WEDI Strategic National Implementation Process (SNIP)
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HIPAA National Provider Identifier White Papers

Impact of NPI on Health Care Providers

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Impact of NPI on Health Care Providers

I. Purpose

The purpose of this paper is to review the overall business impact of the adoption and implementation of the new National Provider Identifier (NPI) on health care providers. This paper addresses Individual and Organizational Providers.

II. Scope

Numerous health care provider perspectives are discussed in this paper. Discussion will be limited to the adopted HIPAA ASC X12 Version 4010A1 and NCPDP Telecommunications Standard 5.1 transactions as these are the standards under which the identifier will be implemented. As new versions of standard transactions are adopted for use, this paper will be updated accordingly.

Because the NPI will affect all providers regardless of whether they currently use covered transactions to bill for services, this paper will also provide some basic HIPAA information that will be essential to understanding the implications of this new rule (69 FR 3434). The paper references other WEDI Strategic National Implementation Process (SNIP) NPI Sub Workgroup white papers written on the NPI implementation. Every effort has been made to minimize duplication between these white papers.

While there are shared issues between the two types of providers, there are uniquely specific business issues each must address. For clarity and convenience, this paper begins an introduction to the NPI and general issues that affect all providers. Issues specific to provider type are then discussed followed by the more complex issues affecting all providers.

III. Definitions

To discuss effectively the business issues associated with the NPI, numerous terms and concepts must be defined. Some of these terms and concepts are the topics of other WEDI NPI Sub Workgroup papers and the reader will be directed to those documents for further edification. This paper will limit its discussion of those topics to an introductory level to facilitate the discussion of other issues in this paper.

Business Associate – An external entity that performs a business function for a covered entity on the covered entity's behalf. Examples include but are not limited to billing services, collection agencies, and clearinghouses.

Covered Transaction – The electronic transfer of health care information for their specifically named purposes as promulgated under 45 CFR 160.103. Examples include but are not limited to eligibility inquiries, claims, remittance advices, and benefit enrollment.

Covered Entity – A health care provider, health plan, or a health care clearinghouse that electronically transmits covered transactions is a Covered Entity. Note: This definition does not supersede the Privacy Rule definition of a covered entity. PHI and ePHI provisions still apply to covered entities under the NPI.

Covered Health Care Provider - A health care provider who transmits any health information in electronic form in connection with a covered transaction is a Covered Health Care Provider. A Covered Health Care Provider is required to obtain and use its NPI in covered transactions.

Health Care Provider – A health care provider is an entity meeting the definition of "health care provider" at 45 CFR 160.103. A health care provider may be an organization or an individual. Examples include but are not limited to physicians, nurses, pharmacists, acute care facilities, pharmacies, group practices, dentists, and home health agencies. *In this paper, the terms "health care providers" and "providers" are interchangeable.*

Identifiers – HIPAA identifiers are data elements that are mandated for use in covered transactions. The NPI was adopted as the standard unique identifier for health care providers in the NPI Final Rule (69 FR 3434).

Legacy Provider Numbers – Provider numbers that are specific to a health plan, i.e., UPIN, Blue Cross, Medicaid, TRICARE, et al.

Legal Entity – This term is used most frequently to qualify enumeration for an Organizational Provider. In this context, a legal entity would include but not be limited to a, corporation, or partnership performing legal business activities and are entitled to receive and use an Employer Identification Number (EIN) assigned by the IRS.

Subpart - Any component of the covered organization health care provider needing an NPI in order to be identified in HIPAA standard transactions. Subpart designation may be based on whether subparts conduct standard transactions, whether existing Federal regulations require them to have unique identifiers to be reimbursed by Federal health plans, or certain other reasons. *Subparts are Organizations (Entity Type 2).*

For the purpose of implementing and maintaining the NPI, i.e., enumeration purposes, providers are delineated as two types of entities. An Entity type code is a data element that categorizes providers for the purpose of NPI assignment.

Entity Type 1 – A health care provider who is an individual. Physicians, nurses, dental hygienists, pharmacists, and physical therapists all meet this definition. *In this paper, Type 1 entities are referred to as Individual Providers.*

Entity Type 2 – A health care provider that is an organization. This provider type includes but is not limited to provider organizations such as hospitals, clinics, home health agencies, long-term care facilities, hospice programs, DME suppliers, and group practices. An Entity type 2 also includes incorporated individuals. This paper uses the generalized term Organizational Providers for Entity Type 2 providers.
This paper will discuss Type Code 2 Entities using three sub categories:

- *Group (multiple provider practices)*
- *Institutional (hospital or other large) providers*
- *Retail-based Providers (Examples: pharmacies, medical supply, and DME Providers)*

Trading Partner – An external entity with which a covered entity exchanges or transacts electronic data. Examples include but are not limited to health plans, referral centers, peer providers, and agencies.

IV. Overview

What is an NPI?
The NPI replaces existing legacy provider numbers used to identify a provider to a health plan. The NPI is assigned for life and is deactivated only under the most extreme circumstances

- Identity theft where the first NPI has been used fraudulently
- The provider's death
- The provider's retirement

If a health care provider is sanctioned or barred from one or more health plans, the provider's NPI remains active.

A provider's cash flow will be directly impacted if the NPI is not implemented with careful consideration and planning. All health care providers are <u>eligible</u> to apply for an NPI regardless of whether or not they conduct covered transactions. The application and transition period began May 23, 2005 and all covered providers must be in compliance by May 23, 2007.

NPI assignment, called enumeration, will be a function of the National Plan and Provider Enumeration System (NPPES). The NPPES is the single source of NPI assignment. In the final rule, the NPPES is referred to as the NPS because it was then known as the National Provider System. The NPPES is the official data repository for provider NPI data, i.e., it is to be considered the centralized, definitive repository. The Enumerator is responsible for the processing of paper NPI applications, updates, and deactivations, resolution of problems, and the source of information concerning the process of obtaining NPIs, furnishing updates, and deactivating NPIs. Application processing includes accepting provider applications, resolving problems with paper and web-based applications, providing guidance on completing applications, and the mailing or e-mailing (depending upon the application method used) of the NPI notifications to

providers. There is only one Enumerator. For an in-depth understanding of the application process, the NPPES and Enumerator, please refer to the NPI Sub Workgroup white paper, "The NPI Registration Process".

Benefits

There are several benefits associated with the NPI conversion. First, it establishes a nationally accepted unique identifier for each provider. As part of an organizations re-credentialing of medical staff, the verification step involving validating provider numbers could become a step that may be simplified or eliminated. Additionally, as adjudication systems have been updated in the past, health plans have re-assigned provider numbers en masse for all provider participants to accommodate necessary system changes; this scenario completely vanishes. With the NPI, all systems must accommodate the 10-digit, numeric format.

The National Uniform Billing Committee (NUBC) and the National Uniform Claim Committee (NUCC) have both recommended that the NPI replace the current provider numbers used on the CMS-1450 (UB-92) and the CMS-1500 claim forms. The UB-04, scheduled for implementation March 1, 2007 with a required conversion as of May 23, 2007, will require use of the NPI. The NPI is accommodated on the current paper ADA Dental Claim Form (2002 and 2002/2004),

The internal administrative overhead all providers incur maintaining plan-specific identifiers will greatly diminish with a single identifier. The NPI application requires less information than most health plan enrollment processes. While enrollment is a separate process and will continue to be required by health plans, there could be a reduction in enrollment processing time. As the NPI does not contain plan-specific intelligence, the processing time for plan and clearinghouse enrollment may decrease. Because the Enumerator is the only entity permitted to assign NPIs, new providers have one point of contact when applying for an NPI. The use of a national, unique identifier in medical records and the Electronic Health Record initiative will be of great benefit to providers and health plans alike.

The Coordination of Benefits (COB) process is directly impacted by the NPI. Individual Providers will enjoy a greatly simplified COB process with health plans. Organizational Providers will need to consider carefully their subpart enumeration strategy to ensure clear COB communication. This added benefit should aid in the payment process between provider and plan.

From an industry perspective, fraud and abuse efforts will eventually be streamlined and providers will be better insulated from potential cross-indexing errors that can occur with multiple identifiers. Additionally, provider tracking for medical record needs and group practice debt collection efforts will also be enhanced with a single identifier.

Covered Health Care Provider

The NPI final rule defines the term "covered health care provider". The NPI does not change the definition of a health care provider. A covered health care provider is a

health care provider who transmits any health information in electronic form in connection with a covered transaction. A covered health care provider is required to obtain and use the NPI in covered transactions. A covered health care provider may be an Entity type 1 or 2. The Entity type code (1 or 2) does not define NPI eligibility; it serves only to facilitate identification and enumeration. Providers who are covered entities (covered providers) are required to obtain an NPI, but providers who are not covered providers who obtain an NPI do not become a covered entity by default.

Providers

Under the NPI rule, all health care providers (as defined in 45 CFR 160.103) are eligible to obtain an NPI. That is, an entity that provides health care as defined under section 1861(u) of the Social Security Act, 42 U.S.C. 1395X (u), is eligible for an NPI. Some health care providers (those who are "covered providers") are required to obtain NPIs. For example purposes only, providers may be generally categorized as:

Providers Eligible But Not Required to Obtain an NPI

Most registered nurses and some clinical (radiology, respiratory therapist) technicians are entities who provide health care but may not bill for services using covered transactions.

Providers Required to Obtain an NPI

Covered entities such as physicians, dentists, chiropractors, psychologists, acute care facilities, long-term care facilities, pharmacies, DME suppliers, and hospice agencies conducting standard transactions are all required to obtain an NPI. Other non-physician practitioners such as Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants are required to obtain an NPI if they conduct standard transactions (e.g., if they bill for their services using covered transactions).

Non-eligible Entities

The final rule stipulates some entities are not eligible to receive an NPI. Billing services and re-pricers bill for health care provided by health care providers, but they are not eligible for an NPI because they do not provide health care. The Final Rule explains that entities that do not meet the definition of "health care provider" found at 45 CFR 160.103 are not eligible for NPIs. Many of these entities are referred to as "atypical service providers." For example, although a taxi may deliver a patient to a health care facility as part of its transportation service, a taxi service is not a health care provider and is not eligible for an NPI. The primary business function of a taxi service is not health care related transportation and it does not meet the regulatory definition of "health care provider" not eligible for an NPI. Similarly, entities such as pastoral/spiritual care providers, family members, au pairs, and others who provide care or administer medications are not considered health care providers because they do not render health care in the normal course of business; they are not eligible for NPIs. Additionally, complementary and alternative medicine (CAM) providers may or may not meet the definition of "health care provider." Most holistic, fitness, some

weight-loss, naturopathic and other entities are examples of CAM providers. If they meet the definition of health care provider for other services they provide, they are eligible for NPI enumeration. The WEDI NPI Sub Workgroup, CMS, and NMEH are jointly developing a white paper to discuss non-eligible entities called "The NPI and Atypical Service Providers". Please refer to that paper for further edification when it is published.

For an executive summary of the NPI Rule and a list of the WEDI NPI Sub Workgroup white papers, please refer to the WEDI "NPI Overview and Educational Reference Guide".

V. Business and Implementation Issues

A. General

Currently, the majority of Individual Providers rely upon agents operating on their behalf to secure legacy provider identifiers from each plan with which the provider is enrolled. The legacy numbers assigned can be limited to a geographic location and/or may be contract-specific. A relationship between the legacy provider number, the provider, and the plan facilitates provider billing and claim adjudication. The legacy provider number is plan-assigned and is linked to the provider's enrollment, not the provider per se. The provider has a one-to-many relationship as a billing entity. The provider can have several "identities" with a single plan depending upon the service being billed. Its value is limited to the confines of those transactions and frequently resembles a taxonomy code in function.

The NPI, however, is assigned for life. *It becomes part of a provider's permanent professional identity.* Providers may now be uniquely identified by NPIs. There is a one-to-one relationship between the NPI and the provider. This relationship is discussed in more detail under the Application and Enumeration headers in each respective section of this paper.

The final rule strongly encourages every health care provider to apply for an NPI and be enumerated; especially if the provider must be identified in a covered transaction by another entity regardless of whether the provider conducts covered transactions in his or her practice. Prescriptions are the quintessential example. Pharmacies must use the NPI to submit an electronic claim. The prescribing physician may not submit claims electronically; however, because the prescribing physician must be identified by the pharmacy, it is in the industry's best interest for that physician to obtain an NPI.

Each provider will undertake several tasks to meet the NPI compliance date. A scalable project plan is in Codicil A. The plan is a suggested course of action; however, not every task applies to every provider situation. The plan can be broken down into two

distinct phases: preparation and execution. The business issues listed in the remainder of this paper follow this approach.

Preparation is a crucial component in implementing the NPI. All affected entities must determine how they will enumerate themselves, how their information systems will support the NPI and secondary identifiers, how their business associates and trading partners will implement and support the NPI, how they will collect NPI data from other providers, and how they will share their NPI data with other entities. Obtaining and appropriately disseminating one's NPI is crucial not only to the provider's revenue cycle/cash flow but to the cash flow of peers and other organizations as well. As the complaint process has been finalized and the enforcement rule has been published, it can be anticipated that non-compliance will not be tolerated when cash flow is interrupted between covered entities. As the enforcement date is in 2007, it is also possible the current contingency plan for TCS compliance will be discontinued by that date. CMS has stated they will provide significant guidance on the NPI and it is anticipated that a hard line will be taken with the NPI compliance date.

State Law Review

A review of state laws should be performed to determine if existing laws conflict or supplement the NPI rule. This important step should not be overlooked. State laws may supplement and in some circumstances, preempt the federal law. For example, Minnesota has a state law that *adds* a requirement. That state law requires the use of NPIs on all claims regardless of the medium used to submit them, e.g., it requires the NPI on paper claims. If a conflict or supplemental requirement is identified, the appropriate steps should be taken to address those findings.

Taxonomy Codes

A business issue that arises in the application process is the use of provider taxonomy codes. Presently, very few health plans require provider taxonomy codes in covered transactions. The provider's taxonomy code is a required data element on the NPI application. Providers will also need to be aware of their taxonomy codes for their practice specialty. Taxonomy codes apply to Individual and Organizational Providers. With the loss of the intelligence within health plan-assigned provider numbers, several large plans are discussing the use of taxonomy codes to drive reimbursement. Taxonomy codes are situationally required in 4010A1 version claims. The situation, as written, specifies that if the taxonomy code is required to adjudicate the claim, it must be reported. Providers should investigate the use of these codes and be prepared to submit or provide their taxonomy code upon request from a provider organization or a health plan. This code set is on the Washington Publishing Company's website, www.wpc-edi.com. A .PDF version of the list may be downloaded free of charge. This code set updates twice yearly.

Providers should include the support of taxonomy codes in the gap analysis of their information systems and interfaces. This is a recommended, proactive step for providers to take.

Tax Identification and DEA Numbers
The Taxpayer Identifying Number (TIN) is used by the Internal Revenue Service to identify a taxpaying entity. There are regulatory requirements for the use of this identifier. In covered transactions, when a TIN is required to be reported, it must be used; the NPI does not replace this identifier. Drug Enforcement Agency (DEA) identifiers were established to identify providers who prescribe controlled substances. The DEA number is not required in any of the named covered transactions. The NPI may not be used in place of a DEA number where the DEA number is required for its regulatory purpose. Use of the DEA number must be restricted to its regulatory use.

State Licensure Processes
Individual Providers should ascertain when their state licensure expires and contact the state licensing agency to ask if there are any NPI-related requirements associated with renewing their license in that state.

B. Entity Type 1 - Individual Providers

Entity Type 1 providers fall into two categories: private practice and employees of Entity Type 2 providers. Private practice providers bill for their services using employed staff or billing services. Providers who are employed by an Organizational Provider may also bill for their services in the same manner or the organization may bill for them.

1. Private Practice Providers

Identify Affected Business Processes/Education Needs
Nearly all office staff members are affected by the NPI. Front desk and patient registration personnel should know how to process information with our without NPIs. Staff should also know how to respond if a provider or office contacts them with NPI information from another provider or group. Credentialing and plan enrollment processes should be reviewed. Billing personnel and financial representatives need to be able to recognize the NPI in claim transactions, understand its purpose, and the requirements of its use.

Policies and procedures should be reviewed and updated accordingly. Staff should know how to address each of the following situations:

- The process for how and when to disseminate the provider's NPI
- The process for how and when NPIs are secured from other providers
- What to do when an NPI is required for processing a claim and the NPI is unknown
- How to address situations where an NPI may be required for a provider who is not required to obtain an NPI (for example, referrals)

Information and Computer Systems - Billing and Clinical
Current and proposed software using legacy provider numbers should be identified. Affected interfaces should also be identified. A gap analysis should be performed as

applicable and discussions should ensue immediately to resolve any gaps identified. Software updates or changes to legacy computer systems, interfaces, translators, or claim scrubbers may need to be scheduled. Billing services and/or the practice's business management personnel should understand the role of the NPI and its affect on software used by the practice.

Critical components to discuss with software vendors include support not only for the NPI, but also secondary identifiers, taxonomy codes (by plan/insurance and provider), and each type of provider required in a covered transaction that is supported by that vendor. A matrix of questions to ask software vendors is in Codicil B. Secondary identifiers are 837 and 835 data elements that provide additional identification information about a provider (see Codicil D and the Workgroup white paper, "Dual Use of NPI & Legacy Identifiers: Voluntary Strategy for Transitional, Dual Use of NPI and Legacy Identifiers in X12 Transactions").

Clinical (Radiology, Cardiology, etc.) imaging, laboratory, and other clinical systems traditionally have not stored legacy provider numbers. However, with the advent of electronic medical records, Regional Health Information Organizations (RHIOs), and the Federal Government's Health Information Technology initiative, it is possible that will change. Because the NPI is unique to the individual provider, it is conceivable that it will be used in an electronic health record system as the provider identifier. Computerized Physician Order Entry and other information systems that have traditionally used mnemonics of some sort to identify providers on orders, transcription, results, and other clinical transactions may now opt for the NPI as that identifier. This minimizes (or could remove) the need for convoluted interface mapping tables between clinical and billing systems. Disparate information systems now have a single link for providers across systems and platforms.

Specific to taxonomy codes, care must be taken to understand how the software supports their use. For example, the taxonomy code is to be used in 837I and 837P transactions when it is situationally required. However, an internal or external reporting requirement may exist whereby the taxonomy code description (not the code itself) is required in the report specifications. If the software does not store both, the provider must determine how this issue will be addressed.

Stand-alone databases should be included in this process. Work done for the HIPAA Privacy and Security implementations may save the NPI implementation team significant work as all of these databases should likely have been identified through those efforts. Research databases should be included in this process.

Trading Partners and Business Associates

Under the final rule, providers are responsible for ensuring that their business associates comply with the provisions of the rule. Providers who use billing services, collection agencies, clearinghouses, re-pricers, third-party administrators, document management/imaging systems, or other vendors must identify those services as well as internal software applications that process or use provider legacy numbers and NPIs.

Discussions with those vendors should begin immediately to ensure their readiness to process NPIs and to ensure the provider's cash flow will not be disrupted. Providers should inquire specifically about the use of crosswalks and data validation processes that will be used during testing and transition periods. An understanding of the trading partner's internal processes can assist the provider in troubleshooting any sudden reimbursement changes. A matrix of questions to ask trading partners and business associates is included in Codicil B.

Application and Enumeration

The website address for the Enumerator is https://nppes.cms.hhs.gov. The web-based application and the paper application are available there. The Enumerator's paper application target processing time, including response, is presently twenty (20) business days. The web application processing time, including response is expected to be five (5) business days. It is anticipated that a high volume of applications during the first few months of the Enumerator's operation will affect processing response time.

The Enumerator bases processing times on the receipt of complete and correctly submitted applications that do not require any clarification or changes. For this reason, it is important that providers secure a copy of the application document (CMS-10114) and develop a process for collecting and *validating* the necessary information. The application is available on the CMS HIPAA website (www.cms.hhs.gov/hipaa/hipaa2), the CMS forms page (www.cms.hhs.gov/forms) and from the Enumerator. The NPI Sub Workgroup white paper, "The NPI Registration Process" provides details regarding the application process, samples of completed paper applications, and screen-prints of the web-based application. That paper also provides examples of clinic, Individual and Organizational Provider applications. Providers may also find a list of the data elements collected on both applications in the NPI final rule. CMS also has a tutorial on its website to assist providers with the application process called the NPI Viewlet.

One important advantage the web-based application has over the paper application process is that there is real-time gap or missing information checking at the end of the application process on line. Providers know immediately if information is missing that will delay processing. The electronic application cannot be filed unless all required information is input. The Enumerator will validate against duplicate and potentially duplicate applications but that validation process is not part of the real-time application process. The SSN validation process is not part of the real-time application process. Web-based applications have been processed since May 23, 2005 while paper-based application processing started July 1, 2005. As of this writing, the bulk enumeration or Electronic File Interchange (EFI) process has not been fully defined. The stated goal is to have this process available the fourth quarter of 2005.

Enumeration decisions must be made carefully, with considerable thought. Organizational Providers are required to determine if they need to identify Subparts. Group practices and similar large clinics fall under the Organizational Provider requirements of the rule. Individual Providers are not permitted to enumerate subparts nor may they be considered subparts; they are allowed to obtain a single NPI.

In applicable covered transactions, this paper recommends using the location of the service (or like data element—see the "Dual Use of NPI & Legacy Identifiers: Voluntary Strategy for Transitional, Dual Use of NPI and Legacy Identifiers in X12 Transactions" white paper) as the default indicator for providers who render services in multiple locations. If a provider uses billing services or clearinghouses for electronic claim submission, discussions regarding the use of the location fields should begin as soon as possible. The same is true for software vendors as the production or source system must be able to store and produce location-specific information. Please refer to Codicil D for a listing of all affected transactions and the identifier data elements affected by the NPI.

It is critical to note that while some health plans in the past have had an interim or surrogate identifier for providers to use (Medicare's UPIN OTH000); there are no interim or surrogate NPIs. If an affected provider fails to acquire an NPI before he or she is ready to bill for services, those claims will probably have to be held until an NPI is received. This is certainly true for covered transactions and paper claim submissions to Medicare.

Current Providers

Providers should apply as quickly as possible for their NPI. Proper preparation and business need assessment is critical to keep the revenue cycle intact. Individual Providers should apply, obtain, and disseminate their NPI as quickly as possible to facilitate testing, transition, and reduce the possibility of interruption of cash flow. The application methodology the provider uses is a business decision that should be made as a result of effective preparation and analysis.

New Providers – Residents and Interns

When a medical student is licensed or credentialed (depending upon state law and/or guidelines), he or she should apply for an NPI. Application processing time is defined by the method chosen to apply for an NPI as noted previously.

Active military, reservists, National Guardsmen, Coast Guard, Public Health Service Privileged Providers, Department of Veterans Affairs Co-Located, and civilian providers working for the Military Health System (MHS)

A memorandum containing policy guidance (Policy HA-002) was submitted January 26, 2005 stating the Department of Defense's (DoD) plan for enumeration. The DoD's policy states that providers* are to apply for their NPI and submit it to the TRICARE Management Activity designated database/repository prior to the May 23, 2007 compliance deadline. Military providers required to obtain an NPI include privileged providers, residents, and non-privileged providers (if they request referrals, consults, or provide billable services). Service branches are to ensure that their affected providers begin applying for an NPI approximately May 23, 2005. Paper applications will be made available in the providers' Military Treatment Facility's credentialing offices. Service branches are also responsible for ensuring that new MHS providers apply and submit

their NPIs appropriately. The memo also specifies monthly reporting requirements and expectations for compliance by date and percentage point.

The Department of Veteran Affairs plans to perform an Electronic File Interchange submission for their employed providers.

Ownership and Responsibility

As the NPI is assigned for the life of the provider and is fully portable within the application of the HIPAA legislation, the dynamics of ownership change radically. To date, the request for a provider number has been synonymous with enrollment with a health plan. With the implementation of the NPI, this is no longer the case. The NPI does not guarantee or create a request for enrollment with a plan. The NPI is a data element that likely will be required as part of the enrollment process. The NPI becomes the single, unique identifier for the provider regardless of where services are performed (see section discussing Taxpayer Identifying Numbers).

On the paper application, providers are required to identify an authorized official's information for an organization. Identifying a contact person for the provider is optional. On the web application, providers are only required to identify a contact person's information. An organization must provide an Authorized Official's name and information. However, providers should pay particular attention to the language in these sections:

> **SECTION 4 – CERTIFICATION STATEMENT** *(Required)*
> By his/her signature, the authorized official binds the provider/supplier to all of the requirements listed in the Certification Statement and acknowledges that the provider may be denied a National Provider Identifier if any requirements are not met. All signatures must be original.
> Stamps, faxed or photocopied signatures are unacceptable. You may include multiple credentials. Use additional sheets of paper for multiple credentials if necessary.
> An authorized official is an appointed official with the legal authority to make changes and/or updates to the provider's status (e.g., change of address, etc.) and to commit the provider to fully abide by the laws and regulations relating to the National Provider Identifier. The authorized official must be a general partner, chairman of the board, chief financial officer, chief executive officer, direct owner of 5 percent or more of the provider being enumerated, or must hold a position of similar status and authority within the provider.
>
> Only the authorized official(s) has the authority to sign the application on behalf of the provider.
>
> By signing this application for the National Provider Identifier, the authorized official agrees to immediately notify the NPI Enumerator if any information in the application is not true, correct, or complete. In addition, the authorized official, by his/her signature, agrees to notify the NPI Enumerator of any changes to the information contained in this form within 30 days of the effective date of the change.
>
> **SECTION 5 – CONTACT PERSON** *(If the contact person is the same person identified in 2A or 4B, complete only item 8, E-mail Address.) (Optional)*
> To assist in the timely processing of the NPI application, provide the name and telephone number of an individual who can be reached to answer questions regarding the information furnished in this application. Please note that if a contact person is not provided, all questions about this application will be directed to the authorized official named in Section 4 or the provider named in Section 2, as appropriate.

In the final rule, *covered providers are held accountable* for updating their NPPES data within thirty (30) days of the change. The authorized official is not listed as a culpable entity in the proposed Enforcement Rule, posted April 18, 2005 in the Federal Register (45 FR 20224). Failure to comply with the final rule's requirements makes the covered

provider (not the Enumerator or the provider's designee) liable for civil monetary fines on a per violation basis. Providers may self-enumerate or use a third party to apply for an NPI on their behalf (called EFI Submission discussed in the following paragraphs). Specific to enforcement, all providers should be aware that the relationship the NPI establishes is between the provider and the Enumerator, regardless of any authorized official or third party relationship established in the application process or contractually.

It is the recommendation of this paper that each provider assumes full ownership and responsibility for securing and maintaining his or her NPI. We recommend that providers apply for their NPIs as soon as it is practical to do so. Deciding whether to self-enumerate is one of the first and most critical decisions a provider must make in this process. It is not a decision to be made without considering long-term implications.

Additionally, because a number of the data elements collected by the Enumerator as part of the application process are considered individually identifiable data elements and are therefore protected under the Privacy Act of 1974, the current security plan for sharing NPIs is very restrictive. The NPI itself is considered protected data under the Privacy Act because it uniquely identifies the provider. Currently there are no plans to allow public access to the NPPES. Extensive discussions are underway to address peer-provider, Organizational Provider, and plan access to NPIs to facilitate covered transactions but no formal plans have been stated. Currently, the relationship between the NPPES and the web user is designed to be one-to-one, e.g., one password for each provider NPI. Any entity with password access to the NPPES for a provider may make the following changes to a provider's NPI data: Change NPI Password, View/Modify Data, and Deactivate NPI. Presently, hierarchical security/access is not in place to support view-only or limited view-only access to a provider's NPI data.

It is critical to note that providers who enumerate via EFI Submitters establish a one-to-many relationship with the NPPES. The application entity (the EFI organization, discussed in the following paragraphs) has access to all the providers' NPI data for which it applied. Sharing that password provides access to all providers' data under that password. Providers who do not take responsibility for applying for an NPI relinquish initial control of his or her NPI data and confer that control to the EFI organization. As of this writing, the process allowing a provider to transfer or assume control of their NPPES password/data is unknown. As NPPES data contains protected data, it is unknown as the extent to which a provider will have to prove his or her identity to effect the change in access/ownership. An Individual Provider's social security number is required for EFI submissions. Self-enumeration also supports true portability for the Individual Provider. If an Individual Provider relocates to another area in the United States, access to and control of his or her NPI data becomes a logistical necessity.

If an Individual Provider is on medical staff at an Organizational Provider's facility, that Organizational Provider may apply for an NPI on behalf of the Individual Provider by virtue of the established relationship as long as the Individual Provider is notified of the action. A proxy application process, i.e., application by a third party (EFI or otherwise)

does not relieve the provider from the responsibility and efforts to appropriately disseminate/disclose his or her NPI to the provider and plan community in that market. In an area where the Individual Provider base is shared across numerous facilities, proper dissemination is critical to uninterrupted cash flow due to missing NPI data in the claim. Additionally, EFI enumeration does not release Individual Providers of their obligation under the NPI final rule to maintain their data with the Enumerator. They may permit such data maintenance as part of the providers' agreement with EFI organizations, but the providers would be held accountable in terms of enforcement.

CMS's position is that dissemination will be very controlled. CMS does not want organizations disseminating provider NPIS to the "marketplace". Even if the provider uses EFI enumeration, the provider, not the EFI submitter, is responsible for disclosing its NPI to those entities who need it in covered transactions. While CMS supports EFI, it does not support any other type of arrangement a provider may make with an organization in which the organization updates the provider's data. In those situations, the provider is essentially letting the other organization represent it when web-based or paper transactions are conducted. If something goes wrong, that provider will have to justify why it made those arrangements with that organization.

EFI enumeration is not without value. If an Organizational Provider employs all (or a majority) of its physicians and is willing to follow the EFI requirements when they are established, EFI enumeration may be a responsible solution for that group of providers. Business decisions need to be made by every provider type to evaluate an application strategy that is in their best interest, to not only meet the compliance deadline but also for that entity's long term needs. Regional Health Information Organizations (RHIOs) are stepping forward to support application and dissemination efforts in some areas. Other regional initiatives are underway to educate and provide application hubs where providers may apply for an NPI with support staff nearby.

The NPI is the unique identifier for providers. Providers who are covered health care providers required to meet the final rule requirements under penalty of civil monetary penalties. There is a one-to-one relationship between the NPI and the provider, making the NPI a part of the provider's professional identity for the life of the provider. This new relationship mandates ownership and the assumption of responsibility for that identifier by the provider. Providers should step up to the plate to actively manage and take part in their enumeration regardless of the means undertaken to do so.

Dissemination and Disclosure

When the Final Rule discusses NPIs being made available to health plans and others from NPPES, the term "dissemination" is used. When the NPI Final Rule discusses the requirement for providers to give their NPIs to others who need it for transactions, it uses the term "disclose." This paper follows that delineation.

Providers should develop a process to disclose their assigned NPI to peers, provider organizations, and health plans with whom the provider practice conducts business.

Providers are also required to disclose their NPIs to other entities when needed to facilitate covered transactions. The Enumerator will notify Individual Providers of their NPIs. If an Individual Provider does not self-enumerate, he or she should have the NPI readily available for disclosure and should not refer the inquiring entity to the third party who applied on behalf of the provider. Providers who refuse to disclose to a legitimate inquiry could potentially create a delay in the entity's revenue cycle and could be subject to a formal complaint to HHS.

It is of vital importance to note that the disclosure to pharmacies performing mail order services and all pharmacies in the provider's geographic area is a new and critical component of the disclosure process for providers. The DEA number is often used as the identification number for providers in NCPDP transactions. The NPI will replace the DEA as the provider identifier in that transaction (although the DEA number will not cease to exist and must still be used for its regulatory purpose).

Providers will need to disclose his/her number to organizations where they have staff privileges or be prepared to supply it to organizations/plans where they are applying for privileges. Many organizations are incorporating the collection of the NPI as part of their credentialing and renewal of privileges processes. The plan/organization notification process should include a cross-reference between the providers' legacy identifier(s) and the provider's new NPI. Care should be taken to validate every number that is linked or cross-referenced. These tasks should be done as early as possible to prevent a delay in the practice's revenue cycle. Providers may be asked by provider organizations and health plans to re-apply for membership, enrollment, or privileges through a formal, but abbreviated process to ensure that covered entities have NPIs for staff/enrolled providers. Providers should apply for NPIs as quickly as possible in anticipation of these efforts.

It is suggested that Individual Providers further disclose their NPIs using the following methodologies:

- Notify those Organizational Providers where your patients are referred, such as hospitals, surgery centers, independent and reference laboratories, etc.
- Notify contracted health plans of the new NPI number
- Add the NPI number to your prescription pad and diagnostic requisition/order forms (or write it on the document)

HHS is expected to publish a Notice regarding data dissemination from the NPPES in the fall of 2005. This paper will be updated when that Notice is published.

Health Plan and Clearinghouse Issues

In Codicil B, a matrix of questions to ask trading partners and business associates is provided. Many health plans will cross-index existing legacy provider numbers (and may continue to do so well after the compliance date) within their adjudication system to continue to support existing reporting infrastructures. It is possible that some health plans will continue to assign provider numbers internally as well. If a plan intends to pursue this methodology, providers should be aware of it and establish a monitoring

process during the Transition Period as well as after converting to the NPI with that plan. The monitors should be set up to ensure appropriate reimbursement and the consistent processing of claims, i.e., claims are not getting "lost" in the plan adjudication system due to a mapping error. Similar tracking monitors should be put into place for a clearinghouse if that entity will perform a crosswalk between legacy and NPIs.

Contracts should be reviewed for changes necessitated by the implementation of the NPI. It is incumbent upon the provider, not necessarily the health plan, to cross-reference legacy and NPIs within and across contracts. Reimbursement issues need to be addressed immediately and contract renegotiations should be a high priority should the need arise. Additionally, providers should pursue updated companion guides from every plan, especially if the plan will require secondary identifiers during the transition period. Providers must shoulder the responsibility of the communication of their NPIs to health plans and clearinghouses. This communication should follow the process suggested in the preceding Dissemination section. The Provider who enumerates quickly will find it easier to work with health plans and clearinghouses.

Health plans may implement the NPI in transactions prior to May 23, 2007. All providers should anticipate this action. Plan claim and remittance volumes directly affect their implementation processes. Health plans that require the embedded intelligence used in legacy provider numbers to adjudicate claims must find new or modified means by which to process claims. This may require an immense update or conversion to their information systems. As this type of change usually occurs at a regional or national scale, it should be expected that conversions would occur prior to the May 23, 2007 compliance date. In an FAQ posted on the CMS website, CMS has stated that health plans may require providers to submit the NPI in covered transactions prior to the compliance date. Plans converting their systems prior to the compliance date are allowed to reject claims submitted without NPIs for covered transactions. This is a compelling argument for health plans and providers to implement a transitional strategy (see Section E. Transition Strategy later in this paper). On June 14, 2005, CMS announced its transition plan for the Fee-for Service Medicare Program. *"Beginning January 3, 2006, and through October 1, 2006, CMS systems will accept an existing legacy Medicare number* ***or*** *an NPI as long as it is accompanied by an existing legacy Medicare number. Beginning October 2, 2006, and through May 22, 2007, CMS systems will accept an existing legacy Medicare number* ***and/or*** *an NPI. This will allow for 6-7 months of provider testing before only an NPI will be accepted by the Medicare Program on May 23, 2007."*

Additionally, health plans may now stipulate that NPI-eligible providers identify themselves with NPIs when conducting non-HIPAA transactions or other business with them. This requirement would facilitate administrative data consistency within their information systems/organization.

Legacy provider identifiers frequently incorporated location-specific intelligence to facilitate adjudication and payment. As the NPI does not possess this intelligence, providers must contact health plans to ascertain how location-specific information will be addressed post May 23, 2007. There are several options available to providers/plans in the 837 transactions. Providers who are still submitting claims via paper could have

more difficulty in these situations. As an industry, we must come to terms with the fact that the standard transactions replace the paper option. It may easily be assumed that virtually all changes and future rules will be developed with the standard transactions in mind. CMS, for example, is consistently using implementation guide language and terminology in program memoranda and transmittal communications—without providing a “crosswalk” to UB or 1500 (paper claim) data elements. The NPI was developed as a component of the standard transactions. Communication and current companion documents are vital to a successful implementation, particularly as they pertain to the location/payment issue.

Collection and Validation

Providers who receive and report referrals or rendering provider data on claims should start soliciting their peers for their NPIs. In preparation for receiving another provider’s NPI, a validation strategy should be put into place as part of his or her practice’s implementation and testing plan. Please refer to the WEDI NPI Sub Workgroup’s Sequencing and Testing White Paper for additional detail and guidance on testing strategies.

Validation is a vitally important component in any provider’s implementation plan and it should not be omitted or given mere cursory attention. All provider NPIs received should be validated regardless of the type of provider (staff, employee, referring, rendering, etc). This may be done by cross-referencing existing provider identifiers within the information system or enrollment/credentialing documents. Organizational Providers may wish to consider developing a regional initiative to minimize costs and workload (see Section F. Regional Initiatives and Codicil C).

Additional Business Issues

Document Imaging/Archival Solutions

Providers who have implemented document-imaging solutions should review that workflow process to determine if there are new documents, i.e., copies of paper applications that will need to be added to that process. Forms/documents currently scanned that will change while implementing the NPI will need to be reevaluated to ensure proper indexing and image capture. Indexing for all archival solutions in use must be reviewed as part of this implementation process. If legacy provider numbers are used as a routing or storage index, providers should seek assistance from the software vendor to determine how legacy numbers will be linked to the NPI for historic retrieval and appropriate continuity in the practice.

Reporting

Internally and externally submitted reports will need to be reviewed for updated NPI and taxonomy requirements. Financial, clinical, and other operational reports should be evaluated. Reports received from business associates and trading partners must be evaluated for required changes and updates.

Grants, accreditation, state/federal agency, and any other organization or entity to which a provider reports data that would include provider identifiers must be identified. Specifications must be reviewed and communication should occur between the provider and organization if there are any questions or concerns with reporting during the transition period or after the compliance date.

Implementation
During the implementation of this rule, providers must keep abreast of updates, clarifications, and guidelines as they are published. This is particularly critical when addressing software change requirements. Providers are strongly encouraged to

- Check the CMS website for updates regularly
- Watch for communications from CMS via list services, transmittals, program memoranda, and Medlearn Matters publications
- Participate in the WEDI NPI Sub Workgroup conference calls (held bi-weekly)
- Subscribe to the WEDI NPI Sub Workgroup (www.wedi.org/snip/)
- Watch for NPI-related seminars, workshops offered by health plans, provider organizations, state or regional SNIP organizations (a listing of SNIP organizations may be found at the above referenced WEDI website)

Since the beginning of the transition period, many professional organizations are stepping forward with recommendations regarding the application and implementation timing of the NPI. This, as well as all the other WEDI NPI Sub Workgroup white papers offers clear guidance and numerous strategies for compliance with the NPI rule. As providers and their business associates and trading partners prepare to implement the NPI, variables are many and complex. Preparation is the key to a successful implementation and deployment of the NPI.

2. Providers Employed by Organizational Providers

Providers employed by Organizational Providers are relieved of a great number of the considerations that must be made as part of this implementation. As corporate or group citizens, these providers may be called upon to assist with a number of implementation processes; it would be rare that they would have to initiate these processes themselves. This does not remove the need for these providers to apply for an NPI (as appropriate) or have ownership of that process.

While the covered Organizational Provider is required to ensure that all affected providers under its employ comply with the NPI Final Rule the Organizational Provider is not required to apply for an NPI for those providers unless they are designated as subparts. The exception to this part of the rule is if those providers are covered entities themselves, in which case they bear the responsibility for complying with the NPI Final Rule. As this population of providers is typically very mobile and, for the same reasons discussed in the Ownership and Responsibility section earlier in this paper, it is recommended that these providers carefully consider application/enumeration options available to them.

Providers employed by Organizational Providers should review the following sections in the Private Practice Providers section of this paper for actionable items to perform as part of the NPI preparation and implementation processes.

- **Overview**
- **Definitions**
- **Business and Implementation Issues - General**
- **Application and Enumeration**
- **Ownership and Responsibility**
- **Implementation**

C. Entity Type 2 - Organizational Providers

For the purpose of this paper, Type Code 2 providers are health care organizations, large or small. These include but are not limited to group practices, ambulatory surgical centers, clinics, retail pharmacies, independent laboratories, DME suppliers/stores, home health agencies, and any other freestanding health care entity that is retail-based or has multiple providers operating as a single legal entity. This paper breaks these providers into Group Practices, Institutional Providers, and Retail-based Providers.

While there are many shared business issues between Individual and Organizational Providers, Institutional and Pharmacy providers are by function the information clearinghouses in the provider community. Organizational Providers' timely reimbursement is dependent upon possessing the required data from the Individual Provider delivering the service for which they will bill. The majority of freestanding providers (pharmacies, laboratories, DME suppliers/stores, ambulatory surgery, diagnostic, physical/occupational therapy centers, et al) rely on referrals. Each of these entities will likely have to have the NPIs for those referring and ordering providers. Ambulance services depending upon how they bill for services will need to have an NPI for their service and for each health care provider employed.

Entity Type 2 providers fall into three categories for discussion: Group Practices, Institutional Providers, and Retail-based Providers. Group practices are multi-provider entities that may be single- or multi-specialty in scope. Examples include but are not limited to large physician practices, physical or occupational therapy groups, sports medicine groups, emergency medicine groups, and anesthesia groups. Large providers include acute care facilities, specialty hospitals, long-term care facilities, and health systems.

1. Organizational Providers - Group Practices

Identify Affected Business Processes/Education Needs

Many office staff members are affected by the NPI. Health plan enrollment processes should be reviewed. Billing personnel and financial representatives need to be able to recognize the NPI in claim transactions, understand its purpose, and the requirements of its use. Patient registration personnel, as a possible point of entry of the NPI into the practice, should know how to process received or missing NPI information.

Policies and procedures should be reviewed and updated accordingly. Staff should know how to address each of the following situations:

- The process for how and when to disseminate the provider's NPI
- The process for how and when NPIs are secured from other providers
- The process for accepting new members into group
- What to do when an NPI is required for processing a claim and the NPI is unknown
- How to address situations where an NPI may be required for a provider who is not required to acquire an NPI (referrals)

If the group or agency outsources billing or technology support, an office manager or someone with authority should be given responsibility for the NPI implementation and enumeration for the group or agency. Individual Providers should apply for their NPIs separately from the group for reasons that will become clear under the Ownership and Responsibility section.

Information and Computer Systems - Billing and Clinical

Current and proposed software in the group's practice that uses provider numbers or identifiers should be identified. Affected interfaces should also be identified. A gap analysis should be performed as applicable and discussions should ensue immediately to resolve any gaps identified. Example gap tools are provided in Codicil G. Software updates or changes to legacy computer systems, interfaces, translators, or claim scrubbers may need to be scheduled. Information services and/or business management personnel should understand the role of the NPI and its affect on software used by the organization. This process should be managed aggressively if these functions are outsourced. This is particularly important in clinics or practices where providers who were not previously required to possess a provider identifier and will start using the NPI in transactions.

Critical components to discuss with software vendors include support not only for the NPI, but also secondary identifiers, taxonomy codes (by plan/insurance and provider), and each type of provider required in a covered transaction that is supported by that vendor. A matrix of questions to ask software vendors is in Codicil B. Secondary identifiers are 837 and 835 data elements that provide additional identification information about a provider (see Codicil D and the Workgroup white paper, "Dual Use of NPI & Legacy Identifiers: Voluntary Strategy for Transitional, Dual Use of NPI and Legacy Identifiers in X12 Transactions").

Clinical (Radiology, Cardiology, etc.) imaging, laboratory, and other clinical systems traditionally have not stored legacy provider numbers. However, with the advent of electronic medical records, Regional Health Information Organizations (RHIOs), and the Federal Government's Health Information Technology initiative, it is possible that will change. Because the NPI is unique to the individual provider, it is conceivable that it will be used in an electronic health record system as the provider identifier. Computerized Physician Order Entry and other information systems that have traditionally used mnemonics of some sort to identify providers on orders, transcription, results, and other clinical transactions may now opt for the NPI as that identifier. This minimizes (or could remove) the need for convoluted interface mapping tables between clinical and billing systems. Disparate information systems now have a single link for providers across systems and platforms.

Specific to taxonomy codes, care must be taken to understand how the software supports their use. For example, the taxonomy code is to be used in 837I and 837P transactions when it is situationally required. However, an internal or external reporting requirement may exist whereby the taxonomy code description (not the code itself) is required in the report specifications. If the software does not store both, the provider must determine how this issue will be addressed.

Stand-alone databases should be included in this process. Work done for the HIPAA Privacy and Security implementations may save the NPI implementation team significant work as all of these databases should likely have been identified through those efforts. Research databases should be included in this process.

Trading Partners and Business Associates

Providers are responsible for ensuring that their business associates comply with the provisions of the final rule making this an important step to perform and document. Providers who use billing services, collection agencies, clearinghouses, re-pricers, third-party administrators, document management/imaging, or other vendors must identify those services and internal software applications that process or use provider legacy numbers and NPIs. Discussions with those vendors should begin immediately to ensure they would be ready to process NPIs and to ensure the provider's cash flow will not be disrupted. A matrix of questions to ask trading partners and business associates is included in Codicil B.

Application and Enumeration

The website address for the Enumerator is https://nppes.cms.hhs.gov. The web-based application and the paper application are available there. The Enumerators paper application target processing time, including response, is presently twenty (20) business days. The web application processing time, including response is expected to be five (5) business days. It is anticipated that a high volume of applications during the first few months of the Enumerator's operation will affect processing response time.

One important advantage the web-based application has over the paper application process is that there is real-time gap or missing information checking at the end of the application process on line. Providers know immediately if information is missing that will delay processing. The electronic application cannot be filed unless all required information is input. The Enumerator will validate against duplicate and potentially duplicate applications but that validation process is not be part of the real-time application process, nor is the SSN validation process part of the real-time application process. Web-based applications have been processed since May 23, 2005 while paper-based application processing started July 1, 2005. As of this writing, the bulk enumeration or Electronic File Interchange (EFI) process has not been fully defined. The stated goal is to have this process available the fourth quarter of 2005.

The Enumerator bases processing times on the receipt of complete and correctly submitted applications that do not require any clarification or changes. For this reason, it is important that providers secure a copy of the sample application document (CMS-10114) and develop a process for collecting and *validating* the necessary information. A copy of the sample application is available on the CMS HIPAA website and in the appendices of the WEDI white paper, "The NPI Registration Process". This white paper provides details regarding the application process, a sample of the paper application, and screen-prints from the web-based application. That paper also provides examples of clinic, Individual and Organizational Provider applications. Providers may also find a list of the data elements collected on both applications in the NPI final rule. CMS also has a tutorial on its website to assist providers with the application process called the NPI Viewlet.

It is critical to note that while some health plans in the past have had an interim or default identifier for providers to use (Medicare's UPIN OTH000); there are no interim or default NPI numbers. If an affected provider fails to acquire an NPI before he or she is ready to bill for services, those claims will probably have to be held until an NPI is received.

EFI enumeration can be costly. The X12N 274 transaction or an XML schema are expected to be required to be used by organizations who wish to enumerate providers using EFI submission. Practices that wish to be EFI submitters, but who do not employ programmers may have to outsource this function. The 274 transaction may be used for data dissemination (keeping in mind that data dissemination is a completely separate function of the NPPES.) EFI submissions will be returned to the submitter electronically and provisions will have to be made to accept the electronic file as well as post the data into the practice's computer system and notify the providers of their NPIs. Practices that use a computer system that disallows the importing of data will have to create a readable version of the electronic file for manual entry into those systems. Final formatting requirements, transmission, editing, response, and security requirements have not been established for the 274 or XML transactions.

Subparts
Enumeration decisions must be made carefully with considerable thought. The concept of subparts arises for Organizational Providers. For the group practice, it is important to understand that Individual Providers who bill for services in the group are required to have an NPI. The group, as a health care provider and legal entity must also obtain an NPI if it bills for services as the Pay-To or Billing Provider in a covered transaction.

Organizational Providers are required to determine if they need to identify subparts. Great care must be exercised in making this decision. Consideration could be given to legal status, state licensure, tax identities, and existing health plan requirements. Specific to the subpart discussion, a covered provider is a healthcare organization or group practice. subparts by definition are not legal entities; a provision of health care is presumed. The subpart designation applies only to a department or group within a larger organization. An individual cannot be a subpart. A clinical laboratory in a hospital may be considered a subpart but the pathologist within cannot (although s/he may obtain an Individual or Type 1 Entity NPI). There are several qualifying criteria for subpart status. For example, two criteria are:

- Does the department/group currently have a separate provider number in order to adhere to Federal Regulation, such as Medicare Enrollment requirements?
- If the department/group were a separate legal entity, would it be a health care provider required to obtain an NPI?

In a group practice, a radiology department or laboratory may be eligible to be enumerated as a subpart but the Organizational Provider (the group) is not required to enumerate them as such. Each entity that is a covered provider is responsible for identifying its subpart(s) so the group must have that discussion and may want to document their decisions regarding subparts. Should a group practice determine to enumerate a subpart, the covered Organizational Provider (the group), not the subpart, is responsible for securing an NPI for the subpart. The covered provider is responsible for ensuring the subparts compliance with NPI rule. The covered Organizational Provider is responsible for communicating subpart NPIs to those who need it. The subpart may perform all these tasks under the direction of the group but the group is responsible for the oversight of the subpart.

It is very important to understand that the NPPES does not associate the Organizational Provider NPIs to their subpart NPIs or any employee individual NPIs. Every NPI assigned is unique to that provider without regard to address, EIN, organization name(s), or any other data element that may be identical or shared between two or more providers. Therefore, it is of paramount importance that careful and accurate cross-referencing or mapping occurs between legacy and NPI numbers. This will ensure continued billing for services and accurate communication between providers and plans. A spreadsheet or similar tool is ideal for this type of analysis and resolution tracking.

A group may operate multiple geographically separate offices. The billing is performed out of each location with funds allocated accordingly; however, the billing provider for all

locations is the group. Each location is eligible, under the rule, for separate enumeration as a subpart. Unique organizational NPIs with one group name could be problematic with coordination of benefits. Coordination of benefits works only if the health plans involved are able to identify effectively the provider, organization or subpart NPI(s). Consistency in claim development is crucial to this process. Claim dictionaries, master tables, etc. must be maintained with great care and the complexity of doing so with multiple subparts increases significantly. This paper endorses the CMS recommendation in the NPI Final Rule of the use of the Service Facility Location Loop (In the ASC X12 837 transactions) as the default indicator for providers who render services in multiple locations within a small geographic area in the same state rather than obtaining a subpart NPI for each location.

Considerations must be made with regard to state licensing and credentialing requirements when determining subparts. If a provider uses billing services or clearinghouses for electronic claim submission, discussions regarding the use of those fields should start as soon as possible. The same is true for software vendors as the production or source system must be able to store and produce that information. Please refer to Codicil D for a listing of the ASC X12 Version 4010A1 transactions and the data elements affected by the NPI.

The discussion of subparts in this paper is intended merely to introduce the concept. The NPI Sub Workgroup has developed a white paper entitled, "NPI Subpart Designation for Organizations". The paper is currently in draft status and is expected to be published in early fall of 2005. To understand the nuances and depth of subpart enumeration, please refer to the subpart white paper when it is published.

Ownership and Responsibility

As the NPI is assigned for the life of the provider and is fully portable within the application of the HIPAA legislation, the dynamics of ownership change radically. Currently, the request for a provider number is a component of enrollment with a plan. With the implementation of the NPI, this is no longer the case. The NPI does not guarantee or create a request for enrollment with a plan or health plan. The NPI is merely a data element that eventually will be required as part of the enrollment process

Currently, the relationship between the Enumerator and the responsible party (i.e., the provider or the EFI organization) is one-to-one, e.g., one password for each provider or EFI organization. Any entity with password access to a provider's record in the NPPES may make the following changes to a provider's NPI data: Change NPI Password, View/Modify Data, and Deactivate NPI. Hierarchical security/access is not in place to support view-only or limited view-only access to a provider's NPI data.

It is the recommendation of this paper that each group practice assumes full ownership and responsibility for securing and maintaining its NPIs. The NPI is the unique identifier for providers. All providers who are covered entities under the NPI rule are required to meet the rule requirements under penalty of civil monetary penalties. Group providers should actively manage and take part in their enumeration regardless of the means

undertaken to do so. Group practices should make a business decision as quickly as possible as to whether or not they intend to apply on behalf of their employed providers (and therefore become an EFI Submitter).

A proxy application process, i.e., application by a third party (EFI or otherwise) does not relieve the provider from the responsibility and efforts to appropriately disseminate/disclose his or her NPI to the provider and plan community in that market. In an area where the Individual Provider base is shared across numerous facilities, proper dissemination is critical to uninterrupted cash flow due to missing NPI data in the claim. Additionally, EFI enumeration does not release Individual Providers of their obligation under the NPI final rule to maintain their data with the Enumerator unless such data maintenance is part of the provider's agreement with the EFI organization.

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EFI enumeration is not without value. If an Organizational Provider employs all (or a majority) of its physicians and is willing to follow the EFI requirements when they are established, EFI enumeration may be a responsible solution for that group of providers. Business decisions need to be made by every provider type to evaluate an application strategy that is in their best interest, to not only meet the compliance deadline but also for that entity's long term needs. Regional Health Information Organizations (RHIOs) are stepping forward to support application and dissemination efforts in some areas. Other regional initiatives are underway to educate and provide application hubs where providers may apply for an NPI with support staff nearby.

As of this writing, EFI Submitters will have to meet the following requirements:

- Be approved by the Enumerator to be an EFI submitter
- Must maintain their (the submitter) organizational demographics with the NPPES just as a provider is required to perform (contacts, authorizations, etc.)
- Ability to submit a compliant 274 or XML transaction over a web connection (an alternative batch process is to be available using CMS-developed software in the future)
- Must obtain a signed authorization from each provider for whom the submitter is filing an application
- Must retain a file of the appropriate authorization form from every provider for whom they are filing an application
- The submitter must use the provider's social security number in their transmission as a data element

- Ensure data are accurate and complete
- Manage corrections to pended records
- It is expected that there will be minimum and maximum file size requirement

Dissemination and Disclosure

When the Final Rule discusses NPIs being made available to health plans and others from NPPES, the term "dissemination" is used. When the NPI Final Rule discusses the requirement for providers to give their NPIs to others who need it for transactions, it uses the term "disclose." This paper follows that delineation.

Providers should develop a process to disclose their assigned NPIs to peers, provider organizations, and health plans with whom the group conducts business. This should be done quickly to prevent a delay in the group's revenue cycle. Groups may need disclose their group number as well as each Individual Provider's NPI to organizations that they have already applied and obtained staff privileges from and be ready to supply it to organizations where they will apply for staff privileges in the future. Many organizations are incorporating the collection of the NPI as part of their credentialing and renewal of privileges processes.

This paper suggests that providers further disclose their NPIs using the following methodologies:

- Notify those Organizational Providers where you refer your patients, i.e., hospitals, surgery centers, free standing and reference laboratories, etc.
- Add NPI numbers to prescription pad and external order forms
- Notify your contracted health plans with your new NPI number

Health Plan and Health Care Clearinghouse Issues

In Codicil B, a matrix of questions to ask trading partners and business associates is provided. Many health plans will cross-index existing legacy provider numbers (and may continue to do so well after the compliance date) within their adjudication system to continue to support existing reporting infrastructures. It is possible that some health plans will continue to assign provider numbers internally as well. If a health plan pursues this methodology, providers should be aware of it and establish a monitoring process during the transitional period and after converting to the NPI with that health plan. The monitors should be set up to ensure appropriate reimbursement and the consistent processing of claims, i.e., claims are not getting "lost" in the health plan adjudication system due to a mapping error. Similar tracking monitors should be put into place for a clearinghouse if that entity will perform a crosswalk between legacy numbers and NPIs. Additionally, providers should pursue updated companion guides from every health plan.

Legacy provider identifiers frequently incorporated location-specific intelligence to facilitate adjudication and payment. As the NPI does not possess this intelligence, providers must contact health plans to ascertain how location-specific information will be addressed post May 23, 2007. There are several options available to providers/plans in the 837 transactions. Providers who are still submitting claims via paper could have

more difficulty in these situations. Standard transactions and DDE replace the paper submission options. It may easily be assumed that virtually all changes and future rules will be developed with the standard transactions in mind. CMS, for example, is consistently using implementation guide language and terminology in program memoranda and transmittal communications—without providing a "crosswalk" to UB or 1500 (paper claim) data elements. The NPI was developed as a component of the standard transactions. Communication and current companion documents are vital to a successful implementation, particularly as it pertains to the location/payment issue.

Collection and Validation
Providers who receive and report referrals or rendering provider data on claims should start soliciting their peers for their NPIs. Upon receiving another provider's NPI, a validation strategy should be put into place as part of the organization's implementation and testing plan. This is a critical and vitally important component in any provider's implementation plan and it should not be omitted or given cursory attention. All provider NPIs received should be validated regardless of the type of provider (staff, employee, referring, rendering, etc). This may be done by cross-referencing existing provider identifiers within the information system or enrollment/credentialing documents.

Pharmacies may wish to cross-reference the DEA number as the DEA data is probably the most current and best managed provider database (for those providers who have a DEA number). Providers may wish to consider a regional effort to minimize costs and workload (see Section F. Regional Initiatives and Codicil C). Please refer to the WEDI NPI Sub Workgroup's implementation, sequencing, and testing White Paper for additional detail and guidance on testing strategies.

Additional Business Issues

Document Imaging/Archival Solutions
Providers who have implemented document-imaging solutions should review that workflow process to determine if there are new documents, i.e., paper applications that will need to be added to that process. Forms/documents that are currently scanned that will change because of implementing the NPI will need to be reevaluated to ensure proper indexing and image capture. Indexing for all archival solutions in place must be reviewed as part of this implementation process. If legacy provider numbers are used as a routing or storage index, providers should seek assistance from the software vendor to determine how legacy numbers will be linked to the NPI for historic retrieval and appropriate continuity in the practice.

Reporting
Internally and externally submitted reports will need to be reviewed for updated NPI and taxonomy requirements. Financial, clinical, and other operational reports should be evaluated. Reports received from business associates and trading partners must be evaluated for required changes and updates.

Grants, accreditation, state/federal agency, and any other organization or entity to which a provider reports data that would include provider identifiers must be identified. Specifications must be reviewed and communication should occur between the provider and organization if there are any questions or concerns with reporting during the transition period or after the compliance date.

Implementation
During the implementation of this rule, providers must keep abreast of updates, clarifications, and guidelines as they are published. This is particularly critical when addressing software change requirements. Providers are strongly encouraged to

- Check the CMS website for updates regularly
- Watch for communications from CMS via list services, transmittals, program memoranda, and Medlearn Matters publications
- Participate in the WEDI NPI Sub Workgroup conference calls (held bi-weekly)
- Subscribe to the WEDI NPI Sub Workgroup (www.wedi.org/snip/)
- Watch for NPI-related seminars, workshops offered by health plans, provider organizations, state or regional SNIP organizations (a listing of SNIP organizations may be found at the above referenced WEDI website)

Since the beginning of the transition period, many professional organizations are stepping forward with recommendations regarding the application and implementation timing of the NPI. This, as well as all the other WEDI NPI Sub Workgroup white papers offers clear guidance and numerous strategies for compliance with the NPI rule. As providers and their business associates and trading partners prepare to implement the NPI, variables are many and complex. Preparation is the key to a successful implementation and deployment of the NPI.

2. Organizational Providers - Institutional

Identify Affected Business Processes
Numerous departments are affected within an institutional provider's organization: Administration, Patient Accounting, Admissions/Patient Access, Managed Care, Pharmacy, Medical Staff, Credentialing, Information Services, Laboratory, Radiology, and others. Patient Accounting, particularly claim billers and financial representatives need to be able to recognize the NPI in claim transactions, understand its purpose, and the requirements of its use. Credentialing and health plan enrollment processes should be reviewed.

Policies and procedures should be reviewed and updated accordingly. Staff should know how to address each of the following situations:

- The process for how and when to disseminate the provider's NPI
- The process for how and when NPIs are secured from other providers
- What to do when an NPI is required for processing a claim and the NPI is unknown

- How to address situations where an NPI may be required for a provider who is not required to acquire an NPI (example: referrals)

The Medical Staff/Credentialing department will need to determine if the NPI will become part of their credentialing process when a provider applies for staff privileges and who is responsible for providing that information in that process. Physician leadership in the organization should be involved and supportive of those decisions.

Human Resources may wish to capture NPI data for all employed clinicians who obtain an NPI and include that data capture as part of their hiring process. The Accounting and/or Decision Support department may wish to use the NPI as an identifier to link billed services to expenses by provider. If the organization has a practice management group, they will need to be made aware of the NPI and its impact to their physicians and the organization.

Education/Training

A tiered training approach based upon business function is recommended for all affected business areas in the organization. Informational overviews of the NPI may be created for all clinical and ancillary staff not required to apply for an NPI. Clinicians and staff physicians (including residents) who are required to enumerate will require concentrated training with an emphasis on the dissemination of their NPIs to the organization. Training on the application process at medical staff meetings may be performed. Hosting monitored sessions with knowledgeable personnel to help providers with the application process could be offered.

The provider organization should consider if it is in the best interest of their organization to educate employed and privileged providers to facilitate collection of their NPI numbers. Education should instill an urgency to apply for an NPI. An equal emphasis should be placed upon disseminating their NPI to peers, provider organizations, and health plans with whom they conduct business (eligibility, referral, or claim submission, for example). Medical staff training could be accomplished through internal newsletters, meeting presentations, and notices throughout the organization. Advertising and news releases are other avenues to consider.

Patient Accounting, Managed Care, Admissions, Scheduling, the Controller and/or Chief Financial Officer, Business Development, and other Revenue Cycle-related departments need an understanding of what the NPI is, how it impacts cash flow, subpart-enumeration (as applicable), and potential health plan contractual implications. Patient Accounting billing personnel and financial representatives must be able to recognize the NPI in claim transactions, understand its purpose, and the requirements of its use. Resources and contacts should be identified for billing personnel regarding the handling of a claim missing a required NPI number. Patient registration and scheduling personnel, as possible points of entry of the NPI into the facility, should know how to process received or missing NPI information. The Chief Information Officer and Information Services personnel must have an understanding of the role of

the NPI, its technical specification (10-digit, numeric character string), and how it will affect software used by the organization.

Information Systems - Billing and Clinical

Current and proposed software that uses legacy provider numbers should be identified. Affected interfaces should also be identified. A gap analysis should be performed as applicable and discussions should ensue immediately to resolve any gaps identified. Software updates or changes to legacy computer systems, interfaces, translators, or claim scrubbers may need to be scheduled. Example gap tools may be found in Codicil G. The gap analysis should include taxonomy codes as well as provider identifiers.

Critical components to discuss with software vendors include support not only for the NPI, but also secondary identifiers, taxonomy codes (by plan/insurance and provider), and each type of provider required in a covered transaction that is supported by that vendor. A matrix of questions to ask software vendors is in Codicil B. Secondary identifiers are 837 and 835 data elements that provide additional identification information about a provider (see Codicil D and the Workgroup white paper, "Dual Use of NPI & Legacy Identifiers: Voluntary Strategy for Transitional, Dual Use of NPI and Legacy Identifiers in X12 Transactions").

Clinical (Radiology, Cardiology, etc.) imaging, laboratory, and other clinical systems traditionally have not stored legacy provider numbers. However, with the advent of electronic medical records, Regional Health Information Organizations (RHIOs), and the Federal Government's Health Information Technology initiative, it is possible that will change. Because the NPI is unique to the individual provider, it is conceivable that it will be used in an electronic health record system as the provider identifier. Computerized Physician Order Entry and other information systems that have traditionally used mnemonics of some sort to identify providers on orders, transcription, results, and other clinical transactions may now opt for the NPI as that identifier. This minimizes (or could remove) the need for convoluted interface mapping tables between clinical and billing systems. Disparate information systems now have a single link for providers across systems and platforms.

Specific to taxonomy codes, care must be taken to understand how the software supports their use. For example, the taxonomy code is to be used in 837I and 837P transactions when it is situationally required. However, an internal or external reporting requirement may exist whereby the taxonomy code description (not the code itself) is required in the report specifications. If the software does not store both, the provider must determine how this issue will be addressed.

Existing as well as proposed purchases of software applications and databases need to be evaluated for NPI support and compliance. Mapping, processing, and validation applications must also be evaluated for compliance for each covered transaction being processed by those tools. Software updates or changes to legacy computer systems, interfaces, translators, or claim scrubbers.

Stand-alone databases, including Research Databases, should be included in this step. Work done for the HIPAA Privacy and Security implementations may save the NPI implementation group significant work as all of these databases should likely have been identified through those efforts.

Trading Partners and Business Associates

Providers are responsible for ensuring that their business associates comply with the provisions of the final rule. Providers who use collection agencies, clearinghouses, re-pricers, third-party administrators, document management/imaging, or other vendors must identify those services and internal software applications that process or use provider legacy numbers and NPIs. Discussions with those vendors should begin immediately to ensure they would be ready to process NPIs and to ensure the provider's cash flow will not be disrupted. A matrix of questions to ask trading partners and business associates is included in Codicil B.

If the organization provides data to physician billing services, need to initiate conversations with those services to ensure their awareness and begin communication between the two entities to ensure a smooth transition.

Application and Enumeration

The website address for the Enumerator is https://nppes.cms.hhs.gov. The web-based application and the paper application are available there. The Enumerators paper application target processing time, including response, is presently twenty (20) business days. The web application processing time, including response is expected to be five (5) business days. It is anticipated that a high volume of applications during the first few months of the Enumerator's operation will affect processing response time.

One important advantage the web-based application has over the paper application process is that there is real-time gap or missing information checking at the end of the application process on line. Providers know immediately if information is missing that will delay processing. The electronic application cannot be filed unless all required information is input. The Enumerator will validate against duplicate and potentially duplicate applications but that validation process is not be part of the real-time application process. Web-based applications have been processed since May 23, 2005 while paper-based application processing began July 1, 2005. As of this writing, the bulk enumeration or Electronic File Interchange (EFI) process has not been fully defined. The stated goal is to have this process available the fourth quarter of 2005.

The Enumerator bases processing times on the receipt of complete and correctly submitted applications that do not require any clarification or changes. For this reason, it is important that providers secure a copy of the sample application document (CMS-10114) and develop a process for collecting and *validating* the necessary information. A copy of the sample application is available on the CMS HIPAA website and in the appendices of the WEDI white paper, "The NPI Registration Process". This white paper provides details regarding the application process, a sample of the paper application, and screen-prints of the web-based application. That paper also provides examples of

clinic, Individual and Organizational Provider applications. Providers may also find a list of the data elements collected on both applications in the NPI final rule. CMS also has a tutorial on its website to assist providers with the application process called the NPI Viewlet.

It is critical to note that while some health plans in the past have had an interim or surrogate identifier for providers to use (Medicare's UPIN OTH000); there are no interim or surrogate NPI numbers. If an affected provider fails to acquire an NPI (or disseminate it to the billing provider) before it is ready to bill for services, those claims will probably have to be held until an NPI is received.

Organizational Providers who employ individual or group providers should make a business decision as quickly as possible as to whether or not the organization intends to apply on behalf of their employed providers (and therefore become an EFI Submitter).

As of this writing, EFI Submitters will have to meet the following requirements:

- Must maintain their (the submitter) organizational demographics with the NPPES just as a provider is required to perform (contacts, authorizations, etc.)
- Ability to submit a compliant 274 transaction over a web connection (an alternative batch process is to be available using CMS-developed software as well)
- Must obtain a signed authorization from each provider for whom the submitter is filing an application
- Must retain a file of the appropriate authorization form from every provider for whom they are filing an application
- The submitter must use the provider's social security number in their transmission as a data element
- Manage line item rejections and make manual corrections to erred applications
- It is expected that there will be a minimum file size requirement

Subparts

Organizational Providers, in addition to obtaining their own NPI, are required to determine if they need to identify subparts within the organization. Great care must be exercised in making this decision. Consideration should be given to legal status, state licensure, federal requirements, tax identities, and existing health plan requirements. Subparts by definition are not legal entities; a provision of health care is presumed. The subpart designation applies only to a department or group within a larger organization. An individual cannot be a subpart. There are several qualifying criteria for subpart status. For example, two criteria are:

- Does the department/group currently have a separate provider number in order to adhere to Federal Regulation, such as Medicare Enrollment requirements?
- If the department/group were itself a legal entity, would it be a health care provider required to obtain an NPI (i.e., would it be a covered health care provider by virtue of conducting standard transactions?

In an acute care facility, a radiology department or laboratory may be eligible to be enumerated as a subpart, but the Organizational Provider (the facility) is not required to enumerate them as such. The covered Organizational Provider, not the subpart, is responsible for securing an NPI for the subpart. The covered provider is responsible for ensuring the subparts compliance with NPI rule. The covered Organizational Provider is responsible for communicating subpart NPIs to those who need it. The subpart may perform all these tasks under the direction of the organization but the organization is responsible for the oversight of the subpart.

It is very important to understand that the NPPES does not associate the Organizational Provider NPIs to their subpart NPIs or any employee individual NPIs. Every NPI assigned is unique to that provider without regard to address, EIN, organization name(s), or any other data element that may be identical or shared between two or more providers. Therefore, it is of paramount importance that careful and accurate cross-referencing or mapping occurs between legacy and NPI numbers. This will ensure continued billing for services and accurate communication between providers and plans.

An organization may operate multiple geographically separate sites. Patient billing may be performed by each location with funds received accordingly, a centralized business office may perform the billing, or a hybrid of both scenarios may exist. Each location is eligible, under the rule, for separate enumeration as a subpart. Unique organizational NPIs with one organization name could be problematic with coordination of benefits. Coordination of benefits works only if the health plans involved are able to identify effectively the provider, organization or subpart NPI(s). Consistency in claim development is crucial to this process. Claim dictionaries, master tables, etc. must be maintained with great care and the complexity of doing so with multiple subparts increases significantly. This paper endorses the CMS recommendation in the NPI Final Rule of the use of the Service Facility Location Loop (In the ASC X12 837 transactions) as the default indicator for providers who render services in multiple locations within a small geographic area in the same state rather than obtaining a subpart NPI for each location.

Considerations must be made with regard to state licensing and credentialing requirements when determining subparts. If a provider uses billing services or clearinghouses for electronic claim submission, discussions regarding the use of those fields should start as soon as possible. The same is true for software vendors as the production or source system must be able to store and produce that information. Please refer to Codicil D for a listing of all affected transactions and the data elements affected by the NPI.

The discussion of subparts in this paper is intended merely to introduce the concept. The NPI Sub Workgroup has developed a white paper entitled, NPI Subpart Designation for Organizations. The paper is currently in draft status and is expected to be published in early fall of 2005. To understand the nuances and depth of subpart enumeration, please refer to the subpart white paper when it is published.

The organization is required to update the NPPES with that data within 30 days of the change. If a health care provider is sanctioned or barred from one or more health plans, the provider's NPI will remain active

Ownership and Responsibility

The NPI is assigned as the organizations permanent identifier. Currently, the request for a provider number is a component of enrollment with a plan. With the implementation of the NPI, this is no longer the case. The NPI does not guarantee or create a request for enrollment with a plan or health plan. The NPI is a data element that will be required as part of the enrollment process.

Currently, the relationship between the Enumerator and the responsible party is one-to-one, e.g., one password for each provider or group NPI. Any entity with password access to the Enumerator website may make the following changes to a provider's NPI data: Change NPI Password, View/Modify Data, and Deactivate NPI. Presently, hierarchical security/access is not in place to support view-only or limited view-only access to a provider's NPI data. Organizations should review their provider enrollment process and determine responsibility for application and maintenance of its NPI(s).

If an Individual Provider is on medical staff at an Organizational Provider's facility, that Organizational Provider may apply for an NPI on behalf of the Individual Provider by virtue of the established relationship as long as the Individual Provider is notified of the action. A proxy application process, i.e., application by a third party (EFI or otherwise) does not relieve the provider from the responsibility and efforts to appropriately disseminate/disclose his or her NPI to the provider and plan community in that market. In an area where the Individual Provider base is shared across numerous facilities, proper dissemination is critical to uninterrupted cash flow due to missing NPI data in the claim. Organizational Providers must be aware of these issues and should address them in their project plan. Organizational Providers' timely reimbursement is dependent upon possessing the required data from the Individual Provider delivering the service for which they will bill. The majority of freestanding providers (pharmacies, laboratories, DME suppliers/stores, ambulatory surgery, diagnostic, physical/occupational therapy centers, et al) rely on referrals. Each of these entities will likely have to have the NPIs for those referring and ordering providers. Ambulance services depending upon how they bill for services will need to have an NPI for their service and for each health care provider employed.

CMS's position is that dissemination will be very controlled. CMS does not want organizations disseminating provider NPIS to the "marketplace". Even if the provider uses EFI enumeration, the provider, not the EFI submitter, is responsible for disclosing its NPI to those entities who need it in covered transactions. While CMS supports EFI, it does not support any other type of arrangement a provider may make with an organization in which the organization updates the provider's data. In those situations, the provider is essentially letting the other organization represent it when web-based or

paper transactions are conducted. If something goes wrong, that provider will have to justify why it made those arrangements with that organization.

EFI enumeration is not without value. If an Organizational Provider employs all (or a majority) of its physicians and is willing to follow the EFI requirements when they are established, EFI enumeration may be a responsible solution for that group of providers. Business decisions need to be made by every provider type to evaluate an application strategy that is in their best interest, to not only meet the compliance deadline but also for that entity's long term needs. Regional Health Information Organizations (RHIOs) are stepping forward to support application and dissemination efforts in some areas. Other regional initiatives are underway to educate and provide application hubs where providers may apply for an NPI with support staff nearby.

Maintenance of the NPI

In the final rule, covered Organizational Providers are responsible for updating their NPPES data within thirty (30) days of the change. Covered Organizational Providers with subparts must update their subpart(s) changes to their NPPES data within thirty (30) days of the change as well. Failure to comply with the final rule's requirements makes the covered provider not the Enumerator, the covered provider's designee or the subpart liable for civil monetary fines on a per violation basis.

As with Individual Providers, there are very limited situations in which an NPI will be replaced or reissued. An NPI will be replaced if it has been used fraudulently. An NPI will be inactivated if the entity is dissolved, disbanded, or closes. If an organization returns to operation, its previous NPI will be reactivated. A new NPI will ***not be required*** in the following circumstances

- Change of ownership
- Change from partnership to corporation
- Change in the State where an organization health care provider is incorporated (ownership and incorporation information is not stored in the NPPES)
- Organization health care provider name changes
- Employer Identification Number changes
- Address changes
- Healthcare Provider Taxonomy classification changes
- State of licensure or State license number changes
- Mergers (After a corporate merger, the surviving organization may continue to use its assigned NPI)

Dissemination and Disclosure

When the Final Rule discusses NPIs being made available to health plans and others from NPPES, the term "dissemination" is used. When the NPI Final Rule discusses the requirement for providers to give their NPIs to others who need it for transactions, it uses the term "disclose." This paper follows that delineation.

Providers should develop a process to disseminate/disclose their assigned NPI number (including subpart NPIs) to business associates and trading partners. This should be done as soon as feasible to prevent a delay in the revenue cycle.

Health Plan and Health Care Clearinghouse Issues

In Codicil B, a matrix of questions to ask trading partners and business associates is provided. Many health plans will cross-index existing legacy provider numbers (and may continue to do so well after the compliance date) within their adjudication system to continue to support existing reporting infrastructures. It is possible that some health plans will continue to assign provider numbers internally as well. If a plan intends to pursue this methodology, providers should be aware of it and establish a monitoring process in a financial department during the Transition period and after converting to the NPI with that plan. The monitors should be set up to ensure appropriate reimbursement and the consistent processing of claims, i.e., claims are not getting "lost" in the plan adjudication system due to a mapping error. Similar tracking monitors should be put into place for a clearinghouse if that entity will perform a crosswalk between legacy and NPI numbers.

Contracts should be reviewed for changes necessitated by the implementation of the NPI. It is incumbent upon the provider, not the health plan, to cross-reference legacy and NPI numbers within and across contracts. Reimbursement issues need to be addressed immediately and contract renegotiations should be a high priority should the need arise. Additionally, providers should pursue updated companion guides from every plan, especially if the plan will require secondary identifiers during the transition period. Providers must shoulder the responsibility of the communication to their NPIs to health plans and clearinghouses. This communication should follow the process suggested in the preceding Dissemination section. The Provider who enumerates quickly will find it easier to work with health plans and clearinghouses.

Health plans may implement the NPI in transactions prior to May 23, 2007. All providers should anticipate this. Plan claim and remittance volumes directly affect their implementation processes. Health plans that require the embedded intelligence used in legacy provider numbers to adjudicate claims must find new or modified means by which to process claims. This may require an immense update or conversion to their information systems. As this type of change usually occurs at a regional or national scale, it should be expected that conversions would occur prior to the May 23, 2007 compliance date. In an FAQ posted on the CMS website, CMS has stated that health plans may require providers to submit the NPI in covered transactions prior to the compliance date. It is important to note that plans converting their systems prior to the compliance date are allowed to reject claims submitted without the NPI for covered transactions. This is a compelling argument for health plans and providers to implement a transitional strategy (see Section E. Transition Strategy later in this paper). On June 14, 2005, CMS announced their transition plan for the Fee-for Service Medicare Program. *"Beginning January 3, 2006, and through October 1, 2006, CMS systems will accept an existing legacy Medicare number or an NPI as long as it is accompanied by an existing legacy Medicare number. Beginning October 2, 2006, and through May 22, 2007, CMS systems will accept an existing*

legacy Medicare number and/or an NPI. This will allow for 6-7 months of provider testing before only an NPI will be accepted by the Medicare Program on May 23, 2007."

Legacy provider identifiers frequently incorporated location-specific intelligence to facilitate adjudication and payment. As the NPI does not possess this intelligence, providers must contact health plans to ascertain how location-specific information will be addressed post May 23, 2007. There are several options available to providers/plans in the 837 transactions. Providers who are still submitting claims via paper and Direct Data Entry (DDE) could have more difficulty in these situations. Standard transactions replace the paper and DDE submission options. It can easily be assumed that virtually all changes and future rules will be developed with the standard transactions in mind. CMS, for example, is consistently using implementation guide language and terminology in program memoranda and transmittal communications—without providing a "crosswalk" to UB or 1500 (paper claim) data elements. The NPI was developed as a component of the standard transactions. Communication and current companion documents are vital to a successful implementation, particularly as it pertains to the location/payment issue.

Additionally, health plans may now stipulate that NPI-eligible providers identify themselves when conducting non-HIPAA transactions or other business with them. For example, this requirement would facilitate administrative data consistency within their information systems/organization.

Collection and Validation

Providers who receive and report referrals or rendering provider data on claims should start soliciting their provider base for their NPIs. Upon receiving a provider's NPI, a validation strategy should be put into place as part of the organization's implementation and testing plan.

Validation is a critically important component in any provider's implementation plan and it should not be omitted or given cursory attention. All provider NPIs received should be validated regardless of the type of provider (staff, employee, referring, rendering, etc). This may be done by cross-referencing existing provider identifiers within the information system or enrollment/credentialing documents. Pharmacies may wish to cross-reference the DEA number as the DEA data is probably the most current and best managed across the provider landscape. Providers may wish to consider a regional initiative to minimize costs and workload (Section F. Regional Initiatives and Codicil C).

Many organizations are incorporating the collection of the NPI as part of their credentialing and renewal of privileges processes. Providers must consider how they will handle the missing NPI that is needed for reimbursement of services provided to a patient. Unlike the Medicare UPIN, number there is not a surrogate number to use for the NPI. Post compliance date, plans may reject or deny claims or transactions missing required and situationally required NPI data. The Organizational Provider will need to determine how it plans to address providers who are unable or unwilling to supply their NPI number. Some organizations are taking a hard stance with providers due to the interruption in cash flow a non-compliant transaction can create. It will take a serious

commitment of the organizations senior management to deny staff privileges to providers who have failed to obtain an NPI number.

Additional Business Issues

Document Imaging/Archival Solutions

Providers who have implemented document-imaging solutions should review that workflow process to determine if there are any new documents, i.e., paper applications that will need to be added to that process. Forms/documents that are currently scanned that will change because of implementing the NPI will need to be reevaluated to ensure proper indexing and image capture. Indexing for all archival solutions in place must be reviewed as part of this implementation process. If legacy provider numbers are used as a routing or storage index, providers should seek assistance from the software vendor to determine how legacy numbers will be linked to the NPI for historic retrieval and appropriate continuity in the practice.

Reporting

Internally and externally submitted reports will need to be reviewed for updated NPI and taxonomy requirements. Financial, clinical, and other operational reports should be evaluated. Reports received from business associates and trading partners must be evaluated for required changes and updates.

Grants, accreditation, state/federal agency, and any other organization or entity to which a provider reports data that would include provider identifiers must be identified. Specifications must be reviewed and communication should occur between the provider and organization if there are any questions or concerns with reporting during the transition period or after the compliance date.

Implementation

During the implementation of this rule, providers must keep abreast of updates, clarifications, and guidelines as they are published. This is particularly critical when addressing software change requirements. Providers are strongly encouraged to

- Check the CMS website for updates regularly
- Watch for communications from CMS via list services, transmittals, program memoranda, and Medlearn Matters publications
- Participate in the WEDI NPI Sub Workgroup conference calls (held bi-weekly)
- Subscribe to the WEDI NPI Sub Workgroup (www.wedi.org/snip/)
- Watch for NPI-related seminars, workshops offered by health plans, provider organizations, state or regional SNIP organizations (a listing of SNIP organizations may be found at the above referenced WEDI website)

With the beginning of the transition period, many professional organizations are stepping forward with recommendations regarding the application and implementation timing of the NPI. This, as well as all the other WEDI NPI Sub Workgroup white papers offers clear guidance and numerous strategies for compliance with the NPI rule. As providers and their business associates and trading partners prepare to implement the

NPI, variables are many and complex. Preparation is the key to a successful implementation and deployment of the NPI.

Testing
Testing should occur with every health plans to which claims are submitted. The plans should notify the provider in advance of their intentions to test and an updated companion guide should be provided prior to testing. Please refer to the WEDI NPI Sub Workgroup's Implementation, Sequencing, and Testing White Paper for additional detail and guidance on testing strategies.

3. Retail-based Providers

Pharmacies, Durable Medical Equipment (DME), and other retail providers have several challenges. These providers will depend almost exclusively on the dissemination of NPI data to update their information systems. Many are corporate owned and should start making inquiries at the appropriate levels as to the corporate strategy for enumeration and dissemination. The same preparation for the NPI is required for these providers as it is for other providers discussed in this paper.

Application and Enumeration
Pharmacies currently use the National Council for Prescription Drug Programs (NCPDP) provider numbers in their covered transactions. NCPDP maintains and disseminates this information. As of May 23, 2005, pharmacists and pharmacies alike became eligible to apply to the Enumerator for an NPI. The Enumerator data set differs significantly from the NCPDP data set and how that will affect NCPDP databases is unknown. For example, NCPDP maintains information such as payment centers and pharmacy parent organizations as well as network affiliations in their database; the NPPES does not.

The NCPDP has stated that it will apply with the Enumerator to be an EFI Submitter when that functionality becomes available. Catherine C. Graeff, NCPDP Sr. V.P. Communications and Industry Relations has stated on NCPDP's behalf that it will not charge pharmacies for their EFI submission service. The NCPDP is asking pharmacies to wait to apply for NPIs until NCPDP is an approved EFI Submitter. At that time, the NCPDP will notify pharmacies, solicit their authorizations, and update their information in the NCPDP database as necessary.

A white paper jointly authored by NCPDP and WEDI SNIP entitled, "Impact of NPI on the Pharmacy Services Sector" will address the specific issues related to the pharmacy services sector and NCPDP's intent. The first draft of that paper has been written and may be expected in the early Fall of 2005.

Retail chain Organizational Providers are encouraged to investigate EFI Submission as an option for their organizations.

Retail-based providers should refer to the following introductory and Organizational Provider – Institutional topics as well.

- **Overview**
- **Definitions**
- **Business and Implementation Issues - General**
- **Ownership and Responsibility**
- **Dissemination and Disclosure**
- **Plan and Clearinghouse Issues**
- **Collection and Validation**
- **Transition Strategy**

Additional Business Issues

- **Document Imaging/Archival Solutions**
- **Reporting**

D. Dental Providers' Business and Transactional Considerations

Dental providers will need to apply for an NPI if they submit standard transactions. The NPI is accommodated on the current paper ADA Dental Claim Form (2002 and 2002/2004), i.e., a code that is ten characters long. The ADA has stated that when the paper form is redrafted, accommodation of an NPI and legacy identifiers by qualifier code will be a design consideration. In addition to the Overview, Definitions, and Business and Implementation Issues – General sections of this paper, Individual dental providers are encouraged to read the Individual Providers section of this paper and group practices are encouraged to read the Organizational Providers – Group Practices section of this paper. The practices billing methodologies and plan requirements will mandate the use of the NPI in their business transactions.

E. Transition Strategy

During the transition period (May 23, 2005 through May 22, 2007), the provider should continue to use legacy provider identifiers in the interim period between application for and receipt of an NPI. However, once a provider receives its NPI, this paper recommends that providers begin transitioning legacy numbers to the NPI in covered transactions as soon as their trading partners and business associates are able to collaborate with them in this very important step. A dual usage of NPI and legacy numbers is recommended for this process. Providers, clearinghouses, health plans, and software vendors will all be ready to test and/or implement the NPI changes at different times. While a coordinated effort would be ideal, it would be difficult to manage or enforce a large-scale transition for the industry.

A Transition strategy, adopted by each covered entity allows independent internal development and collaborative testing/implementation. A dual usage strategy supports

a short-term strategy for testing, validation, and seamless conversion. It also supports a long-term strategy should health plans still require/need legacy identifiers. This process and its business case are detailed in the WEDI NPI Sub Workgroup white paper, "Dual Use of NPI & Legacy Identifiers: Voluntary Strategy for Transitional, Dual Use of NPI and Legacy Identifiers in X12 Transactions".

The NCPDP transaction does not support dual identifiers. A plunge implementation strategy will have to be adopted for all pharmacies. This situation reinforces the need for early application and enumeration by each pharmacy as well as all prescribing providers with whom they partner to provide health care. Health plans are encouraged to collaborate with pharmacies early in the transition period to establish an implementation strategy.

F. Regional Initiatives

Health Care communities, particularly those with a shared pool of providers, may wish to consider a collaborative effort to educate providers about the NPI. Numerous issues surround the NPI implementation, many of which are business issues that affect all payers and providers regardless of whether or not a standard HIPAA transaction is involved. As virtually all aspects of the revenue cycle are affected by this change: eligibility, claim submission, remittance advice, and referrals will all require review in this process.

Several regional efforts have sprung up across the country. The recurring themes in each region include constant and consistent communication, education, and the organized and accelerated enumeration of regional providers. One of the benefits of participation is the sharing of NPIs within the region. The dissemination of NPI numbers by the Enumerator is limited to the applicant or applying entity. The current dissemination plan, by design, virtually requires the communal sharing of NPI numbers between providers, providers and payers, and providers and clearinghouses. With a regional effort in place, the dissemination of NPI numbers is organized, less complex, and insulates the market against an NPI-related cash flow crisis. A business case and template for establishing a regional effort are found in Codicil C.

G. Continuity Planning

As with other implemented phases of HIPAA, a continuity plan should be considered. While it is not anticipated there will be any contingency plan provided by CMS, a provider should evaluate the impact to the revenue cycle of its business with the assumed greatest impact in claim submission and reimbursement. When the rule becomes enforceable law on May 23, 2007, all providers, regardless of type or size should implement a cash flow evaluation plan. This plan should include monitors for reimbursement, denials, rejections, and claim acceptance notices (997 or proprietary reports from plans and clearinghouses). Providers may wish to evaluate the possibility

of establishing a higher cash reserve in the event of key health plans or an industry-wide delay in claim reimbursement. Potential barriers should be identified and providers should determine their business plan to address each identified barrier. A potential barrier might be a plan that is unable to receive or process the NPI on a claim. A provider's continuity plan might be to be ready to submit paper claims, or continue to submit legacy numbers on claims for health plans who place the provider in this situation. Continuity planning requires careful thought and consideration. Mitigation of the negative financial impact to the provider with the NPI implementation is as critical as any other HIPAA-related implementation.

H. Proposed e-Prescribing Rule

As currently written, the proposed e-prescribing rule (42 CFR Part 423) states

"HHS is considering requiring the use of the NPI as the provider identifier for and electronic prescription program under Medicare Part D. We believe that it is necessary to have a unique identifier for these transactions. The NPI is the preferred option, because it is a standard that many entities will be required to use under HIPAA. If use of the NPI is required for e-prescribing transactions involving Medicare Part D drugs at the time the benefit is available in January 2006, prescribers, pharmacies, Part D Sponsors and potentially other entities would be required to implement the NPI for e-prescribing transactions earlier than the current compliance date for the HIPAA covered transactions. The NCVHS also urged HHS to accelerate the enumeration of all providers to support transition to the NPI for e-prescribing. We have been planning to enumerate HIPAA covered providers of the course of several years. Accelerated NPI usage for e-prescribing, there fore, may not be possible, as HHS may not have the capacity to issue NPIs to all covered providers by January 1, 2006."

The NCPDP has proposed the use of an interim identifier, the HCIdea identifier until the NPI compliance date of May 23, 2007 arrives. All affected providers should follow closely the development of this rule.

VI. Acknowledgements

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VII. List of Codicils

Codicil A – Case Study Project Plan
Codicil B – Question Matrices
Codicil C – A Regional Initiative Template
Codicil D – Listing of Affected X12N 4010A1 Transactions
Codicil E – Provider Listing
Codicil F – NPI Educational Material
Codicil G – Example Gap Tools

Codicil A – Case Study Project Plan

Task	Start Date	Finish Date	Resource(s)
Initial Education and Awareness Meeting - Senior Management / Managers / Partners / Group			
Establish Implementation Team			
Secure Resource Allocation Approvals			
Identify Affected Business Units/Departments			
Identify Affected Employed and Contract Employees / Workforce Members			
State Law Review			
Review Regulation			
Develop Taxonomy Strategy			
Identify Affected Information Systems/Databases			
Identify Affected Information Systems/Databases Requiring Updates/Changes			
Identify Affected Processes / Policies / Procedures			
Evaluate Future Software Purchases For NPI Compliance Activities			
Identify affected vendors / business associates / trading partners / other external organizations			
Develop questionnaire for vendors / business associates / trading partners / other external organizations			
Make Business Associate Inquiries			
Software Vendors			
Billing Services			
Third Party Administrators			
OCR/Imaging Services			
Clearing Houses			
Other			
Make Trading Partner Inquires			
Health Plans			
Other			

Task	Start Date	Finish Date	Resource(s)
Determine Location/Subpart Strategy			
Review Regulation and Additional Information Sources			
Identify Existing Provider Numbers Used Within Organization			
Develop Crosswalk Tool to Ensure Accuracy of Strategy as it is Developed			
Identify Potential Qualifying Locations / Departments / Entities			
Review Contracts to Determine Potential Subpart Enumeration Needs			
Contact Identified Health Plans to Determine Contractual Reimbursement Changes			
Develop Proposal / Strategy (Minimal Subpart Enumeration Recommended)			
Secure Approvals - Location / Subpart Strategy			
Information Systems Gap Analysis / Assessment			
Data Flow Assessment			
Identify Interfaces Affected			
Identify Interface Gaps			
Identify Claim Mapping Gaps			
Identify Other Mapping Gaps			
Assessment of Reports			
Identify Reports Affected			
State Reporting Assessment (HIDI, HEDIS)			
Identify Other Outside Report Submissions Affected			
Master Tables/Files			
Identify Master Tables/Files Affected			
Identify Master Table/File Gaps			
Contact External Reporting Agencies			
Request Updated Specifications			
Update Information Systems			
Steps determined based upon vendor approach			

Task	Start Date	Finish Date	Resource(s)
Test System Updates			
Steps determined based upon vendor approach			
Determine Provider Application Process			
Secure Necessary Approvals Provider Application Process			
Update Policies and Procedures			
Credentialing/Medical Staff Appointment and Renewals			
Intern/Resident Enumeration			
Billing Issues Created by Missing NPI Data			
Dissemination			
NPI Data Collection			
Referrals Processing			
Application, Enumeration, and Maintenance			
Other			
Secure Approval for Updated Policies and Procedures			
Develop Contingency Plan			
Apply for NPI(s)			
Determine Provider Education and Training Needs			
Steps determined based upon provider type and needs			
Develop Provider Curriculum			
Steps determined based upon provider type and needs			
Determine Staff Education and Training Needs			
Steps determined based upon staff role and needs			
Develop Staff Education and Training Curriculum			
Steps determined based upon staff role and needs			
Perform Staff Education and Training			
Provider NPI Data Collection			
Steps determined based upon Enumerator decisions and other variables			
Perform Provider Education and Training			

Task	Start Date	Finish Date	Resource(s)
Move Information System Updates into LIVE/Production Environments			
Steps determined based upon established procedures			
Load NPI Data into Information Systems			
Steps determined based upon established procedures			
Disseminate NPIs to Appropriate Entities			
Internal Development and Testing			
Determine strategy for each identified system / application			
Create development plan for each identified system / application			
Create testing / validation strategy for identified system / application			
Implement development strategies			
Test / validate system / application changes			
Document findings			
Test with Trading Partners			
Create Test Claim Files			
Process Test Claim Files			
Remediation			
Re-test as necessary			
Document findings			
Determine Transitional or Conversion Strategy			
By Health Plan			
Implement NPI/Production			
Coordinate Go-Live with/by Health Plans			
Coordinate Go-Live with/by Business Associates			
Coordinate Go-Live with Business Units/Departments			
Implement Production Systems Changes			
Address Post Implementation Issues			
Compile Documentation of Efforts			

Codicil B – Question Matrices

Codicil B
Question Matrices

The following matrices serve as a starting point for providers to begin communications with trading partners and business associates (External Entities) as well as to jump-start their internal implementation. Each provider has different information needs based upon how they conduct business and what type of provider they are. The matrices are not intended to be all-inclusive; they must be modified to meet the business needs of the provider using them. The "X" indicates the entity for which the question is recommended. It is a guide and not intended to indicate a requirement or a restriction. Approach each situation with open communication and exchange as a goal.

Use of the matrices
Not every question applies to every provider situation. The readership is urged not to perform a blanket inquiry to every trading partner or business associate. For providers choosing to use the matrices, this paper recommends the following steps:

Archiving/Imaging and Software Vendors

- Perform a software/report gap analysis to determine which vendors require contact
- Carefully scan each question to determine if it applies to the software
- Determine, as much as possible, what type of response is expected or anticipated. This process will help the provider determine the criticality of the question and its response
- Determine if there are additional questions that need to be asked for each vendor
- Compile a questionnaire for each vendor/application/software that will allow the vendor responses to be documented on the same form. Format the document to facilitate the documentation of any follow-up requirements/findings
- Providers should understand how they will use the information received before receiving it

Health Plan/Third Party Administrator/Billing Service/Health Care Clearinghouse

- Carefully scan each question to determine if there is a business need to be addressed by asking it
- Manage risk by determining which plans provide critical reimbursement to the provider practice/organization. Develop a questionnaire based on those findings. Providers may not wish to ask all questions to all plans based on this evaluation
- Determine, as much as possible, what type of response is expected or anticipated. This process will help the provider determine the criticality of the question and its response
- Determine if there are additional questions that need to be asked for each entity
- Compile a questionnaire that will allow the entity responses to be documented on the same form. Format the document to facilitate the documentation of any follow-up requirements/findings

Codicil B
Question Matrices

Health Plan/Third Party Administrator/Billing Service/Health Care Clearinghouse, continued

- Check the entity's website and provider bulletins to determine if some of the questions to be asked have already been addressed via one of those mediums
- Providers should understand how they will use the information received before requesting it
- It is important to remember that secondary identifiers are not allowed for use after May 23, 2007 in covered transactions.

	Questions Internal to the Practice/Organization	Individual Providers	Organizational Providers
1	What departments are affected?		X
2	What information systems are affected?	X	X
2.1	What information systems need to be altered or updated?	X	X
3	What procedures/processes are affected?	X	X
4	What policies are affected?	X	X
5	What external organizations are affected?	X	X
6	What outbound reporting is affected, i.e., to contracted payers or state/federal agencies?	X	X
7	Which employed providers need enumeration?		X
8	How do we currently obtain/maintain provider numbers?	X	X
8.1	How will that change during implementation/transition (what will be our strategy?)	X	X
8.2	What is our application/enumeration strategy?	X	X
9	What type(s) of education is needed?	X	X
10	How will we address Subpart enumeration?		X
11	How will we disseminate our NPI information internally and externally?		X
11.2	How will the NPI be disseminated to those areas or providers who need my NPI?	X	
11.3	Will we participate in a regional effort for dissemination?	X	X
11.4	How will we get the NPIs from those providers who refer to us?	X	X
12	What will be the coordination/communication process between contracted providers and our organization?	X	X
13	How will we address NPI numbers needed but not received?	X	X
14	Will the NPI be used internally, i.e., payroll, 1099, or credentialing processing?		X
15	How will we address billing for services in multiple locations/Tax IDs?	X	X

	Questions to External Entities	Software Vendor	Billing Svcs	3rd Party Admin	Archiving/ Imaging	Health Plans	Health Care Clearinghouse	NCPDP
	Trading Partners / Business Associates / Organizations							
1	Is there a designated contact for NPI implementation issues?	X	X	X	X	X	X	X
2	Do you have a plan to implement the NPI?	X	X	X	X	X	X	X
2.1	How and when will you communicate your implementation plan?	X	X	X	X	X	X	X
3	When will updated Companion Guides be available?					X		
4	Will you have a transitional period of using both the legacy identifier and the NPI (dual identifier strategy) or do you plan to convert on a certain date (by txn)?					X	X	
4.1	If you will have a transitional period, when will you be able to share that plan?		X	X		X	X	
4.2	If converting without dual identifier transition period, when do you plan to test?		X	X		X	X	
4.3	Do you have a conversion date (tentative or firm)?	X	X	X	X	X	X	X
5	What is your transition plan for the provider enrollment process?			X		X	X	X
6	How will you validate submitted NPIs?			X		X	X	X
7	Will NPIs be validated as part of the adjudication or claims submission process?			X		X	X	
8	Will you require re-enrollment for providers?			X		X		
8.1	How will the enrollment process change?			X		X	X	X
9	Will taxonomy codes be required to adjudicate claims?					X		
10	Will you continue to assign legacy identifiers internally for adjudication?					X		
10.1	How will legacy identifiers be supported in your process?					X		
10.2	How will legacy identifiers be supported in your software?					X		
10.3	Will you discontinue assigning legacy numbers?					X		
10.4	If so, when will you discontinue assigning legacy numbers?					X		
10.5	How will I access legacy identifiers in the system after changes are made to accommodate the NPI?	X		X				

	Questions to External Entities	Software Vendor	Billing Svcs	3rd Party Admin	Archiving/ Imaging	Health Plans	Health Care Clearinghouse	NCPDP
10.6	Structurally, within the system, how will historic reporting be supported between legacy and NPI identifiers?	X	X	X		X	X	
10.7	Will reporting options be canned or will ad hoc reporting be supported?	X	X	X			X	
11	Do you intend to crosswalk legacy identifiers to NPI within your system?	X	X	X	X	X	X	X
11.1	IF YES, describe in detail how the crosswalk will be built/designed, i.e., will it be a map, will existing tables be modified, etc.	X	X	X	X	X	X	X
11.2	How will the crosswalk be maintained?	X	X	X	X	X	X	X
11.3	What will be done to ensure the validity/data integrity of the crosswalk?	X	X	X	X	X	X	X
11.4	Will I be able to list the crosswalk(s)?	X	X	X	X	X	X	X
11.5	Will a data flow chart be made available to display crosswalk structure?	X	X	X	X	X	X	X
11.6	IF NOT, describe in detail what will be done to ensure data integrity	X	X	X	X	X	X	X
12	How will you process same provider/multiple locations claims/remittance advices post-implementation?					X		
13	Do you have subpart requirements?					X		
14	Will you require new Trading Partner Agreements?					X	X	
15	Will you require new Business Associate Agreements?			X			X	
16	Will you require discussions regarding current contracts?					X		
17	Will you re-issue beneficiary cards?			X		X		
18	Will you require the NPI on paper-based transactions?			X		X		
19	Will you require providers to update you in addition to the Enumerator?			X		X	X	X
19.1	What will be the process?			X		X	X	X

	Questions to External Entities	Software Vendor	Billing Svcs	3rd Party Admin	Archiving/ Imaging	Health Plans	Health Care Clearinghouse	NCPDP
20	Are you willing to post your organization's testing and production date/status information to assist with industry coordination?					X	X	
21	Do you qualify as a small health plan?					X		
22	If so, will your organization take the additional year to comply?					X		
23	Will any new charges (one-time or on-going) be incurred to accommodate and maintain any changes made?	X	X	X	X		X	X
24	How will the NPI implementation affect any subscription or other support fees currently in place?	X			X		X	X
	Software / Application / Database General							
25	Will the current version/release be updated or will customers need to move to the next version/release?	X	X		X		X	X
26	When do you expect the software updates to be available to customers?	X			X		X	X
27	When do you expect to receive or implement updates/new versions of software?		X	X		X	X	
28	How will the NPI be supported in the (affected) system/software?	X	X	X	X		X	X
29	What interface changes will need to occur?	X	X		X		X	
30	Will your system be updated to the new UB-04 and once approved, the new CMS-1500 forms in accordance with the NPI changes?	X	X	X	X	X	X	
31	Will there be any costs associated with the NPI related changes?	X	X		X		X	
32	Will the software support primary and secondary identifiers? Explain.	X	X	X	X		X	
33	Does the software support taxonomy codes for providers? Explain.	X	X	X	X		X	

	Questions to External Entities	Software Vendor	Billing Svcs	3rd Party Admin	Archiving/ Imaging	Health Plans	Health Care Clearinghouse	NCPDP
34	How many taxonomy codes per provider are supported? Explain.	X	X	X	X		X	
	Provider Master Files / Tables / Dictionaries							
35	Will the software support primary and secondary identifiers? Explain.	X						
36	Does the software support taxonomy codes for providers? Explain.	X						
37	How many taxonomy codes per provider are supported? Explain.	X						
38	**Insurance/Payer Master Files / Tables / Dictionaries**							
39	Will the software support primary and secondary identifiers? Explain.	X						
40	Are taxonomy codes supported in the Insurance/Payer Files/Tables? Explain.	X						
41	How many taxonomy codes per provider are supported in the Insurance/Payer Files/Tables? Explain.	X						

Codicil C – A Regional Initiative Template

Codicil C
The Business Case for a Regional Initiative

Our Industry

Virtually every provider, health plan, and clearinghouse in the nation will require NPI data. Providers may apply for an NPI using one of two methods: self-enumeration and EFI submission. The Enumerator began processing web-based applications on March 23, 2005. Paper applications have been processed since July 1, 2005. EFI submission (previously known as bulk enumeration) is expected to be implemented late 2005 or early 2006. *Regardless of the method used, providers, health plans, and clearinghouses all need NPI data for the providers in the region they serve.* Entities that conduct covered EDI transactions are required to use the NPI in those transactions as stipulated by implementation guide rules. Health plans may require the use of the NPI in any legitimate business transaction with a provider.

Cost Management and Reduction

A regional initiative promotes implementation strategy development, communication, and the crucial dissemination of provider NPI data.

Collaborative regional undertakings reduce duplicate efforts. Most health care regions share a provider base that comprises their medical staffs and other providers. Nearly all health care providers are eligible to apply for an NPI and many are required to do so. Every provider (individual, group, or large organization) submitting claim and eligibility transactions electronically is dependent upon other providers in the region for their NPI.

Within any region, multiple institutions gather and submit data to the NPI Enumerator. The Enumerator should identify any duplicate submissions and plans to report NPI assignment information for all legitimate submissions. Dissemination, which is secondary only to a provider's application in criticality, must still occur between providers and plans. Collaboration minimizes the costs associated with "silo" approaches made by each provider or provider organization within a region. Additionally, a regional initiative mitigates potential cash flow issues that may arise when plans begin requiring the use of NPIs in covered transactions (which can occur *any time during the transition period* and will occur as of May 23, 2007).

Early provider enumeration and the development of crosswalks between legacy identifiers and NPIs are essential. These needs are particularly critical for organizational providers who must use identifiers for staff and non-staff providers. WEDI (Workgroup for Electronic Data Interchange) estimates that the "systems changes and development cycle" is eighteen months. Immediate planning and implementation allows for coordinated and adequate development and testing time. Data integrity is essential for every crosswalk. Every organization should create a crosswalk to ensure correct provider-to-NPI association. This process also facilitates validating that organization's provider master tables/files in their Health Care Information System (HCIS) and/or billing system. A regional crosswalk supports dissemination while distributing costs and minimizing each participant's scope of work for this component of the implementation process.

Codicil C
The Business Case for a Regional Initiative

Providers and health plans planning to implement the WEDI SNIP recommended Dual Identifier Strategy, benefit from a regional initiative's communal interaction. Referring provider NPIs is a significant concern for providers and plans alike. All participating providers and plans save time and effort in coordinating and implementing the dual strategy when it becomes a collaborative initiative. Testing, timing, and sequencing all come together in a single method and communication model. Using a dual identifier strategy reduces implementation periods and the time needed to maintain duplicate system and business processes. It is important to note that health plans will undoubtedly implement their system changes on a scale and timeline independent of the May 23, 2007 compliance date. These system changes will drive their conversion dates to the use of the NPI in their adjudication processes. As an industry, we talk about transactions, covered and non-covered, but the transaction is merely a device used in the adjudication process and that process is driven by technology. Implementation of a dual identifier strategy on a regional/collaborative scale is extremely powerful.

With the advent of Regional Health Information Organizations (RHIO) and like entities, an organization may already be committed to a regional re-credentialing or an emergency preparedness response project. A regional NPI implementation initiative could either fold into a RHIO or be the springboard to begin one. As the National Health IT initiative builds momentum and policy structure, the benefits of a regional initiative/collaborative of some sort seem imminent. "Grass root" efforts with open collaboration maximize existing resources without external fees. However, there are several third-party organizations seeking to provide quality, cost-effective services to assist regions with the application and dissemination processes. Organizations and regions must determine the best business decision for their situation.

Consistency in Message and Policy

Regional projects provide consistent and timely education to individual providers and organizations about the NPI structure and the enumeration process. While there are cost reduction benefits in these initiatives as well, the overwhelming benefit is effective education and awareness paired with a unilateral message to individual providers. Regional education efforts help assure the inclusion of all provider specialties and their information needs. These initiatives also facilitate plan-provider communication that is not only cost-effective, but also collaborative.

A regional initiative can provide quality, accurate information to all providers and plans while building consensus between provider organizations on how non-compliant providers will be addressed. The NPI reinforces the concept of community and interdependence between all providers, particularly as it applies to cash flow and reimbursement. If organizational providers in a region require a provider's NPI number to be on file in their organization by a certain date (with regionally consistent consequences), the region is insulated against NPI-related cash flow issues.

Codicil C
Regional Initiative Template

The purpose of this template is to provide a basic framework from which a regional initiative could be developed. It is intentionally generic and hopefully customizable to any U.S. healthcare market or region. Each situation is unique based upon the participants, potential and actual, involved. The use of consulting firms or other third parties is neither decried nor endorsed. Those entities are mentioned here solely to provide additional options for the potential process.

Most healthcare markets are competitive for plans and providers alike. Some regions historically work well together while others flounder. Any regional initiative must strive for a neutral ground for all participants.

Establish goals or a mission statement so all entities clearly understand the purpose of the initiative. For example,

- To educate the regional health plan and provider communities about the National Provider Identifier (NPI)
- To accelerate the NPI application and enumeration process in the regional health care community
- To ensure a successful dissemination of NPI numbers across the regional health care community

Someone must take the first steps. Create a working committee to champion a regional NPI implementation effort and recruit partners.

- Develop a business case specific to your region or market
- Create a *draft* implementation plan
  - Include open-ended options that the Initiative will need to make decisions about in its first stages. For example,
    - Short and long-term goals (RHIO?)
    - Will the Initiative apply to be an EFI Submitter?
    - Is there a need to develop an RFP or solicit firms for bids to manage the regional effort?
    - Will the "master list/database" be destroyed post implementation*
- Compile a *draft* of ground rules for all participants. For example,
  - To adhere to an agreed upon strategy for provider enumeration
  - To host one or more education/training events
  - To promote application/enumeration in their organizations
  - To provide an environment (under agreed upon standards and options) whereby providers can apply either via paper application or via the Internet
  - To report provider identifiers to the regional committee**

Codicil C
Regional Initiative Template

Host a meeting of key provider revenue cycle, health plan, and clearinghouse representatives in the region where the committee will present the implementation plan and other materials. Recruit representatives from each entity to participate and assist in the effort. Illustrate how a regional effort can ensure a consistent and accurate flow of information to the community.

- Develop and deploy materials for community education sessions
- Coordinate media releases
  - Educational for community providers
  - Taut the cost savings to the patient and physician communities
- Create a target list of providers to educate
- Create a *draft* presentation for the regional commencement meeting
- Develop *draft* education and training materials for use at community sessions
- Establish guidelines for application sessions
- Develop additional materials as needed

Cornerstones to a successful effort include, but are not limited to

- Ensuring that a community culture is nurtured and enforced
- Creating and managing a provider NPI "list" during the implementation phase to collect NPI numbers**
- Flexibility
- A focus on the common good
- A dissemination plan upon which all participants can agree

*There is only one Enumerator and one NPPES database under the NPI rule. This does not exclude the existence of regional databases but very specific and strict guidelines should be designed that are enforceable. When information regarding the EFI Submission process is available, some of these issues may be defined (or eliminated) within that process.

**This may be accomplished in any number of ways. As the NPI is a protected data element, every effort must be taken to ensure security and promote a sense of trust. Acting in the best interests of their client or employer, legal counsel can shy away from the term "database" or concepts of central repositories of any kind. This is a potential barrier for some organizations that will have to be overcome if they are to participate. An address book is a database by definition. Develop reasonable security measures for your collection, storage, and dissemination processes to solicit buy-in.

Codicil D – Listing of Affected X12N 4010A1 Transactions

NPI Use In
Covered Transactions

Data Elements Requiring or Situationally Requiring NPI Usage after 05/23/07	TXN	LOOP	SEGMENT	DATA ELEMENT	PAGE
Provider Identifier	270	2100C	PRV03	127	82
Provider Identifier	270	2100D	PRV03	127	123
Provider Identifier	271	2120C	PRV03	127	263
Provider Identifier	271	2120D	PRV03	127	339
Provider Identifier	276	2100C	NM109	67	69
Provider Identifier	277	2100C	NM109	67	145
Provider Identifier	834	2310	NM109	67	142
Provider Identifier	835	2000	TS301	127	81
Rendering Provider Primary Identification Number	835	2100	NM109	67	
Rendering Provider Identifier	835	2110	REF02	127	157
Payee Identification	835	1000B	N104	127	73
Service Provider Identifier	278 - Request	2010E	NM109	67	126
Service Provider Identifier	278 - Response	2010E	NM109	67	305
Billing Provider Identifier	837D	2010AA	NM109	67	78
Pay-to Provider Identifier	837D	2010AB	NM109	67	89
Referring Provider Identifier	837D	2310A	NM109	67	189
Rendering Provider Identifier	837D	2310B	NM109	67	197
Laboratory or Facility Primary Identifier	837D	2310C	NM109	67	204
Rendering Provider Primary Identification Number	837D	2420A	NM109	67	291
Assistant Surgeon Identifier	837D	2310D	NM109	67	19
Assistant Surgeon Identifier	837D	2420C	NM109	67	35
Billing Provider Identifier	837I	2010AA	NM109	67	78
Pay-to Provider Identifier	837I	2010AB	NM109	67	93
Attending Physician Primary Identifier	837I	2310A	NM109	67	323
Operating Physician Primary Identifier	837I	2310B	NM109	67	330
Other Physician Identifier	837I	2310C	NM109	67	337
Laboratory or Facility Primary Identifier	837I	2310E	NM109	67	350
Attending Physician Primary Identifier	837I	2420A	NM109	67	464
Operating Physician Primary Identifier	837I	2420B	NM109	67	471
Other Provider Identifier	837I	2420C	NM109	67	478
Billing Provider Identifier	837P	2010AA	NM109	67	86
Pay-to Provider Identifier	837P	2010AB	NM109	67	101
Referring Provider Identifier	837P	2310A	NM109	67	284
Rendering Provider Identifier	837P	2310B	NM109	67	292
Purchased Service Provider Identifier	837P	2310C	NM109	67	300
Laboratory or Facility Primary Identifier	837P	2310D	NM109	67	305
Supervising Provider Identifier	837P	2310E	NM109	67	314
Rendering Provider Identifier	837P	2420A	NM109	67	503
Purchased Service Provider Identifier	837P	2420B	NM109	67	509
Laboratory or Facility Primary Identifier	837P	2420C	NM109	67	516
Supervising Provider Identifier	837P	2420D	NM109	67	525
Ordering Provider Identifier	837P	2420E	NM109	67	531
Referring Provider Identifier	837P	2420F	NM109	67	543

Codicil E – Provider Listing

Codicil E
Provider List

This list serves as a reference to identify the majority of health care providers who are either required or eligible to apply for an NPI. Providers may be required to obtain an NPI depending upon how their services are billed and/or where those services are provided (hospital- or provider-based, for example). Providers should review state and health plan requirements to determine eligibility (and requirements in states where the state law may be more stringent than the federal rule).

The list is intended to be inclusive but not comprehensive. Specialties, specific physician credentialing, taxonomy, and other clinical and academic certifications were generally not taken into consideration in the compilation of this list. Atypical providers are not included in this listing. Readers should refer to the WEDI NPI Sub-workgroup atypical provider white paper for a discussion of those providers.

Individual Providers	Organizational Providers
Audiologist	Acute Care Hospital
Behavioral Health Counselor	Ambulance Service Providers
Certified Midwife	Ambulatory Surgical Center
Certified Respiratory Therapist	Assisted Living Facility
Dental Assistant	Clinical Laboratory
Dental Hygienist	Custodial Care Facility
Emergency Medical Technician (EMT)	Dental Laboratory
Home Health Aide	Health Care Clinics
Nurse Aide	Home Health Agency
Occupational Therapist	Home Infusion Agency
Orthotist	Hospice Agency
Paramedic	Intermediate Care Facility
Pharmacist	Long Term Care Facility
Physical Therapist	Nursing Home
Prosthetist	Pharmacy
Pulmonary Function Technologist	Physician Group Practice
Radiology Technologist	Psychiatric Hospital
Registered Dietitian	Reference Laboratory
Registered Respiratory Therapist	Rehabilitation Hospital
Social Worker	Residential Treatment Center
Speech-Language Pathologist	Respite Care Facility
Chiropractor	Skilled Nursing Facility
Dentist	Specialty Hospital

Codicil E
Provider List

Doctor of Osteopathy	Urgent Care Clinic
Medical Doctor	Durable Medical Equipment Supplier
Optometrist	Eyewear Service Provider
Physician Assistant	Medical Supply Company
Podiatrist	Health Maintenance Organizations
Psychologist	
Residents	
Anesthesiologist Assistant	
Certified Nurse Midwife	
Certified Registered Nurse Anesthetist	
Clinical Nurse Specialist	
Licensed Practical Nurse	
Nurse Practitioner	
Registered Nurse	
Transport Nurse	

Codicil F – NPI Educational Material

Codicil F
The National Provider Identifier

What is a National Provider Identifier?

- The National Provider Identifier (NPI) is the next Identifier mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to be implemented
- The NPI replaces current provider numbers (UPIN and all payer-assigned provider numbers)
- All Covered Entities must use the NPI as the provider's primary identifier in all standard transactions (except claim status inquiry transactions) as of the compliance date

Who is affected?

- Providers eligible to have an NPI include but are not limited to:
    - Physicians
    - Group Practices
    - Nurse Practitioners
    - Radiologists
    - Dentists
    - Chiropractors
    - Clinical Therapists
    - Hospitals
    - Ambulance Services
    - Laboratories
    - HMOs

What must providers do?

- Affected providers must have their NPIs obtained and disseminated by the compliance date, May 23, 2007
- Affected providers must *apply* for an NPI; numbers *will not* be *assigned*
- Health plans may require their enrolled providers to obtain an NPI
- Providers began applying for NPI on May 23, 2005
- Application for an NPI may be made today using an approved paper form (CMS-10114) or on the National Plan and Provider Enumeration System (NPPES) website
- Electronic File Interchange (EFI) Submission is being defined and is expected late 2005, early 2006

What is the NPI nomenclature?

- A unique 10-digit number
- Assigned for life
- No intelligence built into number to assure national portability

Who will administer the NPI database?

- The Centers for Medicaid and Medicare Services (CMS) has oversight and enforcement authority for the NPI
- The National Plan and Provider Enumerator System (NPPES) developed under contract with CMS to accept applications, assign NPIs, and manage database

Codicil F
The National Provider Identifier

What is the time frame for implementation?

- Conversion to NPI must be completed by compliance date, May 2007 (small health plans with less than $5 million annual revenue must comply by May 2008)

The NPI Does Not

- Guarantee reimbursement by health plans
- Make providers covered entities
- Require providers to conduct electronic transactions
- Does not embed payer-specific information about providers in the number

Will health plans still enroll providers?

- Yes, providers will still need to enroll with health plans but instead of receiving an identifier *from* the health plan, the plan will ask the provider *for* their NPI.

How is this different from a UPIN or other provider number today?

- An NPI is assigned by an agent of the a Federal Government for the life of the provider
- NPI data is password-protected
- Many providers who have traditionally not received provider numbers are now eligible and may be required to obtain an identifier
- Some providers are not eligible for an NPI
- Non-compliant providers are subject to civil monetary penalties

What is a Legacy number?

- Any number used by providers today to identify themselves to a health plan

What aspects of my business operations are affected by the NPI?

How operations are affected depends on the type of provider you are, i.e., a group practice, an individual provider who is self-employed, an individual provider employed by an organization, a large provider (hospitals), etc. An abbreviated list of potentially affected areas includes:

- Clinical and billing software used
- Contracts that use legacy identifiers to calculate reimbursement
- Billing
- Eligibility inquiries and referrals
- You may need to start using taxonomy codes when billing for services
- Reports generated using legacy numbers
- Your organization may be required to apply for NPIs for departments within the organization

When may health plans start requiring the use of NPI on claims and other transactions?

- We are currently in the transition period; a plan may make that requirement at any time

Where may I learn how to apply?

- NPI Viewlet

Codicil G – Example Gap Tools

Codicil G
Gap Tools

The following gap tool examples serve as scalable templates for a gap analysis documents. It is recommended that a gap analysis is performed for the provider identifier as well as for taxonomy codes. With relatively minor modifications, the gap tool may also be used as a template for a report gap analysis that documents internal and external reporting needs/changes. Each provider has different information needs based upon how they conduct business and what type of provider they are. The gap tool templates are not intended to be all-inclusive. They assume a multiple-facility status but must be modified to meet the business needs of the entity using them.

Codicil G-1
Listing of suggested data elements/fields to be captured for analysis

Codicil G-2
Example of NPI gap tool

Codicil G-3
Example of Taxonomy gap tool

Codicil G-4
Example of Report documentation tool

Data	Specification / Explanation	Comments
Facility Name or Designation	Internal/Software Identifier/Code	
Facility's Location / Dept	Name of physical location or department	
Vendor Name	The name of the application's vendor	
Name of Application(s) Affected	Line item listing of each application where a provider identifier is stored	
Database/Module Name	Line item listing of each database or module within the application where a provider identifier is stored	
Transaction	Example: 837P	
Implementation Guide Loop	Example: 2010AA	From implementation guide
Implementation Guide Name	Example: Billing Provider Identifier	From implementation guide
Implementation Guide Reference Designator	Example: NM109	From implementation guide
Implementation Guide Requirement (Required or Situational)	Example: Required	From implementation guide
Location(s) of Provider Identifier (Data Element Screen Name)	Line item listing of the screen name of each data element within the database/module where a provider identifier is displayed	
Location(s) of Provider Identifier (Data Element Internal Name)	Line item listing of the internal data element name for each data element within the database/module where a provider identifier is stored	
Is the Data Maintained By the Facility? (Y or N)	Y = personnel enters/maintains data N = Vendor enters/maintains data	
Are Reports Affected (Y or N)	Y = Reports used internally or externally use or report this data element N = No reports use or report this data element	If Y, use a separate document to record the report information.
Is the Data Table Driven/Free Text/ Both/Other (Explain)	Indicate if the field is restricted to a table look-up or if it is free-text	
Does the Field Support the NPI Syntax? (Y or N)	Does the field allow for the use of a 10-digit number?	
Usage: Billing / Clinical / Reporting Only / Other (Explain)	List how field is used in system; can be multiple uses	
Data Owned By (Internal Department)	List the department(s) that "owns" the data	
Vendor or Dept Name	Enter the vendor name. If the app or database is "home grown", name of the department that supports the software	
Vendor/Dept. Contact Info (Name / Phone# / e-mail)	Self-explanatory	
Vendor Support Location & Hours	List the vendor's support city/state and hours of operation	
Employee(s) Responsible for Support of Application / Software / Database	List employee contact for vendor/software	
Is Software/Database Programmed By This Facility? (Y or N)	Y - There is no outside vendor, staff fully supports the software. N - An outside vendor supports the software	
Date Vendor Contacted	Date the vendor was contacted and inquiries about NPI support made	
Findings / Vendor Response	Document findings or responses	
Vendor Follow Up Needed / Date	Self-explanatory	
Follow-Up Performed (Date)	Self-explanatory	
Vendor Review Completed (Date)	Self-explanatory	

Provider Identifier Sample Document

Facility	Facility Location / Dept	Vendor Name	Application(s) Affected	Database/Module	TXN	Loop	Name	Ref Des	REQ	Location(s) of Provider Identifier (Data Element Screen Name)	Location(s) of Provider Identifier (Data Element Internal Name)	Internal (Y or N)	Reports Affected (Y or N)	Table Driven/Free Text/ Both/Other (Explain)	Does Field Support NPI Syntax (Y or N)
East	Enterprise	Vendor X	HUB	HUB	All		All designations using the NPI	NM109	R	Provider Dictionary - INS PIN	provider.ins.pin	Y	Y	Free Text	Y
West	HH		Billing	AR.HH	837P	21010 AA	Billing Provider Number	NM109	R	Assigned in Claim Dict/Page 2, references Provider Dictionary values	provider.ins.pin	Y	N	Table	Y
NEO	LW		Billing	AR.LW	837P	21010 AA	Billing Provider Number	NM109	R	Assigned in Claim Dict/Page 2, references Provider Dictionary values	provider.ins.pin	Y	N	Table	Y
HH	Med Staff Dept	Internal	Access	Physician Database	837P	21010 AA	Billing Provider Number	NM109	R	Phys Ins Number	Phys Ins Number	Y	Y	Free Text	Y

Facility	Usage: Billing / Clinical / Reporting Only / Other (Explain)	Data Owned By (Internal Dpt)	Vendor or Dept Name	Vendor/Dept. Contact Info (Name / Phone# / e-mail)	Vendor Support Location & Hours	Employee(s) Responsible for Support	Programmed Internally (Y or N)	Date Vendor Contacted	Findings / Vendor Response	Vendor Follow Up Needed / Date	Follow-Up Performed (Date)	Vendor Review Completed (Date)
East	Multiple: used by Billing and Trans	Med Staff	Vendor X	Amy Tan / 800.555.5555 x23458 / atan@xyzt.com	MA 0700-1630 M-F	Linda Smith x44444	N	5/31/2005	Current fields will support NPI. No changes required.	N		
West	Billing - Claims	Pt Accounts	V	Bev Shea / 800.555.555 x45875 / bshea@xyz.com	MA 0700-1630 M-F	Mike Rivers x47777	N	6/1/2005	Current fields will support NPI. No changes required.	N		
NEO	Billing - Claims	Pt Accounts	V	Bev Shea / 800.555.555 x45875 / bshea@xyz.com	MA 0700-1630 M-F	Mike Rivers x47777	N	6/1/2005	Current fields will support NPI. No changes required.	N		
HH	Reporting Only	Med Staff	I/T	Daniel Muscoweitz x43333	8-5 M-F	Daniel Muscoweitz x43333	Y	6/2/2005	Will need minor modifications to accommodate. Submitted to Daniel for completion.	N/A		6/2/2005

Taxonomy Code Sample Document

Facility	Facility Location / Dept	Vendor Name	Application(s) Affected	Database / Module	Location(s) of Taxonomy Code (Data Element Screen Name)	Location(s) of Taxonomy Code (Data Element Internal Name)	Editable (Y or N)	Reports Affected (Y or N)	Table Driven/Free Text/ Both/Other (Explain)	Does Field Support Syntax?	Usage: Billing / Clinical / Reporting Only / Other (Explain)
East	Enterprise	Vendor X	HUB	HUB	Provider Dictionary - Specialty	prov.spec	Y	Y	Free Text	Yes but code only; no desc	Multiple: used by Billing and Trans
West	HH		Billing	AR.HH	Assigned inClaim Dict/Page 2, references Provider Dictionary values	provider.tax.cde	Y	N	Table	Yes but code only; no desc	Reporting only
NEO	LW		Billing	AR.LW	Assigned inClaim Dict/Page 2, references Provider Dictionary values	provider.tax.cde	Y	N	Table	Yes but code only; no desc	Reporting only

Example - Taxonomy
Software Gap Tool

Facility	Data Owned By (Internal Dpt)	Vendor or Dept Name	Vendor/Dept. Contact Info (Name / Phone# / e-mail)	Vendor Support Location & Hours	Employee(s) Responsible for Support	Programmed Internally (Y or N)	Date Vendor Contacted	Vendor Follow Up Needed / Date	Follow-Up Performed (Date)	Vendor Review Completed (Date)
East	HIM	Vendor X	Amy Tan / 800.555.5555 x23458 / atan@xyzt.com	MA 0700-1630 M-F	Linda Smith x44444	N	5/31/2005	Y		
West	HIM	V	Bev Shea / 800.555.555 x45875 / bshea@xyz.com	MA 0700-1630 M-F	Mike Rivers x47777	N	6/1/2005	Y		
NEO	HIM	V	Bev Shea / 800.555.555 x45875 / bshea@xyz.com	MA 0700-1630 M-F	Mike Rivers x47777	N	6/1/2005	Y		

Report Sample Document

Report Name	Database / Application / Module Written From	Report Data Element Name	Menus On Which Rpt Is Located	Is Rpt Programmed By Us or Vendor?	Vendor or Dept Name	Vendor/Dept. Contact Info (Name / Phone# / e-mail)	Vendor Support Location & Hours	Date Vendor Contacted	Vendor Follow Up Needed / Date	Follow-Up Performed (Date)	Vendor Review Completed (Date)
Staff Physician Listing	HUB	dr.number	74, 80-120	Us	IT	Amy Tan / 800.555.5555 x23458 / atan@xyzt.com	MA 0700-1630 M-F	5/31/2005	N		
Employed Providers List	Payroll	LicNmbr2	HR124	Us	IT	Bev Shea / 800.555.555 x45875 / bshea@xyz.com	MA 0700-1630 M-F	6/1/2005	N		
Revenue Stats By Physician	Billing	phys.id	Admin Rpts	Us	IT	Bev Shea / 800.555.555 x45875 / bshea@xyz.com	MA 0700-1630 M-F	6/1/2005	N		
Doctor List	StaffPro	dr.ins.nmbr	K	Us	Med Staff	Daniel Muscoweitz x43333	8-5 M-F	6/2/2005	N/A		6/2/2005