WEDI also recommends that providers be empowered to authorize any single third party to aggregate and submit electronic databases to NPPES for bulk enumeration, subject to those third party databases complying with the specifications of CMS.

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 in bulk to the NPPES. Any authorized third party could provide this service to providers as long as 1) it is properly authorized by the provider, and 2) it meets appropriate criteria to be established by CMS/NPPES for minimum size of database, data content, data validation, data attestation, etc.

*CMS Comment: The UPIN database will not be used to populate the NPPES for two reasons: (1) the UPIN database does not contain all of the data required to obtain an NPI; and (2) some of the information in the UPIN database has not been validated. The EFI process will be developed as noted above.*

### **3. Piloting and Testing NPPES and NPI**

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

**Recommendation 3.1:** WEDI urges 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.

***CMS Comment:*** *The NPPES will be tested with the Enumerator and some volunteer health care providers and organizations prior to the effective date (May 23, 2005). We are also considering the feasibility of accepting “live” NPI applications with “real” data over the Internet and on paper from a small number of health care providers in the first few weeks as a “shake-down” period, or pilot. The pilot would involve “live” data that would populate the NPPES.*

**Recommendation 3.2:** WEDI encourages its members to participate in proving, testing and piloting.

***CMS Comment:*** *CMS concurs and has already heard from some health care providers who are interested in participating.*

#### *NPPES Level 2 Users*

**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:** WEDI recommends to CMS that the NPPES be able to provide to Level 2 users all the data elements in the NPPES upon completion of appropriate user agreements. (The user agreements would be between the NPPES and each Level 2 data recipient for the purpose of resolving privacy concerns of data use, including situations under which a provider’s SSN is shared or withheld.)

***CMS Comment:*** *CMS agrees that certain Level 2 users (e.g., HIPAA covered entities) will need certain Privacy Act-protected information in order to conduct standard transactions; however, discussion is ongoing within CMS to determine the releasable data elements. A Notice will be published in the Federal Register that will describe the NPPES data dissemination policies and procedures.*

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

***CMS Comment:*** *CMS believes that approved Level 2 users should be able to access NPPES data electronically. We expect that the Federal Register Notice will address this issue.*

**Recommendation 4.3:** WEDI recommends to CMS that the NPPES should include the X12 274 transaction (“Healthcare Provider Information”) as one of several available options to disseminate the NPPES data.

***CMS Comment:*** *We are studying the X12 274 transaction for use as recommended by WEDI. Our analysis is not yet completed.*

**Recommendation 4.4:** WEDI recommends that CMS should add a Provider Type field to the NPPES and match licensure against provider type rather than matching against provider taxonomy. (In this usage, “Provider Type” refers to provider classifications that are pertinent to licensure, e.g., physicians, dentists and pharmacists. This “Provider Type” is in contrast to Taxonomy and in contrast to the “Type of Provider” in the 837 Professional, e.g., pay-to or bill-to provider.)

*CMS Comment: The data elements comprising the NPPES were established during the rulemaking process, and public comments were addressed at that time. The NPPES, the NPI Application/Update Form, and the RFP for the Enumerator contract, for example, have all been developed using the data elements appearing in the NPI Final Rule. It is far too close to the effective date to revise that list, or to be replacing an existing data element with a new one, especially since there is no industry standard “provider type” code set in existence at this time.. License number and the State where the license was issued are required to be furnished on applications for NPIs from health care providers who report certain Healthcare Provider Taxonomy codes—ones for which every State requires a license. License information will be used to help ensure unique identification of a health care provider, not to ensure that a health care provider has been licensed to perform health care. We believe that the Healthcare Provider Taxonomy Code can serve this purpose adequately, and have taken steps to ensure that the Enumerator is prepared to deal with any issues that may arise from its use.*

**Recommendation 4.5:** WEDI finds that use of provider type and provider taxonomy is unclear in the Final Rule. WEDI charges its NPI PAG to hold further PAG deliberation, including dialogue with CMS, that would lead to recommendations for an appropriate clarification of the rule.

*CMS comment: Public comments were addressed in the NPI Final Rule, and the Final Rule does not indicate that comments on the Proposed Rule reflected any misunderstanding of the use of the Healthcare Provider Taxonomy Code set, which was listed as one of the data elements comprising the National Provider File (now known as the NPPES database). Public comments supported capturing the license number and State for health care providers who are individuals and whose professions are known to require licensure (e.g., physicians), as well as those who are organizations and are known to require licensure (e.g., hospitals) The response stated that capturing the license number and State would be helpful to health plans in matching NPPES records to their own health care provider files. The Final Rule states that some commenters suggested that we capture “Provider type” and “Provider specialty code.” We responded by saying that those terms could have different meanings from health plan to health plan, and that we will capture health care provider type(s), classification(s), and area(s) of specialization as described in the Healthcare Provider Taxonomy Code set, which had been maintained by a workgroup comprised of representatives of national organizations.*

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

*CMS Comment: Public comments on this and the other NPS data elements were addressed in the NPI Final Rule. Comments did not indicate that the proposed data element (called “Other provider number” in the Proposed Rule) be a “required” or even a “situational” data element, or that certain “Other provider numbers” should be required to be reported, and others not required. Therefore, the Final Rule did not change this policy, and indicated that “Other Provider Identification Number” and “Other Provider Identification Type” (found in Section 3, Item C, of the NPI Application/Update Form) were optional. We encourage health care providers to supply this information when applying for NPIs. Although it may be possible to revise this policy in the future with the publication of a Notice in the Federal Register, we believe there is insufficient time to do so prior to the date that the NPI Application/Update form must be ready for use.*

## 5. Timeline for Implementation

**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 preamble in the NPI Final Rule has a caveat which allows unspecified revisions to the data elements listed in the Final Rule [“Final Provisions (§ 162.408(b) and (f))”]. Lack of certainty about those elements that will be available to Level 2 users prevents development of those IT system changes.

**Recommendation 5.1:** WEDI recommends that CMS give the industry the final list of NPPES data elements for data design purposes, including any definitions for any elements not previously defined by the HIPAA regulation, no later than October 31, 2004.

*CMS Comment: The list of data elements has not changed. It will be included in CMS’ Federal Register Notice regarding NPI data dissemination.*

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

*CMS Comment: CMS does not make available routine update, maintenance, and similar systems changes for any of the systems for which it is responsible. If changes to the NPPES are made which directly affect covered entities’ compliance with HIPAA, CMS will post such information on an appropriate CMS web site.*

**Recommendation 5.3:** The NPI PAG recommends that WEDI recommends CMS notify the industry of all changes to the NPPES system by establishing a dedicated CMS listserv.

*CMS Comment: See comment on Recommendation 5.2.*

## ***Section 2: National Provider Identifier Implementation Issues***

### **6. Implementation, Overall Timing, Sequencing and Tracking**

**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:** WEDI recommends that all providers obtain their NPI(s) as early as possible.

*CMS Comment: We expect that covered health care providers would apply for NPIs before noncovered health care providers apply. Even so, the NPPES will not be able to accommodate all 2.3 million covered health care providers applying for NPIs at the same time. We expect to “phase in” enumeration for the first 6 months or so, and will inform WEDI and the rest of the industry as to our plans as soon as possible, and prior to May 23, 2005.*

**Recommendation 6.2:** WEDI requests responses from CMS by October 31, 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?

*CMS Comment: Our comments on each bullet follow.*

What are the additional NPPES system changes and when will they be ready? *Unless testing requires changes to the NPPES, we do not anticipate any changes, except those related to bulk enumeration via the Electronic File Interchange (EFI) process.*

What other bulk enumeration might occur besides UPIN? What are the criteria CMS is using to convert UPIN to NPI? *We will not be bulk-loading the UPIN data into the NPPES; as a result, we will not be using criteria to “convert” UPINs to NPIs. We are working with WEDI to finalize the operation of the EFI process, which will enable organizations to submit files for enumeration of many health care providers.*

When will CMS (Medicare) be ready to accept NPI on data files routinely expected from the industry (such as Medicare encounters)? When will CMS stop issuing UPINs? *These are Medicare NPI implementation issues, similar to issues that other health plans have to address in implementing the NPI. These issues are not related to the enumeration of health care providers, the operations of the NPPES, or the functions of the Enumerator. Medicare will be preparing instructions for its carriers,*

*fiscal intermediaries, and managed care plans that will address the use of NPIs in standard transactions. Medicare will be making its internal decisions with respect to discontinuance of the issuance and/or use of UPINs in standard transactions and will notify appropriate entities in due time.*

**Recommendation 6.3:** WEDI adopts 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 10/31/04;
  - From recommendation 6.2, 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) Initial reporting 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.
  - Those Payers and Clearinghouses that need crosswalk tables use this phase to build them.
- 5) Initial reporting 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 transaction 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.

***CMS Comment: CMS has three responsibilities with respect to NPI implementation: its delegated authority to implement the NPI nationally (NPPES, Enumerator); its role as a covered entity (Medicare, the health plan) to implement the NPI; and its role as the headquarters for the Medicaid program in providing guidance on implementing the NPI to the State Medicaid programs. These steps and the bullet points within them, as listed in Recommendation 6.3, reflect all three of these responsibilities. We are commenting on the steps in Recommendation 6.3 under our delegated authority to implement the NPI:***

- 1) Obtain answers and definitions from CMS by 10/31/04 from Recommendation 6.2, above. ***CMS comment: See response to Recommendation 6.2.***
- 2) Communication & Education (includes data dissemination guidelines, business rules, guides by audience; start this in 2004; education is an ongoing process, not a one-time event; communication/education is CMS’s job with partnership from the industry). ***CMS comment: We agree that education is an ongoing process. We have begun the work described in this bullet and have already shared documents with WEDI and others. We are undertaking a national outreach plan that will touch all major industry groups and have publicly described that plan. While we will offer as much guidance as possible, covered entities must take responsibility for their own implementation of the NPI once NPIs have been assigned to health care providers.***
- 3) Specifications for deployment of systems changes. Start Enumeration. Set expectations for not sending the NPI until Step 3. ***CMS comment: We do not understand this bullet. See our comment on Recommendation 6.2 regarding NPPES system changes.***
- 4) Initial reporting phase A. This is an agreement between parties to “begin.” Provider sends NPI in addition to legacy number. Clearinghouse passes NPI and legacy number (when a clearinghouse is involved). Payers accept NPI with legacy number as the secondary ID. Those payers and clearinghouses that need crosswalk tables use this phase to build them. ***CMS comment: While CMS believes this is a logical approach, we have no authority to recommend or require that covered entities follow this approach.***
- 5) Initial reporting phase B. All parties are using and passing NPI (provider, vendor, clearinghouse, and payer). Based on agreements between partners. Some may test 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). ***CMS comment: While CMS believes this is a logical approach,***

*we have no authority to recommend or require that covered entities follow this approach.*

- 6) Migration phase. Continue to send the NPI plus 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 NPI sent. ***CMS comment: While CMS believes this is a logical approach, we have no authority to recommend or require that covered entities follow this approach.***
- 7) Shut down of legacy identifier. Payers use NPI as primary identifier. Create plans for transaction runoff (run-out). Establish adjustments timeline. Allow rejections based on NPI sent. Pursue “bad” data with entity that sent it to you. It ultimately works back to the provider and the entry in NPPES. ***CMS comment: While CMS believes this is a logical approach, we have no authority to recommend or require that covered entities follow this approach.***

Recommendation 6.4: Further discussion is needed regarding timing of implementation and WEDI charges SNIP with responsibility for developing further sequencing details, as it did for the transactions final rule. ***CMS comment: We concur with this recommendation.***

## **7. Cross-Indexing the NPI**

**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 desirable for this effort.

**Recommendation 7.1:** WEDI recommends 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.

***CMS comment: We believe this recommendation was made under the assumption that CMS would be populating the NPPES with data from the UPIN file. As explained in our earlier comments, we will not be populating the NPPES with UPIN data. As a result, we will not be developing crosswalk logic or criteria to share. The NPPES database will contain any other health care provider identifiers that are furnished to the NPPES by health care providers when applying for NPIs. The Notice on data dissemination will provide details on how that information will be shared.***

**Recommendation 7.2:** As a recommendation to the health care industry, WEDI recommends that trading partner migration begin ASAP so that health plans can begin building or validating 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 6.3.

*CMS comment: While CMS believes this is a logical approach, we have no authority to recommend or require that covered entities follow this approach.*

### ***Section 3: Requirements and Rule Interpretation Issues***

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

**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 WEDI consensus is to encourage universal use of the NPI. Although CMS makes 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:** WEDI recommends that the NPI should be used on paper forms and other non-standard or non-HIPAA transactions.

*CMS comment: While CMS believes this is a logical approach, the NPI Final Rule does not apply to non-standard transactions. We have no authority to recommend or require that covered entities follow this approach.*

**Recommendation 8.2:** WEDI recommends that organizations responsible for paper forms change their usage instructions or their forms to accommodate the NPI.

*CMS comment: While CMS believes this is a logical approach, the NPI Final Rule does not apply to non-standard transactions. We have no authority to recommend or require organizations to change their usage instructions or paper forms.*

## **9. Identifiers in Addition to the NPI**

**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:** WEDI charges its NPI PAG to 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.

*CMS comment: We believe there is sufficient information in the standard claims transactions and/or changes can be made to internal processes in order to eliminate the need to use any identifier other than the NPI to identify a health care provider as such in standard transactions. CMS (as a health plan) is willing to assist the NPI PAG in studying this issue further if necessary.*

## 10. NPI Subpart Enumeration

**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. The preamble language states:

“These entities, according to Federal statute and regulations, must be issued their own identification numbers in order to bill and receive payments from Medicare. The Federal statutes and regulations similarly affect the Medicaid program.”

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:** WEDI recommends 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 its non-Medicare payers using the subpart NPI. Conversely stated, the organization would not submit Medicare ESRD bills using a subpart NPI but non-Medicare ESRD bills using the parent organization NPI.

*CMS comment: The recommendation to bill all health plans uniformly goes beyond the scope of the NPI Final Rule. A covered organization health care provider may decide to designate subparts along the lines of organizations that are required to have Medicare billing numbers, enabling the subparts to have NPIs. Those NPIs would be used to bill Medicare once the NPI is implemented. Using the same level of granularity*

*to bill other health plans could create problems for the other health plans, which they would have to resolve in their NPI implementation activities.*

**Recommendation 10.2:** WEDI recommends to the CMS Office of HIPAA Standards (OHS) that OHS create and maintain a single source document which consolidates all the current federal requirements pursuant to which covered entities must obtain subpart NPIs.

*CMS comment: Federal regulations concerning Medicare billing numbers and Medicare enrollment are the responsibility of CMS' Office of Financial Management (OFM). On December 23, 2004, CMS' OFM forwarded a listing of organizational entities that are required by regulation to have Medicare billing numbers. CMS does not know of similar regulatory requirements within other Federal health programs (such as the Department of Defense, the Department of Veterans Affairs, or the Indian Health Service). CMS has furnished the WEDI SNIP NPI Subworkgroup on Subparts with the names of contacts in those health programs.*