
**WEDI Strategic National Implementation Process (SNIP)
SNIP Transactions Workgroup
National Provider Identifier Sub Workgroup**

HIPAA National Provider Identifier White Papers



NPI Subpart Designation for Organizations

September, 2005

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NPI Subpart Designation for Organizations

I. Purpose

The purpose of this white paper is to provide clarification and recommendations regarding National Provider Identifier (NPI) subparts. This white paper will not go into impacts to various health care types (Providers, Plans, etc...), enrollment and so forth as those are discussed in other WEDI white papers and workgroups.

II. Scope

The scope of this white paper will be:

1. Expand on the recommendations identified in the WEDI PAG Final Report.
2. Identify other business and implementation issues related to the designation and use of NPI for subparts.
3. Provide recommended courses of action to address these issues.
4. Give examples of how provider organizations may decide to enumerate.

In some areas of the White Paper, this Workgroup hopes that CMS will respond to questions regarding some of the uncertainty with subparts. Please note that there will be updates and versions of this working document.

III. Definitions

Business grouping – A grouping, in which an individual provider practices, comprised of one or more individual practitioners or a grouping of facilities. A business grouping is a health care provider as this is the organization that is conducting the billing and/or is receiving the payment for either its practitioners and/or facilities. This is illustrated in the HIPAA regulations, under 45 CFR 160.103 (Pg. 82799 from the Privacy Regulations) – “*Health care provider* means a provider of services (as defined in section 1861(u) of the Act, 42 U.S.C. 1395x(u)), a provider of medical or health services (as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s)), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.”.

Covered Entities – Health plans, health care clearinghouses, and health care providers as defined by the Health Insurance Portability and Accountability Act (HIPAA) regulations at 45 CFR 160.103.

Federal Program Regulation – Any and all federal regulations applying to federal health programs. When applicable to only one federal health program, the program will be specifically identified.

Health Care Federal Program Regulated Entity – A health care provider (an organization or individual) who determines its NPI enumeration based on Federal Program Regulations.

Health Plan-assigned Identifiers – Proprietary numbers that plans have assigned to provider(s) today that are required to be used in transactions conducted with the health plan. Often these are called “legacy” identifiers or numbers.

Health Care Providers – Entities that meet the regulatory definition of “health care provider” found at 45 CFR 160.103. “Covered health care” providers are those who conduct any of the HIPAA standard transactions (referred to as “covered transactions” in this White Paper), whether or not they use a business associate to do so. All health care providers are eligible for NPIs; covered health care providers, and subparts of covered organization health care providers who conduct standard transactions, must obtain and use NPIs.

Legal Entity – This term is used most frequently when describing NPI enumeration of organization providers and designation of subparts. In this context, a legal entity would include but not be limited to corporation or partnership performing legal business activities and are entitled to receive and use an IRS-assigned Employer Identification Number.

Organization - An entity, other than an individual, that is licensed, certified or otherwise authorized to provide medical services, care, equipment or supplies in the normal course of business. An organization health care provider may be the legal entity (i.e., a covered organization provider) or a subpart of a covered organization provider.

Subparts - Any component of the covered organization health care provider who needs 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 billing numbers in order to be reimbursed by Federal health plans, or certain other reasons. Subparts requiring an NPI will obtain Organization or Entity Type Code 2 NPIs.

Taxonomy Code – The following definition is taken from the Washington Publishing Company’s (WPC) Taxonomy website: “The Provider Taxonomy is a unique alphanumeric code, ten characters in length. The code list is structured into three distinct “Levels” including Provider Type, Classification, and Area of Specialization. The Provider Taxonomy Code List allows a single provider (individual, group, or institution) to identify their specialty category. Providers may have one or more than one taxonomy associated to them. When determining what code or codes to associate with a provider, the user needs to review the requirements of the trading partner with which the code(s) are being used.” The Taxonomy Code List is maintained by the National Uniform Claim Committee (NUCC) and can be found at:

<http://www.wpc-edi.com/taxonomy>.

Trading Partner – An entity that exchanges health care data or transactions.

Transaction – An electronic exchange of data between covered entities, as defined in the Transactions Rule. The covered health care provider is required to use the NPI to identify itself in mandated HIPAA standard transactions no later than the May 23, 2007 NPI compliance date. Health plans and health care clearinghouses must begin accepting and using NPIs in standard transactions by May 23, 2007 (small health plans have until May 23, 2008).

IV. Background Information from the Final Rule Regarding Subparts

The following references are from the NPI Final Rule Preamble (45 CFR Part 162, published in the Federal Register January 23, 2004).

A. The Organization’s Responsibility with Subparts

Pg. 3439: “The subparts are simply parts of the legal entity. The legal entity—the covered entity—is ultimately responsible for complying with the HIPAA rules and for ensuring that its subparts and/or health care components are in compliance. The organization health care provider, of which the subpart is a part, is responsible for ensuring that the subpart complies with the implementation specifications in this final rule. The organization health care provider is responsible for determining if its subpart or subparts must be assigned NPIs, as discussed above in this section of the preamble. The organization health care provider is also responsible for applying for NPIs for its subparts or for instructing its subparts to apply for NPIs themselves. (That is, it is not necessary that an application for an NPI be made by the organization health care provider on behalf of its subpart.)”

B. Federal Program Enrollment

Pg. 3438: “An entity that meets certain Federal statutory implementation specifications and regulations is eligible to participate in the Medicare program. Our definition of “health care provider” at § 160.103 (45 CFR) includes those eligible to participate in Medicare as described in Federal statute (that is, in § 1861(s) and § 1861(u) of the Social Security Act (42 U.S.C.)). These entities, according to Federal statute and regulations, must be issued their own identification numbers in order to bill and receive payments from Medicare. The Federal statutes and regulations similarly affect the Medicaid program.”

V. WEDI NPI Policy Advisory Group (PAG) Recommendations Related to Subparts

The following are the two recommendations specific to subparts from the NPI PAG meeting held by WEDI in June 2004. This information was pulled directly from the Letter of Recommendation to Secretary Thompson on the results of the NPI PAG, dated September 30, 2004.

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

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

Note: The CMS Office of HIPAA Standards (OHS) became the Office of E-Health Standards and Services (OEES) during the second quarter of 2005.

VI. Recommendation 10.1: Determining Subpart enumeration according to Federal Regulation and uniformly bill health plans with the chosen level of granularity.

The following information is provided by the Subparts Workgroup.

The NPI Final Rule sets the circumstances under which a covered organization provider may designate subparts for NPI assignment. Subparts function as organization providers but they are not legal entities—they are part of a legal entity. The NPI Final Rule states that the covered organization provider is responsible for determining if it has subparts and if those subparts are required by the NPI Final Rule to obtain NPIs or by other Federal regulatory requirements to have billing numbers. There is uncertainty regarding the way in which providers are enumerated today with respect to Federal regulatory requirements, such as Medicare enrollment requirements. Thus, the specific recommendation of 10.2 is for CMS’ OEES to address this.

Subpart Workgroup members provided background information, matrixes, and grids regarding how their current organizations or associations enumerate for Federal programs (e.g. Medicare). Appendix A – Subparts Matrix was created based on the

different analyses completed by Workgroup members, associations who participated and information provided in Appendix B also. The matrix is broken out into Inst (Institutional) Common, Inst Not Common, Prof (Professional) Common, Prof Not Common, and Other HC (Health Care Entities). “Common” is when most of the analyses provided agreed upon whether that type of entity would enumerate today and for which they would obtain a NPI. “Not common” were those that the analyses disagreed whether or not they “enumerate” today and receive another form of identification. A health care provider may need to make the determination whether that is a subpart designation that their organization needs.

Upon further investigation, it was documented that there is lack of uniformity among Medicare carriers in their enumeration schemas, which sometimes differed from State to State. During the discussions, some Workgroup members offered that in their experience, not all carrier enumeration requirements were based upon the Medicare program federal regulation. When this is the case, the Workgroup believes that the decision is up to the organization provider whether they want to enumerate for further granularity, based upon the Final Rule. The question arose, ‘If a provider does not enumerate to the needed specificity of the carrier (payer/plan), can the carrier (payer/plan) reject the transaction based on insufficient NPI specificity?’ If the carrier is requesting enumeration outside of Federal Regulations, the answer to this question would seem to be ‘No’, as the Final Rule precludes a health plan from requiring a provider to obtain additional NPIs (45 CFR 162.412 (b)). A health plan may not require a health care provider that has been assigned an NPI to obtain an additional NPI. This also gets to the issue of what the impact will be on payers’ adjudication business processes if the level of subpart enumeration is completely up to providers. It could also create the same scenario most providers are in today, enumerating according to each health plan’s needs to build intelligence into these identification numbers for processing.

VII. Recommendation 10.2 – CMS’ OHS to create a single source document.

The following information is provided by the Subparts Workgroup.

CMS’ Office of Financial Management provided Appendix B to the WEDI SNIP NPI Workgroup. Upon further review of the 855 Medicare Enrollment forms compared to Appendix B, there were more questions specific to the document/guidance that CMS provided.

1. Listing 1: It is not clear whether every entity type on this form is currently “enumerated” with a different Medicare provider identification number or whether this enrolls the provider’s overall organization and issues one Medicare provider identification number for the various service types checked off on the CMS 855 Enrollment form. Scenario: Health Care Provider Hospital is an Acute Care, Psychiatric, Alcohol/Drug services and Rehabilitation. Do each of these “units” get a number or is the Hospital given one provider number and is enrolled with

these different services under that number?

2. Listing 2: Appears vague regarding whether every type is enumerated or the organization as a whole, similar to Listing 1. Also, Listing 1 and 3 specifically indicate that these are enumerated for each location. Listing 2, which looks to be more of Professional types of services, does not appear to be enumerated per location.
3. Listing 3: There are some entities under this list that have enumerated under Listing 1 and 2. Does this list then indicate that the provider would get another number beyond the other two Lists?
4. The listings did not match up to the most current available CMS 855 Enrollment Forms available from CMS via their website. Note: New drafts of the 855 Enrollment forms are available for comment until September 8, 2005 and can be found at: <http://www.cms.hhs.gov/regulations/pra/>
 - a. Some provider types on the forms were not included in the listings, e.g. Multiple Hospital Component in a Medical Complex, Rehabilitation Agency (unit of a Hospital), Psychiatric Unit (of Hospital), Hospital—Long-Term (Swing-Bed unit), Physiotherapy Group
 - b. Some provider types on the listings were not on the forms, e.g. Slide preparation facility, Radiation therapy center, Ambulatory surgical center, Oxygen supplier, Rehabilitation agency
 - c. Some entities on the listings are not health care providers, e.g. grocery store, department store

When the subpart Workgroup members reviewed this information, there were some entity types, which CMS had listed as needing a subpart identification, yet the members did not necessarily agree.

This list only addresses the Medicare Federal Regulations, but section IV, B mentioned that this “similarly affects the Medicaid programs”. Are Medicaid programs then included or not? Also, by all Federal Requirements, it was asked whether this included other Federal Programs beyond Medicare – Dept. of Defense, Veterans Administration, TRICARE, etc... The Subparts Workgroup is still researching these particular issues.

VIII. CMS’ Response to the WEDI PAG Recommendations Posted to WEDI Website on 05/02/2005

The following information was taken from the CMS Response document that can be found at:

http://www.wedi.org/cmsUploads/pdfUpload/commentLetters/pub/May_2005_HHS_NPI_Reponse.pdf

10. NPI Subpart Enumeration

WEDI PAG Discussed Issue: The NPI Final Rule creates “subparts” of institutions that in certain situations need or may use their own Type 2 NPIs, but the Final Rule neither requires nor prohibits uniform practices for usage of any subpart NPIs across multiple payers. The preamble language states:

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

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

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

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

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

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

IX. Business and Implementation Issues

A. Crosswalking Identifiers, Enumeration Granularity, and Additional Information for Transactions

The NPIs assigned to providers who are organizations, subparts, and individuals will replace all current identifiers (i.e., health-plan assigned identifiers and other legacy identifiers) for covered entities, when identifying themselves in the HIPAA covered transactions. There is concern how the health plans will be able to handle the NPIs in order to continue to process transactions correctly. For further clarification regarding health plan related items, the Subparts Workgroup recommends reviewing the ["Impact of the National Provider Identifier \(NPI\) on Health Plans and Payers White Paper"](#).

1. Some health plans will be creating crosswalks between the identifiers they assigned and the NPIs, or they may enlist the help of a clearinghouse or other vendor to assist with the crosswalks.
 - a. For some health plans, there may be several health-plan assigned identifiers that will have several numbers that will be cross walked to one NPI, or there may be a need to crosswalk multiple NPIs to a single health plan-assigned identifier.
 - b. The crosswalk of numbers will depend on how the plan was using the health plan-assigned identifiers prior to using the NPI.
2. Health plans may determine that additional information along with the NPI will be required in order to process transactions correctly without the built-in intelligence that the current health plan-assigned numbers often have. Some examples are, but are not limited to:
 - a. Provider Taxonomy Code: Appendix A does indicate Taxonomy Codes that could be associated with an NPI in order to provide further clarification. This would often indicate the particular specialty. For those provider types on Appendix A without a Taxonomy Code, there will either need to be other indicators or additional Taxonomy codes requested.
 - b. Name, Address, and/or Zip Code: For those health plans that tie their current health plan numbers to locality or specific contracts for processing.

- c. Pricing/Processing Platform: Some health plans have health-plan assigned identifiers that route the transactions to one or multiple platforms to be processed. In these instances, it may be more difficult for the health plan to determine a solution.
3. For some health plans, it may become necessary to renegotiate current contracts if the information within the transaction is not sufficient to process the transaction according to current contracts.
4. In pharmacy transaction processing, the NCPDP Provider ID is the predominant method for identifying the pharmacy. The industry will move to the NPI. Currently the pharmacy industry is discussing a possible recommendation that when filling out the NPI Application/Update Form, in the “Other Provider Identification Numbers” section, the applicant send the NCPDP Provider ID in the first “Other” slot. When NPI files are sent out from the NPPES, this cross-reference of NPI to NCPDP Provider ID will be provided as cross-reference. Another white paper has been created titled “NPI and the Pharmacy Industry”. Please review that white paper for further Pharmacy/NPI related information.
5. There was a question whether or not the subpart or organization NPIs would replace certification numbers required by Federal Programs such as CLIA or Mammography numbers within transactions. We received the following information from a contact at CMS: “CLIA Numbers and Mammography Certification Numbers are not health care provider identification numbers, nor do they necessarily link 1-to-1 with health care providers. The NPI will not replace the CLIA Number or the Mammography Certification Number when those numbers are called for in HIPAA standard transactions, because the NPI does not serve the purposes that are served by CLIA Numbers and Mammography Certification Numbers.” Also, this will hold true for DEA numbers. Another white paper is being created titled “NPI and Independent Clinical Laboratories”. Please review that white paper for further NPI Laboratory Industry related information.

B. Communication

Providers and health plans will need to be able to communicate the granularity of NPI enumeration. There needs to be open discussions regarding whether the provider’s level of granularity, or lack of, will allow a smooth migration from the health plan’s current identifiers to the provider’s NPI(s). The “NPI Implementation, Timing and Sequencing White Paper” may address this in more detail.

There will also need to be communication to vendors that providers and plans use if those vendors will need to have a crosswalk of the plan’s identifiers to the NPI(s).

For internal processes, providers will need to work with all areas impacted by enumerating and using subparts in order to continue with current business practices. See the “[Impact of the NPI on Health Care Providers](#)” white paper for further impacts.

C. CMS' Response Concerns

1. Recommendation 10.1:

- a. Sentence 1 and Sentence 4: CMS states requiring that providers bill all health plans uniformly goes beyond the scope of the NPI Final Rule and that such uniform billing could cause the health plans difficulty. Reviewing the Rule, it does look like the nature of HIPAA is to address uniformity and simplification in covered transactions.

Page 3434 from the Rule states within Section I. Background: "In order to administer its programs, a health plan assigns identification numbers to its providers of health care services and its suppliers. A health plan may be, among other things, a Federal program such as Medicare, a State Medicaid program, or a private health plan. The identifiers it assigns are frequently not standardized within a single health plan or across health plans, which results in the single health care provider having different identification numbers for each health plan, and often having multiple billing numbers issued within the same health plan. This complicates the health care provider's claims submission processes and may result in the assignment of the same identification number to different health care providers by different health plans."

Also, on Page 3468, the Rule states: "After the compliance date, health care providers will no longer have to keep track of and use different identifiers with different health plans when conducting standard transactions. This should simplify health care provider billing systems and processes and reduce administrative expenses. A standard identifier should facilitate and simplify coordination of benefits, resulting in faster, more accurate payments." If the health care provider does not bill uniformly to each health plan, there will be difficulty in trying to do Coordination of Benefits for each health plan. Administrative simplification does not occur if each provider or system bills each health plan on a different NPI schema. Providers and other impacted health care entities would be in the same position as they are today in trying to administer various health plan identifiers based on different health plans.

From Page 3468, it appears that health plans are also going to benefit from this: "Upon the NPI compliance dates, health plans' coordination of benefits activities should be greatly simplified because all health plans will use a unique standard health care provider identifier for each health care provider." Although the Workgroup agrees billing at the same level of granularity will be difficult initially, as the industry continues to move forward, it should be a one-time cost impact as the Rule mentions in the Health Plan section of Page 3468.

The 'Dear Provider' letter issued by CMS on May 6, 2005 specifically included statements that support the philosophy of using the same NPI to bill all health plans.

'The National Provider Identifier (NPI) will be the single provider identifier, replacing the different provider identifiers you currently use for each health plan with which you do business.' (p. 1)

'The NPI will replace health care provider identifiers that are in use today in standard transactions. Implementation of the NPI will eliminate the need for health care providers to use different identification numbers to identify themselves when conducting standard transactions with multiple health plans.' (p. 2)

'The same NPI is used for every health plan.' (p. 3)

- b. Sentence 2: "A covered organization health care provider may decide to designate subparts along the lines of organizations that are required to have Medicare billing numbers, enabling the subparts to have NPIs." It was the understanding of this Workgroup that it was required that organization health care providers must enumerate based on Health Care Federal Regulated Programs. The above CMS response implies that the organization health care provider has a choice. The NPI Final Rule requires covered organization health care providers to be aware of any Federal regulations that require entities to obtain billing numbers in order to bill Federal health programs, such as Medicare. *Those* Federal regulations require certain providers (which might be subparts) to have billing numbers. To ensure compliance with *those* Federal regulations, covered organization health care providers would need to be sure that subparts are designated for the components of those organization providers that need billing numbers for those Federal health programs. That is why the NPI Final Rule says what it says in Sentence 2. A covered organization health care provider may designate subparts in that way, but the NPI Final Rule does not say that it must because that would translate to setting a requirement for the NPI Final Rule when the requirement lies within the Medicare Federal regulations.
2. Recommendation 10.2: The list of impacted health care entities was sent to the WEDI SNIP Workgroup. This document actually caused more questions than providing guidance. Section VI above on pages 5-6 addresses the additional questions/concerns.

X. NPI Subparts Workgroup Recommendations

A. Enumeration of Subparts

The objective of the NPI is to provide simplification for the industry in using a uniform numbering schema to identify Providers, Organizations, and subparts within the electronic transactions. In order to attain this, it is recommended that:

1. Enumerate subparts that function as covered providers but which are not legal entities.
2. Enumerate according to Federal Program Regulations. The Common Tabs (Inst, Prof) under Appendix A are good places to start.
3. While fewer NPIs may appear to provide greater efficiency when conducting business with Trading Partners, the provider has the choice beyond the Federal Regulations, based on their business needs, to identify further subparts in standard transactions. The business processes of the payer/plan, as transaction receivers, may experience significant impacts based on the variability of provider subpart enumeration decisions. The amount and type of input that payers/plans are able to have on provider subpart enumeration will directly correlate to the significance of these impacts. For Example, a health care provider organization may need to identify the business grouping within the standard transactions, such as electronic remittances. In this instance, the health care provider organization would enumerate that business grouping for a subpart NPI.
4. When enumerating for subparts, arrange services according to the business needs of the organization and enumerate subparts in that manner, if it is unable to “lump” services together under one organization NPI. Again, the business processes of the payer/plan, as transaction receivers, may experience significant impacts based on the variability of provider subpart enumeration decisions. The amount and type of input that payers/plans are able to have on provider subpart enumeration will directly correlate to the significance of these impacts.

B. Implementation

Providers should complete a full, detailed analysis and project plan prior to beginning implementation. For further clarification regarding provider related items, the Subparts Workgroup recommends reviewing the [“Impact of the NPI on Health Care Providers”](#) white paper. Providers are advised to await responses to industry questions, as outlined in Sections VII and IX, prior to implementation. The Workgroup recognizes that each provider organization must make its own business decision as to how long their project plans can wait for additional clarification, and provide example recommendations in Section XI for enumeration schema in the event organizations wish to move forward. Please refer to the “NPI Implementation, Timing and Sequencing White Paper” for recommendations on specific implementation timelines.

Additionally, given that many large provider organizations are considering electronic file interchange (EFI, also known as bulk enumeration), as their method of requesting NPIs. EFI is not anticipated until later in 2005, it may be early 2006 until organizations realistically begin enumeration.

1. Providers must communicate their intentions with their Trading Partners (which includes and is not limited to: Clearinghouses and Health Plans.). When communicating the NPIs to Trading Partners, all NPIs for the health care provider organization should be communicated.
2. Providers should use the same level of subpart NPIs in standard claims transactions to all health plans in order to facilitate better Coordination of Benefits (COB).

XI. Example of Provider Subpart Enumeration

The diagram on the following page is an example of a large complex health care system and how it may decide to enumerate. The enumeration schema is based on the common items noted in Appendix A and based on Provider business needs.

Business groupings, along with other administrative functions, manage billing systems and process remittances for the providers in the group. Enumerating with a subpart NPI is consistent with the Rule as the group is a portion of the organization that could stand alone as a separate entity providing health care.

If “Each” is indicated in the box, it means that each entity location enumerates for an NPI. Also, if the health care provider has a more simplified setup and it is solely one of these entities, it would also enumerate to receive an organization NPI. For example, you may be a Skilled Nursing Facility. The Skilled Nursing Facility would enumerate for an organization NPI.

In the following chart, the following is the scenario presented: Large complex health care system. Next to each of the entity types, the coordinating Letter/Number that is on the diagram on the page following the scenario, is notated in parenthesis.

Institutional Entities:

- 1 Institutional Business Grouping (A1)
 - 2 Hospitals – 1 subpart for each General Hospital (M1-2)
 - M2 has the following units/departments that would subpart enumerate:*
 - Acute Care (M3)
 - Psychiatric (M4)
 - Critical Access (M5)
 - Rehab Unit (M6)
 - Speech Pathology (M7)
 - Occupational Therapy (M8)
 - Alcohol & Substance Abuse (M9)

- Renal Dialysis (M10)
 - Skilled Nursing Facility (M11)
 - Nursing Facility (M12)
 - Mammography (M13)
 - Home Health Agency Sub Unit (M14)
- 1 Psych Hospital (M15)
- 1 Comprehensive Rehabilitation Facility (M16)
- 1 Rehab Agency/Hospital (M17)

- 1 Home Health Business Grouping (A2)
 - 1 Home Health Agency (M18)
 - 1 Hospice (M19)

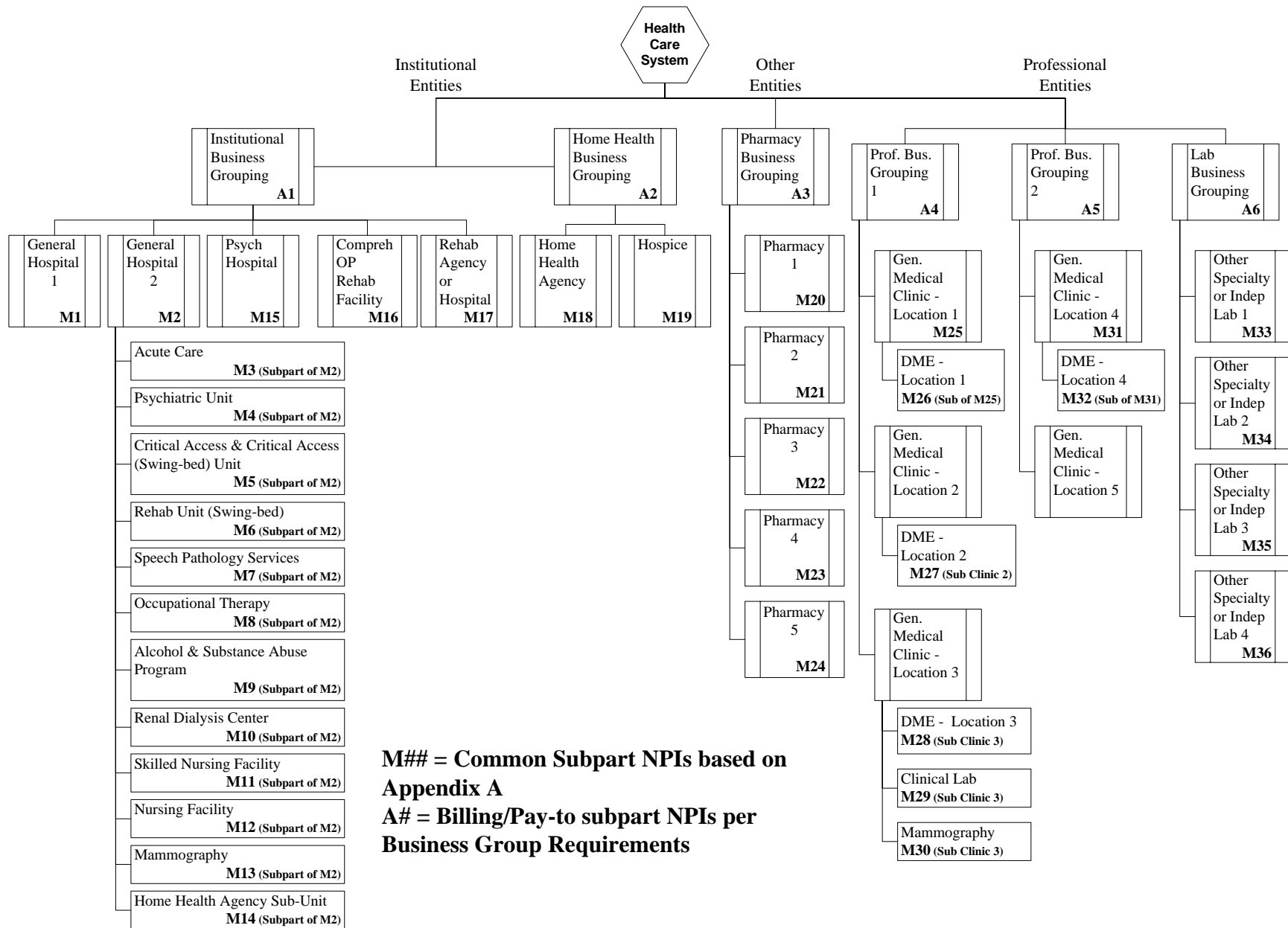
Other Healthcare Entities:

- 1 Pharmacy Business Grouping (A3)
- 5 Pharmacies (M20-M24)

Professional Entities:

- 2 Professional Business Groupings (A4-5). There are 5 clinics split between the two business groupings.
 - Prof. Bus. Grouping 1 (A4)
 - 3 General Medical Clinics – The 3 clinics share 1 Tax ID and determine beyond the 1 Subpart NPI for the 1 clinic, there is no need to enumerate each individual clinic. On the diagram, only 1 clinic is thus shown with a subpart NPI. (M25)
 - DME for each of the 3 clinics would get a NPI for each physical location. (M26-28)
 - Clinic #3 has the has these other units/departments for subpart enumeration:
 - Clinical Lab (M29)
 - Mammography (M30)
 - Prof. Bus. Grouping 2 (A5)
 - 2 General Medical Clinics – The 2 clinics share 1 Tax ID and determine beyond the 1 Subpart NPI for the 1 clinic, there is no need to enumerate each individual clinic. On the diagram, only 1 clinic is thus shown with a subpart NPI. (M31)
 - Clinic #4 under this business grouping also provides DME. (M32)
- 1 Lab Business Grouping (A6)
 - 4 Labs (M33-36)

For other listed specialty units/departments within a hospital or clinic, per the current Medicare enrollment process, these would receive an additional health plan-assigned identifier today as also shown on Appendix A. The conclusion then, is that subpart NPIs may be needed to comply with this same requirement in the future.



XII. Acknowledgements

WEDI/SNIP would like to express its appreciation to the authors for their efforts in preparing this White Paper:

Sub-work group Leaders:

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- ❑ Gail Kocher, Highmark
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- ❑ Laurie Darst, Mayo
- ❑ Larrie Dawkins, Wake Forest University Health Sciences
- ❑ Eileen M. Dock, United Healthcare
- ❑ Hope Furtado, TM Floyd & Company, LLC
- ❑ Ann Geyer, Tunitas Group
- ❑ Lynne Gilbertson, NCPDP
- ❑ Luanne Green, EDS – Wisconsin Medicaid
- ❑ Kathy Jonzzon, Delta Dental
- ❑ Laurie Juarez, Delta Dental
- ❑ Deb Legreid, WI Medicaid/DHCF
- ❑ Harvey Mintz, CSC
- ❑ Steven Moe, Group Health Cooperative
- ❑ Diana Pompa, BCBS of Arizona
- ❑ Lisa Pralle
- ❑ Pam Shomler, Medical Associates
- ❑ Janet Spear, BCBS of Minnesota
- ❑ Arlon Sturgis, EKOLU & Associates
- ❑ Patricia Tarantino, BCBS of Massachusetts
- ❑ Kristine Weinberger, ACS Inc.
- ❑ David Williams, Premera
- ❑ MaryAnne Zingaro, BCBS of Florida

Organizations Contributing to the Federal Regulation Analyses:

NCHICA NPI Workgroup
Aurora Health Care
Wake Forest University Health Sciences
Minnesota HIPAA Collaborative
Centers for Medicare & Medicaid Services

WEDI/SNIP also expresses its appreciation for the contributions, guidance, and support provided by:

- Patricia Peyton, Centers for Medicare and Medicaid Services (CMS)
- Charlie Waldhauser, Centers for Medicare and Medicaid Services (CMS)

Appendix A - Enumeration Matrix

Institutional Group Numbers (Potential Subparts) Common

**Each entity or location that is enrolled in the Medicare Program is required to have it's own Medicare Number per Medicare Doc.

HOSPITALS	TAXONOMY	TAXONOMY DEFINITION	NOTES	Medicare
General**	282N00000X	A health care organization that has a governing body, an organized medical staff and professional staff and inpatient facilities and provides medical nursing and related services for ill and injured patients 24 hrs per day, seven days per week. For licensing purposes, each state has its own definition of hospital.		XXXXXX
Acute Care**	282N00000X	An acute general hospital is an institution whose primary function is to provide inpatient diagnostic and therapeutic services for a variety of medical conditions, both surgical and non-surgical, to a wide population group. The hospital treats patients in an acute phase of illness or injury, characterized by a single episode or a fairly short duration, from which the patient returns to his or her normal or previous level of activity.		XXXXXX
Psychiatric Unit**	273R00000X	<p>In general, a distinct unit of a hospital that provides acute or long-term care to emotionally disturbed patients, including patients admitted for diagnosis and those admitted for treatment of psychiatric problems on the basis of physicians' orders and approved nursing care plans. Long-term care may include intensive supervision to the chronically mentally ill, mentally disordered or other mentally incompetent persons; (2) For Medicare, a distinct part of a general acute care hospital admitting only patients whose admission to the unit is required for active treatment, whose treatment is of an intensity that can be provided only in an inpatient hospital setting, and whose condition is described by a psychiatric principal diagnosis contained in the Third Edition of the American Psychiatric Association Diagnostic and Statistical Manual or in Chapter 5 (Mental Disorders) of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM).</p> <p>The unit must furnish, through the use of qualified personnel, psychological services, social work services, psychiatric nursing, occupational therapy, and recreational therapy. The unit must maintain medical records that permit determination of the degree and intensity of treatment provided to individuals who are furnished services in the unit; the unit must meet special staff requirements in that the unit must have adequate numbers of qualified professional and supportive staff to evaluate inpatients, formulate written, individualized, comprehensive treatment plans, provide active treatment measures and engage in discharge planning.</p>	Excluded from PPS (The Prospective Payment System.).	XXXXXX
Psychiatric Hospital	283Q00000X	An organization including a physical plant and personnel that provides multidisciplinary diagnostic and treatment mental health services to patients requiring the safety, security, and shelter of the inpatient or partial hospitalization settings.		

HOSPITALS	TAXONOMY	TAXONOMY DEFINITION	NOTES	Medicare
Rehabilitation Unit (Swing-Bed)	273Y00000X	<p>In general, a distinct unit of a general acute care hospital that provides care encompassing a comprehensive array of restoration services for the disabled and all support services necessary to help patients attain their maximum functional capacity. Source: AHA Annual Survey p. A10 1996 AHA Guide. For Medicare, a distinct part of a general acute care hospital providing inpatient rehabilitation services that meets the following requirements. Rehabilitation Units have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient program or assessment; ensure that the patients receive close medical supervision and furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy and occupational therapy, plus, as needed, speech therapy, social services or psychological services and orthotic and prosthetic services; have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician</p> <p>in consultation with other professional personnel who provide services to the patient; use a coordinated multidisciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment , and that team conferences are held at least every two weeks to determine the appropriateness of treatment; have a director of rehabilitation who provides services to the unit and its inpatients for at least 20 hours a week, is a doctor of medicine or osteopathy, is licensed under State law to practice medicine or surgery, and has had, after completing a one-year hospital internship at least two years of training or experience in the medical management of inpatients requiring rehabilitation services.</p>	Excluded from PPS.	XXXXXX
Rehabilitation Agency or Hospital	283X00000X	A hospital or facility that provides health-related, social and/or vocational services to disabled persons to help them attain their maximum functional capacity.		XXXXXX
Speech Pathology Services	284300000X		Procedure types not hospital specialty, so possible Special Hospital	XXXXXX
Occupational Therapy	284300000X		Procedure types not hospital specialty, so possible Special Hospital	XXXXXX
Mammography	261QR0206X			XXXXXX
Critical Access**	282NC0060X	Definition to come.		XXXXXX
Critical Access (Swing-Bed Unit)**	275N00000X	Medicare Defined Swing Bed Unit - A unit of a hospital that has a Medicare provider agreement and has been granted approval from HCFA to provide post-hospital extended care services and be reimbursed as a swing-bed unit.		XXXXXX

HOSPITALS	TAXONOMY	TAXONOMY DEFINITION	NOTES	Medicare
Alcohol & Substance Abuse Program**	276400000X, 324500000X	276400000X: A distinct part of a hospital that provides medically monitored, interdisciplinary addiction-focused treatment to patients/clients who have psychoactive substance use disorders (commonly referred to as alcohol and drug abuse or substance abuse.). 324500000X: A facility or distinct part of a facility that provides a 24 hr therapeutically planned living and rehabilitative intervention environment for the treatment of individuals with disorders in the abuse of drugs, alcohol, and other substances.		XXXXXX
Renal Dialysis Center**	261QE0700X			XXXXXX
In-Patient	282N00000X			
OTHER INSTITUTIONAL TYPES				
Hospice	315D00000X - Inpatient 251G00000X - Community Based	Inpatient - A provider organization, or distinct part of the organization, which renders an interdisciplinary program providing palliative care, chiefly medical relief of pain and supporting services, which addresses the emotional, social, financial, and legal needs of terminally ill patients and their families where an institutional care environment is required for the patient. Community Based - Definition to come.		XXXXXX
Skilled Nursing Facility	314000000X	(1) A skilled nursing facility is a facility or distinct part of an institution whose primary function is to provide medical, continuous nursing, and other health and social services to patients who are not in an acute phase of illness requiring services in a hospital, but who require primary restorative or skilled nursing services on an inpatient basis above the level of intermediate or custodial care in order to reach a degree of body functioning to permit self care in essential daily living. It meets any licensing or certification standards set forth by the jurisdiction where it is located. A skilled nursing facility may be a freestanding facility or part of a hospital that has been certified by Medicare to admit patients requiring subacute care and rehabilitation; (2) Provides non-acute medical and skilled nursing care services, therapy and social services under the supervision of a licensed registered nurse on a 24-hour basis.	These organizations have in effect an agreement to participate in Medicare. If any of these are incorporated, then it's an Organization. If not incorporated on it's own, then these could be considered Subparts.	XXXXXX
Nursing Facility	313M00000X	An institution (or a distinct part of an institution) which- (1) is primarily engaged in providing to residents- (A) skilled nursing care and related services for residents who require medical or nursing care, (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases; (2) has in effect a transfer agreement with one or more hospitals.		XXXXXX
Home Health Agency	251E00000X	Definition to come.		XXXXXX
Home Health Agency - Including Sub-unit		Medicare had this broken out differently.		XXXXXX
Comprehensive Outpatient Rehab Facility	261QR0401X			XXXXXX

APPENDIX B

Medicare Regulations for Health Care Provider Billing Numbers Date prepared: 12/04 by CMS Central Office

The Workgroup for Electronic Data Interchange (WEDI) requested that CMS provide a listing of the types of health care providers that are required by Federal regulations to be assigned numbers for use as billing numbers in the Medicare program. In response to WEDI's request, three listings are attached:

- Listing 1 is a list of health care provider types who send their Medicare claims to fiscal intermediaries.
- Listing 2 is a list of health care provider types who send their Medicare claims to carriers.
- Listing 3 is a list of health care provider types who send their Medicare claims to durable medical equipment regional carriers (DMERCs).

WEDI believes that this information may be useful to covered organization health care providers in determining the designation of subparts (as described in the NPI Final Rule), as the entities appearing in these listings might equate to components of covered organization health care providers that could be designated as subparts.

Listing 1: *Entities that must have billing numbers for claims to be processed by Medicare fiscal intermediaries:*

- Community mental health center
- Comprehensive outpatient rehabilitation facility
- End-stage renal disease facility
- Federally-qualified health center (FQHC)
- Histocompatibility laboratory
- Home health agency
- Home health agency (subunit)
- Hospice
- Hospital¹
 - General
 - Alcohol/drug
 - Acute care
 - Children’s (excluded from PPS)
 - Critical access
 - Critical access (swing-bed unit)
 - Long-term (excluded from PPS)
 - Psychiatric (excluded from PPS)
 - Short-term (general and specialty)
 - Short-term (swing-bed unit)
 - Rehabilitation (excluded from PPS)
 - Rehabilitation (swing-bed unit)
- Indian Health Service facility
- Organ procurement organization
- Occupational therapy facility
- Outpatient physical therapy
- Religious non-medical health care institution (RNHCI)
- Rural health clinic
- Skilled nursing facility
- Speech pathology facility

¹ Each “Hospital” and each entity listed under “Hospital” that is enrolled in the Medicare program is required to have its own Medicare billing number.

Listing 2: *Entities that must have billing numbers for claims to be processed by Medicare Part B carriers:*

Ambulatory surgical center
Ambulance service supplier
Community mental health center
Hospital department
Independent clinical laboratory
Independent diagnostic testing facility
Mammography screening center
Managed care plan (non-Medicare + Choice [non-Medicare Advantage])
Mass immunization roster biller only
Medical faculty practice plan
Medicare + Choice (now known as Medicare Advantage) organization
Multi-specialty clinic or group practice
Occupational therapy group
Other medical care group
Physical therapy group
Portable X-ray facility
Public health/welfare agency
Radiation therapy center
Rural health clinic
Single-specialty clinic or group practice
Slide preparation facility
Voluntary health/charitable agency

Listing 3: *Entities (suppliers of durable medical equipment, prosthetics, orthotics, or supplies) that must have billing numbers for claims to be processed by Durable Medical Equipment Regional Carriers (DMERCs):^{2 3}*

Ambulatory surgical center
Grocery store
Home health agency
Hospital
Intermediate care nursing facility
Medical supply company
Medical supply company with orthotics personnel
Medical supply company with prosthetics personnel
Medical supply company with registered pharmacist
Medical supply company with respiratory therapist
Medicare + Choice organization (now known as Medicare Advantage)
Managed care plan (non-Medicare + Choice [now known as Medicare Advantage])
Nursing facility (Other)
Oxygen supplier
Pharmacy
Rehabilitation agency
Skilled nursing facility
Department store

² Each separate physical location of these entities must have its own Medicare billing number.

³ The Medicare program permits certain individuals (i.e., optometrists, opticians, prosthetists, orthotists, occupational therapists, physical therapists, and physicians) to enroll, as individuals, in the Medicare program as “suppliers of DME, prosthetics, orthotics, or supplies.” We have excluded these practitioners from Listing 3 because they are individuals and, as such, would not be eligible to be considered subparts of organization health care providers.